



DATE: **MAR 15 2002**

TO: Institute and Center Directors
Institute and Center Executive Officers
Institute and Center Budget Officers
OD Senior Staff

FROM: Acting Director, NIH
Deputy Director for Management, NIH

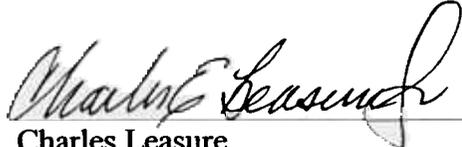
SUBJECT: FY 2001 Chief Financial Officer Act (CFO) and Government
Management Reform Act (GMRA) Audit

Attached are the results of our CFO/GMRA audit for FY 2001. We earned an unqualified opinion from our independent auditors, Ernst and Young, LLP on our financial statements. This is the third year in a row that we have earned an unqualified opinion and is a distinguished accomplishment.

The audit report identifies several internal control weaknesses that we will need to address. In this regard, we will be discussing with Senior OD staff, Executive Officers, and others, alternative approaches for tackling these weaknesses over the next several months.

If we may be of assistance in this matter, you may call Steven Berkowitz on 496-9115 or e-mail him at sb29k@nih.gov.


Ruth L. Kirschstein, M.D.
Acting Director, NIH


Charles Leasure
Deputy Director for Management, NIH

Attachment

**Memorandum**

MAR - 4 2002

Date Deputy Inspector General
From for Audit Services

Subject Report on the Financial Statement Audit of the National Institutes of Health for
Fiscal Year 2001 (A-17-01-00009)

To Ruth D. Kirschstein
Acting Director
National Institutes of Health

The attached final report presents the results of the audit of the Fiscal Year (FY) 2001 financial statements of the National Institutes of Health (NIH). A certified public accounting firm, Ernst and Young, LLP (EY), undertook the audit in support of the Departmentwide financial statement audit by the Office of Inspector General (OIG) and in accordance with the Government Management Reform Act of 1994. The OIG exercised technical oversight and quality control over the audit.

The audit objectives were to determine whether (1) the NIH consolidated balance sheets as of September 30, 2001 and 2000, and the related consolidated statements of net cost for the FYs then ended, as well as the consolidated statements of changes in net position and financing, and the combined statement of budgetary resources for the FY ended September 30, 2001, were fairly presented in all material respects; (2) NIH internal controls provided reasonable assurance that transactions were properly recorded and accounted for to permit the preparation of reliable financial statements; and (3) NIH complied with laws and regulations that could have a direct and material effect on the financial statements.

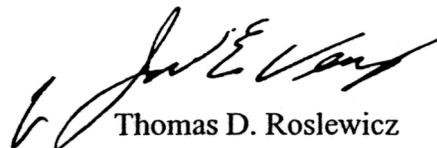
In the auditor's opinion, the financial statements referred to above present fairly, in all material respects, the financial position of NIH as of September 30, 2001 and 2000, and its net costs for the years then ended; as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2001 in conformity with accounting principles generally accepted in the United States.

While progress has been made in providing reliable financial information, the auditor's report on internal controls noted a repeat material weakness in the area of financial systems and processes. The NIH continues to be impaired by the absence of a fully integrated financial management system, as well as the lack of sufficient financial analyses and reviews. In addition, this year a material weakness was noted in the area of investments in management systems due to inadequate and inconsistent documentation to support decisions made regarding the new systems and to support the tracking of financial activities. The report on internal controls also noted eleven reportable conditions; one was a new issue, nine were repeat reportable conditions, and one was downgraded from a material weakness reported in FY 2000.

In the report on compliance with laws and regulations, the auditors noted that NIH's financial management systems are not fully compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA) in the areas of analysis and development of financial statements; preparation and use of adjusting journal entries; and tracking and analysis of outstanding obligations, accounts payables, and accounts receivables in its subsidiary ledgers. Furthermore, the auditors noted an instance, exclusive of the FFMIA, of noncompliance with laws and regulations that are required to be reported under *Government Auditing Standards* or Office of Management and Budget Bulletin 01-02. This instance related to requirements of Title 42, *The Public Health Service Act*.

The firm has incorporated comments to the report where appropriate. Officials in your office have concurred with the recommendations and have or are in the process of taking corrective action. We would like to thank you and your staff for the cooperation and assistance in working with us and the firm on the FY 2001 financial statement audit.

We would appreciate your views and the status of any further action taken or contemplated on EY's recommendations within 60 days. Should you wish to discuss this report, please call me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157. Please refer to the Common Identification Number A-17-01-00009 in all correspondence relating to this report.



Thomas D. Roslewicz

Attachment

cc:
George Strader
Deputy Chief Financial Officer
Department of Health and Human Services

Charles E. Leasure, Jr.
Chief Financial Officer
National Institute of Health
Department of Health and Human Services

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REPORT ON THE FINANCIAL STATEMENT
AUDIT OF THE NATIONAL INSTITUTES OF
HEALTH FOR FISCAL YEAR 2001**



**JANET REHNQUIST
INSPECTOR GENERAL**

**MARCH 2002
A-17-01-00009**



Memorandum

MAR - 4 2002

Deputy Inspector General
for Audit Services

Report on the Financial Statement Audit of the National Institutes of Health for
Subject Fiscal Year 2001 (A-17-01-00009)

To Ruth D. Kirschstein
Acting Director
National Institutes of Health

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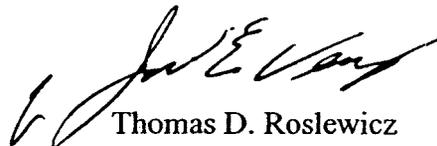
In the auditor's opinion, the financial statements referred to above present fairly, in all material respects, the financial position of NIH as of September 30, 2001 and 2000, and its net costs for the years then ended, as well as the changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for FY 2001 in conformity with accounting principles generally accepted in the United States.

While progress has been made in providing reliable financial information, the auditor's report on internal controls noted a repeat material weakness in the area of financial systems and processes. The NIH continues to be impaired by the absence of a fully integrated financial management system, as well as the lack of sufficient financial analyses and reviews. In addition, this year a material weakness was noted in the area of investments in management systems due to inadequate and inconsistent documentation to support decisions made regarding the new systems and to support the tracking of financial activities. The report on internal controls also noted eleven reportable conditions; one was a new issue, nine were repeat reportable conditions, and one was downgraded from a material weakness reported in FY 2000.

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The firm has incorporated comments to the report where appropriate. Officials in your office have concurred with the recommendations and have or are in the process of taking corrective action. We would like to thank you and your staff for the cooperation and assistance in working with us and the firm on the FY 2001 financial statement audit.

We would appreciate your views and the status of any further action taken or contemplated on EY's recommendations within 60 days. Should you wish to discuss this report, please call me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157. Please refer to the Common Identification Number A-17-01-00009 in all correspondence relating to this report.



Thomas D. Roslewicz

Attachment

cc:
George Strader
Deputy Chief Financial Officer
Department of Health and Human Services

Charles E. Leasure, Jr.
Chief Financial Officer
National Institute of Health
Department of Health and Human Services

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REPORT ON THE FINANCIAL STATEMENT
AUDIT OF THE NATIONAL INSTITUTES OF
HEALTH FOR FISCAL YEAR 2001**



**JANET REHNQUIST
INSPECTOR GENERAL**

**MARCH 2002
A-17-01-00009**



NATIONAL INSTITUTES OF HEALTH

Audited Annual Financial Statements

Fiscal Years Ending September 30, 2001 and September 30, 2000

Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services, and
Director of the National Institutes of Health

We have audited the consolidated balance sheets of the National Institutes of Health (NIH), an operating division of the Department of Health and Human Services as of September 30, 2001 and 2000, and the related consolidated statements of net cost for the years then ended, and the statements of changes in net position and financing and combined statements of budgetary resources for the fiscal year ended September 30, 2001. These financial statements are the responsibility of the NIH's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits for the years ended September 30, 2001 and 2000 in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*. These standards and requirements require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the NIH as of September 30, 2001 and 2000, and its net costs for the years then ended and the changes in net position, budgetary resources, and its reconciliation of net costs to budgetary obligations for the fiscal year ended September 30, 2001, in conformity with accounting principles generally accepted in the United States.

Our audits were conducted for the purpose of expressing an opinion on the financial statements referred to in the first paragraph. The information in the Management's Discussion and Analysis (MD&A) and the Supplemental Information is not a required part of the NIH's financial statements, but is considered supplementary information required by OMB Bulletins 97-01, as amended, and 01-09 as applicable, *Form and Content of Agency Financial Statements*. Such information has not been subjected to the auditing procedures applied in the audit of the financial statements, and accordingly, we express no opinion on it.

However, we were unable to assess the control risk relevant to NIH's governmental transactions and balances, as required by OMB Bulletin 01-02, because reconciliations were unable to be performed with certain federal trading partners as required by January 7, 2000 technical amendments to OMB Bulletin 97-01.

In accordance with *Government Auditing Standards*, we have also issued our reports as of and for the year ended September 30, 2001 dated January 31, 2002, on our consideration of the NIH's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Ernst + Young LLP

January 31, 2002



NATIONAL INSTITUTES OF HEALTH

Audited Annual Financial Statements

Fiscal Years Ending September 30, 2001 and September 30, 2000

NATIONAL INSTITUTES OF HEALTH

Management's Discussion and Analysis
Audited Annual Financial Statements for FY 2001 and FY 2000

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INTRODUCTION

General Purpose and Requirements.

This document, referred to as the "Annual Financial Statement," contains the National Institutes of Health's (NIH) management discussion and analysis and its audited financial statements for fiscal year 2001.

This document serves several purposes. It discloses the NIH financial position and results of operations. It provides information that demonstrates the effective use of NIH resources in order that Congress, the public, OMB, Federal agencies and others may assess the NIH's management performance and stewardship. And it meets the legislative and regulatory guidelines for financial reporting.

This document has been prepared in accordance with the requirements of 31 U.S.C. 3515(a) or (b), which have been further defined in the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994. The format of this document meets the requirements of the Office of Management and Budget (OMB) and the Department of Health and Human Services (DHHS) form and content for audited financial statements as well as the Statements of Federal Financial Accounting Standards (SFFASs) recommended by the Federal Accounting Standards Advisory Board (FASAB).

MANAGEMENT DISCUSSION & ANALYSIS

General Description.

This section complies with the format and content defined in OMB Bulletin No. 97-01. It contains a brief description of the NIH, its mission, activities, programs, financial results, and financial condition. In adherence to the guidelines set forth under the Government Performance and Results Act (1993), this overview also contains performance goals and results that are consistent with the measures used by NIH as part of its GPRA implementation efforts.



THE NIH MISSION AND ITS LONG TERM GOALS

Introduction

Begun as a one-room Laboratory of Hygiene in 1887, the National Institutes of Health is today the Federal focal point for biomedical research in the United States and one of the leading medical research centers in the world. From a total budget of \$300 in 1887, the NIH budget has grown to more than \$20 billion in 2001.

Today, NIH not only conducts research in its own laboratories, but it also supports non-Federal researchers working in universities, medical centers, hospitals, and research institutions throughout the country and abroad. In this manner, the NIH expands fundamental knowledge about the nature and behavior of living systems, improves and develops new strategies for the diagnosis, treatment, and prevention of disease, reduces the burdens of disease and disability, and ensures a continuing cadre of outstanding scientists for future advances.

NIH Mission

The mission of the National Institutes of Health is to uncover new knowledge about the prevention, detection, diagnosis, and treatment of disease and disability. The NIH carries out this mission in several ways. It conducts research in its own laboratories. It supports research of non-Federal scientists in universities, medical centers, hospitals, and research institutions throughout the country and abroad. It helps train research investigators. And it fosters communication of medical information.

Medical innovation is one of the principal foundations on which America's past successes in improving healthcare have been built. It is where hope for the future resides. History provides abundant evidence that medical progress rarely occurs without the sustained pursuit of advances in basic and behavioral science. Through the conduct and support of medical research, the NIH seeks to expand fundamental knowledge about the nature and behavior of living systems; to improve and develop new strategies for the diagnosis, treatment, and prevention of disease; and to reduce the burdens of disease and disability.

**Long Term
Goals**

The NIH invests the public's resources and support for medical science in three basic and interrelated ways. **First and foremost, the NIH conducts and supports medical research. Second, it contributes to the development and training of the pool of scientific talent. Third, it participates in the support, construction, and maintenance of the laboratory facilities necessary for conducting cutting-edge research.**

The long term goals of NIH encompass the following important domains of agency activity:

- Increase understanding of normal and abnormal biological functions and behavior.
- Improve prevention, diagnosis, and treatment of diseases and disabilities.
- Promote development of a talent base of well-qualified, highly trained, and diverse investigators capable of yielding the scientific discoveries of the future.
- Secure facilities for research that are modern, efficient, and safe.

The agency's activities and strategies discussed throughout this plan are directed at realizing all of these overarching goals.

NIH ORGANIZATIONAL STRUCTURE**Organizational
Structure**

The NIH is one of eight health agencies of the Public Health Services which, in turn, is part of the U.S. Department of Health and Human Services. The NIH is comprised of many separate components, mainly Institutes and Centers (ICs, or "Institutes"). While its "campus" consists of 75 buildings on more than 300 acres in Bethesda, Maryland, the NIH has additional research and administrative facilities in Rockville, Frederick, and Baltimore, Maryland as well as in North Carolina, Arizona, and Montana.

The NIH that is "visible" to most Americans encompasses the research institutes focused on diseases (e.g., cancer or diabetes), primary organ systems (e.g., heart, eye, or kidney), or a stage of life (e.g., children or the aging). Yet, no less essential to the Nation's health are the NIH programs that address overarching scientific needs and opportunities. Included here are such efforts as deciphering the human genome, understanding cellular and tissue biology and physiology, training investigators in relevant scientific fields, and developing an array of technologies dictated by the needs of cutting-edge research. All are scientific innovations that transform clinical practice and enhance the capabilities and quality of routine medical treatment.

**Research
Communities**

The Extramural Research Community. More than \$8 out of every \$10 dollars appropriated to NIH flows out to the scientific community at large—the "extramural research community"—of which the lion's share supports individual scientists. The extramural research community comprises scientists affiliated with universities, hospitals, and other research facilities located in all 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and points abroad. This extramural research community is premised on several factors: ***Independence***, embodied in "investigator-initiated" research; ***Accountability***, embodied in peer review of scientists by scientists as the primary basis for judging the merits of research proposals and



awarding funds; and *competition*, embodied in the powerful incentives of reward and recognition among the most highly trained scientists in the world.

The Intramural Research Community. A much smaller fraction of the funds—approximately 11 percent of the budget—supports a core program of basic and clinical research activities aimed at providing scientific, clinical, and educational benefits to the citizens of the United States and the world. This in-house—*intramural*—research program includes the NIH Clinical Center (CC) and other laboratories and research facilities residing on the NIH campus and as far away as Montana. These facilities are administered and staffed by NIH scientists, physicians, nurses, technicians, and administrators. These individuals support or conduct biomedical research in the laboratories or deliver patient care to those individuals and families from around the globe who come to participate in NIH experimental treatments.

NIH CORE PROGRAMS

Introduction

The NIH undertakes its mission through activities in three Core Program Areas: 1) *Research*, 2) *Research Training and Career Development*, and 3) *Research Facilities*.

The *Research Program* represents all aspects of the medical research continuum. This includes basic research (which may be disease-oriented), observational and population-based research, behavioral research, health services research, and clinical research. The latter includes research to understand both normal health and disease states, to move laboratory findings into medical applications, to assess new treatments, and to compare different treatment approaches. In addition, the timely dissemination of medical and scientific information is a key component of the Program. This includes providing benefits to human health and care through the expeditious transfer of results from the research laboratory to the patient's bedside.

The *Research Training and Career Development Program* addresses the need for creative and capable personnel to conduct medical research. The primary goal of NIH support for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the nation's health. Our ability to maintain the momentum of recent scientific progress and our international leadership in medical research depends upon the continued development of new, highly trained investigators.

The *Research Facilities Program* focuses on ensuring that the scientists we support have suitable facilities in which to conduct their work. NIH recognizes that ensuring broad access to these technologies creates efficiencies that make the research dollar go farther. Appropriate research technologies can help speed up the pace of research and lead to more medical research advances and effective treatment for illnesses.

The Core Programs are aggregates of the many specific programs and activities underway across the NIH. This aggregation is due to the cross cutting nature of disease and scientific discovery. By aggregating activities that are intrinsically collaborative and complementary, NIH neither omits nor minimizes the significance of any particular activity that contributes to a major function or operation for the agency as a whole. (Table 1)



| Resources | Budget Mechanisms | Core Programs | Program Areas |
|---|--|--|---|
| \$20.5 billion appropriated for FY 2001 NIH Staff Extramural Scientists Contractors Universities, Research Centers and NIH Facilities | <ul style="list-style-type: none"> • Research Project Grants • Research Centers • Other Research • Research Training • R&D Contracts • Intramural Research • Research Management and Support • Cancer Control • Construction • Library of Medicine • Office of the Director • Buildings and Facilities | Research | Research Communication of Results Technology Transfer Research Leadership and Administration |
| | | Research Training and Career Development | Training Support and Outreach |
| | | Research Facilities | Intramural Modernization and Maintenance Extramural Assistance |

Table 1. NIH Core Program Areas

Research Program

NIH's research Institutes and Centers (ICs) maintain extensive medical research programs on numerous topics in their areas of focus. The Core Research Program concentrates these topics into 4 functional areas: Research, Communication of Results, Technology Transfer, and Research Leadership and Administration. (Table 2)

In addition to providing grant support to the extramural research community through a competitive application process, most of the ICs also conduct their own research in NIH's intramural laboratories. Each year, NIH receives proposals to initiate new research--from the most promising and productive scientists at universities and research centers throughout the country and, where special opportunities exist, from scientists abroad.

