

**FINANCIAL MANAGEMENT INFORMATION  
AND ACCOUNTABILITY**



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## FINANCIAL MANAGEMENT INFORMATION AND ACCOUNTABILITY

### FINANCIAL MANAGEMENT RESPONSIBILITY

The responsibility for financial management and related activities at HHS is delegated to the Assistant Secretary for Management and Budget (ASMB), who also serves as the Chief Financial Officer (CFO) and the Chief Information Officer (CIO). The Office of the CFO at HHS was established within the Office of the Secretary as a result of the Chief Financial Officers Act of 1990. The HHS CFO is appointed by the President and confirmed by the Senate. The HHS career Deputy CFO, a Deputy Assistant Secretary, heads the Office of Finance (OF). Other offices reporting to the ASMB include the Office of Grants and Acquisition Management (OGAM), the Office of Budget, the Office Information Resource Management (OIRM), the Office of Human Resources (OHR), and the Administrative Services Center (ASC). This section of the HHS FY 1996 Annual Accountability Report provides highlights of various financial management and related activities.

Financial management responsibility also rests with the CFOs of the HHS Operating Divisions (OPDIVs). The OPDIV CFO Offices were established to further implement the CFO Act.

### FINANCIAL MANAGEMENT POLICY AND PLANNING

The Office of Finance has responsibility for many new and ongoing initiatives such as developing and implementing accounting and financial policies, systems and reports; implementing financial and program performance measurement; prompt payment; budget execution; improving reliability of financial information, implementing debt collection, implementing all financial management legislation, and integrating all of the financial management initiatives. These initiatives are coordinated with the various OPDIVs of HHS through the policy-level HHS CFO Council and the operational-level Financial Policies Group (FPG). Accounting

operations were moved from the Office of Finance to the Program Support Center (PSC) in HHS' 1995 reorganization. PSC provides administrative services for most of the HHS OPDIVs.

Information exchange among all financial management staff at HHS has been expanded and improved with the installation of electronic mail systems and internet access. ASMB has established Home Pages on the world wide web for internal and external users. The address for external users is [<http://www.hhs.gov/progorg/asmb/asmbhome.htm>].

HHS is involved in financial policy formulation at the governmentwide level through participation in the U.S. CFO Council and its work groups and the Federal Accounting Standards Advisory Board (FASAB) task forces.

In recent years, there has been an expanding list of financial management legislation. Implementation of this legislation requires intensified efforts in the areas of systems development, financial reporting, debt collection, inter-agency cooperation, policy development, and monitoring activities. These intensified efforts are being accomplished in an environment of reduced staffing, hiring freezes, and cost containment. The list of financial management legislation includes:

- Prompt Pay Act of 1982
- Federal Managers Financial Integrity Act (FMFIA) of 1982
- Chief Financial Officers (CFOs) Act of 1990
- Cash Management Improvement Act (CMIA) of 1990
- Government Performance and Results Act (GPRA) of 1993
- Government Management Reform Act (GMRA) of 1994
- Federal Financial Management Improvement Act (FFMIA) of 1996
- Debt Collection Improvement Act (DCIA) of 1996
- Information Technology Management Reform Act (ITMRA) of 1996

The Office of Finance publishes (and posts on the internet) HHS' annual Financial Management Status Report and Five Year Plan. The report details the status of and plans for the broad array of financial management initiatives and ongoing work projects in the financial management arena. The information contained in the Five Year Plan may eventually be included in the HHS Annual Accountability Report in future efforts to streamline reporting.

**FINANCIAL REPORTING AND ACCOUNTING STANDARDS**

**Audited Financial Statements**

This HHS FY 1996 Annual Accountability Report includes the first-ever Departmentwide audited

financial statement, in compliance with the Government Management Reform Act (GMRA) of 1994. The statements are discussed in the section of this report entitled "Financial Management Information and Accountability." The Departmentwide statements were produced by combining the OPDIV financial statements; elimination of inter-entity transactions was not possible, though the ability to identify and eliminate inter-entity transactions is a goal of the FY 1997 financial statements. In FY 1996, audit coverage was significantly expanded to include OPDIVs representing 99.6% of HHS' total assets, though in the cases of CDC and NIH the audit work resulted in a management letter, and in the case of HCFA the auditor disclaimed an opinion. A synopsis of the audit work and opinions rendered for 1995 and 1996 is presented below.

**Financial Statements**

Entity	FY 1995			FY 1996		
	Prepared	Scope of Review/Audit	Report/Opinion Rendered	Prepared	Scope of Review/Audit	Report/Opinion Rendered
Departmentwide	Prototype - combined	Unaudited	No	Yes - combined	Full Scope	Disclaimer
HCFA	Yes	Limited Scope (Balance Sheet only)	Disclaimer	Yes	Full Scope	Disclaimer
ACF*	Yes	Pre-audit survey	Management Report	Yes	Full Scope	Qualified
NIH	Yes	N/A	N/A	Yes	Internal Control Assessment	Management Report
HRSA*	Yes	N/A	N/A	Yes	Full Scope	Qualified
CDC/ATSDR	Yes	N/A	N/A	Yes	Internal Control Assessment	Management Report
SAMHSA*	Yes	N/A	N/A	Yes	Full Scope	Qualified
IHS*	Yes	Limited Scope (Balance Sheet only)	Disclaimer	Yes	Full Scope	Qualified
FDA	Yes	Pre-audit survey	No	Yes	Full Scope	Qualified
AoA*	Yes	N/A	N/A	Yes	N/A	N/A
AHCPR*	Yes	N/A	N/A	Yes	N/A	N/A
OS*	Yes	N/A	N/A	Yes	N/A	N/A

\* Serviced by Program Support Center (PSC). Reviews of the "processing of transactions by service organizations" (based on Statements of Auditing Standards No. 70 ("SAS 70")) were performed in FY 1996 for the following cross-servicing systems: PSC Accounting Systems, NIH Computer Center, PSC Payroll System, PSC Parklawn Computer Center, PSC Payment Management Service.

HHS has benefited substantially from the financial statement audit processes instituted since the CFOs Act of 1990 (See accompanying information box on "Benefits of Audited Financial Statements."). For example, we have improved our internal controls in our computer centers, identified cross-cutting accounting problems, and identified an error rate for Medicare fee-for-service claims.

### **Limitations of the Financial Statements**

In accordance with OMB Bulletin 94-01, "Form and Content of Agency Financial Statements," we are disclosing the following limitations of the HHS FY 1996 financial statements, which are contained in this accountability report.

- The financial statements have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of the Chief Financial Officers (CFOs) Act of 1990 as amended by the Government Management Reform Act of 1994.
- While statements have been prepared from HHS' books and records in accordance with the formats prescribed by OMB, the statements are different from the financial reports used to monitor and control budgetary resources which are prepared from the same books and records.
- The statement should be read with the realization that they are for a component of a sovereign entity, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation, and the payment of all liabilities other than for contracts can be abrogated by the sovereign entity.

Since this is our first Departmentwide audit opinion, we wanted to explain to our stakeholders the significance of the disclaimer opinion we obtained, as well as the "clean opinion," we are striving for in the future. The FY 1996 "disclaimer of opinion" from our auditors, the OIG, means that the audit did not provide sufficient audit evidence for the auditors to render an opinion on the fairness of the financial statements. This is due largely to weaknesses identified in the HCFA audit, which are described later in this report.

One of the most significant findings in the FY 1996 audit process has been the significantly high error rate in Medicare's fee-for-service claims. The substantial sums involved (estimated between \$17.8 and \$28.6 billion) have been addressed in a management action plan, as explained in other sections of this report.

We are striving for an unqualified, or "clean," audit opinion; meaning that our financial statements "*fairly present*" the financial position and results of operations for the period, in accordance with Generally Accepted Accounting Principles (GAAP) as defined for the Federal Government (or FedGAAP). It is the same level of assurance provided by auditors of publicly-traded companies.

We have many ongoing efforts aimed at improving the accuracy of all of our accounting records — down to the transaction level, which form the basis of our Departmentwide financial statements. You will read about these efforts at appropriate points throughout this report and in our HHS annual Financial Management Status Report and Five Year Plan.

Additionally, we note that the U.S. Department of the Treasury, which maintains the Medicare Trust Funds as custodial accounts, had the Treasury OIG conduct a limited scope audit of both the Medicare Part A and Medicare Part B Trust Funds' financial statements. Both audits resulted in "clean" opinions. Those trust fund balances are reflected as assets on both HCFA's and HHS's financial statements. (On the FY 1997 consolidated governmentwide financial statements, HHS's assets and Treasury's liabilities related to the trust funds would be eliminated.)

The General Accounting Office participated in some aspects of the FY 1996 financial statement audit. For the FY 1997 financial statement audit, GAO will conduct audit work related to the first-ever Governmentwide (executive branch) financial statement audit, such as reviewing the audit work of both the HHS OIG and the private sector auditors.

### **Benefits of Audited Financial Statements**

In the years since the CFOs Act began requiring audited financial statements of selected Federal entities, HHS has welcomed and benefited from the audits. We believe that financial statement audits result in more than just a piece of paper with an auditor's opinion on it. Entities subjected to financial statement audits get an unbiased third party evaluation of financial management processes, internal controls, and financial information systems, all of which are the source of information presented in the financial statements. The auditor also attests to the fairness of the information presented in the financial statement.

Often, auditors cite weaknesses in old systems and processes that had gone unrecognized by busy managers. Sometimes, auditors cite weaknesses that managers were aware of, but did not have the resources to fix. When an independent third party reports that a weakness is significant enough to have an impact on the reliability of the entity's financial operations, it helps management to properly prioritize resources among competing activities and helps to ensure that problem areas are appropriately addressed.

At HHS, we have benefited in many ways from the financial audit process and the findings of our auditors. Without the financial statement audit process, these issues may not have come to light, and we might not have had the opportunity to better manage our dollars and our programs. Here are just a few of the benefits we have seen from the financial statement audits at HHS in the last several years:

- Identification of weaknesses in several OPDIVs in cross-cutting areas such as accounting for property, weaknesses in electronic data processing (EDP) controls, and accounting for grants that had gone undetected for years.
- Broader-based management's commitment toward timely implementation of corrective action plans, motivated by the public nature of the audit reports and statutory reporting deadlines.
- Effective deterrence to fraud, waste, abuse, or negligence. (The HCFA 1996 audit resulted in the first statistical-sampled-based estimate of errors in Medicare claims payments, a rate that turned out to be quite significant, requiring immediate management attention.)
- Encouragement of greater accountability, maintenance of internal controls, and adherence to policies, procedures, and standards.
- Institutionalization of annual financial statement reporting to the public, improved reliance on financial information, and greater accountability for our share of Federal dollars.

Financial management at HHS has seen significant gains since the passage of the CFOs Act of 1990, and we have witnessed some very real benefits from the audit process. We believe taxpayers are entitled to expect that their Federal Government can properly account for the billions of tax dollars and other funds entrusted to it, and we are committed to doing our part by working toward a "clean" opinion on the HHS financial statements.

## **New Accounting Standards**

In FY 1996, there were no new accounting standards to be implemented. However, in FY 1997 HHS will be implementing SFFAS Nos. 4 and 5, “Managerial Cost Accounting Concepts and Standards,” and “Accounting for Liabilities of the Federal Government,” respectively. HHS expects to be in compliance with both standards for FY 1997. HHS is represented on the U.S. CFO Council’s task force which is addressing the challenges of implementing the cost accounting standard. The Office of Finance is implementing these new standards by revising the Departmental Accounting Manual (DAM), and working with Financial Policies Group sub-groups.