The NIH identifies goals and a budget strategy annually to maximize support for basic biomedical research, to promote health, and to better understand the biological and behavioral basis for disease to improve prevention and treatment of human disorders.

The nation's investment in medical research has a long history of success. In recent years, NIH has been able to report annually on advances that represent outstanding achievements in science. Typically, these achievements are the result of past investments made with the belief that medical research will lead to improvements in the nation's health. The Federal effort devoted to medical research, combined with private sector efforts, can and does, improve the length and quality of our lives.

Scientific research is best viewed as an investment for the long term—because of the intrinsic difficulties and uncertainties of probing the unknown. Discoveries and significant advances typically emerge in an uneven way over time and are, as a practical matter, largely impossible to predict in advance. Once in hand, however, progress can often proceed rapidly. Accordingly,



NIH's performance goals for the Research Program focus on broad, long-run achievements in key areas that reflect the agency's mission.

| Research Program | | | |
|------------------------|---|---------------------|----------------------|
| Budget | FY 2000 Actual Cost | FY 2001 Actual Cost | Percent Change |
| | \$14,690 million | \$16,007 million | 9.0 percent increase |
| Major Functional Areas | <p>Research—NIH's ongoing scientific enterprise. This includes research conducted through grant awards and contracts to individual investigators and organizations in the Extramural Research community. It also includes research conducted at NIH's Intramural labs. The intended long-run outcomes of all these activities are increased understanding of normal and abnormal biological functions and behavior and improved prevention, diagnosis, and treatment of diseases and disabilities.</p> | | |
| | <p>Communication of Results—Communicate scientific results and health information to the medical research community, health care providers, patients, and the general public.</p> | | |
| | <p>Technology Transfer—Promote the efficient transfer of the new technology forthcoming from NIH research to the private sector to facilitate the development of new drugs and other products of benefit to human health.</p> | | |
| | <p>Research Leadership and Administration</p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>Priority setting</i>—implementing decision-making mechanisms and policies that ensure NIH research is responsive to emerging health needs, scientific opportunities, and new technologies. <input type="checkbox"/> <i>Grants administration and peer review</i>—maintaining effective and efficient grants administration and a high quality of peer review to ensure the most meritorious research projects are considered for funding. <input type="checkbox"/> <i>Agency management and administrative support</i>—ensuring that management and administrative functions necessary to support the NIH mission are carried out effectively and efficiently. | | |

Table 2. NIH Core Research Program

Research Training and Career Development Program

The Research Training and Career Development Program addresses the NIH's major, long-term goal to "promote the development of a suitable talent base of well qualified, highly trained, and diverse investigators capable of yielding the scientific discoveries of the future." (Table 3)

To achieve this long-term outcome, NIH provides training support through National Research Service Award (NRSA) and other Career Development Awards programs and undertakes outreach activities to encourage individuals' interest in scientific careers. These programs are designed to increase our ability to attract and retain the best and brightest minds in biomedical research and to develop a corps of well-trained, highly skilled individuals who are ready to "hit the road running" as post-doctoral researchers and principal investigators. NIH's training and career development programs are also designed to enhance the diversity of the biomedical research labor force.



The NRSA training programs teach pre- and post-doctoral trainees how to conduct innovative, high-quality science—including how to choose problems, choose model systems, develop logical hypotheses, design experiments, and conduct research with the highest ethical standards. The multi-disciplinary approach used helps trainees recognize the connections among different fields that aid a scientist in selecting the best approach to a research problem. Career development programs ensure that the NIH can recruit and retain clinicians in order to advance medical knowledge and public health.

| Research Training and Career Development Program | | | |
|--|--|---------------------|-----------------------|
| Budget | FY 2000 Actual Cost | FY 2001 Actual Cost | Percent Change |
| | \$871 million | \$1,118 million | 28.4 percent increase |
| Major Functional Area | Training Support and Outreach—Enhance training programs at the pre-doctoral, postdoctoral, and early career developmental levels to ensure a continuing supply of capable individuals in areas of National need; and encourage participants to pursue research careers and foster the recruitment and retention of under represented groups into careers as researchers. | | |

Table 3. NIH Core Research Training and Career Development Program

Research Facilities Program

The Research Facilities Program addresses NIH's long-term goal to "secure facilities for research that are modern, efficient and safe." NIH's activities and resources in this Core Program area are directed along two principal lines: Intramural Modernization and Improvements and Extramural Assistance. (Table 4)

Intramural Modernization and Improvements—NIH occupies Federally-owned facilities, which undergo refurbishment to keep pace with rapidly changing technologies and priorities in medical and behavioral research. In addition to the buildings located on the main NIH campus in Bethesda, Maryland and the National Institute of Environmental Health Science (NIEHS) campus in Research Triangle Park, North Carolina, the NIH maintains several off-campus field stations. These include the following:

- The NIH Animal Center in Poolesville, Maryland.
- The Frederick Cancer Research and Development Center at Fort Detrick in Frederick, Maryland.
- The Gerontology Research Center in Baltimore, Maryland.
- The Rocky Mountain Laboratory in Hamilton, Montana, and New Iberia, Louisiana.

Facilities revitalization goals are established through a process that includes an annual evaluation of building and facility program priorities. This effort culminates in the NIH Buildings and Space Plan, the Agency Capital Plan, and a Five-Year Development Program. Other tools used to plan, program, and budget for capital assets include: Facility assessments and surveys, engineering studies, technologically driven initiatives and advancements, changes



in regulatory requirements, and the recommendations of the approved NIH Facilities Master Plan.

The Buildings and Facilities program (B&F) is composed of five major areas: Essential Safety and Health Improvements, Repair and Improvements, New Construction, Renovations, and Building Equipment/System Upgrades. The focus of the B&F is to provide facilities which are in compliance with applicable safety, accreditation, and other regulatory requirements; efficient in terms of indoor and outdoor environment and energy consumption; and effective in meeting research needs.

Extramural Assistance—NIH is authorized under the Public Health Service Act to “make grants to public and non-profit private entities to expand, remodel, renovate or alter existing research facilities or construct new research facilities” for medical and behavioral research and research training. These extramural research facilities grants are awarded competitively, with grantee institutions required to obtain matching funds for the specific project awarded. The NIH collaborates with the National Science Foundation to assess the condition of existing research facilities and identify construction priorities nationwide. These studies provide the major source of objective data for national research infrastructure policy and facility planning. When particular projects are identified, the NIH offers competitive funding opportunities. This support encompasses the “bricks & mortar” modernization and replacement of existing research facilities—all of which result in new capabilities that can open areas of innovative research activity.

| Research Facilities Program | | | |
|-----------------------------|--|------------------------|----------------------|
| Budget | FY 2000 Actual Cost | FY 2001 Actual Cost | Percent Change |
| | \$187 million | \$179 million | 4.5 percent decrease |
| Major Functional Areas | Intramural Modernization and Improvements – Support the construction, renovation, and maintenance of NIH research facilities located on the Bethesda campus and at off-campus field stations to enable NIH intramural researchers to continue to conduct state-of-the-art medical research. | | |
| | Extramural Assistance —Assist in the construction and modernization of non-Federal facilities at academic institutions and other centers of research excellence to enhance their ability to begin new and continue to conduct high-quality research. | | |

Table 4. NIH Core Research Facilities Program

SUMMARY OF FY 2001 PERFORMANCE GOALS

This part of the Management Discussion and Analysis describes several of NIH’s performance goals and targets for FY 2001 and their respective outcomes as of November 29, 2001. The presentation is organized according to the three Core Programs that NIH identifies for GPRA purposes: Research, Research Training and Career Development, and



Research Facilities. The performance goals for these Programs are subsequently divided according to the major functional areas involved.

Research Program

Research

Goal: Develop critical genomic resources, including the DNA sequences of the human genome and the genomes of important model organisms and disease-causing microorganisms.

FY 2001 Targets

Human Genome Project:

1. Worldwide effort completes "full shotgun" of human genome sequence (95% complete, 99.9% accurate).
2. Finish one-third of human genome (accuracy of at least 99.99%).
3. Identify 2,500,000 human single nucleotide polymorphisms (SNPs).
4. Complete 2X depth of coverage toward the working draft of the mouse genome (90% coverage, 99% accurate).
5. Complete 1X depth of coverage toward the working draft of the rat genome (90% coverage, 99% accurate).

Genomes of Pathogenic Microbes:

6. Complete sequencing of five additional bacterial pathogens and five chromosomes of protozoan parasites.
7. Augment existing knowledge of pathogen genomes by initiating sequencing projects for at least six additional genomes (bacterial, fungal, parasitic).
8. Complete worldwide sequencing effort of the entire genome of *Plasmodium falciparum*.

FY 2001 Accomplishments

Human Genome Project:

1. The Human Genome Project public consortium succeeded in meeting its target to complete a "full shotgun" of the human genome sequence.
2. Fifty-four percent of the genome was in the completely finished form that has an accuracy of 99.99 percent and no remaining, close-able gaps.
3. The public database that serves as a central repository for SNPs (dbSNP) had received submissions for 3,845,467 SNPs for the human genome as of September 30, 2001.
4. 3X depth of coverage of the mouse DNA sequence has been achieved.
5. The Rat Sequencing Consortium has completed nearly 2X coverage of the rat genome in whole genome sequence reads.



Genomes of Pathogenic Microbes:

6. The genome sequences of five bacterial pathogens were published in FY 2001. Also, manuscripts are in preparation for five other bacterial pathogens. Sequencing of more than five chromosomes of protozoan parasites is ongoing.
7. NIH initiated genome-sequencing projects for nine pathogens in FY 2001.
8. The sequences of chromosomes 2 and 3 have been published and outstanding progress has been made on the remaining chromosomes. Preliminary sequence data and annotation for chromosomes 10, 11, and 14 are available. It is anticipated that the complete genome sequence of *P. falciparum* will be published in 2002.

Communication of Results
Goal: Establish a Clinical Trials Database, as required by the FDA Modernization Act

ClinicalTrials.gov
A service of the National Institutes of Health
Developed by the National Library of Medicine
Linking patients to medical research

FY 2001 Targets

1. Promote the database as a resource for patients, physicians, researchers, community health groups and others.
2. Complete an implementation study to determine the optimal design and function of a toll-free telephone to facilitate access to information in the Clinical Trials Database.
3. Expand the number of industry-sponsored clinical trials in the database by 250 and the number sponsored by other Federal agencies by 100.

FY 2001 Accomplishments

1. NIH promoted the ClinicalTrials.gov database as a resource for patients, physicians, researchers, community health groups and others. The site receives about 2 million hits per month and hosts approximately 5,300 visitors daily.
2. NIH completed an implementation study in March 2001 to determine the optimal design and function of a toll-free telephone service to facilitate access to the clinicaltrials.gov database.
3. The number of industry sponsored clinical trials was increased to over 100. The number sponsored by Federal agencies doubled in FY 2000.

Technology Transfer
Goal: Increase the number of scientists who have received training in technology transfer.

FY 2001 Target

1. Seek to have 15% of scientists complete the training module, and/or attend technology transfer seminars.

FY 2001 Accomplishments

1. The full implementation of the system was delayed to allow NIH Scientific Directors to participate in the review of the system before the "official" launch date in FY 2002.



Research Leadership and Administration:

Grants Administration and Peer Review

Goal: Improve Electronic Research Administration (ERA) technology and enhance communication with the extramural community.

FY 2001 Targets

1. Implement electronic progress reporting with all 65 newly on-line institutions participating in the FDP.
2. Begin pilot testing of progress reporting for multi-project mechanisms.

FY 2001 Accomplishments

1. In the initial pilot, the opportunity to test the system was extended to all 65 FDP institutions. Outcomes of the pilot identified the need to redesign the system in a new technological architecture. This decision afforded the opportunity for further business process reengineering. All business process reengineering for the new system has been completed.
2. Pilot testing for the basic functionality involved in reporting complex mechanisms will begin in FY 2002. The technological infrastructure necessary for development of the system in the new technological environment has been put in place.

Research Leadership and Administration:

Management and Administration

Goal: Expand the use of Performance Based Contracting (PBC).

FY 2001 Target

1. Allocate \$21.2 million of the available NIH contracting dollars to PBC-eligible contracts.

FY 2001 Accomplishments

- 1 The NIH allocated \$36.5 million of its available contracting dollars to PBC-eligible contracts during FY 2001.

Research Leadership and Administration:

Management and Administration

Goal: Improve the efficiency of the small acquisition process by continuing to expand the purchase card program.

FY 2001 Target

1. \$200 million in orders.

FY 2001 Accomplishments

The dollar volume of purchase orders reached \$196 million in FY 2001.



Research Training and Career Development Program

Training Support

Goal: Increase the pool of clinical researchers trained to conduct patient-oriented research.

FY 2001 Targets

1. Issue at least 80 awards each in the K23 and K24 categories over the course of the fiscal year.

FY 2001 Accomplishments

1. The NIH made a total of 184 new K23 awards and 58 K24 awards in FY 2001.

Research Facilities Program

Intramural Modernization and Maintenance

Goal: Complete the Mark O. Hatfield Clinical Research Center.

FY 2001 Target

1. Complete 50 % of construction.

FY 2001 Accomplishment

1. Construction of the Mark O. Hatfield Clinical Research Center reached the 50% phase as scheduled in FY 2001.

Intramural Modernization and Maintenance

Goal: Complete the Louis Stokes Laboratories Building.

FY 2001 Target

1. Complete construction.

FY 2001 Accomplishment

1. Construction of the Louis Stokes Laboratories Building was completed in FY 2001.

OTHER ACCOMPANYING INFORMATION

Operations and Broad Strategy

NIH's mission to advance medical knowledge and sustain the nation's medical research capacity is accomplished by sustained Federal stewardship. It is achieved through a number of fundamental principles that underlie NIH's broad planning and management of its programs and resources. These principles comprise the basic context in which NIH's goal setting and strategic planning operate.

■ **Provide scientific leadership and establish research priorities.** Establishing research priorities is essential to ensuring that science meets national public health priorities and uses resources effectively. The NIH uses a multi-level system to establish and review research priorities. The NIH Director, in collaboration with IC directors and their respective advisory councils and boards and the biomedical research community, guides the priority-setting process. Additional input is sought from the Department of Health and Human Services (DHHS), Congress, and the public. Reflecting the research priorities identified through this process, ICs examine research initiatives and public health needs to ensure that the NIH is committing Federal resources to projects and programs that will achieve the greatest yield from the nation's medical research investment.

Public health priorities and scientific opportunities are the primary drivers in the allocation of resources. In general, the NIH sponsors research that addresses public health priorities to find ways to prevent, treat, or cure disease and to minimize pain and suffering. But public health priorities alone are not enough; there must also be some real opportunity for success.

How do we identify areas of increased scientific opportunity? New knowledge comes from the pursuit of answers to new questions. The rate-limiting step in the generation of new knowledge is not the number of experiments conducted, but rather the number of new hypotheses or questions raised. When an arena of research is enjoying an exponential increase in the number of new questions, it is, indeed, an area of scientific opportunity. New questions emerge as a result of several converging factors, including the creativity of individual investigators, the emergence of new methods and tools that allow previously unanswered questions to be addressed, and what is already known about a problem. It is imperative that the NIH capitalizes on these advances by investing funds in areas of scientific opportunity.

■ **Fund the best research.** Research Project Grants (RPGs) are the core mechanism for NIH support to the individual investigator. Other mechanisms include Program Project Grants, which support multi-disciplinary projects conducted by several collaborating investigators, and Center Grants, which are used to fund multi-disciplinary programs of medical research. Research proposals are submitted to the NIH by scientists working at universities, and at medical, dental, nursing, and pharmacy schools, schools of public health, non-profit research foundations, and private industry. NIH support for a project includes the salaries of the scientists and technicians. It also includes the cost of equipment such as lasers or computers; the cost of supplies such as chemicals and test tubes; and the cost of procedures involved with research subjects. Lastly, NIH awards include indirect costs associated with the costs of doing the research, such as maintenance of

NIH Operating Principles

- *Provide scientific leadership and establish research priorities.*
- *Fund the best research.*
- *Conduct leading-edge research in NIH laboratories.*
- *Effectively disseminate scientific results and research-based health information.*
- *Facilitate the development of health-related products through technology transfer.*
- *Ensure a continuing supply of well-trained laboratory and clinical investigators.*
- *Sustain our Nation's research facilities.*
- *Collaborate and coordinate with others.*

buildings, electricity, library services, and administrative support. Part of the NIH budget is also spent on research and development contracts, which are awarded to non-profit and commercial organizations for work requested and overseen by the NIH.

The NIH funds are awarded through a highly competitive process to the most promising and productive scientists. Extramural research proposals are first evaluated by expert scientific peer review panels composed of non-NIH scientists who are among the most knowledgeable and respected in their fields. The proposals are then reviewed by independent advisory councils whose members include the lay public. This two-tiered independent review system is critical to ensuring that NIH funds the best research proposals.

■ ***Conduct leading-edge research in NIH laboratories.*** The NIH also conducts basic and clinical research in its own (intramural) laboratories. Projects are selected on the basis of scientific merit and public health need. Each institute maintains a Board of Scientific Counselors, composed of external experts, that reviews the intramural programs and makes recommendations to the Institute Director. The intramural program enables scientists to apply the results of laboratory research to patient care and to seek answers in the laboratory to questions that arise in the clinical setting. This national resource permits the NIH to respond rapidly to critical health problems and emergencies and to take advantage of emerging opportunities.