HHS is involved with the development of accounting standards, with representation on various Federal Accounting Standards Advisory Board (FASAB) and Standard General Ledger (SGL) task forces. In the immediate future, HHS will be particularly involved in the development of the standard for disclosing information about the Medicare Trust Funds. Standards will be developed both at the Departmental level (where Medicare Trust Fund assets are shown as investments in Treasury Securities) and at the Governmentwide level (where the inter-entity eliminations process will likely net to zero the Medicare Trust Fund Investments and the Treasury debt to the Trust Funds).

## **Report Streamlining**

This Annual Accountability Report has been designed to include summaries from various financial management reports. In the future, as part of the U.S. CFO Council streamlining effort, HHS may decide that the summaries provided in the Annual Accountability Reports will serve to replace the separate reporting processes. This report incorporates information from the following reports into one streamlined Annual Accountability Report.

- Audited Financial Statements
- Auditor’s Opinion
- Program and Financial Performance Reporting
- Budgetary reporting and information
- Federal Managers Financial Integrity Act (FMFIA)
- Prompt Payment Reporting
- OIG Semiannual Report
- OIG Orange Book
- OIG Red Book
- Management Report on Final Action
- Healthy People 2000 and other health statistics

## MANAGEMENT INTEGRITY, INTERNAL CONTROLS, AND AUDIT RESOLUTION

Management's control over HHS' processes, programs, systems, and funds are evaluated in several different ways. Briefly, the evaluations or reviews are performed via: 1) the review of internal control weaknesses under the Federal Managers' Financial Integrity Act (FMFIA), 2) the financial statement audits performed under the Government Management Reform Act (GMRA), and 3) the various audits and reviews of the Office of Inspector General compiled in the Orange Book, Red Book, and Semiannual reports. Summaries and comparisons of these findings are presented in Appendices to this Accountability Report. The audited financial statements are presented in Section III of this report, followed by the auditors' report in Section IV.

In the first Departmentwide financial statement audit, conducted for FY 1996, there were seven scope limitations (including instances of insufficient audit evidence) which precluded the auditor (the OIG) from expressing an opinion on the financial statements. This disclaimer of opinion is largely due to issues related to HCFA, since all other OPDIV audits received qualified opinions. The auditor also identified five categories of material internal control weaknesses (two of which contributed to the disclaimer of opinion) in FY 1996.

HHS FY 1996 Audit Issues		
Issue Category	Scope Limitation* Causing Disclaimer of Opinion	Material Weakness
Medicare Accounts Payable	√	√ **
SMI Revenue	√	
Medicare/Medicaid Accounts Receivable	√	√ **
Cost Reports	√	
Net Position Balance	√	√
Pension Liability	√	
Initial Audit	√	
Electronic Data Processing (EDP) Controls		√
Grants Oversight and Accounting		√
Monitoring National Compliance (Claims Error Rate)		√

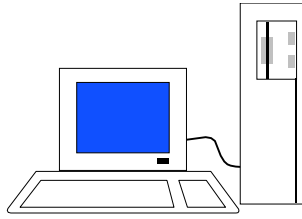
\*Including insufficient audit evidence.

\*\*Consolidated into one material weakness citing both accounts payable and receivable.

The auditor's report on the FY 1996 HHS financial statements provides details on the audit findings for both the Departmentwide and the OPDIV audits. As this Accountability Report is intended to report on past activities, it will not contain details of action plans to correct these findings which will be implemented by management. However, we expect that several of the FY 1996 scope issues to be resolved in FY 1997, including those categories of SMI revenue, net position, pension liability, and initial audit. Most of the more challenging issues are found at HCFA and include the claims error rate, accounts payable and receivable, and cost reports. Management has developed corrective action plans for these complex issues.

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## INFORMATION RESOURCES MANAGEMENT AND FINANCIAL INFORMATION SYSTEMS



The HHS Offices of Finance and Information Resources Management are working to improve the automated systems environment and technology, in part by applying the requirements for performance and results-based management, capital planning, and investment review contained in the Information Technology Management Reform Act (ITMRA) of 1996. The Deputy Chief Information Officer chairs the Departmental investment review board, and the Deputy Chief Financial Officer is a member. Plans are in the process of being developed for the implementation of the ITMRA in FY 1997.

The improvement of financial management systems continues to be one of HHS' highest priorities. Accordingly, the Department expends significant resources to improve the operation and development of financial policy and participates on numerous committees impacting financial management systems.

In FY 1995, HHS took steps to reduce its duplication of information systems, and centralized functions at the newly-formed Program Support Center (PSC). PSC is providing support services, including information systems and data processing, for the majority of HHS' OPDIVs, while HCFA (which accounts for the majority of HHS dollars), NIH, FDA, and CDC perform their own accounting.

In 1996, HHS continued expansion of the Financial Information Reporting System (FIRS) database. The primary objective of FIRS is to provide an improved methodology of determining the estimated outlays for the "pooled" appropriations that are processed through the Payment Management Service. "Pooled" appropriations are

grant dollars drawn down by the grantee with no identification of which documents (programs) to which the amounts should be allocated. This is allowed because many grantees are recipients of numerous grant awards in multiple programs. On a quarterly basis, information on accurate allocations of dollars spent are provided to HHS by the grantees and the "pooled" estimates and accounting records are adjusted and allocated appropriately. Better access to information on "pooled" appropriations drawdowns by grantees facilitates improved outlay estimations for budgeting staff. Eventually, HHS plans for FIRS to have query capability for financial information arrayed along budgetary lines.

The Department's financial management systems are integrated. Financial information is electronically transmitted between the centralized systems and the OPDIVs' accounting systems. Four cross-servicing systems at the Program Support Center (PSC) received SAS 70 reviews in FY 1996, and no significant findings were reported. These SAS 70 reviews enable OPDIVs and external customers to place reliance on the internal controls of those central systems.

In anticipation of the Year 2000, most of the HHS OPDIVs have developed a schedule for implementing solutions to the Year 2000 problems. HHS has over one thousand major applications, and the cost of conversion of most of those systems will be absorbed into existing budgets. HHS estimates that its Year 2000 conversion costs over FYs 1997 - 2000 will be \$90.7 million.

Cost accounting is one of the many issues that will have an impact on the Department's financial systems. HHS is currently exploring the current system capabilities that are available to meet the cost accounting requirement. As GPRA programs are defined, HHS will look to the Common

Accounting Number (CAN) to be able to report cost by program. Plans will be finalized as guidance is issued by JFMIP and the CFO Council.

HHS will continue to identify opportunities to streamline and consolidate operations in the financial management arena. The use of front-end modules that provide an automated feed to accounting systems will be pursued. Also, planning for systems changes required by OMB, GAO, and Treasury will be a coordinated effort through the HHS Financial Policy Group to determine the best methods to implement required changes to Departmental financial management systems. HHS will continue to be involved in governmentwide policy groups to remain abreast of and to influence required changes. The Five Year Plan includes the implementation of these changes and portrays a realistic approach based on available resources.

HHS is taking steps to improve the coordination of national health statistics gathered by organizations nationwide and by the OPDIVs through the formation of the Data Council. The work of the Data Council will facilitate better analysis and monitoring of statistics on the health and well-being of the population, especially with respect to the impact of changes in health and human services programs.

### **Medicare Transaction System (MTS)**

The Medicare Transaction System (MTS) initiative is an effort to develop and implement a single, automated Medicare payment processing system and replace the nine different systems now in use. By implementing one single, standardized automated information system, HCFA expects to vastly improve the efficiency and quality of Medicare operations saving \$200 million annually in administrative costs; improve the oversight of Medicare intermediaries and carriers; and increase the effectiveness of program safeguards against waste, fraud and abuse. It is the most significant infrastructure change HCFA has ever undertaken and is daunting and more complex than originally

contemplated. HCFA has learned a great deal in the past three years about ways to improve the management of complicated technology projects with significant assistance from GAO. HCFA's recent decisions to issue a stop work order to the MTS software developer and to reassess the MTS development strategy are examples of prudent project management. HCFA is acutely aware of both the visibility of projects such as these and the responsibility inherent in the investment of public funds. HCFA will continue to analyze the cost and savings of MTS development strategies and will include calculations of return on investment (ROI). HCFA's current reassessment of MTS development strategies will include an economic and risk analysis of alternative development strategies. Concurrent with MTS development efforts, HCFA is moving to a standard Medicare A and B system for ongoing claims processing to ensure early project savings available from the elimination of systems and data centers.

### **Electronic Funds Transfer Implementation (EFT)**

HHS participates in the governmentwide electronic funds transfer (EFT) implementation plan to meet legislated EFT goals. It is mandated that all Federal payments be made via EFT by January 1999. In FY 1996, our progress toward EFT goals included:

- EFT capabilities in all OPDIVs
- Increased EFT payments to vendors and travelers
- Implemented a quarterly report from OPDIVs of status of EFT payments
- 99% of PSC payments to grantees through EFT
- 94% of PSC salary payments through EFT
- Increased use of credit cards
- Draft EFT Implementation Plan to Treasury.

### **Electronic Benefits Transfer (EBT)**

The May 1994 Report to the Vice President provided the blueprint for implementing a nationwide EBT System by March 1999 that

provides Federal and State program beneficiaries access to their benefits. According to the Report, the goal of EBT is to use one card, which is user-friendly to provide unified electronic delivery of benefits under a federal-State partnership. In FY 1996, OMB transferred responsibility to GSA for coordinating Electronic Commerce (EC) initiatives governmentwide with agencies with a significant investment in EC, including HHS. OMB broadly defined EC to include the Electronic Benefits Transfer Program (EBT), formerly under the Federal EBT Task Force, whose functions were transferred to GSA. GSA has stated that its new role in EBT is as an agent for the participating agencies, and that GSA would leave program policy to the program agencies, including the Department of Agriculture's Food and Consumer Service (USDA/FCS), which is the lead program agency for EBT, along with OMB and Treasury.

As one of the EBT Principals along with OMB, Treasury, GSA and the USDA/FCS, HHS continues to actively support the Vice President's goal of nationwide EBT. However, due to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which eliminated the Aid to Families with Dependent Children (AFDC) program replacing it with the Temporary Assistance to Needy Families (TANF) Block Grant, the Administration for Children and Families (ACF) has no ongoing role in EBT implementation. From a CFO perspective, the Department is working with ACF with regard to the preparation of ACF's first financial statements for FY 1996 under the Government Management Reform Act (GMRA), which will include the TANF program. HHS also continues to keep apprised of EBT policies for their potential impact on States with regard to state-administered HHS programs including TANF.

The Office of Inspector General, since the inception of the EBT program, has also been active in its implementation. As a member of the governmentwide EBT Risk Management Forum, OIG is helping to ensure that necessary control and accountability measures are installed in the system to prevent fraud and abuse and to promote effective, efficient and cost conscious delivery of benefits to recipients. This includes recommending card security measures and developing risk assessments. Currently, the OIG is working with other OIGs in the audit work group led by the Department of Agriculture OIG to develop system audit procedures for reviewing EBT benefit cards, access controls, processing controls, security management, payment controls and performance measures.