■ ***Effectively disseminate scientific results and research-based health information.*** The NIH develops and disseminates informational materials to individuals and groups, including medical and scientific organizations, industry, the media, and volunteer and patient organizations. Information dissemination efforts have expedited the translation of NIH's scientific advances and technologies into important diagnostic, preventive, and therapeutic products. In addition, they have brought about major health-enhancing changes in public attitudes and behaviors, such as reduction of smoking and better control of high blood pressure and high cholesterol levels. To effectively reach diverse audiences, whose knowledge of science and health differ, the NIH disseminates information ranging from highly technical research advances to the steps individuals can take to improve their own health.

The NIH disseminates information on scientific findings and technologies to scientific and other health professionals through various avenues. These may include scientific publications, workshops and symposia, scientific meetings, consensus development conferences, press releases, special physician education programs, and clinical alerts concerning immediate health and safety issues. NIH also provides access to information about scientific articles, NIH research grants, clinical trials, and treatment through extensive electronic databases.

To respond to the public, Congress, and the media, the NIH employs information offices, clearinghouses, electronic databases, Internet-based information services, public education programs, publications and press releases as well as direct responses by letter and telephone. These provide information regarding participation in research protocols; the best current information on disease prevention and health promotion, diagnosis, and treatment of specific diseases and disorders; information about ongoing research; and referrals to other sources of information.



■ ***Facilitate the development of health-related products through technology transfer.*** The NIH has a statutory authority to transfer new biomedical technologies to the private sector for further development and commercialization. NIH's technology transfer programs ensure that the public investment in NIH research leads rapidly to beneficial health-related products, including preventives, diagnostics, therapeutics, and vaccines.

Many NIH research results are converted into commercial medical products, typically through the publicly available knowledge base created by NIH-supported research. The public also benefits from NIH technology transfer activities, including Cooperative Research and Development Agreements (CRADAs) with the private sector and the licensing to industry of intellectual property rights arising out of CRADAs and other NIH research. Virtually all NIH licenses negotiated with industry produce royalties.

■ ***Ensure a continuing supply of well-trained laboratory and clinical investigators.*** Whereas supporting research is essential, it is equally important to ensure the availability of well-trained investigators who reflect our Nation's diversity and who have specialized knowledge, methodological expertise, and creativity. The NIH's research training grant portfolio covers all the career stages that are key to the recruitment, training, and retention of productive medical researchers.

One of the goals of research training is to teach pre- and post-doctoral students how to conduct innovative, high-quality science, including how to identify problems, develop hypotheses, design experiments, choose model systems, and see connections among different fields that allow a scientist to make quantum leaps in understanding a problem. Mentors are a critical training resource, serving as role models and providing guidance that ensures trainees develop into successful investigators.

■ ***Sustain our Nation's research facilities.*** The NIH must continually support the development, maintenance, and renewal of physical resources that are vital to the rapid pace of scientific discovery. The past achievements of medical research have required access to state-of-the-art laboratories. Up-to-date and safe research facilities are essential to assuring continued progress in the medical sciences. To support intramural research, NIH constructs new facilities and renovates existing ones. The NIH also provides support to extramural grantees through research facilities construction grants designed to assist in the construction and modernization of non-Federal research facilities.

■ ***Collaborate and coordinate with others.*** The NIH collaborates and coordinates on an ongoing basis with other Federal agencies and research organizations where research interests intersect and when joint efforts will enhance the individual activities of each entity. Medical research benefits from multiple perspectives being brought to bear on a particular problem. Collaborative efforts bring diverse domains of expertise together and can facilitate a more rapid response to emerging opportunities. In addition, collaborative efforts work to produce the best possible science while making the most economical use of the resources available.

These collaborative endeavors frequently involve the NIH's sister agencies in DHHS, including the Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ). Nonetheless, the full scope of the NIH's collaborative activities—both in the past and those contemplated for the future—is



far wider, including many other Federal agencies, government bodies, non-governmental organizations, and industry.

Results of Operations

The NIH received an increase of approximately 14.5 percent in its budget authority from congressional appropriations for FY 2001 compared with FY 2000. This increase was part of a bipartisan effort to double the NIH FY 1998 budget by FY 2003.

The net cost of NIH operations for FY 2001 was \$17,304 million; of this amount, \$16,007 million was for the Research Program; \$1,118 million was for the Training and Career Development Program; and \$179 million was for the Facilities Program.

The net cost for the NIH Research Program increased by 9.0 percent from FY 2000. The net cost for the NIH Training and Career Development Program increased by 28.4 percent from FY 2000. The net cost for the NIH Facilities program decreased by 4.5 percent from FY 2000, representing the completion of certain construction projects during FY 2001.

To further illustrate the three major programs that the NIH supports during fiscal year 2001, the NIH funded 34,122 research project grants, 1,061 research centers, 16,464 full-time training positions, 3,271 research career awards, and 1,313 research contracts. In addition, the NIH employs staff who conducts research in NIH laboratories, collaborate and oversee extramural research portfolios, review grant and contract applications, and conduct stewardship over NIH resources.

The following table compares the number of grants and contracts that NIH funded in FYs 1999, 2000, and 2001:

| <i>ITEM</i> | <i>FY 1999 Actual</i> | <i>FY 2000 Actual</i> | <i>FY 2001 Actual</i> |
|------------------------------|-----------------------|-----------------------|-----------------------|
| Research Project Grants | 30,233 | 32,184 | 34,122 |
| Research Centers | 909 | 951 | 1,061 |
| Full-Time Training Positions | 15,768 | 15,830 | 16,464 |
| Research Career Awards | 2,591 | 2,898 | 3,271 |
| Research Contracts | 1,159 | 1,219 | 1,313 |

By far the largest NIH asset is its fund balance with the U.S. Treasury. This balance of \$19,721 million represents the amount of resources that has not been disbursed to grantees, contractors, research fellows, intramural scientists, or other NIH employees as of September 30, 2001.

The NIH provides research goods and services on a reimbursable basis to other Federal government agencies. As of September 30, 2001, the amount due NIH from these agencies was approximately \$108 million. NIH property, plant, and equipment include both real and personal property in facilities and research laboratories located in Maryland, North Carolina, Montana, and Arizona. The historic cost less accumulated depreciation of these assets total \$1,151 million.



As of September 30, 2001, the PMS had advanced to grantees almost \$991 million more than we had advanced to PMS, thus we have an accrued grant liability of \$991 million.

Collaboration with Other Federal Agencies

NIH conducts research in partnerships with other Federal agencies in areas of mutual interest or where the benefits from cooperation are strong. These collaborative endeavors often involve the NIH's sister agencies in DHHS, such as the Centers for Disease Control and Prevention (CDC), and the Agency for Healthcare Research and Quality (AHRQ). Partnerships with other agencies have included the Department of Energy (DOE) and the National Aeronautics & Space Administration (NASA).

A sampling of NIH's diverse research collaborations with other Federal agencies is as follows:

- **Human Genome Project.** NIH is currently working with the Department of Energy (and with other international collaborators) on the major effort to sequence the large and complex human genome. This endeavor is widely regarded as the single most important project currently in biology and biomedical science.
- **DNA Polymorphism Discovery Resource.** In one of numerous related studies, NIH worked recently with CDC and several independent scientists to assemble DNA samples from several hundred U.S. residents with ancestry from all the major regions of the world. This material will provide a resource of immense value for identifying human genetic variations, through which other studies can seek to relate to health and disease.
- **National Emphysema Treatment Trial.** NIH is collaborating with the Centers for Medicare and Medicaid Services and the AHRQ in a multi-center clinical trial designed to determine the role, safety, and effectiveness of bilateral lung volume reduction surgery in the treatment of emphysema.
- **Managing Pfiesteria and other harmful algal blooms.** In 1997, NIH worked collaboratively with a number of major Federal agencies to develop a coordinated research strategy to identify ways to manage the health and environmental threats associated with *Pfiesteria* and other harmful algae blooms. These included the National Oceanic and Atmospheric Administration (NOAA), the Environmental Protection Agency (EPA), CDC, the U.S. Department of Agriculture (USDA), Department of the Interior (DOI), and the Food and Drug Administration (FDA).

Relationships with Private Industry

The NIH also works with private industry in a number of ways to further NIH's research mission and to facilitate the flow of new biomedical knowledge and technologies to the private sector for further development and commercialization.

Among the various kinds of relationships possible, direct collaboration on research projects—such as in the areas of vaccines, medical imaging, or other diagnostic tools—is one important approach. Another is NIH's substantial efforts to facilitate the transfer of publicly funded research findings and technologies to the private sector. Additionally, NIH undertakes clinical trials on new drugs and therapies that may have considerable commercial interest to the private sector.

Some examples of these relationships with the private sector include:

- ***Vaccine research and development.*** Most currently available vaccines, as well as those in the development pipeline, have resulted from collaborations between partners in the public and private sector, including Federal and state governments, small and large corporations, academic research institutions and non-governmental organizations.
- ***Technology Transfer through Cooperative Research and Development Agreements (CRADAs).*** CRADAs are one major technology transfer mechanism used by NIH to enable private companies to work collaboratively with Federal laboratory scientists and technologists in activities with the promise of yielding new technologies. (The CRADA mechanism was established by the Congress in 1986.)

Clinical Trials. For example, NIH conducted a Phase I/II trial of recombinant methionyl human stem cell factor in patients diagnosed with acquired aplastic anemia. This trial was sponsored by Amgen, Inc., the private industry producer of the recombinant methionyl human stem cell factor.

In the future, we may be expanding substantially our collaborations with private industry as we seek better vaccines to prevent and drugs to treat biological threats.

NIH Anti-Bioterrorism

The NIH anti-bioterrorism research program is targeted at the design, development, evaluation and approval of the specific public health tools (diagnostics, therapies and vaccines) needed to control a bioterrorist-caused outbreak. This research includes the development of rapid, accurate diagnostics for natural and bioengineered microbes; effective antimicrobial medicines to treat those infected; and protective vaccination for those at risk of exposure. Basic research provides the essential underpinning for the other research areas. A major new area of emphasis for NIH is the generation of genome sequence information on potential bioterrorism agents. The results of this basic genomics research, coupled with other biochemical and microbiological information, are expected to facilitate pursuit of the development of diagnostics, therapies and vaccines.

Post-September 11, 2001, Activities

Since September 11, 2001, the NIH has conducted multiple evaluations on the status and direction of biomedical research in the areas of bioterrorism prevention and treatment, and evaluated what the nation and NIH should do

to support this research. The scope of these evaluations have expanded or contracted several times as threats and related information have evolved.

The future implications of our efforts is that we may be expanding substantially our investment in basic and clinical research aimed at identifying vaccines to prevent and better drugs to treat a variety of biological threats.

NIH Business System



The need for a new business system that incorporates a modern general ledger with integrated subsidiary and business management systems has been identified in recent audit reports as a major step towards removing a material weakness that the NIH has related to accounting systems and financial reporting. The lack of an integrated modern system has led to the NIH receiving a material weakness related to non-compliance with the U. S. Standard General Ledger, the preparation of external financial statements, and the labor intensive process for reconciling most subsidiary systems to the general ledger. Moreover, lacking a modern system requires that the NIH use non-standard journal transactions and may lead to internal control deficiencies.

In part to address these system weaknesses and internal control deficiencies, the National Institutes of Health (NIH), after extensive evaluation of its administrative processes and its current information technology support, has decided to implement an Enterprise Resource Planning (ERP) system, known as the NIH Business System (NBS). The purpose of the system is to enhance administrative support to its biomedical research mission and to replace aging legacy computer support systems. Beyond being a simple automation effort, this project seeks to combine the latest technology with proven best business practices to provide a new level of support to research.

The Administrative Management Systems Steering Committee (AMSSC) provides executive management oversight and decision making for the NBS. The charter vests the AMSSC with the authority to make all policy decisions emerging from the implementation of the NBS, as well as those required for timely implementation. The AMSSC is co-chaired by the Deputy Director for Management, the senior program official of the NIH business community, and the Director, National Institute on Drug Abuse, the representative of the IC Directors, which is the senior decision making body at the NIH. The AMSSC is comprised of senior NIH managers and representatives from stakeholder groups who use the support systems that will ultimately be incorporated into the NBS.

In September 2000, a contract award was made to Oracle for the NBS system software. A three to four year implementation phase is planned. When completed, the NBS will be a single, integrated, transaction-based system. It will link NIH administrative and scientific support functions, including those not currently available through the Administrative Database (ADB). Implementation will include active involvement of the NIH community in all major aspects of developing and deploying the NBS.

NIH Security Program

The NIH security program protects the confidentiality, integrity, and availability of networks and information systems in NIH's ICs. The NIH Incident Response Team (IRT) serves as the focal point for NIH computer security incidents 24 hours a day, 7 days a week (24x7). The IRT identifies computer security incidents, characterizes the nature and severity of incidents, and provides immediate diagnostic and corrective actions when appropriate. The IRT works with Information Systems Security Officers (ISSOs), who serve as the focal points for security policy within ICs. Automated tools used by the IRT include:

- **Scanning tools** – These tools assess the security of hosts connected to the NIH network (NIHnet) by searching for vulnerabilities that hackers use to gain unauthorized access to systems.



- **Intrusion detection software** – This identifies specific attacks levied on NIH systems by monitoring network traffic 24x7 for intrusion signatures.
- **Firewalls** – The IRT uses the NIH firewall to block specific viruses, incident types, and known hacker IP addresses. Some ICs also have their own firewalls that are customized according to their security requirements.
- **Anti-virus software** – NIH uses virus-scanning software to detect and remove viruses at the NIH firewall, the Microsoft Exchange e-mail server, and servers and desktop workstations.

The NIH security program also is responsible for the following activities:

- Administering an NIH-wide IT security awareness training program that provides and develops specialized IC awareness training and support.
- Coordinating the development of System Security Plans and Risk Assessments.
- Developing security policies and guidelines.
- Performing audits of computer account de-registration process to ensure that accounts are being discontinued for unauthorized users who leave NIH or transfer between ICs.
- Maintaining inventories of IT assets, including telecommunications and biomedical equipment.
- **Physical Security** – NIH enforces physical security procedures to protect systems resources located at the NIH Computer Center from access by unauthorized individuals. Control over access to the NIH Computer Center is maintained through the following:
 - The Chief of the Systems Operations Management Section (SOMS) exercises sole approval authority over all computer room cardkey access privileges other than for fire, police, and emergency rescue personnel.
 - The SOMS reviews weekly reports of cardkey holders with computer room access.
 - Certification review of employees whose job requires that they have cardkey access.
 - Cross-check of authorized cardkey personnel against current CIT employees.
 - Requiring a fading badge for individuals who must have unescorted access.
 - Requiring the display of an “Escort Required” badge for all other personnel.
- **Disaster Recovery Plans** – The CIT Disaster Recovery Program is an ongoing effort to minimize the impact of a disaster that would interrupt the functional capabilities (facilities and services) of the organization. CIT defines a disaster to be any unplanned event or problem that disrupts the NIH Computer Center from providing services and functions that are necessary to the operation of the designated critical applications for a period of 72 hours or longer.
- **Contingency Plans** – The NIHnet Backbone Contingency Plan provides a plan for preparedness in the event of an incident or disaster on the NIHnet Backbone that could potentially impact critical mission and business functions. NIH also conducts system contingency plans to ensure that systems continue to be processed in the event of unanticipated system failures.



NIH Infrastructure Security Initiative

NIH Actions to Increase Physical Security following the September 11, 2001, Terrorists Attacks

Immediately following the attacks on the World Trade Center and the Pentagon, the National Institutes of Health increased the physical security at all its facilities to ensure the following:

- Protect staff, visitors and patients from physical harm and emotional distress.
- Preserve the reputation of the NIH, its programs and staff.
- Secure the intellectual assets of the NIH and its staff from being damaged, destroyed or stolen.
- Guard the physical assets of the NIH and its staff and visitors from being damaged, destroyed, or stolen.

The actual measures employed were selected to balance the need for vigilance with a commitment to foster ongoing mission activities within the existing physical context at each NIH facility. Underlying these responses is a set of “core security principles” that shape the policies and operations:

- NIH facilities (owned and leased) are managed and operated to support mission activities.
- NIH facilities are for the sole use of NIH staff, contractors, visitors, patient and patient visitors, and affiliates.
- The NIH Director is responsible for establishing policies that govern security and the safety of people and property in and on NIH owned and leased real property.
- Security procedures and access control to NIH facilities will vary in response to the perceived level of risk and in accordance with direction from the Executive Office, Congress, and local law enforcement.
- The entire NIH community is responsible for the security and protection of NIH staff, patients, and visitors as well as NIH’s intellectual, electronic, and physical assets.
- Security cannot be “optional.”

The NIH convened three groups with interlocked membership to manage security planning, policy, and operations. Under the active leadership of the NIH Acting Director, an NIH Security Task Force was assembled. This Security Task Force ratifies overall Agency security policy and planning and is the liaison with other Federal and state entities on security policy and response. Members of NIH organizations involved in actually delivering security provide staff support to the Task Force.

Planning and design of security operations and security infrastructure is the responsibility of the Safety and Security Planning Committee. Chaired by the NIH Chief Security Officer, the Safety and Security Committee develops security and safety operating policies, plans the safety and security physical infrastructure and general operational response, and provides plans and cost



estimates for improving NIH's security infrastructure and operations. The following represent some of the documents and reports produced by this Committee:

- *NIH Facility Survey and Risk Assessment (Confidential).*
- *NIH Interim Security.*
- *Operating Procedures at Each of Four GSA Levels.*
- *NIH Security Response Summary.*
- *NIH Bio-Security Plan.*
- *Conditions for Access to and Use of NIH Facilities for Group Functions, Activities, and Special Events.*

The committee members represent NIH organizations involved in security and safety operations, facilities management, and laboratory science programs. The Safety and Security Planning Committee is the point of contact with NIH field stations and assists them with security response planning and policy.