HHS is also participating in a GSA-supported contractor effort with the Western Governors' Association (WGA), on implementing EBT pilot programs under the WGA's Health Passport Program in several western states (Wyoming, Nevada, and North Dakota). The pilots are scheduled to begin in 1998. This pilot effort involves the Medicaid program, as well as Head Start, Maternal and Child Health and CDC programs, in addition to the Agriculture Department's Women, Infants and Children (WIC) Program. GSA says that HHS program offices (HCFA, ACF, PHS, CDC) will be directly involved in the pilots, in addition to Agriculture and the Urban Institute which is doing the evaluation of the pilots. GSA is also working with the Social Security Administration, the Departments of Education and Veterans Affairs, and others to gather information about potential applications in those areas which may have some limited interface with HHS programs.

## FINANCIAL ANALYSIS AND INTERPRETATION

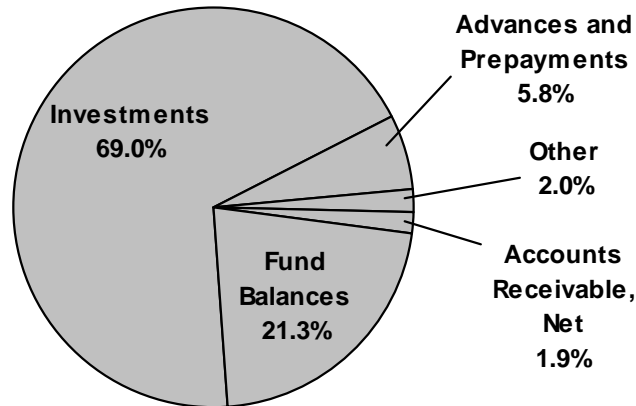
### Analysis of Financial Position (Balance Sheet)

In this Annual Accountability Report, HHS is presenting its Statement of Financial Position, as of the fiscal year end for 1995 (unaudited) and 1996 (audited). It is made up of three principal components; assets, liabilities and net position and is similar to the balance sheet in the private sector; total assets less total liabilities owed equals net position (also called fund balance). Readers are encouraged to refer to Section III of this report for the financial statements.

#### *Assets*

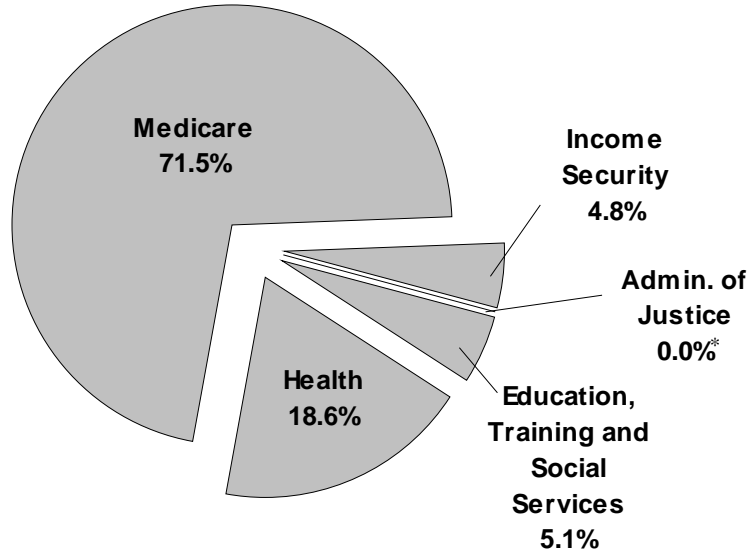
HHS had approximately \$221 billion in total assets at fiscal year end (FYE) 1996, compared to \$218 billion at FYE 1995 (unaudited). Assets can be analyzed from three perspectives: type, budget function, and OPDIV. Each perspective reveals information about the composition and concentrations in assets. Investments account for the bulk of assets (categorized by type), followed by Fund Balances and Advances and Prepayments.

### HHS FYE 1996 Assets by Type



When assets are analyzed by budget function, Medicare, which has its own budget function category, appears very similar in size (71% of assets) to the investments when assets are grouped by type. This is because the Medicare program holds title to the Investments in Treasury Securities. The Health function (which covers the Medicaid program, NIH, HRSA, CDC, SAMHSA, IHS, FDA, and AHCPR) accounts for almost 19% of HHS' assets.

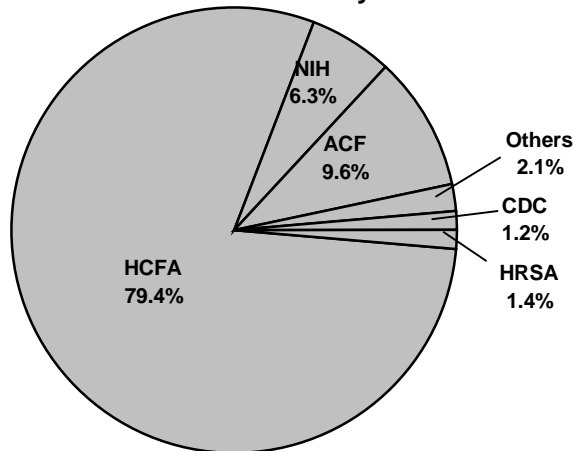
### HHS FYE 1996 Assets by Budget Function



\* Less than .1%

When assets are analyzed by OPDIV, HCFA accounts for 79% of HHS' assets due largely to Medicare Trust Fund Investments in Treasury Securities and receivables. With almost ten percent and six percent of HHS' assets respectively, ACF and NIH assets are largely invested in Fund Balance with Treasury and Advances to the Public (which are related to grants).

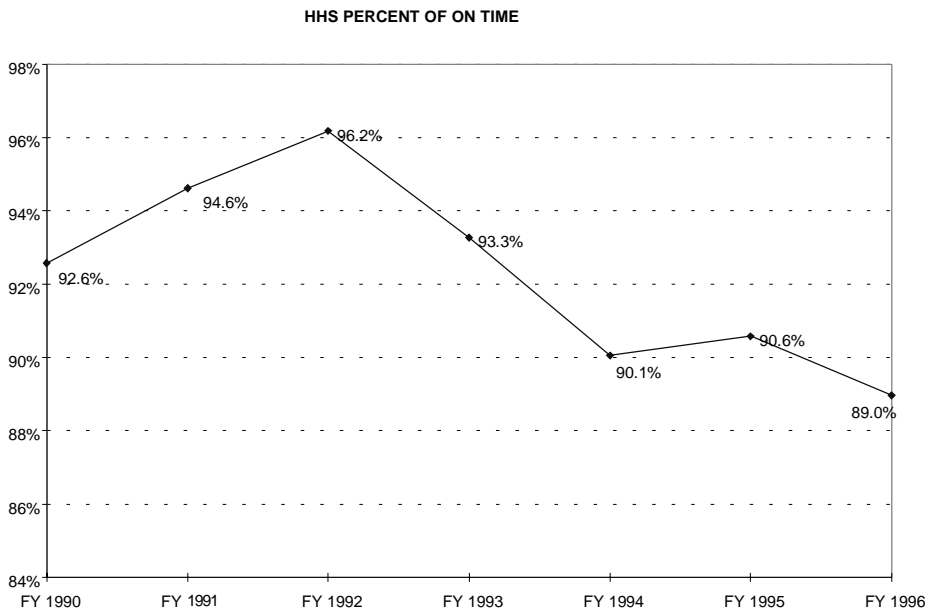
### HHS FYE 1996 Assets by OPDIV



*Cash Management and Prompt Payment.* Fund Balance at Treasury, the equivalent of “cash in bank” accounted for 21% of total assets. One of the most important aspects of managing cash is the prompt payment of invoices and other payables in order to minimize the payment of interest and penalties. During FY 1996, HHS:

- paid 1.3 million vendor invoices valued at \$3.1 billion
- paid 89% of these invoices on time, compared to 90.6% in 1995
- paid interest penalties of \$630,868, on 3.8% of vendor payments
- paid an average penalty of only \$13.56, and an average of \$206 in penalties for every \$1 million in vendor payments.

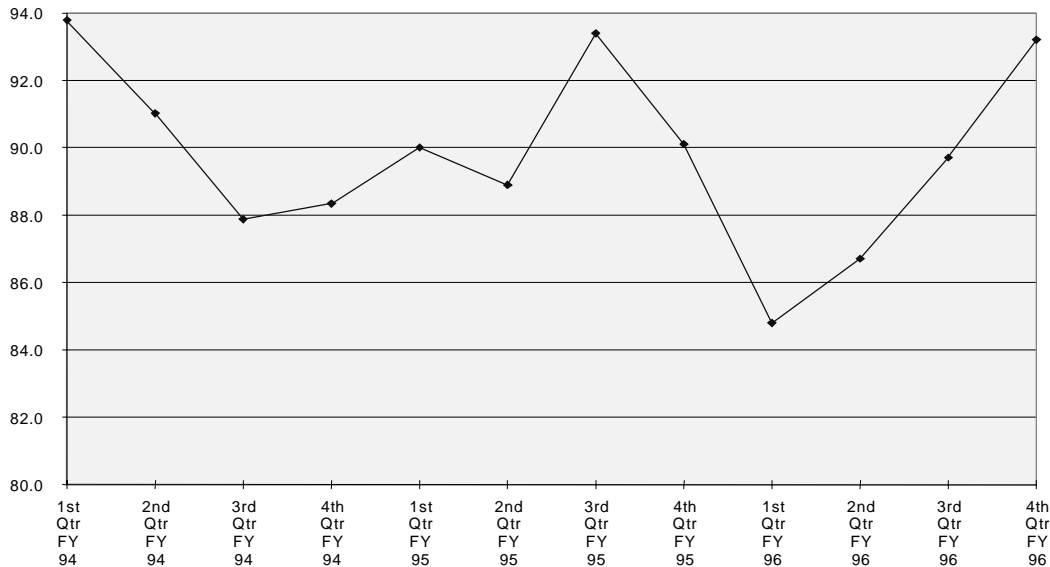
Historically, HHS had high rates of prompt payment, but as the accompanying chart indicates, in recent years HHS’s prompt pay rates have deteriorated. Adjustments have been made to extract pre-1995 Social Security Administration prompt pay figures from those presented below.



The declining prompt payment rates are due to deterioration of rates at NIH, where the 1996 prompt pay rate was only 75.1%. There appears to be a number of causes for NIH’s poor performance including staff reductions, turnover, and the untimely receipt of information from the decentralized 115 procurement offices. However, NIH staff developed an action plan that had five specific improvement items. These improvement steps were all partially, or fully, implemented during FY 1996. Some steps include actions to continue into FY 1997. Currently NIH has shown a substantial improvement in timely payments for the last two quarters of FY 1996 and this improvement has continued, although at a somewhat slower rate through the first quarter of FY 1997.

Although HHS’s quarterly performance has fluctuated in the last 3 years, the cumulative on time percentage for the last three years has been 90%.

ON TIME PERCENT BY QUARTER



We continue to seek methods to improve our payment performance through the use of improved automation, increased use of Electronic Funds Transfer (EFT), increased use of the government procurement card, and increased use of Electronic Data Interchange. At the end of FY 1995 HHS closed our 10 Regional Finance Offices and transferred the payment functions back to various headquarters offices. As our human resources continue to be reduced we must depend more on new and improved automated processes. HHS has one staff member detailed full time to the CFO Financial Implementation Team for Electronic Commerce (FITEC) that is addressing financial issues related to implementing electronic commerce in the government. Meanwhile we are trying to increase the use of EFT and EDI under the existing systems configurations to meet the legislative mandate to make all payments by EFT by the year 1999. Our goal is to increase vendor payments made electronically by 65% and travel payments to 75% by the end of FY 1997.

*Investments.* When analyzing HHS assets by type, the accompanying pie chart reveals that the bulk of HHS assets (69%) are held in the Medicare Trust Funds, which are administered by HCFA and maintained by the U.S. Treasury Department. The Investments are the assets of the Medicare Trust Funds, and are interest-bearing notes because the Treasury Department pays interest to the Trust Funds for Treasury's use of the monies in the fund. (The Trust Funds are discussed in other sections of this report in more detail. Readers are also referred to the HCFA FY 1996 Financial Statements and the Trustees' Reports.)

*Advances and Prepayments.* Advances and Prepayments make up almost six percent of HHS assets, and they are largely attributable to 1) NIH research grants and 2) ACF grants to States. Auditors cited the reconciliation of advances as a weakness in several OPDIV FY 1996 financial statement audits. Now that we are aware of this cross-cutting problem area, we can address the issues in a systematic, coordinated fashion.

*Accounts Receivable and Debt Collection Management.* HHS had approximately \$3.7 billion (net due from public) in receivables at FYE 1996. The volume of these receivables represents a significant management challenge. HCFA, HRSA, and NIH account for 99% of HHS net receivables. HHS' gross accounts receivable from the public (approximately \$5.7 billion) are offset by allowances for doubtful accounts of \$2.0 billion (35% of gross receivables). There are also some (\$0.2 billion) in receivables from other Federal agencies.

Accounts receivable are the focus of HHS' "debt collection" activities, as HHS pursues every available avenue to collect debt owed to the Federal Government from non-Federal sources. HHS's Chief Financial Officer has long supported aggressive debt management practices throughout the Department. In addition to managing the standard cadre of debt collection tools (tax refund offset, administrative and salary offset, private collection agencies, referrals to the Justice Department, etc.), the Debt Collection Improvement Act (DCIA) of 1996 established several challenging initiatives and deadlines. In recognition of the magnitude and complexity of the DCIA, the CFO alerted the HHS financial community to his support of the Act and convened a special work group under the Office of Finance to review the major policy and operational implications of the DCIA. Senior HHS management has been briefed on the magnitude of the Act.

Major DCIA implementation hurdles include: the development/modification of systems to refer delinquent debts to and interact with the new Treasury programs such as the Treasury Offset Program (TOP), the Treasury's Debt Management Service Center (DMSC), and Treasury designated Debt Collection Centers; applying to become a Treasury designated Debt Collection Center; reviewing all debt portfolios for potential sale to the private sector; establishing policies and procedures to bar delinquent debtors from receiving Federal

loans; improving debt management reporting systems; obtaining Tax Identification Numbers (TIN) for all persons doing business with HHS; reporting write offs to the Internal Revenue Service; disseminating the names of delinquent debtors to the public; increasing Civil Monetary Penalties to adjust for inflation; making payments by electronic funds transfer; implementing administrative wage garnishments; and assisting States in recovering State debts, etc.

The DCIA work group established five initial priorities: an analysis of the provisions of the Act itself; the development of an updated Departmentwide inventory of all debts, both administrative and programmatic; an analysis of existing HHS debt management regulations and other associated legal requirements such as the Privacy Act's "altered system of records" requirements; a review of HHS debts to determine their potential suitability for sale; and establishing working relationships with Treasury staff.

Our analysis determined that a single policy standard would not allow all HHS OPDIVs the flexibility needed to implement the varied provisions of the Act. OPDIVs were empowered to implement the individual provisions of the Act to allow for unique program differences.

A Departmentwide inventory of all debts was completed which will be an invaluable tool in quickly identifying programs with unique debt management differences (statute-derived) and assessing the impact of the Act on HHS receivables.

HHS debt management regulations were determined to be sufficient to implement the two major provisions of the Act (TOP and DMSC) though they will need to be updated after Treasury publishes revisions to the existing Governmentwide "Federal Claims Collection Standards" regulations next year. However, it was determined that we needed to revise our "altered systems of records" under the Privacy Act. Meetings were held with

General Counsel and we expect that they will be updated and published in the Federal Register in the first half of FY 1997.

A preliminary survey of all OPDIVs on the suitability of the potential sale of receivables was also completed. Preliminary results reflect a low suitability of HHS debts as they are not collateralized though further study utilizing the expertise of the private sector is planned.

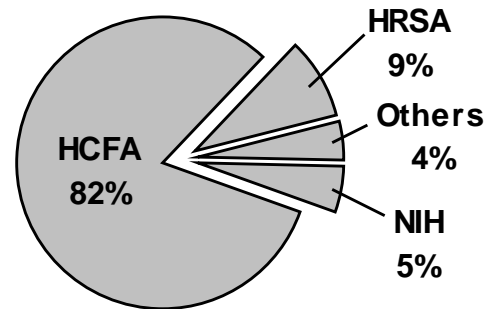
OPDIVs have been alerted to the payment waiver provisions under TOP and were requested to analyze their programs for potential waiver candidates. The newly created Program Support Center will pursue designation as a Debt Collection Center and is starting to prepare an application to submit to Treasury, pending receipt of Treasury standards.

We have worked closely with Treasury staff and anticipate being one of the first agencies to refer delinquent debt to the Treasury TOP and DMSC programs. We have targeted our first referrals for the second quarter of FY 1997 and anticipate being able to refer other eligible debts on a phased in basis thereafter.

At the end of FY 1996, 99% of grant payments and 94% of salary payments were made by EFT. The existing Departmentwide Electronic Commerce project will be expanded to include the new DCIA EFT requirements.

Additionally, we have developed draft regulations increasing covered Civil Monetary Penalties by the rate of inflation and we expect to publish them in final in early FY 1997.

## HHS FYE 1996 Receivables by Operating Division



*Property, Plant, and Equipment (PP&E).* PP&E represents almost \$1.4 billion (or less than one percent) of HHS' assets. The bulk of HHS' PP&E is held by NIH (with numerous high-tech research centers), IHS (with many facilities), FDA, and CDC. The FY 1996 financial statement audits revealed that accounting for and managing property is a cross-cutting problem area at HHS, and we will be developing a coordinated approach to resolving those issues. In FY 1997, HHS amended its policy on capitalization thresholds, raising the threshold from \$5 thousand to \$25 thousand. This will help reduce the burden of accounting for smaller equipment purchases.

### *Liabilities*

Relative to HHS' assets, there are few liabilities, mainly because neither the law nor Federal accounting standards recognize any long term liabilities associated with the accumulated excess trust fund receipts. In FY 1997, FASAB will continue to address disclosure and other representation issues for social insurance programs as they develop an accounting standard on the topic. HHS will be working with FASAB in the development of that standard. Most of HHS' liabilities are for accounts payable, typically for services provided under grants and contracts, and most are associated with the Medicare program.

The noteworthy item in HHS' liabilities is the Amount of unfunded liabilities (also called "Liabilities not covered by budgetary resources"). These unfunded liabilities are caused by the inherent differences between the way funds are appropriated in the Federal budget process, and how they are accounted for under generally accepted accounting principles (GAAP). Budgets are formulated on more of a cash basis, while GAAP is on an accrual basis.

The amount of unfunded liabilities accumulated at FYE 1996 is approximately \$9.2 billion. This amount consists of: 1) estimates for accruals of Medicaid claims incurred at the State level but not yet reported to HCFA, 2) Medicaid program deferrals and disallowances under appeal, and 3) annual leave, disability, and pension expenses accruing for today's employees that will require future funding.

The federal budget process does not recognize the future employee benefits costs of today's employees, but instead budgets for those future expenses in the future years when they are actually paid. The result is that while employee expenses (present and future) are recorded in accrual financial statements, they are under-represented in the Federal budget.

### ***Net Position***

Net position is the difference between total assets and total liabilities shown on the statement of financial position. The statement further breaks down net position by *unexpended appropriations*, *invested capital*, *cumulative results of operations* and *future funding requirements*.

*Unexpended appropriations* is the amount of authority granted by Congress that has not been expended or used. It amounted to \$50,535 million, attributed mostly to ACF and NIH. *Invested capital* of \$1,727 million represents the initial investment in a revolving fund and also the amount of funds that have been used to purchase property, plant and equipment in all funds. Invested capital is reduced as assets are depreciated, sold, transferred to another entity or otherwise disposed of, or when a revolving fund is dissolved.

The *Cumulative results of operations* means the net difference, since the inception of the activity, between (1) expenses and losses and (2) financing sources, including appropriations, revenues and gains i.e., the net accumulation of profits and losses since the beginning of the organization. It amounted to \$122,395 million at FYE 1996, attributed largely to the HCFA accumulations of revenues over expenses.

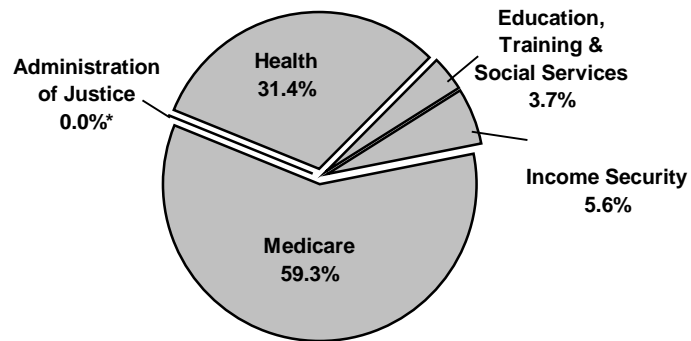
The final component of net position is *future funding requirements* amounting to \$9,204 million. This element represents the amount of liabilities for which Congress has not yet appropriated funds. Examples include annual leave expense and pension expense for Federal employees. This amount is subtracted from net position in the statement of financial position. The amount of future funding required should agree with the total of unfunded liabilities reported in the liability section on the statement of financial position.

## Analysis of Revenue and Financing Sources

Under Federal accounting standards, federal agency revenues includes receipts from the sale of goods and services, and financing sources includes appropriations. For ease of discussion, both will be referred to as “revenues.”

HHS’ revenues can be analyzed from three perspectives, as is shown in the accompanying charts. In the illustration by budget function, it is apparent that Medicare received 59% of HHS revenues in FY 1996, Health (including Medicaid) received 31%, and Income Security (including Aid for Families with Dependent Children) received almost 6%.