In addition to these two committees, the NIH Security Officer also convened an operational round table where the NIH operations directly involved in managing the campus on a day-to-day basis address on-going operational matters. This group is continually monitoring and adjusting the specifics of access control and physical security at the NIH campus and local rental facilities.

Access Control. Since September 11, 2001, the NIH has enforced strict access controls to all its facilities. The following actions have been taken:

- Cars are challenged at all perimeter access points onto the NIH campus. Visitor cars and service vehicles are inspected for contraband. Vehicles with valid NIH parking permits driven by staff with valid NIH IDs are waved through perimeter checkpoints. However, these vehicles may be subject to random inspections by NIH security.
- All vehicles entering parking garages under buildings on the NIH campus also are inspected.
- NIH police and uniformed contract inspectors are engaged in securing the perimeter.
- All NIH personnel must display a valid NIH ID card.
- Entrance to NIH buildings is either via cardkeys or a security guard checkpoint. In buildings with security guards, visitors must show a valid photo ID and sign in/out. At facilities with many outside visitors, security personnel screen or search bags and use metal detectors. NIH also conducts surveillance at loading docks.

Laboratory Safety and Security. The NIH has a long history for safely and securely managing the acquisition, storage, use and disposal of low-level biological agents and radioactive materials used in its laboratories. The NIH operates a pathogen registration program to monitor on-going infectious disease research from a safety and health perspective. Laboratories are inspected on a routine basis. Safety training is a high priority. In managing biological materials which may be considered especially sensitive, NIH policies and operations exceed the requirements set forth in 42 CFR 72.6-Additional Requirements for Facilities Transferring or Receiving Select Agents.



The future implications of these efforts may result in changes to the NIH campus landscape and making risk assessments of current systems and standards of operation to ensure that we protect people, facilities, and networks on the NIH campus and surrounding NIH office and laboratory facilities.

LIMITATIONS OF THE FINANCIAL STATEMENTS

The NIH has prepared these financial statements to report the financial position and results of operations of the NIH, pursuant to the requirements of 31 U.S.C. 3515(b). While we have prepared these statements from the books and records of the NIH in accordance with the formats prescribed by the Office of Management and Budget, the statements are in addition to the financial reports used to monitor and control budgetary resources that we prepare from the same books and records.

The user of these statements should realize that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides budgetary resources to do so.

NATIONAL INSTITUTES OF HEALTH

Audited Annual Financial Statements

**Fiscal Years Ending
September 30, 2001
September 30, 2000**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
ANNUAL FINANCIAL STATEMENTS
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED BALANCE SHEET
As of September 30, 2001 and 2000
(Dollars in Thousands)**

| | 2001 | 2000 |
|---|---------------|---------------|
| ASSETS | | |
| Intragovernmental: | | |
| Fund balance with Treasury (Note 2) | \$ 19,721,462 | \$ 16,574,173 |
| Investments (Note 3) | 21,200 | 16,877 |
| Accounts receivable (Note 4) | 107,996 | 109,657 |
| Advances and prepayments (Note 5) | 25,695 | 17,390 |
| Total Intragovernmental | \$ 19,876,353 | \$ 16,718,097 |
| Accounts receivable (Note 4) | \$ 2,835 | \$ 9,900 |
| Cash and other monetary assets | 104 | 104 |
| Inventory and related property (Note 6) | 12,095 | 12,955 |
| General property, plant and equipment, net (Note 7) | 1,150,508 | 976,173 |
| Other Assets (Note 5) | 1,876 | 1,660 |
| | \$ | \$ |
| Total Assets | | |
| LIABILITIES | | |
| Intragovernmental liabilities: | | |
| Accounts payable (Note 8) | \$ 12,167 | \$ 39,624 |
| Accrued payroll and benefits (Note 9) | 19,648 | 18,133 |
| Other (Note 11) | 9,593 | 12,024 |
| Total Intragovernmental | \$ 41,408 | \$ |
| Accounts payable (Note 8) | \$ 178,715 | \$ 150,383 |
| Accrued grants liability (Note 12) | 991,064 | 863,225 |
| Environmental and disposal costs (Note 13) | 10,700 | 8,700 |
| Federal employee and veterans' benefits (Note 14) | 64,271 | 57,863 |
| Accrued payroll and benefits (Note 9) | 249,401 | 232,540 |
| Deferred revenue (Note 10) | 28,513 | 21,440 |
| Other (Note 11) | 70,513 | 69,562 |
| | \$ 1,593,177 | \$ |
| Total Liabilities | | |
| NET POSITION (Note 15) | | |
| Unexpended appropriations | \$ 18,268,835 | \$ 15,333,599 |
| Cumulative results of operations | 1,140,351 | 911,796 |
| Total Net Position | \$ 19,409,186 | \$ 16,245,395 |
| Total Liabilities and Net Position | \$ 21,043,771 | \$ 17,718,889 |

The financial statements should only be read in connection with the accompanying notes to the financial statements.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED STATEMENT OF NET COSTS
For the Years Ended September 30, 2001 and 2000
(Dollars in Thousands)**

| | FY 2001 Combined Total | FY 2001 Intra-NIH Eliminations | FY 2001 Consolidated Total | FY 2000 Consolidated Total |
|--|------------------------------|--------------------------------------|----------------------------------|----------------------------------|
| Research Program | | | | |
| Costs: | | | | |
| Intragovernmental | \$ 2,036,910 | \$ (1,181,531) | \$ 855,379 | \$ 635,702 |
| With the public | <u>\$ 15,370,550</u> | <u>\$ -</u> | <u>\$ 15,370,550</u> | <u>\$ 14,287,293</u> |
| Total costs | <u>\$ 17,407,460</u> | <u>\$ -</u> | <u>\$ 17,407,460</u> | <u>\$ 14,923,095</u> |
| Less earned revenues: | | | | |
| Intragovernmental | \$ 1,348,536 | \$ (1,181,531) | \$ 167,005 | \$ 130,676 |
| From the public | <u>\$ 51,578</u> | <u>\$ -</u> | <u>\$ 51,578</u> | <u>\$ 101,990</u> |
| Total earned revenues | <u>\$ 1,400,114</u> | <u>\$ (1,181,531)</u> | <u>\$ 218,573</u> | <u>\$ 232,666</u> |
| Net research costs | \$ 16,007,346 | \$ - | \$ 16,007,346 | \$ 14,690,329 |
| Training/Career Development Program | | | | |
| Net training/career development costs | \$ 1,118,276 | \$ - | \$ 1,118,276 | \$ 870,728 |
| Facilities Program | | | | |
| Net facilities costs | \$ 178,609 | \$ - | \$ 178,609 | \$ 187,006 |
| Net Cost of Operations | <u>\$ 17,304,231</u> | <u>\$ -</u> | <u>\$ 17,304,231</u> | <u>\$ 15,748,063</u> |

The financial statements should only be read in connection with the accompanying notes to the financial statements.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2001
(Dollars in Thousands)**

| | | |
|--|----|-------------|
| Net Cost of Operations | \$ | 17,304,231 |
| Financing Sources (Other than exchange revenue): | | |
| Appropriations Used | | 17,418,554 |
| Other Budgetary Financing Sources | | 38,534 |
| Imputed Financing Sources | | 83,525 |
| Other Non Budgetary Financing Sources | | 14,156 |
| | | <hr/> |
| Net Results of Operations | \$ | 250,538 |
| Prior Period Adjustment (Note 17) | | (21,983) |
| | | <hr/> |
| Net Change in Cumulative Results of Operations | \$ | 228,555 |
| Increase in Unexpended Appropriations | | 2,935,236 |
| | | <hr/> |
| Change in Net Position | \$ | 3,163,791 |
| Net Position: Beginning of Period | | 16,245,395 |
| | | <hr/> |
| Net Position: End of Period | \$ | 19,409,186 |
| | | <hr/> <hr/> |

The financial statements should only be read in connection with the accompanying notes to the financial statements.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2001
(Dollars in Thousands)**

Budgetary Resources:

| | | |
|--|-----------|-------------------|
| Budget Authority | \$ | 20,520,559 |
| Unobligated Balances - Beginning of Period | | 356,757 |
| Spending Authority from Offsetting Collections | | 1,424,328 |
| Adjustments | | (95,210) |
| | | <hr/> |
| Total Budgetary Resources | \$ | 22,206,434 |
| | | <hr/> <hr/> |

Status of Budgetary Resources:

| | | |
|--|-----------|---------------------|
| Obligations Incurred | \$ | 21,736,379 |
| Unobligated Balances - Available | | 255,137 |
| Unobligated Balances - Not Available | | 214,918 |
| | | <hr/> |
| Total Status of Budgetary Resources | \$ | \$22,206,434 |
| | | <hr/> <hr/> |

Outlays:

| | | |
|---|-----------|---------------------|
| Obligations Incurred | \$ | 21,736,379 |
| Less: Spending Authority from Offsetting Collections and Adjustments | | 1,429,757 |
| Subtotal | | 20,306,622 |
| | | <hr/> |
| Obligated Balance, Net -Beginning of Period | | 16,213,825 |
| Less: Obligated Balance, Net -End of Period | | 19,246,157 |
| | | <hr/> |
| Total Outlays | \$ | \$17,274,290 |
| | | <hr/> <hr/> |

The financial statements should only be read in connection with the accompanying notes to the financial statements.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED STATEMENT OF FINANCING
For the Year Ended September 30, 2001
(Dollars in Thousands)**

RESOURCES USED TO FINANCE ACTIVITIES:

Budgetary Resources Obligated

| | |
|---|-------------------|
| Obligations Incurred | \$ 21,736,379 |
| Less: Spending Authority from offsetting Collections and Recoveries | <u>1,429,757</u> |
| Obligations Net of Offsetting Collections and Recoveries | 20,306,622 |
| Less: Offsetting Receipts | <u>9,592</u> |
| Net Obligations | <u>20,297,030</u> |

Non-Budgetary Resources

| | |
|--|-------------------|
| Imputed Financing from Costs Absorbed by Others | 83,525 |
| Other Non-Budgetary Financing Sources | <u>14,156</u> |
| Net non-budgetary resources used to finance activities | 97,681 |
| Total Resources Used to Finance Activities | <u>20,394,711</u> |

RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS

| | |
|---|-------------------|
| Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided | 2,897,708 |
| Budgetary offsetting collections and receipts that do not effect net cost of operations: | |
| Other | 38,534 |
| Resources that finance the acquisition of assets or liquidation of liabilities | <u>284,401</u> |
| Total Resources Used to Finance items not part of the Net Cost of Operations | 3,220,643 |
| Total Resources Used to Finance the Net Cost of Operations | <u>17,174,068</u> |

COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD

Components Requiring or Generating Resources in Future Periods:

| | |
|--|--------------|
| Increase in annual leave liability | 7,203 |
| Increase in environmental and disposal liability | 2,000 |
| Decrease in exchange revenue receivable from the public | 6,864 |
| Other | <u>7,393</u> |
| Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods | 23,460 |

Components Not Requiring or Generating Resources:

| | |
|--|----------------|
| Depreciation and amortization | 61,604 |
| Losses or (Gains) from reevaluation of assets and liabilities | 378 |
| Other | <u>44,721</u> |
| Total Components of Net Cost of Operations That Will Not Require or Generate Resources | 106,703 |
| Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the current period | <u>130,163</u> |

| | |
|-------------------------------|------------------------------------|
| NET COST OF OPERATIONS | \$ <u><u>17,304,231</u></u> |
|-------------------------------|------------------------------------|

The financial statements should only be read in connection with the accompanying notes to the financial statements.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS
September 30, 2001 and 2000
(Dollars in Thousands)**

- Note 1: Significant Accounting Policies**
- 2: Fund Balance with Treasury**
- 3: Investments**
- 4: Accounts Receivable**
- Note 5: Advances and Prepayments**
- Note 6: Inventory and Related Property**
- Note 7: General Property, Plant and Equipment**
- Note 8: Accounts Payable**
- Note 9: Accrued Payroll and Benefits**
- Note 10: Unearned Revenue**
- Note 11: Other Liabilities**
- Note 12: Accrued Grants Liability**
- Note 13: Environmental and Disposal Costs**
- Note 14: Federal Employees and Veterans' Benefits**
- Note 15: Net Position**
- Note 16: Operating Leases**
- Note 17: Prior Period Adjustments**
- Note 18: Statement of Budgetary Resources**
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED FINANCIAL STATEMENTS
NOTES TO THE FINANCIAL STATEMENTS
September 30, 2001 and 2000
(Dollars in Thousands)**

Note 1. Significant Accounting Policies

Basis of Presentation and Accounting Standards

We have prepared the accompanying consolidated financial statements to report the financial position and results of operations of the National Institutes of Health (NIH), pursuant to the requirements of the Chief Financial Officers Act of 1990 as enhanced by the Government Management Reform Act of 1994. We have prepared these financial statements from the accounting records of NIH in accordance with accounting principles generally accepted in the United States. These statements are different from other budget reports, also prepared by the NIH pursuant to Office of Management and Budget (OMB) directives, which we and others use to monitor and control NIH's use of budgetary resources. The consolidated financial statements are presented in conformity with OMB Bulletin No. 97-01 (as amended) "Form and Content of Agency Financial Statements" and as appropriate OMB Bulletin No. 01-09 "Form and Content of Agency Financial Statements."

On October 9, 1999, the American Institute of Certified Public Accountants (AICPA) Council passed a resolution recognizing that standards promulgated by the Federal Accounting Standards Advisory Board (FASAB) constitute accounting principles generally accepted in the United States (GAAP) under Rule 203, "Accounting Principles," of the AICPA's *Code of Professional Conduct*. As a result, the federal accounting principles that we use to prepare our audited financial statements are in conformity with GAAP.

The statements should be read with the realization that they are for a component of a sovereign entity of the United States Government, and that unfunded liabilities reported in the financial statements cannot be liquidated without the enactment of an appropriation.

The financial statements consolidate the balances of discrete Institute and Center appropriations, plus a number of accounts used for suspense, collection of receipts, the NIH Service and Supply Fund, the NIH Management Fund, and the NIH Buildings and Facilities appropriation. Material intra-NIH eliminations are removed from the consolidated balance sheet, consolidated statement of net cost, and the consolidated statement of changes in net position. The effects of intra-NIH transactions are not eliminated in the presentation of the other principal statements. These other statements are labeled as combined statements rather than consolidated statements.

Reporting Entity

The NIH is an Operating Division (OPDIV) of the Department of Health and Human Services (DHHS), which is a Cabinet agency of the Executive Branch of the United States Government. The NIH is composed of separate and distinct Institutes and Centers each with a separate, annual appropriation from the Congress and, most critical to the question of priorities, each with a mission established by the Congress. By law each must be funded and each is committed to certain domains of medical science (e.g., cancer, heart disease, aging, mental health). The NIH is the steward of medical and behavioral research for the nation. Its mission is to sponsor and conduct medical research that leads to better health for all Americans. The NIH accomplishes its mission by conducting and supporting research throughout the world.

Basis of Accounting

We have prepared the accompanying financial statements on an accrual basis and a budgetary basis of accounting. Under the accrual method, revenues are recognized when earned and expenses are recognized when a liability is incurred without regard to receipt or payment of cash. In addition, NIH transactions are recorded on a budgetary basis. Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds.

Entity and Non-Entity Assets

Entity assets are those assets that the NIH holds and has the authority to use in its operations. Non-entity assets are assets the entity holds but does not have the authority to use. An example of a non-entity asset is accounts receivable from National Research Service Award recipients who do not perform their service obligation. We collect these amounts but do not have the authority to use these amounts in our operations.

Fund Balance with the U.S. Treasury

The U.S. Treasury processes receipts and disbursements. "Fund Balances with Treasury" cash balances are reconciled monthly with balances reported by the U.S. Treasury and adjusted at year-end to the reconciled Treasury balances. Any discrepancies that may occur are primarily due to timing differences on transactions involving the Division of Payment Management (DPM), DHHS Central Payroll, and foreign payments. Differences with Treasury balances may exist for those accounts that receive miscellaneous receipts but do not require budgetary resources to receive or use the receipts. Funds received by the Conditional Gift Fund are deemed restricted.

The non-entity fund balance with Treasury includes collections of Royalties from licensees on behalf of inventors, cash withheld for fellowship tax withholdings, and general fund receipts.

Investments

The NIH invests some of its Gift Fund accounts in short-term U.S. Treasury securities.

Accounts Receivable

Accounts receivable consists of amounts owed to NIH by other Federal agencies and the public. The non-entity accounts receivable amount comprises amounts due NIH under the National Research Service Award program.

Advances and Prepayments

Advances are cash outlays made by NIH to its grantees, employees or others to cover a part or all of the recipient's anticipated expenses or as advance payments for the costs of goods and services NIH receives. Prepayments are payments made to cover certain periodic expenses before they are incurred.

Inventory and Related Property

Materials and supplies for resale or use comprise equipment fabrication parts, renovation parts, and supply stock that are maintained in the Service and Supply Fund (SSF). The materials and supplies are valued using the moving-average method and are stated at cost.

General Property, Plant and Equipment

Property, plant and equipment (PP&E) are valued at cost. Depreciation and amortization are calculated on a straight-line basis over the estimated useful lives of the assets. Personal property is depreciated over useful lives ranging from 5 to 20 years. Real property is depreciated over useful lives of 30 years. All PP&E with an initial acquisition cost of \$25,000 or more and an estimated useful life of two years or greater are capitalized.

Liabilities

Liabilities are recognized for amounts of probable future outflows or other sacrifices of resources as a result of past transactions or events. However, no liability may be paid by the NIH absent approved budgetary resources.