**HHS FY 1996 Revenues and Other Financing Sources  
by Budget Function**

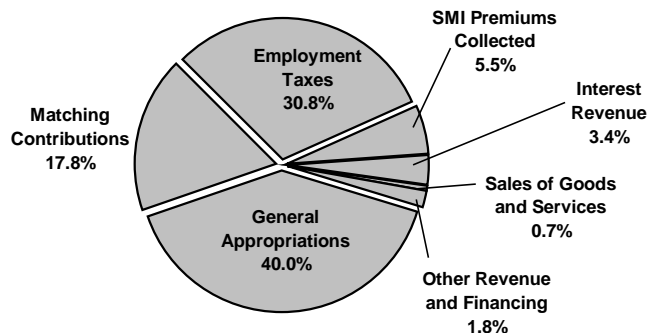


\* Less than .1%

HHS had three major types of revenue, displayed in the accompanying chart:

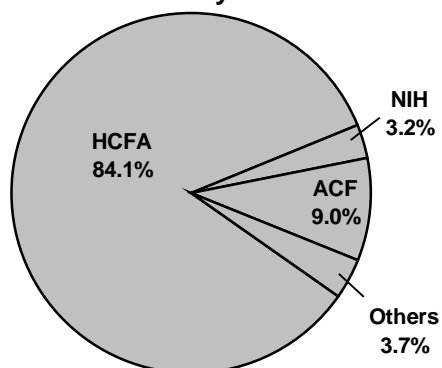
- general appropriations (includes matching contributions for Medicare Part B program),
- employment taxes which help fund Medicare Part A
- insurance premiums paid by Medicare Part B enrollees.

**HHS FY 1996 Revenues and Other Financing Sources  
by Type**



In evaluating revenue by OPDIV, HCFA accounted for 84%, ACF for 9%, NIH 3%, and all others combined did not reach 4%.

**HHS FY 1996 Revenues and Other Financing Sources by OPDIV**

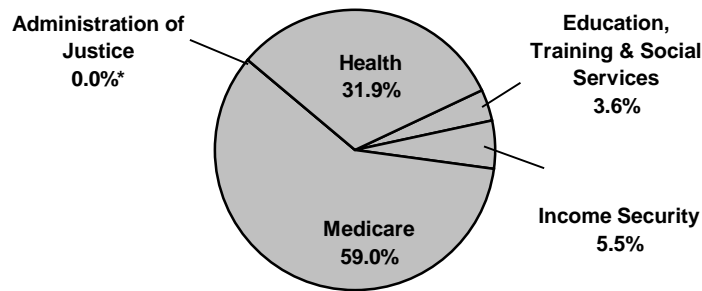


## Analysis of Expenses

HHS' total expenses grew approximately 11% from FY 1995 to FY 1996. The excess of expenses over revenues for FY 1995 and FY 1996 were \$1,155 million and \$11,512 million, respectively. Medicare accounts for 59% of HHS' total expenses. The accompanying charts provide information on expenses, categorized by budget function, expense type, and OPDIV.

The Medicare budget function category represents 59% of HHS expenses, the largest category. The Health budget function ranks second with approximately 32% of expenses, and includes expenses from the Medicaid program and most other OPDIVs (except for ACF and AoA).

**HHS FY 1996 Expenses by Budget Function**



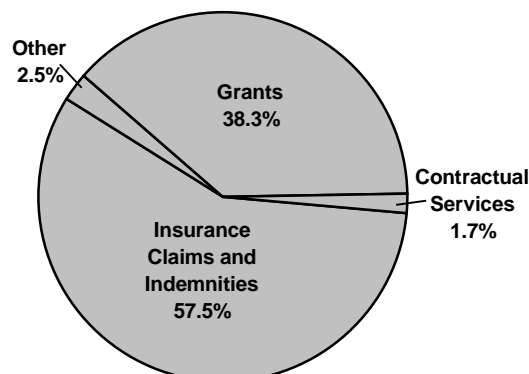
\* Less than .1%

The two major expense categories at HHS, accounting for over 95% of expenses by type, are:

- *insurance claims* under Medicare for health services provided to beneficiaries, and
- *grants* 1) for health-related research and 2) to States for Medicaid and AFDC.

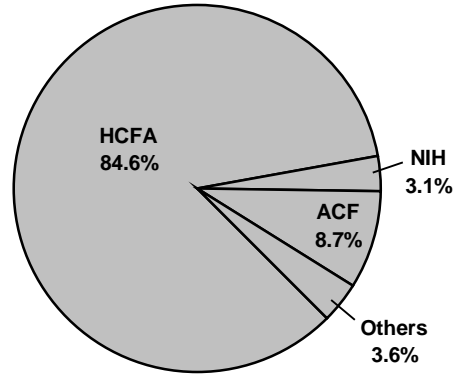
The *insurance claims and indemnities* represent health care payments under Medicare. Increasing costs of health care services and the growth of Medicare enrollment helped produce a 16.9% increase in *insurance claims and indemnities* expense from the prior fiscal year. *Grants* expense, however, only increased approximately two percent from FY 1995 to FY 1996. All other expense types, including contractual services, amounted to slightly over four percent of total expenses.

**HHS FY 1996 Expenses by Type**



HCFA accounts for approximately 85% of HHS' expenses due to their responsibility to administer the Medicare and Medicaid programs. ACF accounts for approximately nine percent of total expenses, most of which is related to their grants to States.

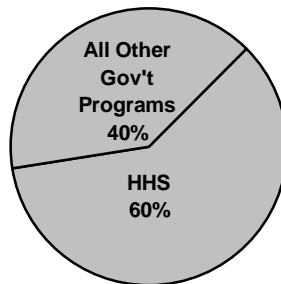
**HHS FY 1996 Expenses by OPDIV**



***Grants Management***

As the largest granting component in the Federal Government, the Department of Health and Human Services plays a key role in the Federal grants management arena. Of the \$220 billion plus in Federal grants awarded yearly, HHS, through its 300 plus assistance programs, awards approximately 140 billion dollars of these funds. Stewardship and oversight responsibilities for HHS grant programs involve a variety of administrative functions being performed on an ongoing basis. These administrative functions include: assisting OMB in its revisions of key OMB Circulars pertinent to grants administration; providing training and developing related guidance documents on these revised OMB circulars; strengthening HHS indirect cost negotiation capabilities; resolving grantee audit findings and correcting deficiencies in accounting systems, internal controls, and other management systems; updating internal Departmental grants administrative procedures; and developing a Departmentwide grants management information system to organize and consolidate data across all HHS grant programs.

**HHS and Governmentwide Grant Spending for FY 1996**



During Fiscal Year 1996, HHS provided substantial technical comments to OMB on the final versions of Circular A-21, *Cost Principles for Educational Institutions* and Circular A-133, *Audits of Institutions of Higher Education and Other Non-Profit Institutions*. With respect to developing guidance on newly revised OMB Circulars, HHS undertook the update of the ASMB C-10, *A Guide for State and Local Government Agencies - Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government*. This document was issued and became effective in April 1997.

Monitoring of Federal reimbursement of grantee indirect costs was strengthened and HHS' indirect cost negotiation capabilities were enhanced by HHS efforts in the development of revised standards for use in assessing special studies undertaken by colleges and universities. In addition, HHS' efforts in the reassessment of reasonable premiums charged for various types of self-insurance funds operated by State governments and related accumulated cash reserve balances for these funds should result in cost savings to the Federal government.

HHS continued with its implementation of the Grants Policy Directive System which is replacing the Departmental Grants Administration Manual with current and concise policy guidance. The directive outlining essential information to be provided to potential applicants for HHS grant awards was issued and development began on a key directive pertinent to Departmental funding and competitive review policies. Effort also continued on the development of TAGGS (Tracking Accountability in Government Grants System). The initial TAGGS Menus and Screen Prototypes were developed to provide an outline of both the basic structure for querying data contained in TAGGS and the type of reporting capability that will be available. The prototype for the Grants Document Library, which provides HHS grants management

staff with on-line access to the most up-to-date policies, regulations, and other pertinent grants-related information, was also completed. Auditors cited the need for an Departmentwide system to track and identify grantees' compliance with the Single Audit. This key grant management monitoring tool serves as an additional assurance of the fiscal integrity of grant funds. The Department has a task force to address this issue in a systematic, coordinated fashion.

### ***Procurement Management***

In FY 1996, approximately 900 HHS procurement personnel awarded and administered over 700,000 procurement actions worth more than \$3.7 billion. Also, HHS obligated an additional \$1.5 billion from the Medicare Trust Fund for contracts with Medicare intermediaries and carriers. These procurement actions and contracts helped to meet the Secretary's goals of: ensuring cost-effective health care and human services; ensuring the integrity of the Medicare Program; enhancing health promotion and disease prevention; improving access to health care for all Americans; and providing adequate support for biomedical research. For example, ASMB worked in partnership with NIH to craft the competitive procurement strategy to award a \$55 million contract for NIH's Division of Computer Research and Technology — to provide essential computer support permitting HHS to achieve critical R&D missions.

Major procurement accomplishments in FY 1996 include the following:

- HHS developed and implemented a customer-oriented, results-driven and GPRA-compliant Acquisition Performance Measurement and Improvement System. The system tracks performance progress using the following survey instruments and measures: Employee Survey — Quality Work Environment, Executive Leadership, and Project Officer Performance; Customer Survey — Timeliness,

Service/Partnership, and Quality; and Manager Survey — Mission Goals, Work-Force Quality, Information Technology and Data Collection, and Acquisition Excellence.

- The Department's Acquisition and Project Officer Training Program provided comprehensive, formal training for both contracting professionals and project officers. 1,700 training slots were used by contracting personnel and 2,800 training slots were used by project officers. Moreover, HHS initiated the design of a CD-ROM instructional module that will provide cost-effective, customized, high-quality training for HHS project officers. The CD-ROM will be used to replace two 4-day platform training courses. Also, the Department developed a special course on the high-profile area of performance-based service contracting, as well as a special seminar on the Federal Acquisition Streamlining Act and Federal Acquisition Reform Act.
- HHS used purchase cards to buy over \$38 million of goods and services; and played a leading role in developing and publicizing the Governmentwide Purchase Card Interactive Customer Assistance CD-ROM — offering cost-effective, customized, high-quality, Just-in-Time training for many purchase card users.
- HHS refined its automated capability — under the Federal Acquisition Computer Network (FACNET) — to award simplified acquisitions (under \$100,000) in an expedited fashion, at NIH, PSC, HCFA, FDA, CDC, and OS.
- HHS upgraded its Departmental Contracts Information System to improve the reliability, timeliness and utility of procurement management data, as well as to support executive decision-making.

### *Travel*

The Office of Finance continues to be involved with several initiatives dealing with travel. Comparatively speaking, travel costs are not a significant factor relative to HHS's total budget. However, due to its high visibility and to relieve any public misperception that tax dollars are being spent to finance junkets for Federal employees, the processes established over time to prevent abuses have become very elaborate. Various interagency work groups have concluded that the vast majority of Federal travelers are honest and have suggested initiatives intended to streamline and simplify the travel regulations and processes while still maintaining system integrity and sufficient internal controls.

HHS is working to implement, to the maximum extent possible, the various recommendations of the National Performance Review (NPR) and the Joint Financial Management Improvement Program (JFMIP) as they relate to travel. HHS has redelegated all travel authorities that had traditionally been held at a very high level, based upon the NPR recommendations stressing the empowerment of management. Also, HHS is using the Internet to provide employees around the country with easy access to the Travel Management System (TMS) for travel expense reporting and reimbursement claims.

The focus on the JFMIP travel recommendations is to improve governmentwide travel policies by applying common sense to the development of new policies and guidelines, and to assert that successful travel programs are those that embody simplicity and integrity. To that end, HHS is stressing the increased usage of the government provided travel card. HHS is also focusing on continued improvement in the payment history and decreasing the delinquency rate of HHS employees, who repay the government issued account personally and are reimbursed by HHS for official travel expenses.

# **FINANCIAL STATEMENTS**



**U.S. Department of Health and Human Services**  
**Combining Statement of Financial Position**  
**As of September 30, 1996 and 1995**

(in millions)

	Education, Training and Social Services	Health	Medicare	Income Security	Admin. of Justice	FY 1996 Totals	FY 1995 Totals (Unaudited)
<b>Assets</b>							
Entity Assets:							
Fund Balances with Treasury (Note 2)	\$ 8,562	\$ 33,987	\$ (666)	\$ 5,262	\$ 25	\$ 47,170	\$ 53,750
Investments (Note 3)	-	6	152,980	-	-	152,986	143,397
Accounts Receivable, Net: (Note 4)							
From Federal Agencies	3	143	4	43	1	194	162
From the Public	1	590	3,050	20	-	3,661	3,221
Interest Receivable (Note 3)	-	-	2,899	-	-	2,899	2,885
Advances: (Note 5)							
To Federal Agencies	10	499	-	31	16	556	657
To the Public	2,732	4,401	68	5,190	6	12,397	13,665
Inventories	-	69	-	-	-	69	117
Property and Equipment, Net (Note 6)	-	1,334	47	-	-	1,381	1,346
Non-Entity Assets:							
Accounts Receivable, Net (Note 4)	-	265	-	7	-	272	138
<b>Total Assets</b>	<b>\$ 11,308</b>	<b>\$ 41,294</b>	<b>\$ 158,382</b>	<b>\$ 10,553</b>	<b>\$ 48</b>	<b>\$ 221,585</b>	<b>\$ 219,338</b>
<b>Liabilities</b>							
Funded Liabilities:							
Payables: (Note 7)							
Due Federal Agencies	\$ 5	\$ 416	\$ 16	\$ 7	\$ -	\$ 444	\$ 283
Due the Public	9	8,851	36,079	16	1	44,956	36,856
Advances: (Note 5)							
From Federal Agencies	443	309	-	4	21	777	1,694
From the Public	-	282	351	-	-	633	453
Accrued Payroll and Benefits	7	85	11	8	1	112	77
Unfunded Liabilities:							
Annual Leave	10	224	19	12	1	266	208
Disability Compensation	3	123	7	11	2	146	146
Other Liabilities	-	5,664	-	-	-	5,664	59
Pensions (Note 8)	-	3,134	-	-	-	3,134	2,938
<b>Total Liabilities</b>	<b>477</b>	<b>19,088</b>	<b>36,483</b>	<b>58</b>	<b>26</b>	<b>56,132</b>	<b>42,714</b>
<b>Net Position (Note 9)</b>							
Unexpended Appropriations	10,380	29,689	-	10,441	25	50,535	49,985
Invested Capital	-	1,680	47	-	-	1,727	1,572
Cumulative Results of Operations	464	(24)	121,878	77	-	122,395	128,416
Future Funding Requirements	(13)	(9,139)	(26)	(23)	(3)	(9,204)	(3,349)
<b>Total Net Position</b>	<b>10,831</b>	<b>22,206</b>	<b>121,899</b>	<b>10,495</b>	<b>22</b>	<b>165,453</b>	<b>176,624</b>
<b>Total Liabilities &amp; Net Position</b>	<b>\$ 11,308</b>	<b>\$ 41,294</b>	<b>\$ 158,382</b>	<b>\$ 10,553</b>	<b>\$ 48</b>	<b>\$ 221,585</b>	<b>\$ 219,338</b>

The accompanying notes are an integral part of these statements

**U.S. Department of Health and Human Services  
Combining Statement of Operations and Changes in Net Position  
For the Fiscal Years Ended September 30, 1996 and 1995**

(in millions)

	<u>Education, Training and Social Services</u>	<u>Health</u>	<u>Medicare</u>	<u>Income Security</u>	<u>Admin. of Justice</u>	<u>FY 1996 Totals</u>	<u>FY 1995 Totals (Unaudited)</u>
<b>Revenues and Financial Sources</b>							
Appropriated Capital Used: (Note 11)							
General Appropriations	\$ 12,787	\$ 106,438	\$ -	\$ 19,452	\$ 20	\$ 138,697	\$ 142,592
Matching Contributions	-	-	61,702	-	-	61,702	36,988
Employment Taxes	-	-	106,943	-	-	106,943	98,054
SMI Premiums Collected (Note 11)	-	-	18,931	-	-	18,931	19,243
Interest Revenue	-	-	11,791	-	-	11,791	12,583
Sales of Goods and Services	21	2,195	-	100	3	2,319	2,182
Other Revenue and Financing	1	164	6,069	-	-	6,234	5,968
	<u>12,809</u>	<u>108,797</u>	<u>205,436</u>	<u>19,552</u>	<u>23</u>	<u>346,617</u>	<u>317,610</u>
<b>Expenses</b>							
Operating:							
Personnel Costs	130	3,494	1,145	170	16	4,955	4,648
Travel and Transportation	3	127	4	7	-	141	144
Rent, Communication and Utilities	17	330	23	26	2	398	341
Printing and Reproduction	1	36	5	1	-	43	54
Contractual Services	95	3,986	1,826	44	2	5,953	6,099
Supplies and Materials	1	421	3	2	-	427	393
Grants	12,539	105,463	31	19,287	3	137,323	134,716
Insurance Claims and Indemnities (Note 12)	-	114	205,835	-	-	205,949	171,194
Other Operating Expenses	3	185	3	16	-	207	715
Depreciation and Amortization	-	103	5	-	-	108	96
Other Non-Operating Expenses	-	134	2,491	-	-	2,625	365
	<u>12,789</u>	<u>114,393</u>	<u>211,371</u>	<u>19,553</u>	<u>23</u>	<u>358,129</u>	<u>318,765</u>
Excess of Revenues and Financing Sources	20	(5,596)	(5,935)	(1)	-	(11,512)	(1,155)
Net Position, Beginning Balance	9,675	42,723	127,132	8,582	26	188,138	190,773
Adjustments (Note 10)	-	(12,217)	703	-	-	(11,514)	(8,891)
Net Position, Restated Beginning Balance	9,675	30,506	127,835	8,582	26	176,624	181,882
Excess of Revenues and Financing Sources	20	(5,596)	(5,935)	(1)	-	(11,512)	(1,155)
Non-Operating Changes	1,136	(2,704)	(1)	1,914	(4)	341	(4,103)
Net Position, Ending Balance	<u>\$ 10,831</u>	<u>\$ 22,206</u>	<u>\$ 121,899</u>	<u>\$ 10,495</u>	<u>\$ 22</u>	<u>\$ 165,453</u>	<u>\$ 176,624</u>

The accompanying notes are an integral part of these statements

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
NOTES TO THE FINANCIAL STATEMENTS  
AS OF SEPTEMBER 30, 1995(UNAUDITED) AND 1996**

**1. SIGNIFICANT ACCOUNTING POLICIES**

**Basis of Presentation**

The financial statements have been prepared to report the financial position and results of operations of the U.S. Department of Health and Human Services (HHS) as required by the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994. They have been prepared from Departmental records in accordance with the form and content requirements of OMB Bulletin 97-01 and follow the hierarchy of accounting principles and standards contained therein. These statements are therefore different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control HHS's use of budgetary resources.

Statements of cash flows and statements of budgetary resources and actual expenses are not included as principal financial statements for HHS and Operating Division (OPDIV) reports. The Office of Management and Budget (OMB) approved HHS's request to waive these requirements for FY 1996 reporting.

The financial statements combine the balances of about one hundred forty discrete appropriations and fund accounts, plus a number of accounts used for suspense, collection of receipts and general Governmental functions. Account balances are combined from the financial statements of HHS's twelve OPDIVs, each issued under separate cover. Supplemental information is accumulated from the OPDIV reports, regulatory reports and other sources within HHS. Information is generally presented herein on a summary level, hence, greater detail on OPDIV programs and activities is found in the annual reports prepared by the OPDIVs.

For most HHS programs, transactions are recorded on an accrual accounting basis and a budgetary basis. The cash basis is used by HCFA for Medicare benefit payments and for Medicaid Program draws by States to cover current quarter expenses. For both programs, an accrual method adjustment is made by recording year-end estimates of unpaid liabilities. Under the accrual method, revenues are recognized when earned and expenses are recognized when a liability is incurred, without regard to the receipt or payment of cash.

**Terminology**

Certain terms are used on the statement of financial position which may be unfamiliar to readers who are not working within the Federal financial community: *Entity* assets are those assets which the reporting entity holds and has the authority to use in its operations; *Non-entity* assets are those the entity holds but does not have the authority to use; *Unfunded* liabilities are for which budget authority has not been received; *Future Funding Requirements* is a component of net position disclosing the sum of all unfunded liabilities of the entity.

### **Financing Sources**

Congressional appropriations are the primary funding source for most of the Department's programs. For financial statement purposes, appropriations are recognized as a financing source as expenses are incurred.

Medicare's HI Trust fund is financed by a 1.45 percent tax on employee earnings required to be paid by both U.S. employers and employees; (2) The SMI Trust fund receives premium payments from Medicare beneficiaries and these amounts are matched approximately 3 to 1 by Congressional appropriations. Interest revenue on investments is recognized as it is earned.

Reimbursable service agreements between HHS activities and with other Federal agencies generally recognize revenues when the related expenses are incurred. Revolving funds and reimbursable agreements recognize revenue when goods are delivered or services rendered. Various user fees are collected to recover the full cost of services provided.

### **Retirement Plans**

Most HHS employees participate in the Civil Service Retirement System (CSRS) or the Federal Employee Retirement System (FERS). Under CSRS, HHS makes matching contributions equal to 7 percent of basic pay. For FERS employees, HHS contributes the employer's matching share for Social Security and contributes an amount equal to one percent of employee pay to a savings plan and matches up to an additional 4 percent of pay. Most employees hired after December 31, 1983 are covered by FERS. The Office of Personnel Management reports on CSRS and FERS assets, accumulated plan benefits, unfunded liabilities, if any, applicable to Federal employees.

Note 8 provides information on the HHS-administered Public Health Service Commissioned Corps Retirement System.

### **Leave**

Annual leave is accrued as it is earned, and the accrual is reduced as leave is taken. The accrual for accumulated annual leave is based on current year pay rates. Sick leave and other types of leave are expensed as leave is taken.

### **Funds With U.S. Treasury**

HHS does not maintain cash in commercial bank accounts. Cash receipts and disbursements are processed for HHS by the U.S. Treasury. The balance of this account primarily represents amounts available to pay current liabilities.

### **Accounts Receivable**

Accounts receivable consist of amounts owed to the Department by other Federal agencies and the public. Amounts due from the public are presented net of allowances for uncollectible accounts. The estimate of an allowance is based on past collection experience and/or an analysis of the outstanding balances.

### **Loans Receivable**

Loans are accounted for as receivables after funds are disbursed. In accordance with Credit Reform legislation, for loans obligated prior to October 1, 1991, loan principal, interest, and other costs are reduced by an allowance for estimated uncollectible amounts based on historical data and current market factors. For loans obligated on or after October 1, 1991, the loans receivable is reduced by an allowance equal to the present value of the subsidy costs associated with these loans.

### **Investments**

Medicare Trust fund balances in excess of current needs are invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

### **Inventories**

HHS maintains inventories almost entirely for consumption by the purchasing OPDIV or other HHS components. Most inventories are of a medical nature, consisting of such materials as pharmaceuticals, medical supplies, biological products and vaccines. Generally, these inventories are recorded at (1) the lower of cost (using weighted-average cost method) or market, or (2) historical cost.