Liabilities Covered by Budgetary Resources are those liabilities funded by available budgetary resources including budget authority and spending authority from offsetting collections. The majority of liabilities covered by budgetary resources include amounts payable to vendors who have provided goods or services to NIH and for accrued payroll.

Liabilities Not Covered by Budgetary Resources are those liabilities incurred for which funding has not yet been made available through congressional appropriations. Examples are environmental cleanup costs, Federal employee and veterans benefits, and earned annual leave.

Environmental Cleanup Costs

Statement of Federal Financial Accounting Standard (SFFAS) No. 5 provides criteria for recognizing a contingent liability for environmental cleanup costs. The NIH has an environmental cleanup liability that we further explain in footnote 13.

Federal Employee and Veterans' Benefits

The NIH recognizes amounts reported by the Department of Labor (DOL) for Federal Employee's Compensation Act (FECA) payments. Most NIH employees participate in either the Civil Service Retirement System (CSRS) or the Federal Employee Retirement System (FERS). Under CSRS, NIH makes matching contributions equal to 7 percent of basic pay. For FERS employees, The DHHS 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 U.S. Office of Personnel Management (OPM) reports on CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities, if any, applicable to Federal employees.

OMB's Bulletins 97-01, 01-09, and SFFAS No. 5 requires agencies to recognize the value of pension benefits and other post retirement benefits expected to be funded and paid by the OPM in the future. These benefits include retirement payments, health insurance, and life insurance. Since these programs are normally administered by OPM, NIH does not recognize any liability on its balance sheet for these items. The unfunded imputed costs are reported on the FY 2000 and FY 2001 Consolidated Statement of Net Costs, and the FY 2001 Consolidated Statement of Financing. The imputed financing sources are reported on the FY 2001 Consolidated Statement of Changes in Net Position and the FY 2001 Consolidated Statement of Financing.

Accrued Payroll and Benefits

The NIH recognizes liabilities for employee leave earned but not taken. Annual leave is accrued as earned and expended as taken. Sick and other types of leave are expended as taken but not accrued when earned.

Accrued Grants Liability

Statement of Federal Financial Accounting Standard (SFFAS) No. 5, requires that we record the amounts "due and payable to grantees" that they will ultimately report as expenditures. The DHHS Division of Payment Management (DPM), manager of DHHS' central grants payment system, calculated an estimate for the amounts due and payable for all DHHS grant programs, which we subsequently recorded in our accounting system. Another portion of the grant accrual, known as the Incurred But Not Reported (IBNR) amount, represents expenses that grantees have incurred prior to September 30, 2001 that they did not report to us on their 4th quarter report. We estimated this amount using information we developed that showed that we had approximately 2 weeks of IBNR cost to record as a liability. We estimated the amount by dividing our 4th quarter estimated grant accrual by 92 days and multiplying by 2 weeks to derive the estimated liability.

Revenues and Other Financing Sources

Funding for the NIH is classified as revenue or other financing sources. Revenue is an inflow of resources that the Government demands, earns, or receives by donation. Revenue comes from two sources: exchange transactions and non-exchange transactions. Exchange revenues arise when a Government entity provides goods and services to the public or to another Government entity for a price. Another term for "exchange revenue" is "earned revenue." Non-exchange revenues arise primarily from the Government's power to demand payments from the public (e.g., taxes, duties, fines and penalties) but also include donations. Other financing sources include appropriations used, transfers of assets from other Government entities, and imputed financing.

Financing sources for the NIH are provided through Congressional appropriations and include both annual and multi-year appropriations. The NIH Central Service Offices and Centers provide reimbursable services to the NIH and other Federal government agencies. For financial statement purposes, appropriations are recognized as a financing source as accrued expenses are incurred. In addition, the NIH receives unsolicited gifts and grants and engages in Cooperative Research and Development Agreements with the private sector.

Leases

The NIH leases real estate facilities, primarily office and warehouse space, from the General Services Administration and others under operating leases.

Canceled Appropriations and Undelivered Orders

Payments may be required of up to one percent of current year appropriations for valid obligations incurred against canceled appropriations. We are not aware of any valid obligations incurred against cancelled appropriations. One percent of current year appropriations are \$230 million and \$203 million for fiscal year 2001 and 2000, respectively.

The amount of budgetary resources obligated for undelivered orders for our appropriated and non-appropriated funds at the end of the period totaled \$ 17,961,910 and \$ 496,265, respectively.

Use of Estimates in Preparing Financial Statements

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Intra-Governmental Relationships and Transactions

In the course of its operations, NIH has relationships and financial transactions with other Federal agencies. These transactions primarily involve the General Services Administration for building leases, interagency agreements to collaborate on research projects, sales of goods and services from the NIH Service and Supply Fund, and assessments from the NIH Management Fund.

Statement of Federal Financial Accounting Standard Number 10

In FY 2001, the requirements of Statement of Federal Financial Accounting Standard Number 10 on internal use software became effective. The Statement of Federal Financial Accounting Standard Number 10 requires that we capitalize the cost for internal use software development as an asset and amortize the cost over its useful life. Previously, the costs for internal use software would be expensed as incurred. The NIH and the DHHS' policy is that we capitalize internal use software development costs of \$500,000 or greater in a revolving fund or \$1,000,000 or greater in an appropriated account. The NIH is engaged in software development activities for four major enterprise IT systems, and the expected costs for each of these four systems will be greater than \$1,000,000, and the NIH decided to consolidate the budgeting, accounting, and tracking of these system in it Service and Supply Fund account rather than have the costs spread among 28 – 30 different appropriations. See Note 10 for a full description of how NIH is budgeting and accounting for the costs for these four enterprise IT systems.

Note 2. Fund Balance with Treasury

The NIH's undisbursed account balance with the Department of the Treasury at September 30, 2001, and 2000, is \$ 19,721,462 and \$ 16,574,173, respectively. The Trust Funds balance is comprised of the Unconditional, the Conditional, and the Patient Benefit Gift Funds. The Revolving Funds balance includes the Service and Supply Fund. The Other Funds balance includes the Management Fund, Cooperative Research and Development Agreements Fund, Royalties Fund and balances in deposit, clearing, and suspense related accounts. The following is a breakdown of the NIH Fund Balance:

| | <u>September 30, 2001</u> | | | <u>September 30, 2000</u> | | |
|--------------------|--------------------------------|---|----------------------|--------------------------------|---|----------------------|
| | <u>Entity</u> <u>Assets</u> | <u>Non-</u> <u>entity</u> <u>Assets</u> | <u>Total</u> | <u>Entity</u> <u>Assets</u> | <u>Non-</u> <u>entity</u> <u>Assets</u> | <u>Total</u> |
| Appropriated Funds | \$ 19,324,634 | \$ | \$ 19,324,634 | \$ 16,314,842 | \$ | \$ 16,314,842 |
| Trust Funds | 40,719 | | 40,719 | 32,405 | | 32,405 |
| Revolving Funds | 126,647 | - | 126,647 | 16,062 | - | 16,062 |
| Other Funds | 226,425 | 3,037 | 229,462 | 209,775 | 1,089 | 210,864 |
| Totals | <u>\$ 19,718,425</u> | <u>\$ 3,037</u> | <u>\$ 19,721,462</u> | <u>\$ 16,573,084</u> | <u>\$ 1,089</u> | <u>\$ 16,574,173</u> |

Note 3. Investments

The NIH invests trust fund cash that is in excess of current needs in U. S. Treasury securities. The U. S. Treasury Department is the NIH's agent and advisor for investing. The majority of NIH's investments in securities are held to maturity and provision is made for unrealized gains or losses. All investments are classified as Intragovernmental Securities. Investments are summarized below.

| | <u>September 30, 2001</u> | | <u>September 30, 2000</u> | |
|--------------------------------|---------------------------|---------------|---------------------------|---------------|
| Marketable Securities: | | Interest | | Interest |
| Amortization Method | | | | |
| Value at Par | \$ | 21,685 | \$ | 17,486 |
| Unamortized (Discount) Premium | \$ | (485) | \$ | (609) |
| Net Investments | \$ | <u>21,200</u> | \$ | <u>16,877</u> |

Note 4. Accounts Receivable

Accounts receivable from Federal agencies consists of sales of research goods and services from the Service and Supply Fund to other Federal agencies. Amounts due from the public are presented net of an allowance for uncollectible accounts.

Entity assets are those assets that the NIH holds and has the authority to use in its operations. Non-entity assets are assets the entity holds but does not have the authority to use. An example of a non-entity asset is accounts receivable from National Research Service Award recipients who do not perform their service obligation. We collect these amounts but do not have the authority to use these amounts in our operations. The estimate of the allowance is based on past collection experience and/or analysis of the outstanding balances, primarily relating to National Research Services Awards.

| | Accounts Receivable Principal | Interest Receivable | Accounts Receivable Gross | Accounts Allowance | Net Receivables Combined | Intra NIH Eliminations | Net Receivables Consolidated |
|----------------------------|-------------------------------------|------------------------|---------------------------------|-----------------------|--------------------------------|------------------------------|------------------------------------|
| September 30, 2001: | | | | | | | |
| Intragovernmental | | | | | | | |
| Entity | \$ 128,543 | \$ - | \$ 128,543 | \$ - | \$ 128,543 | \$ (20,547) | \$ 107,996 |
| Total Intragovernmental | \$ 128,543 | \$ - | \$ 128,543 | \$ - | \$ 128,543 | \$ (20,547) | \$ 107,996 |
| With the Public | | | | | | | |
| Entity | \$ 799 | \$ - | \$ 799 | \$ - | \$ 799 | \$ - | \$ 799 |
| Non-Entity | 6,008 | 4,172 | 10,180 | (8,144) | 2,036 | - | 2,036 |
| Total, With the Public | \$ 6,807 | \$ 4,172 | \$ 10,979 | \$ (8,144) | \$ 2,835 | \$ - | \$ 2,835 |
| September 30, 2000: | | | | | | | |
| Intragovernmental | | | | | | | |
| Entity | \$ 128,999 | \$ - | \$ 128,999 | \$ - | \$ 128,999 | \$ (19,342) | \$ 109,657 |
| Total Intragovernmental | \$ 128,999 | \$ - | \$ 128,999 | \$ - | \$ 128,999 | \$ (19,342) | \$ 109,657 |
| With the Public | | | | | | | |
| Entity | \$ 7,664 | \$ - | \$ 7,664 | \$ - | \$ 7,664 | \$ - | \$ 7,664 |
| Non-Entity | 6,788 | 4,390 | 11,178 | (8,942) | 2,236 | - | 2,236 |
| Total, With the Public | \$ 14,452 | \$ 4,390 | \$ 18,842 | \$ (8,942) | \$ 9,900 | \$ - | \$ 9,900 |

Note 5. Advances and Prepayments

Advances are made by NIH to others to cover part or all of the recipient's anticipated expenses or as advance payments for the costs of goods and services NIH receives. NIH has no Non-Entity Other Assets.

The NIH has established an IT Software Development account within its Service and Supply Fund to aggregate the budgeting and accounting for major enterprise IT systems for which the NIH is engaged. The NIH Institutes provide advances to the Service and Supply Fund and the Service and Supply Fund treats these advances as unearned revenue until expenses are incurred. Once the Service and Supply Fund recognizes expenses for IT software amortization, the NIH will recognize revenue in the Service and Supply Fund and bill the expense to the Institutes, thus liquidating the Institutes advance. The balance reflected in the unearned revenue account is the advance received from the Institutes that the Service and Supply Fund has not earned. The balance in the unearned revenue account and the advances on the Institutes books are eliminated as part of the development of consolidated financial statements.

At September 30, 2001, the intra-NIH eliminations amount of \$88,634 is related to IT Software Development. The remaining intra-NIH eliminations amount of \$98,707 is related to activities between the NIH Institutes and the NIH Management Fund which provides goods or related services to the Institutes. At September 30, 2000, the intra-NIH eliminations amount is entirely related to activities between the NIH Institutes and the NIH Management Fund

Other Assets are comprised of the following:

| | Entity Other Assets | |
|------------------------------------|---------------------|--------------------|
| | September 30, 2001 | September 30, 2000 |
| Intragovernmental: | | |
| Advances to Other Federal Entities | \$ 213,036 | \$ 106,606 |
| Less: Intra-NIH Eliminations | (187,341) | (89,216) |
| Total | \$ <u>25,695</u> | \$ <u>17,390</u> |
| With the Public: | | |
| Other Advances | \$ 1,876 | \$ 1,660 |
| Total | \$ <u>1,876</u> | \$ <u>1,660</u> |

Note 6. Inventory and Related Property

NIH's Inventory and Related Property consist of tangible personal property. Inventory and Related Property are items within the SSF that are for sale to and use by the NIH Institutes and Centers. Inventory and Related Property are recognized and reported as assets when purchased. Ultimately, these items are reported as an operating expense in the period they are issued to NIH Institutes and Centers. The items in Inventory and Related Property are valued using the moving-average method and are stated at cost, which at September 30, 2001, and 2000, is \$ 12,095 and \$ 12,955, respectively.

Note 7. General Property, Plant and Equipment

The following table summarizes property, plant and equipment balances as of September 30. Useful lives are assigned based on input from the NIH Office of Logistics Management in consultation with the end user of the asset. Depreciation is calculated on a straight-line basis.

| | <u>Depreciation Method</u> | <u>Est. Useful Lives</u> | <u>Acquisition Cost</u> | <u>Accumulated Depreciation</u> | <u>2001 Net Book Value</u> | <u>2000 Net Book Value</u> |
|--|----------------------------|--------------------------|-------------------------|---------------------------------|----------------------------|----------------------------|
| Land & Land Rights | N/A | N/A | \$ 14,336 | \$ | \$ 14,336 | \$ 14,336 |
| Construction in Progress | N/A | N/A | 390,260 | | 390,260 | 361,187 |
| Buildings, Facilities & Other Structures | Straight Line | 30 yrs | 1,029,925 | (515,528) | 514,397 | 407,784 |
| Internal Use Software | Straight Line | Various | 9,607 | - | 9,607 | - |
| Equipment | Straight Line | 5-20 yrs | 424,549 | (202,641) | 221,908 | 192,866 |
| Totals | | | \$ 1,868,677 | \$ (718,169) | \$ 1,150,508 | \$ 976,173 |

Note 8. Accounts Payable

Accounts payable primarily consists of amounts due to vendors for goods and services received. Accounts payable also include amounts due for progress in contract performance and miscellaneous other payables.

| | <u>Intragovernmental</u> | <u>With the Public</u> | <u>Total</u> |
|--------------------------------|--------------------------|------------------------|-------------------|
| September 30, 2001: | | | |
| Covered by Budgetary Resources | \$ 32,714 | \$ 178,715 | \$ 211,429 |
| Less: Intra-NIH Eliminations | (20,547) | - | (20,547) |
| Total, Consolidated | \$ 12,167 | \$ 178,715 | \$ 190,882 |
| September 30, 2000: | | | |
| Covered by Budgetary Resources | \$ 58,966 | \$ 150,383 | \$ 209,349 |
| Less: Intra-NIH Eliminations | (19,342) | - | (19,342) |
| Total, Consolidated | \$ | \$ 150,383 | \$ |

Note 9. Accrued Payroll and Benefits

Accrued payroll, represents salaries and wages and other benefits that have been earned but are unpaid at the end of the month. 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.

| | <u>Intragovernmental</u> | | | <u>With the Public</u> | | |
|---|---|---|------------------|---|---|-------------------|
| | <u>Liabilities Covered by Budgetary Resources</u> | <u>Liabilities Not Covered by Budgetary Resources</u> | <u>Total</u> | <u>Liabilities Covered by Budgetary Resources</u> | <u>Liabilities Not Covered by Budgetary Resources</u> | <u>Total</u> |
| September 30, 2001: | | | | | | |
| Accrued Payroll And Leave | \$ | \$ | \$ | \$ 159,378 | \$ 90,023 | \$ 249,401 |
| Payroll Withholding | 9,075 | | 9,075 | | | |
| Accrued Workers Compensation (including FECA) | | 10,573 | 10,573 | | | |
| Totals | <u>\$ 9,075</u> | <u>\$ 10,573</u> | <u>\$ 19,648</u> | <u>\$ 159,378</u> | <u>\$ 90,023</u> | <u>\$ 249,401</u> |
| September 30, 2000: | | | | | | |
| Accrued Payroll And Leave | \$ | \$ | \$ | \$ 149,720 | \$ 82,820 | \$ 232,540 |
| Payroll Withholding | 8,052 | | 8,052 | | | |
| Accrued Workers Compensation (including FECA) | | 10,081 | 10,081 | | | |
| Totals | <u>\$ 8,052</u> | <u>\$ 10,081</u> | <u>\$ 18,133</u> | <u>\$ 149,720</u> | <u>\$ 82,820</u> | <u>\$ 232,540</u> |

Note 10. Unearned Revenue

Unearned revenue is recorded as a liability until it is earned. The NIH engages in collaborative research with the private sector using Cooperative Research and Development Agreements (CRADAs). Typically a collaborating partner will provide the NIH with resources to engage in research projects. For accounting purposes, we treat all cash received for CRADAs as unearned or deferred revenue until we use the funds to pay for expenses incurred as part of the collaborative effort.

The NIH has established separate enterprise IT software development accounts within its Service and Supply Fund to aggregate the budgeting and accounting for major enterprise IT systems for which the NIH is engaged. Consolidating these costs for these systems will allow NIH to more readily comply with the requirements of Federal Accounting Standards Advisory Board Statement of Federal Financial Accounting Standard Number 10, which provided accounting standards for internal use software. This standard requires that we capitalize the cost for software development as an asset and amortize the cost over its useful life. Previously, the costs for internal use software would be expensed as incurred. The NIH and the DHHS' policy is that we capitalize internal use software development costs of \$500,000 or greater in a revolving funds or \$1,000,000 or greater in an appropriated account. The expected costs for each of these four systems will be greater than \$1,000,000, and the NIH decided to consolidate the budgeting, accounting, and tracking of these system in one account rather than have them spread among 28 – 30 different appropriations.