### **Property and Equipment**

Property and equipment purchases and additions are valued at cost. Equipment is capitalized when its cost is \$5,000 or more and it has a useful life of more than two years. Both property and equipment are depreciated on a straight-line basis over the estimated useful life of the item. Land is not depreciated. Normal maintenance and repair costs are expensed as incurred.

### **Liabilities**

Liabilities are recognized for amounts of probable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so.

Unfunded liabilities are incurred when funding has not yet been made available through Congressional appropriations or current earnings. HHS recognizes such liabilities for employee annual leave earned but not taken, amounts billed by the Department of Labor for Federal Employee's Compensation Act (disability) payments, and for Medicaid audit disallowances under appeal and for deferrals. The total unfunded liabilities equals the future funding requirements provision in the net position.

In accordance with Public Law and existing Federal accounting standards, no estimated liability is recorded for any future payments expected to be made on behalf of the nation's current workers (upon their retirement or disability) who are currently contributing to the Medicare Hospital Insurance (HI) Trust Fund.

**Obligations Related to Canceled Appropriations**

Payments may be required from current year appropriations due to obligations incurred against canceled appropriations. The total obligations related to cumulative canceled appropriations is estimated to be \$622.2 million as of September 30, 1996.

**Intra-Governmental Relationships and Transactions**

In the course of its operations, HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these being with the Social Security Administration (SSA) and the U.S. Treasury Department. The SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The U.S. Treasury Department receives the cumulative excess of Medicare receipts and other financing over outlays, and issues interest-bearing securities in exchange for the use of those monies. At the Governmentwide level, the assets related to the trust funds on HHS' financial statements and the corresponding liabilities on the Treasury's financial statements would be eliminated.

**Grant Awards**

The Single Audit Act of 1984, as revised, provides that recipients of Federal financial assistance funds, such as those provided by HHS, have an annual audit of its activities performed by an independent Non-federal auditor. The results of these audits provide information to Federal awarding agencies about the validity of Federal financial awards expenditures, adequacy of internal controls over Federal assistance and the extent of compliance with grant rules and regulations. Disallowed costs identified pursuant to these audits are used to reduce future years' grant awards or returned to the awarding agency. Such reduction or returned awards are reported in the year such determination is made.

**2. FUND BALANCES WITH TREASURY**

HHS's undisbursed account balances are listed below by fund type. Other funds includes balances in deposit, suspense, clearing and related non-spending accounts.

	(millions)	
Fund Type:	1996	1995
Trust Funds	\$ (524)	\$ 133
Revolving Funds	731	635
Appropriated Funds	46,611	52,697
Other Funds	352	285
Total	\$ 47,170	\$ 53,750

**3. INVESTMENTS**

The Health Care Financing Administration (HCFA) invests Medicare Trust Funds' cash that is in excess of current needs in U. S. Treasury Special Issues. These issues are exclusive to Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds and are purchased and redeemed at face value. Certificates are short-term and pay from 6 7/8 to 7 1/8 percent. Bond

interest rates range from 6 1/4 to 13 3/4 percent. Bonds mature at various dates from June 1997 to June 2011. The accrued interest receivable on the investments totaled \$2,899 million as of September 30, 1996.

The National Institutes of Health (NIH) invests a portion of their trust fund cash in short-term U. S. Treasury Securities. The balances include principal and accrued interest.

	(in millions)	
	1996	1995
Issue Type:		
HI Certificates	\$ 2,852	\$ 262
SMI Certificates	3,949	-
HI Bonds	122,953	129,602
SMI Bonds	23,226	13,514
HCFA Totals	152,980	143,378
NIH Securities	6	19
Total	<u>\$ 152,986</u>	<u>\$ 143,397</u>

#### 4. ACCOUNTS AND LOANS RECEIVABLE, NET

The Health Care Financing Administration's (HCFA) Medicare receivables are primarily due to overpayments to providers, beneficiaries, physicians and suppliers, and to claims where Medicare should be secondary payer. The Medicaid balance is the net realizable value of disallowances in dispute with the States.

Loans receivable are included for the Health Education Assistance Loans (HEAL) program which is administered by the Health Resources and Services Administration. The balance represents defaulted loans which have been paid to lenders under the guarantee, and includes principal and interest.

HHS non-entity receivable balances represent amounts that cannot be used by HHS once collected. Such receipts are transferred to the General Fund of the U.S. Treasury.

PROGRAM/TYPE	(in millions)			
			1996	1995
	Gross Receivables	Allowances	Net Receivables	Net Receivables
Entity - Public:				
Medicare	\$ 4,946	\$ 1,896	\$ 3,050	\$ 2,636
Medicaid	41	-	41	93
HEAL Loans	439	120	319	281
Other Public	257	6	251	211
Total	<u>\$ 5,683</u>	<u>\$ 2,022</u>	<u>\$ 3,661</u>	<u>\$ 3,221</u>
Entity - Federal	<u>\$ 194</u>	<u>\$ -</u>	<u>\$ 194</u>	<u>\$ 162</u>
Non-Entity	<u>\$ 491</u>	<u>\$ 219</u>	<u>\$ 272</u>	<u>\$ 138</u>

**5. ADVANCES**

Advances made to others are classified as assets on the statement of financial position. Most of HHS's \$12.3 billion consists of advances made from grant program funds to the disbursing account maintained at the Program Support Center's (PSC) Payment Management Division. These advances are identified as "public" because the recipients of these grants are not Federal entities, being mostly state and local governments, but include universities, other non-profit organizations and individuals. Although most of this end of year balance has been disbursed to grantees, expense is not recognized until reconciliations of the grant accounts determine the specific appropriations (within OPDIVs) to be charged. A small portion of the balance is for employee travel and emergency salary advances. The Federal balance is for amounts advanced to other Federal agencies to provide goods and services to HHS.

Liabilities were recorded for amounts advanced to HHS by other Federal agencies for the provision of goods and services.

**6. PROPERTY AND EQUIPMENT, NET**

Balances for the major categories of HHS property and equipment are listed below, recognized at acquisition cost.

(in millions)				
Category	Cost	Accumulated Depreciation	1996	1995
			Net Book Value	Net Book Value
Land	\$ 32	\$ -	\$ 32	\$ 19
Buildings	1,428	732	696	735
Equipment	1,210	557	653	592
Total	<u>\$ 2,670</u>	<u>\$ 1,289</u>	<u>\$ 1,381</u>	<u>\$ 1,346</u>

**7. PAYABLES - DUE THE PUBLIC**

Accounts Payable are amounts owed for goods and services received from, progress in contract performance made by, and rents due to others. Benefits payable recognize accrued entitlement benefits earned in the current (or prior) periods, but not yet paid.

The balances below are all funded, i.e., budget authority has been received. Unfunded Medicaid benefits payable of \$5,609 million are presented under Other Liabilities.

(millions)		
	1996	1995
Benefit Payables:		
Medicare Claims	\$ 36,046	\$ 21,981
Medicaid	8,136	14,077
Other:		
Accounts Payable	323	371
Loan Guarantees	346	322
Vaccine Liability Claims	105	105
Total	<u>\$ 44,956</u>	<u>\$ 36,856</u>

## 8. PENSION LIABILITY

HHS administers the Public Health Service Commissioned Corps Retirement System for approximately 6,100 active duty officers and 3,400 retirees or survivors. Authorized by Public Law 78-410, it is a defined benefit plan and is non-contributory. Having no plan assets at the end of a year, funding is provided entirely on a “pay as you go” basis by Congressional appropriations. Administrative costs are not borne by the plan. (Note: Amounts presented on the financial statements related to the retirement system are for the periods FY 1995 and 1994, respectively.) Benefits of \$132 million were paid to participants in FY 1995. This amount was net of offsets for social security, Veteran’s Administration benefits, and contributions for survivor benefits. The actuarial present value of accumulated plan benefits is \$3,134 million, of which \$493 million is nonvested. The assumed interest rate is 6.75 percent. Economic assumptions are the same as those used by the Military Retirement System. Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system.

## 9. NET POSITION

Net position is the residual difference between assets and liabilities. Unobligated appropriations are either available for obligation or not available (permanently or temporarily) pursuant to a specific provision in law. Undelivered orders represents appropriations obligated (i.e. legally reserved) for the amount of goods or services ordered but not yet received.

Invested capital represents the net investment of the Government in the Department. This includes the corpus of revolving funds, net book value of capital assets purchased with appropriations and donations. The cumulative results of operations represents the net profit or loss of the entity since inception. Balances are recorded in future funding requirements to identify the amount of future years’ appropriations that will be needed to liquidate liabilities recognized as of the end of the current fiscal year. A future funding requirement does not represent a legal obligation, or indicate a violation of anti-deficiency laws, but tends to be the result of recording accrued expenses under applicable accounting standards.

The Medicaid program has recorded a \$5.6 billion future funding requirement. FY 1996 is the first time HCFA has accrued a liability for Medicaid service expenses incurred but not claimed by the States as of the end of the fiscal year. This information was provided by the States in response to a survey issued by HCFA in November, 1996. The liability (\$11.1 billion out of the total \$13.7 billion for Medicaid) is an estimate of medical services provided but not yet billed to the States, or billed but not yet paid by the States.

(in millions)				1996
Unexpended Appropriations:	Trust Funds	Revolving Funds	Appropriated Funds	Totals
Unobligated:				
Available	\$ 38	\$ 254	\$ 4,302	\$ 4,594
Unavailable	-	-	9,039	9,039
Undelivered Orders	3	60	36,839	36,902
Invested Capital	52	90	1,585	1,727
Cumulative Results of Operations	121,916	(51)	530	122,395
Future Funding Requirements	(78)	(28)	(9,098)	(9,204)
Total	<u>\$ 121,931</u>	<u>\$ 325</u>	<u>\$ 43,197</u>	<u>\$ 165,453</u>

## 10. ADJUSTMENTS

During FY 1996, HCFA recorded adjustments to various balances which related to prior periods' activity. The Medicaid adjustment of (\$12,217) million detailed below includes (\$9,564) million as HCFA's estimate of Medicaid services incurred but not reported as of September 30, 1995, based on data provided by the States in the November 1996 HCFA survey. An additional (\$2,653) million represents Medicaid expenses applicable to FY 1995 that exceeded advances drawn by the States in FY 1995.

The Medicare program had net adjustments of \$703 million. Payments of \$1.3 billion to Health Maintenance Organization (HMO) plans that were charged to FY 1995, were later found to be expenses of FY 1996. Accounts Receivable for Medicare contractor HI overpayments were overstated in FY 1995 by \$602 million.

Net Position Beginning Balance Adjustments:	(in millions)
Medicaid estimate of services incurred but not claimed at fiscal year end 1995	\$ (9,564)
Medicaid expenses exceeding advances drawn by States during 1995	<u>(2,653)</u>
Subtotal	<u>(12,217)</u>
Medicare HMO charges expensed in 1995, attributable to 1996	1,305
Medicare HI contractor overpayments in 1995	<u>(602)</u>
Subtotal	<u>703</u>
Total	<u><u>\$ (11,514)</u></u>

## 11. SMI PREMIUMS COLLECTED AND FEDERAL MATCHING CONTRIBUTIONS

Supplementary Medical Insurance (SMI) benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and matched by the Federal Government. The monthly SMI premium for the first 3 months of FY 1996 was \$46.10; the monthly premium for the remainder of the fiscal year was \$42.50. Premiums collected from beneficiaries totalled \$18.9 billion in FY 1996 (\$19.2 billion in FY 1995) and were matched by a \$54.7 billion contribution from the Federal Government (\$37 billion in FY 1995). In March, 1996, the Federal Government contributed an additional \$7 billion to SMI to restore a shortfall in matched funds related to FY 1995 premium revenue, resulting in a total matching contribution of \$61.7 billion during FY 1996. While this amount is included in FY 1996 revenue (the year of appropriation), we (HCFA and HHS) are currently working with OMB, GAO, and the OIG to determine the most appropriate year for recognizing the revenue considering both the accounting standards and budgetary law issues involved. This effort may result in a prior period accounting adjustment in the FY 1997 financial statements of both HCFA and HHS. HCFA uses the Payments to the Health Care Trust Funds appropriation to match SMI premiums collected from beneficiaries.

## **12. MEDICARE CLAIMS ESTIMATED IMPROPER PAYMENTS**

Federal Government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. This process has less than a 1 percent error rate. For the external billing process, i.e., the documentation provided by providers to support their claims, the estimated range of improper payments at the 95 percent confidence level is \$17.8-28.6 billion, or about 11 to 17 percent of the \$168.6 billion of processed fee-for-service payments reported by HCFA. Providers are supposed to retain supporting documentation and make it available upon request. The majority of the errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, non-covered or unallowable service, and incorrect coding. Similar audit procedures were not performed in FY 1995; therefore, the estimated improper payments are not presented for FY 1995.

U.S. Department of Health and Human Services  
 Supplemental Combining Statement of Financial Position by Operating Agency: Division  
 As of September 30, 1996

	(in millions)												
	HCFA	NIH	ACF	AoA	AHCPR	CDC	FDA	HRSA	IHS	SAMHSA	OS	PSC	IHS - wide
<b>Assets</b>													
Entity Assets:													
Fund Balances with Treasury Investments	\$ 15,906	\$ 9,664	\$ 13,510	\$ 227	\$ 146	\$ 2,141	\$ 359	\$ 2,763	\$ 1,172	\$ 1,089	\$ 112	\$ 81	\$ 47,170
Accounts Receivable, Net:	152,980	6	-	-	-	-	-	-	-	-	-	-	152,986
From Federal Agencies	4	24	4	-	-	10	10	29	19	9	43	42	194
From the Public	3,097	191	1	-	-	2	14	332	4	-	20	-	3,661
Interest Receivable	2,899	-	-	-	-	-	-	-	-	-	-	-	2,899
Advances:													
To Federal Agencies	-	29	38	1	18	404	5	25	13	5	18	-	556
To the Public	667	3,565	7,685	225	-	1	3	10	10	213	18	-	12,397
Inventories	-	10	-	-	-	35	-	-	13	-	-	-	69
Property and Equipment, Net	49	461	-	-	-	136	214	5	497	2	-	17	1,381
Non-Entity Assets:													
Accounts Receivable, Net	265	-	7	-	-	-	-	-	-	-	-	-	272
Total Assets	\$175,867	\$13,950	\$21,245	\$ 453	\$ 164	\$ 2,729	\$ 605	\$3,164	\$ 1,728	\$1,318	\$ 211	\$ 151	\$221,585
<b>Liabilities</b>													
Funded Liabilities:													
Payables:													
Due Federal Agencies	\$ 287	\$ 58	\$ 5	\$ -	\$ 3	\$ 8	\$ 15	\$ 20	\$ 24	\$ 6	\$ 7	\$ 11	\$ 444
Due the Public	44,215	135	16	-	2	36	17	464	42	6	10	13	44,956
Advances:													
From Federal Agencies	-	103	467	-	-	92	-	-	47	32	1	35	777
From the Public	352	108	-	-	-	1	-	172	-	-	-	-	633
Accrued Payroll and Benefits	12	-	6	1	1	18	24	7	29	2	9	3	112
Unfunded Liabilities:													
Annual Leave	20	65	9	1	1	29	42	15	60	5	13	6	266
Disability Compensation	7	38	3	-	-	10	-	26	44	3	13	2	146
Other Liabilities	5,609	-	-	-	-	-	-	54	1	-	-	-	5,664
Pensions	-	-	-	-	-	-	-	-	-	-	-	3,134	3,134
Total Liabilities	50,502	507	506	2	7	194	98	758	247	54	53	3,204	56,132
<b>Net Position</b>													
Unexpended Appropriations	9,074	13,052	20,219	454	164	2,399	294	2,181	991	1,391	173	143	50,535
Invested Capital	49	459	-	-	-	171	214	318	511	2	-	3	1,727
Cumulative Results of Operations	121,878	35	532	(2)	(6)	4	41	2	84	(121)	11	(63)	122,395
Future Funding Requirements	(5,636)	(103)	(12)	(1)	(1)	(39)	(42)	(95)	(105)	(8)	(26)	(3,136)	(9,204)
Total Net Position	125,365	13,443	20,739	451	157	2,535	507	2,406	1,481	1,264	158	(3,053)	165,453
Total Liabilities & Net Position	\$175,867	\$13,950	\$21,245	\$ 453	\$ 164	\$ 2,729	\$ 605	\$3,164	\$ 1,728	\$1,318	\$ 211	\$ 151	\$221,585

**U.S. Department of Health and Human Services  
Supplemental Combining Statement of Operations and Changes in Net Position by Operating Division  
For the Fiscal Year Ended September 30, 1996**

(in millions)

	<u>HCFA</u>	<u>NIH</u>	<u>ACF</u>	<u>AoA</u>	<u>AHCPR</u>	<u>CDC</u>	<u>FDA</u>	<u>HRSA</u>
<b>Revenues and Financial Sources</b>								
Appropriated Capital Used:								
General Appropriations	\$ 85,826	\$ 10,010	\$ 31,191	\$ 871	\$ 140	\$ 1,954	\$ 855	\$ 3,351
Matching Contributions	61,702	-	-	-	-	-	-	-
Employment Taxes	106,943	-	-	-	-	-	-	-
SMI Premiums Collected	18,931	-	-	-	-	-	-	-
Interest Revenue	11,791	-	-	-	-	-	-	-
Sales of Goods and Services	35	987	22	-	66	211	121	242
Other Revenue and Financing	6,174	58	1	-	-	1	-	-
Total Revenue and Financing Sources	<u>291,402</u>	<u>11,055</u>	<u>31,214</u>	<u>871</u>	<u>206</u>	<u>2,166</u>	<u>976</u>	<u>3,593</u>
<b>Expenses</b>								
Operating:								
Personnel Costs	1,162	1,072	117	11	20	398	609	147
Travel and Transportation	6	27	3	-	-	24	20	4
Rent, Communication and Utilities	24	138	15	2	3	35	72	10
Printing and Reproduction	5	19	1	-	2	6	3	1
Contractual Services	1,941	2,235	98	4	54	289	181	181
Supplies and Materials	3	166	1	-	-	145	23	4
Grants	91,466	7,269	30,956	853	61	1,246	20	2,954
Insurance Claims and Indemnities	205,835	-	-	-	-	-	3	108
Other Operating Expenses	4	26	3	-	-	1	32	14
Depreciation and Amortization	5	45	-	-	-	18	11	1
Other Non-Operating Expenses	2,491	101	-	-	-	7	-	21
Total Expenses	<u>302,942</u>	<u>11,098</u>	<u>31,194</u>	<u>870</u>	<u>140</u>	<u>2,169</u>	<u>974</u>	<u>3,445</u>
Excess of Revenues and Financing Sources	<u>(11,540)</u>	<u>(43)</u>	<u>20</u>	<u>1</u>	<u>66</u>	<u>(3)</u>	<u>2</u>	<u>148</u>
Net Position, Beginning Balance	151,057	13,297	17,820	400	177	2,423	482	2,308
Adjustments	<u>(11,514)</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Net Position, Restated Beginning Balance	139,543	13,297	17,820	400	177	2,423	482	2,308
Excess of Revenues and Financing Sources	<u>(11,540)</u>	<u>(43)</u>	<u>20</u>	<u>1</u>	<u>66</u>	<u>(3)</u>	<u>2</u>	<u>148</u>
Non-Operating Changes	<u>(2,638)</u>	<u>189</u>	<u>2,899</u>	<u>50</u>	<u>(86)</u>	<u>115</u>	<u>23</u>	<u>(50)</u>
Net Position, Ending Balance	<u>\$ 125,365</u>	<u>\$ 13,443</u>	<u>\$ 20,739</u>	<u>\$ 451</u>	<u>\$ 157</u>	<u>\$ 2,535</u>	<u>\$ 507</u>	<u>\$ 2,406</u>

**U.S. Department of Health and Human Services  
Supplemental Combining Statement of Operations and Changes in Net Position by Operating Division (continued)  
For the Fiscal Year Ended September 30, 1996**

(in millions)

	<u>IHS</u>	<u>SAMHSA</u>	<u>OS</u>	<u>PSC</u>	<u>HHS - wide</u>
<b>Revenues and Financial Sources</b>					
Appropriated Capital Used:	\$ 1,991	\$ 2,141	\$ 197	\$ 170	\$ 138,697
General Appropriations	-	-	-	-	61,702
Matching Contributions	-	-	-	-	106,943
Employment Taxes	-	-	-	-	18,931
SMI Premiums Collected	-	-	-	-	11,791
Interest Revenue	310	21	102	202	2,319
Sales of Goods and Services	-	-	-	-	6,234
Other Revenue and Financing	-	-	-	-	-
	<u>2,301</u>	<u>2,162</u>	<u>299</u>	<u>372</u>	<u>346,617</u>
Total Revenue and Financing Sources					
<b>Expenses</b>					
Operating:	745	47	188	439	4,955
Personnel Costs	46	1	7	3	141
Travel and Transportation	43	5	28	23	398
Rent, Communication and Utilities	2	3	1	-	43
Printing and Reproduction	738	138	39	55	5,953
Contractual Services	80	-	2	3	427
Supplies and Materials	516	1,962	20	-	137,323
Grants	-	3	-	-	205,949
Insurance Claims and Indemnities	81	1	16	29	207
Other Operating Expenses	24	-	-	4	108
Depreciation and Amortization	-	2	-	3	2,625
Other Non-Operating Expenses	-	-	-	-	-
	<u>2,275</u>	<u>2,162</u>	<u>301</u>	<u>559</u>	<u>358,129</u>
Total Expenses					
Excess of Revenues and Financing Sources	<u>26</u>	<u>-</u>	<u>(2)</u>	<u>(187)</u>	<u>(11,512)</u>
Net Position, Beginning Balance	1,464	1,493	63	(2,846)	188,138
Adjustments	-	-	-	-	(11,514)
Net Position, Restated Beginning Balance	<u>1,464</u>	<u>1,493</u>	<u>63</u>	<u>(2,846)</u>	<u>176,624</u>
Excess of Revenues and Financing Sources	26	-	(2)	(187)	(11,512)
Non-Operating Changes	(9)	(229)	97	(20)	341
Net Position, Ending Balance	<u>\$ 1,481</u>	<u>\$ 1,264</u>	<u>\$ 158</u>	<u>\$ (3,053)</u>	<u>\$ 165,453</u>