These systems include the NIH Business System, which is replacing the legacy administrative database and central accounting system, the Electronic Research Administration system, which is replacing the legacy grants management systems and supporting the federal government-wide Federal Commons, the Clinical Research Information System, which is replacing the legacy Clinical Center's Medical Information System, and the NIH-specific costs associated with the DHHS' Enterprise Human Resources Project, which is replacing the DHHS' legacy human resources and payroll systems.

The NIH Acting Director and the NIH IC Director's established and approved a multi-year plan for these enterprise IT systems along with the approval to collect additional amounts to cover estimated contingencies, unknowns, other legitimate needs, and other variables to provide for the financing and business flexibility necessary when procuring and developing ERP packages. This more business-like approach to financing makes these projects ideal candidates for funding out of the NIH Service and Supply Fund. The Acting Director and the IC Directors have discretion under the "necessary expenses" doctrine to decide that these are necessary and bona fide needs of their individual appropriations.

We are following the tenets of the Clinger-Cohen Act by planning, presenting, and executing our development of these complex multiple project systems over a total project multi-year horizon. What NIH learned from its preliminary assessment of ERPs is that the line between success and failure is a function of how well we treat these complex projects as a multi-year undertaking. As such, we must have certainty as to having the resources to carry-out these projects.

Our Service and Supply Fund statute allows us to seek reimbursement in advance (42 USC 231) to ensure that we have sufficient funds to operate a cycle of business-type operations. Amounts credited to the NIH Service and Supply Fund are treated as unobligated balances and are available for obligation until the purpose is achieved.

In FY 2001, based upon a plan that included the estimated cost for the 4 systems, the NIH assessed the Institutes their prorata share based on the formula approved by the NIH leadership. The FY 2001 assessment when added to the FY 2000 assessment sums to approximately \$83 million. Over and above the \$83 million, our project managers identified the need for contingency funds to ensure that NIH had resources identified and available to meet unanticipated needs and other unknowns. The NBS project manager had requested a contingency fund of almost \$9.5 million; the eRA project manager had requested a contingency fund of almost \$3 million; at the same time, the NIH needed a contingency fund for the new department-wide EHRP system of \$7 million. The NIH cumulatively collected approximately \$28 million over the \$83 million to provide the funds for contingencies and unknowns for all four enterprise IT systems.

The assessments for the IT systems are established to allow the NIH Service and Supply Fund to break even over time. This is a common feature of a revolving fund---over time they will break even. This means that in any given year the amount that NIH charges its customers may be more or less than its actual cost. To ensure that the Fund breaks-even over time, the NIH adjusts the charges/assessments. For example, for several reasons, the NIH did not obligate as much as it had originally planned in FY 2001 when the IT systems assessments were first approved. To ensure that the Fund did not retain excess funds, the IT Board of Governors and the NIH Funding Advisory Review Committee used these funds to reduce the assessment for FY 2002 from what they otherwise would have been.

The NIH Institutes provide advances to the Service and Supply Fund and the Service and Supply Fund treats these advances as unearned revenue until expenses are incurred. When the Service and Supply Fund recognized an expense for IT system planning, for example, it recognized an expense and billed the expense to the Institute against the existing Institute advance, thus recording the expense on the Institute's books and recognizing revenue on the Service and Supply Fund's books. The NIH will amortize as an expense the software development costs over three years. Once the Service and Supply Fund recognizes the amortization expense for a particular IT software development effort, the NIH will recognize revenue in the Service and Supply Fund and bill the expense to the Institutes, thus liquidating the Institute's advance. The balance reflected in the unearned revenue account is the advance received from the Institutes that the Service and Supply Fund has not expensed. The balance in the unearned revenue account and the advances on the Institute's books are eliminated as part of the consolidated financial statements.

In addition, the NIH Central Service Offices and Centers provide reimbursable services to the NIH through the NIH Management Fund. The NIH eliminates for purposes of its consolidated financial statements any unearned amounts advanced from the Institutes and treated as unearned revenue on the NIH Management Fund's books.

At September 30, 2001, the intra-NIH eliminations amount of \$88,634 is related to IT software development. The remaining intra-NIH eliminations amount of \$98,707 is related to activities between the NIH Institutes and the NIH Management Fund, which provides goods or related services to the Institutes. At September 30, 2000, the intra-NIH eliminations amount is entirely related to activities between the NIH Institutes and the NIH Service and Supply Fund and NIH Management Fund.

| | <u>Intragovernmental</u> | | | <u>With the Public</u> | | |
|--------------------------------------|---|---|--------------|---|---|--------------|
| | <u>Liabilities Covered by Budgetary Resources</u> | <u>Liabilities Not Covered by Budgetary Resources</u> | <u>Total</u> | <u>Liabilities Covered by Budgetary Resources</u> | <u>Liabilities Not Covered by Budgetary Resources</u> | <u>Total</u> |
| September 30, 2001: | | | | | | |
| Deferred Revenue | \$ | \$ 187,341 | \$ 187,341 | \$ | \$ 28,513 | \$ 28,513 |
| Less: Intra-NIH Eliminations | | (187,341) | (187,341) | | | |
| Consolidated Deferred Revenue Totals | \$ | \$ | \$ | \$ | \$ 28,513 | \$ 28,513 |
| September 30, 2000: | | | | | | |
| Deferred Revenue | \$ | \$ 89,216 | \$ 89,216 | \$ | \$ 21,440 | \$ 21,440 |
| Less: Intra-NIH Eliminations | | (89,216) | (89,216) | | | |
| Consolidated Deferred Revenue Totals | \$ | \$ | \$ | \$ | \$ 21,440 | \$ 21,440 |

Note 11. Other Liabilities

Liabilities for clearing accounts are used for unclassified transactions when there is a reasonable presumption that the amounts belong to the NIH. These accounts are established to temporarily hold transactions that will subsequently be credited to a receipt or expenditure account of the NIH.

Custodial Liabilities are classified as *Intragovernmental* and *With the Public*. The *Intragovernmental* custodial liability is for collections of miscellaneous receipts that the NIH turns over to the U.S. Treasury. The NIH receives general fund receipts for grantee or contractor audit disallowances, Freedom of Information Act payments, and miscellaneous receipts that NIH returns to the U.S. Treasury. The *With the Public* custodial liability represents the amount the NIH collects on behalf of others that had not been disbursed as of September 30. These amounts are for collections associated with inventor royalties. The NIH collects royalties from its licensing activities for which a portion is paid to inventors under the Federal Technology Transfer Act. The amounts that are recognized as other accrued liabilities are for amounts not otherwise classified as accounts payable. Other accrued liabilities are predominantly for utilities, rentals, and exhibit space.

| | <u>Intragovernmental</u> | | | <u>With the Public</u> | | |
|-----------------------|---|---|--------------|---|---|--------------|
| | <u>Liabilities Covered by Budgetary Resources</u> | <u>Liabilities Not Covered by Budgetary Resources</u> | <u>Total</u> | <u>Liabilities Covered by Budgetary Resources</u> | <u>Liabilities Not Covered by Budgetary Resources</u> | <u>Total</u> |
| September 30, 2001: | | | | | | |
| Liabilities for | | | | | | |
| Deposit Funds and | | | | | | |
| Clearing Accounts | \$ - | \$ - | \$ - | \$ 18,388 | \$ - | \$ 18,388 |
| Custodial Liabilities | | 9,587 | 9,587 | - | 3,037 | 3,037 |
| Other | 6 | - | 6 | 49,088 | - | 49,088 |
| Consolidated | | | | | | |
| Other Liabilities | \$ 6 | \$ 9,587 | \$ 9,593 | \$ 67,476 | \$ 3,037 | \$ 70,513 |
| September 30, 2000: | | | | | | |
| Liabilities for | | | | | | |
| Deposit Funds and | | | | | | |
| Clearing Accounts | \$ - | \$ - | \$ - | \$ 17,923 | \$ - | \$ 17,923 |
| Custodial Liabilities | - | 9,586 | 9,586 | - | 1,089 | 1,089 |
| Other | 2,438 | - | 2,438 | 50,550 | - | 50,550 |
| Consolidated | | | | | | |
| Other Liabilities | \$ 2,438 | \$ 9,586 | \$ 12,024 | \$ 68,473 | \$ 1,089 | \$ 69,562 |

Note 12. Accrued Grants Liability

Grant advances are liquidated upon the grantee's reporting of expenditures on the quarterly SF-272 Report (Federal Cash Transaction Report). In many cases, these reports are received several months after the grantee actually incurs the expense, resulting in an understated grant expense in the financial statements. To mitigate this, DHHS developed Departmentwide procedures used by NIH to estimate and accrue amounts due grantees for their expenses, both realized and accrued, through September 30.

The NIH records the estimated accrual for amounts due to grantees for their expenses at the end of the fiscal year. If the amount of outstanding advances exceeds the amount of the accrual, the NIH reports an asset for "Advances to Grantees." Otherwise, the NIH reports a liability called "Accrued Grant Liability," equal to the amount that the accrual exceeds the outstanding advances.

The liability is the estimated amount due to grantees and contractors to cover project costs. Usually, we provide funds to the Payment Management Division in advance of grantees incurring costs, but as of September 30, our grantees and contractors have incurred costs in advance of our providing funds to cover the expense. The liability predominantly comprises the Incurred But Not Reported (IBNR) amount, which represents approximately two weeks of expenses that grantees have incurred prior to September 30, that they did not report to us on their 4th quarter 272 Report.

| | <u>September 30, 2001</u> | <u>September 30, 2000</u> |
|---|---------------------------|---------------------------|
| Grant Advances Outstanding (before year-end grant accrual) \$ | 2,918,955 | \$ 4,037,738 |
| Less: Estimated Accrual for Amounts Due to Grantees | 3,910,019 | 4,900,963 |
| Net Grant Liability | <u>\$ (991,064)</u> | <u>\$ (863,225)</u> |

Note 13. Environmental Clean-up Costs

Environmental and Disposal Costs are the costs of removing, containing, and or disposing of (1) hazardous waste from property, or (2) material and/or property that consists of hazardous waste at permanent or temporary closure or shutdown of associated Property, Plant and Equipment. Federal government accounting and reporting standards require all entities to report a liability for any probable and measurable clean-up costs for which they are responsible or for which they have assumed responsibility. The NIH management has determined that the active projects probably will result in an environmental clean-up. The liability is based on the estimated cost to clean-up similar sites over the estimated time it would take for the clean-up.

| <u>Project or Activity</u> | <u>Method for Assigning Cost</u> | <u>Total Estimated Cleanup Cost</u> | <u>Liabilities With the Public Not Covered by Budgetary Resources</u> |
|-------------------------------------|---------------------------------------|-------------------------------------|---|
| September 30, 2001 | | | |
| Bitterroot Valley Sanitary Landfill | Estimated Cost of Similar Remediation | \$ 3,000 | \$ 3,000 |
| Caribbean Primate Research Center | Estimated Cost of Similar Remediation | 5,700 | |
| Lexington, KY Tract V | Estimated Cost of Similar Remediation | 2,000 | 2,000 |
| Total | | \$ <u> 10,700</u> | <u> 10,700</u> |
| September 30, 2000: | | | |
| Bitterroot Valley Sanitary Landfill | Estimated Cost of Similar Remediation | \$ 3,000 | \$ |
| Caribbean Primate Research Center | Estimated Cost of Similar Remediation | 5,700 | 5,700 |
| Total | | \$ <u> 8,700</u> | <u> 8,700</u> |

Note 14. Federal Employees and Veterans' Benefits

These amount represents NIH's share of Federal Employees' Compensation Act benefits based on a Department of Labor (DOL) actuarial liability computation. The projected future liability was determined using the paid losses extrapolation method calculated over a 37 year time span.

The actuarial amount allocated to NIH for FY 2001 and FY 2000 is based upon the actual payments made to the DOL for fiscal years 1990 through 2000 and 1989 through 1999 respectively. The amounts of \$ 64,271 and \$ 57,863, at September 30, 2001 and 2000 respectively, are classified as not covered by budgetary resources since the payments will be made from future appropriations.

Note 15. Net Position

Net position is the difference between assets and liabilities. Net position is comprised of unexpended appropriations and cumulative results of operations. Unexpended appropriations comprises two components: (1) unobligated appropriations that are either available for obligation or not available (permanently or temporarily) pursuant to a specific provision in law, and (2) undelivered orders, which represents appropriations obligated (i.e., legally reserved) for the amount of goods or services ordered but not yet received. Cumulative results of operations represents the net difference between (1) expenses and losses and (2) financing sources, including appropriations used, and revenues and gains since the inception of the NIH. The following is a breakdown of the NIH Net Position at September 30.

| | <u>Other Funds</u> | <u>Revolving Funds</u> | <u>Appropriated Funds</u> | <u>2001 Totals</u> | <u>2000 Totals</u> |
|----------------------------------|------------------------|----------------------------|-------------------------------|------------------------|------------------------|
| Unexpended Appropriations: | | | | | |
| Unobligated, | | | | | |
| Available | N/A | N/A | \$ 102,370 | \$ 102,370 | \$ 143,483 |
| Unavailable | N/A | N/A | 204,555 | 204,555 | 145,216 |
| Undelivered Orders | N/A | N/A | 17,961,910 | 17,961,910 | 15,044,900 |
| Subtotals | N/A | N/A | 18,268,835 | 18,268,835 | 15,333,599 |
| Cumulative Results of Operations | \$ 612,628 | \$ 47,919 | 479,804 | 1,140,351 | 911,796 |
| Net Position | <u>\$ 612,628</u> | <u>\$ 47,919</u> | <u>\$ 18,748,639</u> | <u>\$ 19,409,186</u> | <u>\$ 16,245,395</u> |

Note 16. Operating Leases

The NIH leases several buildings primarily from the General Services Administration at various sites located in Montgomery County and Baltimore, Maryland and Research Triangle Park, North Carolina. The buildings are used for office, laboratory, and warehouse space to meet the mission of NIH. Generally, the NIH leases do not contain cancellation rights. The following is a breakdown of future operating lease payments at September 30.

Future Payments Due:

| <u>Fiscal Year</u> | <u>2001 Total</u> | <u>2000 Total</u> |
|-----------------------------|-----------------------|-----------------------|
| Year 1 | \$ | \$ 51,138 |
| Year 2 | | 50,321 |
| Year 3 | | 49,727 |
| Year 4 | | 49,259 |
| Year 5 | | 47,906 |
| After 5 years | | 314,434 |
| Total Future Lease Payments | \$ | \$ |

Note 17. Prior Period Adjustment

The prior period adjustments on the FY 2001 financial statements relate to changes in accounting policy and corrections of errors. The table below lists the components of the prior period adjustment.

| | | |
|--|----|---------------|
| Asset Revaluation | \$ | 15,606 |
| Adjustment to Current Year Expenses | | 11,532 |
| Adjustment to Advances and Prepayments | | (6,114) |
| Adjustment to Beginning Net Position | | 5,463 |
| Other smaller adjustments | | (4,504) |
| Prior Period Adjustments | \$ | <u>21,983</u> |

During FY 2001, the NIH performed a review of its general property, based on that review, an adjustment to accumulated depreciation was made. This resulted in a prior period adjustment of \$ 15,607. A prior period adjustment of \$ 11,532 was made as a result of reviewing intra-OPDIV transactions.

The prior period adjustment of \$ 6,114 represents a change in our accounting procedures to record an advance by a NIH Institute or Center to the NIH Management Fund. This advance is then offset by a liability for unearned revenue that is recorded by the NIH Management Fund. In the past, the NIH Institutes or Centers expensed such amounts as a current cost. The prior period adjustment of \$6,114 reduces prior years' expenses and reclassifies the amount that should still be recognized as an advances by a NIH Institute or Center.

The prior period adjustment of \$ 5,463 represents the cumulative effect of corrections of errors to prior years' net position identified during the roll-forward analysis.

Note 18. Statement of Budgetary Resources

The Statement of Budgetary Resources reflects the budgetary resources available to the NIH and the status of those resources. The budgetary resources obligated for undelivered orders for our appropriated and non-appropriated accounts at the end of FY 2001 totaled \$ 17,961,910 and \$ 496,265 respectively. Unobligated and obligated balances withdrawn or canceled and returned to the Department of the Treasury for FY 2001 totaled \$ 91,835.

Note 19. Statement of Financing

The Consolidated Statement of Financing was prepared in accordance with OMB's Bulletins 01-09. The Statement of Financing reflects the resources NIH used to finance its net cost of operations. Included on this statement are costs for which NIH does not use current budgetary resources. These costs include \$ 7,203 for accrued unfunded annual leave, which NIH accrues as a cost when the leave is earned. This amount is classified as unfunded since the payments will be made from future appropriations. In addition, this statement reflects the imputed cost attributable to the NIH for expenses incurred by other Federal agencies. For example, the NIH recognized \$ 83,525 for the actuarial cost of pension and other related benefits for current NIH employees.

Required Supplementary Stewardship Information

**U.S. Department of Health and Human Services
National Institutes of Health
Stewardship Investments
Investment in Research and Development
For the Year Ended September 30, 2001
(in thousands)**

The NIH Research Program includes all aspects of the medical research continuum, including basic and disease-oriented research; observational and population-based research; behavioral research; and clinical research, including research to understand both health and disease states, to move laboratory findings into medical applications, to assess new treatments or compare different treatment approaches; and health services research. The timely dissemination of medical and scientific information is also a critical component of NIH's Research Program. Furthermore, NIH regards the expeditious transfer of the results of its medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

| | <u>1997</u> | <u>1998</u> | <u>1999</u> | <u>2000</u> | <u>2001</u> | <u>Total</u> |
|------------------|-------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Basic Research | N/A | \$ 6,622,750 | \$ 8,148,239 | \$ 8,814,197 | \$ 9,604,408 | \$ 33,189,594 |
| Applied Research | N/A | 4,415,167 | 5,432,160 | 5,876,132 | 6,402,938 | 22,126,397 |
| Total | | <u>\$ 11,037,917</u> | <u>\$ 13,580,399</u> | <u>\$ 14,690,329</u> | <u>\$ 16,007,346</u> | <u>\$ 55,315,991</u> |

Required Supplementary Stewardship Information

**U.S. Department of Health and Human Services
National Institutes of Health
Stewardship Investments
Investment in Human Capital
For the Year Ended September 30, 2001
(in thousands)**

The NIH Research Training and Career Development Program addresses the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the Nation's health. Our ability to maintain the momentum of recent scientific progress and our international leadership in medical research depends upon the continued development of new, highly trained investigators.

| | <u>1997</u> | <u>1998</u> | <u>1999</u> | <u>2000</u> | <u>2001</u> | <u>Total</u> |
|--|-------------|-------------|-------------|-------------|--------------|--------------|
| Research Training and Career Development | N/A | \$ 660,465 | \$ 820,483 | \$ 870,728 | \$ 1,118,276 | \$ 3,469,952 |

Required Supplementary Information

National Institutes of Health
Condensed Balance Sheet
Franchise and Intragovernmental Support Revolving Fund
As of September 30, 2001
(in thousands)

Assets

| | |
|--|-------------------|
| Fund balance with Treasury | \$ 126,647 |
| Accounts receivable | 11,992 |
| General property, plant and equipment, net | 32,838 |
| Other Assets | 16,524 |
| Total Assets | <u>\$ 188,001</u> |

Liabilities

| | |
|-------------------|-------------------|
| Accounts payable | \$ 37,183 |
| Deferred revenue | 88,634 |
| Other liabilities | 14,265 |
| Total Liabilities | <u>\$ 140,082</u> |

Net Position

| | |
|---|--------------------------|
| Cumulative results of operations | \$ 47,919 |
| Total Net Position | <u>\$ 47,919</u> |
| Total Liabilities and Net Position | <u><u>\$ 188,001</u></u> |

Required Supplementary Information

**National Institutes of Health
Condensed Statement of Net Cost
Franchise and Intragovernmental Support Revolving Fund
For the year ended September 30, 2001
(in thousands)**

| Program/Business Line | <u>Intra- governmental</u> | <u>With the Public</u> | <u>Gross Costs</u> | <u>Less: Earned Revenue</u> | <u>Net Costs (Revenue)</u> |
|---------------------------------|---------------------------------------|-----------------------------------|-------------------------------|--|---|
| Administrative Services | \$ 63,516 | \$ 217,528 | \$ 281,044 | \$ 298,636 | \$ (17,592) |
| Information Technology | 28,595 | 97,930 | 126,525 | 129,457 | (2,932) |
| Instrumentation Services | 2,320 | 7,946 | 10,266 | 9,984 | 282 |
| Animal Services | <u>9,035</u> | <u>30,945</u> | <u>39,980</u> | <u>40,841</u> | <u>(861)</u> |
| Total | <u>\$ 103,466</u> | <u>\$ 354,349</u> | <u>\$ 457,815</u> | <u>\$ 478,918</u> | <u>\$ (21,103)</u> |

Required Supplementary Information

U. S. Department of Health and Human Services National Institutes of Health DEFERRED MAINTENANCE For Year Ended September 30, 2001

The National Institutes of Health estimates that its deferred maintenance is approximately \$137.9 million. This estimate is based upon a condition assessment conducted by NIH building and facilities engineers. The following table displays the condition of NIH assets and the estimated cost to return the asset to an acceptable condition.

| <u>Category</u> | <u>Asset Condition</u> | <u>Cost to Return to Acceptable Condition</u> |
|-----------------|------------------------|---|
| General PP&E | | |
| Land | 1 | \$0 |
| Buildings | 3 | \$137.9 million |
| Equipment | 2 | \$0 |

Asset condition is assessed on a scale of 1-5 as follows:

Excellent=1; Good=2; Fair=3; Poor=4; Very Poor=5

A "fair" or 3 rating is considered acceptable operating condition. Although PP&E categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of "fair" or above may still report necessary costs to return them to acceptable condition.

Required Supplementary Information

**U.S. Department of Health and Human Services
National Institutes of Health
INTRAGOVERNMENTAL ASSETS
For the Year Ended September 30, 2001
(Dollars in Thousands)**

| <u>Agency</u> | <u>Fund Balance with Treasury</u> | <u>Investments</u> | <u>Accounts Receivable</u> | <u>Advances and Prepayments</u> |
|----------------------------|---------------------------------------|--------------------|--------------------------------|---|
| Department of the Treasury | \$ 19,721,462 | \$ 21,200 | | |
| All Other Federal Agencies | | | \$ 107,996 | \$ 25,695 |
| Total | \$ 19,721,462 | \$ 21,200 | \$ 107,996 | \$ 25,695 |

Required Supplementary Information

U.S. Department of Health and Human Services
National Institutes of Health
INTRAGOVERNMENTAL LIABILITIES
For the Year Ended September 30, 2001
(Dollars in Thousands)

| <u>Agency</u> | <u>Accounts Payable</u> | <u>Accrued Payroll and Benefits</u> | <u>Other</u> |
|---|-------------------------|-------------------------------------|-----------------|
| Department of Treasury | | | \$ 9,593 |
| Department of Health and Human Services | \$ 3,866 | | |
| Office of Personnel Management | | \$ 9,075 | |
| Department of Labor | | 10,573 | |
| All Other Federal Agencies | 8,301 | | |
| Total | <u>\$ 8,301</u> | <u>\$ 19,648</u> | <u>\$ 9,593</u> |

Report of Independent Auditors on Internal Control

To the Inspector General of the
Department of Health and Human Services, and
the Director of the National Institutes of Health

We have audited the consolidated balance sheets of the National Institutes of Health (NIH), an operating division of the Department of Health and Human Services (DHHS) as of September 30, 2001 and 2000, and the related consolidated statements of net costs for the fiscal years then ended and the consolidated statement of changes in net position and financing and combined statements of budgetary resources for the fiscal year ended September 30, 2001, and have issued our report thereon dated January 31, 2002. We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

In planning and performing our audits, we considered NIH's internal control over financial reporting by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 01-02. We did not test all internal control relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act, such as those controls relevant to ensuring efficient operations. The objective of our audits was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

NIH management is responsible for establishing and maintaining internal control. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of internal control are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting principles generally accepted in the United States; and data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information. Because of inherent limitations in any internal control, errors and irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of internal control to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment, could adversely affect the NIH's ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal control, misstatements, losses, or noncompliance may nevertheless occur and not be detected. However, we noted certain matters discussed in the following paragraphs involving the internal control and its operation that we consider to be reportable conditions. We consider the first two matters noted—Financial Systems and Processes and Investments in Management Systems—to be material weaknesses.

MATERIAL WEAKNESSES

Financial Systems and Processes (Repeat Condition)

Background

Although the Office of Financial Management maintains centralized financial systems, produces accounting policies and procedures, analyzes account data and prepares financial statements, NIH's accounting structure is decentralized in that day-to-day decisions and processing of transactions is primarily performed at the more than 28 Institutes and Centers (IC). In fiscal year (FY) ended September 30, 2001, these transactions totaled approximately \$21.0 billion in assets and \$17.3 billion in total net costs.

OMB Circular A-127, *Financial Management Systems*, requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. NIH relies on this decentralized organization, complex and antiquated systems and ad hoc reporting to accumulate data for financial reporting due to the lack of an integrated financial accounting system.

While progress was made, including:

- Contracting with consultants to assist in the resolution of reportable conditions identified in FY 2001;
- Continuing to enhance the automated closing process;
- Improving its analysis by NIH of its obligations, expenditures, and advances;
- Improving the research and resolution of differences at the individual grant level between information reported by the DPM and the NIH;
- Enhancing its current web-based accounting analysis package; and
- Automating certain processes including the fellowship stipend and health insurance process, the new loan repayment program, and the royalty inventor payment process.

Significant financial management issues continue to impair NIH's ability to accumulate, analyze, and distribute reliable financial information. Our review of the internal control disclosed numerous weaknesses in NIH's ability to report accurate financial information. NIH's central accounting system lacks integration with certain subsidiary systems, does not facilitate the preparation of the financial statements, has not fully adopted the Treasury Standard General Ledger, and contains insufficient internal control to detect incorrect entries for its ICs in a timely fashion. Additionally, certain reconciliation processes were

not adequately performed to ensure differences between subsidiary systems and the general ledger were properly identified, researched and resolved and that account balances were complete and accurate. Finally, NIH lacked formalized procedures to analyze accounting data, and sufficient source documentation to support reported financial information.

Integrated financial systems, a sufficient number of properly trained personnel, and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner. As deadlines for the submission of audited financial statements continue to be accelerated, the need for improved financial management accounting systems and processes become critical if NIH is to meet these deadlines.

Lack of Integrated Financial Management System

NIH's financial management systems are not fully compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair NIH's abilities to adequately support accounts receivable and other financial balances reported.

As reported in 2000, NIH needs to take corrective actions in order to improve the effectiveness and efficiency of the financial statement process, and the accountability over its financial resources. Further, the system, which dates back to the early 1970s, is not designed for financial reporting purposes and lacks certain system interfaces. For examples:

The NIH maintains its outstanding obligations for grants, accounts payable, and accounts receivable subsidiary files in the Open Document file. The Open Document file tracks transactions based on the document number instead of the vendor or grantee. As a result, if a change or error is made in the document number, the expenses and related obligations are sometimes classified as two entries. This results in (1) the appearance of overpayment or overstatement of accruals against obligations and outstanding obligations without activity, and (2) difficulty in properly analyzing reported financial activity. During our review of NIH's Open Document file, we identified negative balances for approximately 2,272 items totaling \$48 million representing undelivered orders—as compared to last years approximate 2,426 items equaling \$121 million.

- For the Payment Management System that tracks obligations, advances and expenditures for grants, NIH received a listing of 35 pages relating to transactions that were identified as differences between NIH's general ledger system and the payment management system. While many transactions are timing differences, the remaining transactions require manual research to resolve.
- For the property systems, NIH recorded entries totaling an absolute value of \$15.5 million to bring the general ledger in agreement to the subsidiary system. NIH identified this difference, performed the research and resolved the differences.
- NIH's time and attendance system that maintains activity to support the more than 14,000 employees is not integrated with the Central Payroll system.

Certain stand-alone computer systems administered by NIH's Service and Supply Fund are currently not interfaced with NIH's general ledger. These systems perform ordering and billing transactions.

We noted several instances where NIH does not use all standard general ledger accounts or NIH has continued to use accounts no longer contained on the standard Treasury general ledger. As a result, numerous entries are required at year end to balance and close accounts to be in accordance with Treasury's closing procedures. The following cases of noncompliance with the United States Standard General Ledger were noted:

- An automated journal entry continues to post transactions to the Advances and Reimbursements Receivable—Unbilled Account. When transactions are posted to the 1314 account, there is no audit trail for a document to be tracked. At September 30, 2001, unbilled account receivable balance totaled \$88 million.
- Currently, transactions related to reimbursable accounting are not recorded to the proper general ledger account as defined by the U.S. General Ledger. The specific general ledger account affected is the 4240—Unfilled Customer Orders.
- NIH does not populate accounts 5700 (Appropriated Capital Used) and 5790 (Other Financing Sources) until the closing process calculates and populates these accounts.

In 1998, NIH launched a systems implementation project, known as the NIH Business System (NBS) that will replace the existing administrative and management systems used by NIH staff. The NBS is an NIH-wide effort that is organizationally located within the Office of the Deputy Director for Management, NIH. Once the new system is fully implemented, it is intended to provide improved financial information for better decision-making, potential cost savings and a means to meet current federal accounting and budgetary reporting requirements. Although NIH has initiated steps in implementing its new system, NBS is not expected to be fully operational until 2007.

Financial Analyses and Reporting

Although each IC is responsible for initiating transactions, monitoring budgets, and retaining documentation to support each transaction, the Office of Financial Management and the Chief Financial Officer (CFO) Branch is responsible for the oversight of financial activities within the ICs and ensuring the completeness and accuracy of financial information. At year-end, the Office of Financial Management uses a systematic process to summarize trial balances from the ICs and to record thousands of adjusting, closing, and elimination entries — many of which represent entries to bring the subsidiary and general ledger accounts into balance or to correct errors. Subsequent to the systematic process, additional entries were recorded to adjust account balances manually through a series of spreadsheets to generate amounts for financial statement purposes. During fiscal year 2001, the NIH continued to refine its process of reviewing its subsidiary accounts, but efforts are still required to ensure that subsidiary and general ledger accounts are analyzed as an ongoing part of financial management.

Although NIH has made improvements, insufficient analyses, inadequate supervisory reviews, limited formalized accounting and internal control procedures and processes, and the continuing need to train personnel in the application of government accounting and budgetary reporting requirements continues to impact the reliability of NIH's financial statements. NIH currently relies on the use of stand-alone computer processes, ad-hoc reports, and manual spreadsheets to generate financial statements. As a result, the Office of Financial Management needs to enhance internal control procedures to gain further assurance that transactions were processed and recorded properly, that information from the general ledger used in developing financial statements is reliable and the risk of material misstatement or omission is reduced to a low level.

During fiscal year 2001, we found that certain reconciliation processes were not adequately performed to ensure differences were properly identified, researched and resolved in a timely manner and that account balances were complete and accurate. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures.

Journal Entries—During fiscal year 2001, NIH recorded approximately 19,000 entries totaling an absolute value of over \$348 billion using a transaction code that is normally used when table driven entries, regulated by the Department of Health and Human Services, are not available. Our review of these transactions identified the following:

- A series of entries allowing for the posting of paired entries where one side of the entry posts to the proprietary accounts while the other side posts to the budgetary accounts resulting in imbalances between the budgetary and proprietary trial balances.

Property entries to roll-forward balances to the current period totaling an absolute value of \$1.2 billion were recorded to move from one fiscal year to another in November 2000.

Year-end closing entries for 28 ICs for fiscal year 2000 were recorded primarily in February and March 2001.

Because these entries override the routine driven table entries, enhanced procedures in supervisory review and reconciliation and analysis would provide for the more timely identification and resolution of these errors that, if not resolved timely, could result in a material misstatement of the financial statements.

Preparation of Financial Statements—Although progress was made in the preparation of the financial statements, NIH needs to streamline and document its processes to effectively accumulate, assemble and analyze information to timely develop its financial statements on a routine and recurring basis. For example, although NIH was able to issue preliminary financial statements by mid December 2001, we noted 64 entries totaling an absolute value of approximately \$28 billion to adjust account balances from the trial balance to prepare financial statements manually through a series of spreadsheets. As of January 2002, entries identified in the preparation of financial statements had not been recorded in the general ledger. Management indicated that a factor contributing to this shortfall was the lack of an integrated financial system.

Intra- and Inter-Agency Transactions—OMB Bulletin 97-01, *Form and Content of Agency Financial Statements*, technical amendments, dated January 7, 2000 require that government entities reconcile inter- and intra-agency transactions with its trading partners. We noted that NIH did not perform confirmations and required reconciliations for elimination entries with trading partners.

Net Position—NIH does not perform adequate periodic analyses of its net position. At September 30, 2001, NIH could not resolve an unidentified difference of \$.5 million in its changes in net position. Because NIH has 160 entries recorded to its net position accounts during the year, detailed analysis of accounts on a more frequent basis would help to identify and resolve these differences on a timely basis.

Accounts Payable and Undelivered Orders—Although NIH compares its subsidiary ledger to its general ledger, differences are not researched on a timely basis for resolution. For example, the September 2001 reconciliation for undelivered orders identified a difference totaling \$193 million. Based on our review, we noted that the difference was due to an improper account being included as part of the reconciliation process. Because of no supervisory review and no further investigation of the difference, the difference remained unresolved until it was identified in the audit process. Additionally, NIH does not properly age its accounts payable balances so that proper analysis of accounts payable can be performed. An official memorandum stated that on an annual basis, NIH generally systematically removes payables and obligations in amounts less than \$1,000 and greater than two years old, and amounts less than \$5,000 with no activity in three years from its payable system. However, our procedures identified that 17 out of 30 accounts payable items totaling \$121,000 were invalid. Additionally, 18 out of 30 undelivered orders totaling \$324,000 were invalid. During our analysis we noted:

- Transactions that had been incorrectly recorded in early years because analysis was never performed overstated accounts payable.
- Transactions that were recorded as estimates when an order was placed were not adjusted to actual amounts when the invoices were received, resulting in balances that were not valid.
- Over \$2 million in accounts payable and \$87 million in undelivered orders related to years earlier than 1998.

The current aging process of accounts payable uses the date of the latest transaction, whether it represents a collection or an accrual, to determine the age. However, the results are not being used for analysis purposes. If performed correctly, the aging process identifies those transactions that are old and may not represent liabilities to the organization.

Grant Advances, Obligations, and Expenditure to General Ledger Reconciliations—Although reconciliations have been prepared, differences are not being thoroughly investigated and corrected in a timely manner. During our review of reconciliations between advances and expenditures reported by NIH and those reported by DPM, we noted that although comparisons were performed throughout the year noting large differences, ranging from \$217 million to \$1.5 billion, formal investigation of those differences did not take place until after September 30, 2001. Additionally, NIH has developed and implemented historical analyses of its grant authorizations, expenditures, and advance information as reported from its general ledger. However, when fluctuations were identified, NIH did not formally document reasons surrounding such fluctuations.

Accounts Receivable— We noted that NIH has not performed adequate analyses to identify invalid transactions. During our review of accounts receivable transactions, we noted that for billed Accounts Receivable, 23 of 29 transactions tested were considered invalid. Additionally, for unbilled Accounts Receivable, 22 of 36 transactions tested were considered invalid, based on our review of supporting documentation.

* * * *

Finally, as reported in FY 2000, NIH does not have formalized policies and procedures for developing the financial statement, the financial reporting analyses functions, or certain transaction processes. The U.S. General Accounting Office’s (GAO) *Standards for Internal Control in the Federal Government* requires that internal control and all transactions need to be clearly documented in properly maintained management directives, administrative policies, or operating manuals. As part of these formalized procedures, NIH should document its identification of sources for certain information needed to comply with the disclosure requirements of OMB Bulletin 97-01 and accounting principles generally accepted in the United States. Once formalized policies are completed, personnel should be properly trained to ensure policies are properly implemented and adhered to.

Given the severity of these issues, including system and process limitations and needed expertise in the new and future financial reporting requirements, it will take a sustained commitment and a qualified support team to resolve these issues in preparation for fiscal year 2002 and future years.

Recommendation

NIH should continue to improve its internal control by implementing changes for effectively detecting errors and irregularities in a timely manner. We recommend that NIH strengthen controls to improve the reliability and documentation of its financial information to include:

- Continue to develop the new business system to facilitate the consolidation and development of financial statements in compliance with the FFMIA.
 - Perform or oversee periodic reconciliations for all major financial balances and developing supporting documentation that reflects management’s understanding of the composition of the accounts.
 - Increase the number of personnel, especially at the junior levels, versed in the preparation of financial statements, the related support, and the analyses and reconciliations required to ensure accurate financial information.
- Develop formalized procedures for performing periodic detailed reviews of transactions within the subsidiary ledgers.

Investments in Management Systems

OMB Circular 123, *Management Accountability and Control*, states “in developing and executing strategies for implementing or reengineering agency programs and operations, Federal entities should design management structures that help ensure accountability of results and are used to reasonably ensure that

- Resources are used consistent with the agency mission, Programs and resources are protected from waste, fraud, and mismanagement,
- Laws and regulations are followed, and
- Reliable and timely information is obtained, maintained, reported and used for decision-making.”

For investments in technology, the GAO’s guide *Assessing Risks and Returns: A Guide for Evaluating Federal Agencies’ IT Investment Decision-making* states the following:

- Achieving maximum benefits from an investment project, while minimizing risks, requires that the project be consistently monitored and managed for successful results. Agency executives should be actively engaged in monitoring all of the projects in the investment portfolio, making decisions, and taking actions to change the course of a project, if necessary.
The organization should maintain documentation of all decisions, changes, actions and results that have occurred throughout the project’s life cycle.
- All projects should have complete and accurate information, including costs.
The project is being reviewed at the appropriate levels.

During FY 1999, NIH initiated the planning and implementation of four new management systems with expected costs of over \$400 million. One of the largest of these projects—the NIH Business System (NBS)—is a \$112 million project being developed to replace NIH’s financial management system. The existing system, in its current state, is not compliant with the FFMIA. Once fully implemented, the NBS is expected to enable administrative/scientific support that is cost effective, provide more accurate and timely information, and facilitate the scientific mission of the NIH.

During FY 2000, the Deputy Director for Management convened a working group, the Information Technology (IT) Enterprise Systems Funding workgroup, to develop recommendations for allocating enterprise IT costs among the ICs and to develop recommendations for a long-term NIH-wide IT funding strategy. This workgroup presented their recommendations to the Budget Officers, the Executive Officers, the IT Board of Governors, the Funding Advisory Review Board, and the IC Directors. Based on recommendations from this workgroup, NIH elected to create an IT investment fund in its revolving fund, specifically the Service and Supply Fund (SSF), to support the software

- Enhance high level exception driven analysis techniques to obtain reports each month and, array the reported information in a method that facilitates comparisons month to month, year to year against actual and budgeted amounts, and against NIH management expectations to identify and follow-up on emerging trends and anomalies in reported balances. Late in FY 2001, NIH hired a consultant to develop high-level analysis. NIH expects these analyses to be fully implemented within the next few months.
- Direct ICs to review subsidiary ledgers and the status of funds for the current and prior years with obligated or available funding for reasonableness, and obtain query access to financial systems to identify and investigate unusual items.
- Update current accounting policy and procedures manual to include (1) processing procedures for recurring transactions, (2) formal procedures for account analyses, (3) formalized procedures in the use and approval of manual entries, and (4) required year-end closing procedures to ensure the accuracy of recorded transactions and consistency in the way transactions are processed by the approximately 28 entities and NIH, as a whole.
- Update procedures to ensure greater accountability of ICs responsible for audit documentation and to ensure that required accounting reports, subsidiary ledgers, and adequate documentation are available on a timely basis to support the Treasury-required and financial statements reporting requirements. This would include develop procedures in conjunction with the ICs to analyze both undelivered orders, accounts receivable, obligations, advances, and accounts payable.
Provide additional training for financial and IC personnel to ensure that they understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.
- Update immediate accounting needs to improve the accuracy of financial information. This would entail identifying the necessary sources of information, the necessary disclosures, and analysis that should be performed by the Office of Financial Management to ensure the reliability of balances, completeness of disclosures, and the adequacy of presentation of financial information.
- Strengthen the approval process, especially reconciliations and entries not programmed in NIH's general ledger or dictated by the Department of Health and Human Services' accounting manual.
- Develop a process to properly age obligations, accounts receivable, accounts payable balances, undelivered orders, and advances so that enhanced analysis can be performed. Analyze the current process for "purging" old accounts payable and undelivered orders balances to ensure the criteria is effective in removing stale items.

development of IT enterprise funds. The SSF was established to provide a central means for consolidating the financing and accounting of business-type operations involving the sales of services, including mainframe computing, procurement, and other administrative activities.

Based on the IT Enterprise Systems Funding workgroup's Options and Recommendations Report, the NIH found flexibility in using this recommendation because:

- Provided a systematic way to accumulate funds to help defray the costs of software development for IT enterprise systems in the future.
- Did not require funding from specific mechanisms, since an IT Investment Fund is an aggregation of funds to support software development for a number of IT enterprise systems.
- Permitted annual levels to be collected for this fund to be set flexibly to accommodate to changing plans or projected changes in realities, etc.
- Afforded NIH the opportunity to support software development for both current and planned IT enterprise systems.

Allowed ICs to take advantage of having unexpected funds available at the end of a given fiscal year to pay down on their future commitments toward this fund.

Promoted more rigorous IT planning and management. Each IT project's funding requirements would have to be planned for and specified in advance for a multi-year time period.

Recognized IT software projects as an ongoing infrastructure need, rather than as optional projects.

- Allows for immediate implementation, since there is no need for Congressional, OMB, or DHHS approval.

Additionally, the NIH IT Enterprise Systems Funding workgroup requested a legal opinion of the Office of the General Counsel (OGC) of the legality of the option. It was informed that the OGC provided a favorable legal opinion for the recommended IT investment fund.

Once agreed to by management, the process for obtaining funds from the ICs was developed. The NIH estimated its expected expenditures for IT systems for the moving five years to be funded incrementally based on the lives of the projects. To develop the IC assessments, NIH estimated amounts based upon fiscal needs for a given year and will assess these amounts to the ICs. In FY 2001 the ICs were charged their minimum assessment during May 2001 but were advised that they could supplement these amounts by up to 40% of its share of the total expected contribution for the four systems. The supplemental contribution took place during the fourth quarter.

Under the plan, the ICs would treat the funds transferred to the Service and Supply Fund (SSF) as obligated in the same manner and to the same extent as they would any other

procurement from the revolving fund. DHHS' OGC found that the procedures used by NIH, i.e., a charter for the SSF, approval of the annual funding by the NBS Steering Committee and by the NIH Acting Director, allocations to the ICs and finally provision of funds allocated by the ICs as documented through the ICs providing Common Account Numbers (CAN) to the SSF satisfies the requirements for obligating the funds by the ICs. A CAN is a series of numbers used within the accounting system to summarize transactions that are related to a specific budget activity, cost center, or project. Additionally, NIH uses the CAN structure to move funds between the IC's and the revolving funds.

Although extensive planning has been performed, we noted inadequate and inconsistent documentation to support decisions made regarding the new systems and to support the tracking of financial activities, including estimated costs, advances and obligations. Additionally, we noted that certain key information was not readily available. Although information was requested as early as October 12, 2001, certain documentation was not provided until January 2002. We believe that these inadequacies are inconsistent with the requirements of OMB Circular A-123. We noted the following:

NIH maintains a project office to oversee its NBS initiatives. Although files are maintained, documentation to support key decisions and approvals are not maintained within the files. For example:

- Although discussions were held with the OGC as to the legality of transferring appropriated single-year funds from its ICs to its no-year revolving funds on June 22, 2000, and the Acting Director of NIH requested a legal decision on May 31, 2001, NIH could not provide a legal decision or written authorization from its Office of General Counsel until January 2002. During January 2002, the OGC asserted that NIH's recommended funding mechanism using the SSF to develop its new IT systems was proper and that the budget approval process legally could support a binding agreement between the ICs and the revolving fund.
- Although briefings were held with DHHS' Chief Information Officer (CIO) and the Chief Financial Officer (CFO) on its NBS, NIH's documentation to support DHHS' authorization to proceed was a letter from the former CFO/CIO that included certain requirements that needed to be fulfilled if the authorization to proceed was to be provided. NIH responded to the questions but no formal written documentation was obtained by NIH to indicate that the authorization to proceed was given.
- Additionally, as part of the conditional approval, bi-annual progress briefings were required between NIH and DHHS, NIH management indicated that the meetings were not scheduled nor held during FY 2001. DHHS management indicated that it monitors progress through its participation and NIH participation in the Unified Financial Management System (UFMS) meetings—

the Department's initiative to develop a financial management system—and the UFMS project management office's participation on the NIH New Business System project.

- NIH's OGC asserted that one component of the binding agreement between the IC and the SSF is the ICs providing a CAN to the SSF. NIH could not provide documentary evidence for two institutes, the National Institute of Allergy and Infectious Disease (NIAID) and National Center for Complimentary and Alternative Medicine (NCCAM), which had contributions during FY 2001 to the new systems of \$9.4 million and \$844,000, respectively. Subsequent to September 30, 2001, the two ICs confirmed that a phone conversation was held providing the CANS to the SSF.
- Through a letter dated September 11, 2000, OMB rejected the initial apportionment for the revolving fund indicating due to the inclusion of the funding for information technology investments OMB required further documentation prior to approval. The memorandum indicated that the funding for FY 2000 had been approved but future funding would be contingent on further review. Although subsequently approved, NIH could not provide documentation of discussions with OMB. Per NIH management, agreement was achieved through a phone call between NIH and OMB during late Fall 2000.
- Based on the August 15, 2000 board minutes of the DHHS Information Technology Investment Review Board, the DHHS budget office asked whether Congress had been informed about the New Business System. NIH indicated that Congress was fully aware of the project; however, when asked for documentation to support the Congressional awareness, only documentation presented to OMB for apportionment purposes was presented to us.
- NIH was unable to track activity, including obligations, advances, and costs related to its NBS. For example: we noted the following:
 - NIH identified a \$3.5 million error in deferred revenue related to IT systems during its reconciliation of its SSF's deferred revenue accounts for the year ended September 30, 2001. The reconciliation was performed in January 2002.
 - During our testing of undelivered orders, we identified a negative undelivered order for \$154,000 for one IC related to the NIH's New Business System. NIH indicated that the undelivered order was negative due to an error in billing the fourth quarter allocation to the ICs. NIH inadvertently excluded the allocation to two funds within the Office of the Director thus causing the ICs' amounts to be higher than they should have been. The correction of this error, totaling \$2.2 million for all ICs, was not recorded until January 2002.
 - The bona fide need rule states "a fiscal year appropriation may be obligated only to meet a legitimate, or bona fide, need arising in, or in some cases arising prior to but continuing to exist in the fiscal year for which the appropriation

was made". To fund its four system initiatives, during FY 2000 and 2001, NIH directed its ICs to advance to the Revolving fund approximately \$112 million for its four new systems initiatives. For FY 2001 assessments, advance contributions were performed during the third quarter where 75% of the advances took place with the remaining 25% performed during the fourth quarter. As of September 30, 2001, approximately \$64 million was obligated to support its planning and development phases, which included \$34 million in costs that had been incurred by September 30, 2001. NIH indicated that the \$47 million differences between advances and obligations within the SSF were the result of delayed obligations and NIH's development of a \$28 million contingency fund that would support any unexpected costs of the four projects. Although DHHS' OGC found sufficient obligations within the SSF fund to meet the bono fide rule, NIH did not reassess and correlate the needs of the fund prior to its charge to the ICs in September 2001 for \$20.9 million.

- Although NIH indicated that it reassessed project costs on a quarterly basis, total contributions from the ICs was reviewed annually allowing for excess funding to meet the needs of the SSF. NIH indicated to the extent it had significant fluctuations between advances from the ICs and obligations incurred in a single year, it would adjust future year's advances to ensure overall contributions from the ICs correlated with project costs.
- Although NIH set up a \$28 million contingency fund based on fourth quarter contributions from its ICs to support unexpected project costs, the basis for the FY 2001 contribution could not be determined. Based on discussions with management, approximately \$20 million could be specifically attributed to system implementation plans. NIH management indicated that its IT board of governors believed that based on industry standards the contingency fund should total 10% of total projected costs; however current expected project costs total over \$400 million. Based on the original implementation plan, the contingency fund was expected to be funded over the course of three years. NIH management has performed extensive planning for its four new systems—developing implementation plans, projected costs and life cycles. However, we identified discrepancies in how projects were planned versus the execution of the plans. For example:

- NIH management indicated that they estimate costs based on a five year plan even though original plans identified costs projected over an eight year period.
- Deviations of costs between the implementation plan in a given year and actual costs incurred are not being formally documented.
- SSF could not readily identify projected costs of individual projects. We noted several documents used in decision-making where projected costs by system did not agree. We noted ranges of total projected costs between \$400 million to over \$800 million. We understand that

differences may be attributable to estimates based on different dates, longer periods of time, or that documentation may be for different purposes.

- NIH management indicated that funding of IT projects is not based on implementation plans but based on the priorities of a given year as defined by various IT and management committees. Although deviations from the implementation plan are permitted, these deviations should be formally documented.

Recommendation

We recommend that NIH, in conjunction with DHHS, develop and implement policies and procedures with an appropriate internal control to ensure authorized cost-effective and efficient systems implementation. These policies procedures would include the following:

- Processes to ensure a correlation of (1) amounts contributed by the ICs versus the obligations incurred by the SSF and (2) executed costs and deadlines versus original projections/budgets.
- A critical path identifying when and from whom required written authorizations should be obtained.
- Documentation supporting the OGC’s concurrence during the system life cycle as appropriate to ensure that complex authorizing and approval activities are conducted.
- Maintenance of files that would include required planning documents, project costs, critical written authorizations, and submissions required by OMB and DHHS. Financial management requirements, including journal entries, basis for allocation of funding from the ICs, analyses requirements based on required submissions of OMB and DHHS, and appropriate supervisory and departmental review of costs and financial activity.

Reportable Conditions

Required Authorizations and Documented Supervisory Review (Repeat Comment)

During our audit, we noted that certain documentation to support contracts, grants, fixed assets, and cash disbursements had not been properly approved. For example, we noted:

Eleven items related to purchase of fixed assets where the requestor and/or internal approver had not signed the requisition.

- Two instances where the Grants Management Specialist and Grants Management Officer's electronic signatures were the same person.
- One instance where the Request for Proposal had not been signed.
- One instance where the Small Business Administrator had not signed the DHHS Small Business/Labor Surplus Set-Aside Review Form.
- One instance where the contracting officer had not approved the DHHS Small Business/Labor Surplus Set-Aside Review Form.
- One instance where the contracting officer and the branch chief had not authorized the Request for Contract.
- One instance where the contracting officer had not authorized the Project Officers Technical Questionnaire.

Further, we noted that supervisory reviews of reconciliations and analysis performed by staff accountants were not evident through our review of the documentation provided. U.S. GAO's *Standards for Internal Control in the Federal Government* states that qualified and continuous supervision should be provided to ensure that internal control objectives are achieved. Except for Fund Balance with Treasury, reconciliations related to accounts receivable, accounts payable, undelivered orders, net position, fixed assets, and advances and certain analysis performed to support the financial statements were not signed off and dated as approved. Without the date of approval, we could not determine whether the analysis was performed in a timely manner.

Recommendation

We recommend that NIH:

- Develop policies and procedures describing minimum levels of authorization.
- Place a stronger emphasis on policies requiring written authorization. NIH should perform periodic reviews to ensure each IC is complying with applicable procedures. All authorizing signatures should be dated so that effective dates and timeliness issues can be determined.
- Develop policies and procedures identifying the level of supervisory review required for financial statements and related supporting documentation, financial analysis, and reconciliations. Once completed, the authorization should be documented on the procedure to show evidence of the review.

Grant Financial Management Oversight (Material Weakness in 2000)

Background

The NIH utilizes grants with a myriad of colleges, universities, research institutions, and corporations to leverage its activities in promoting and funding research and education initiatives nationwide. Through structured peer review and other processes, the NIH has developed tools intended to facilitate grant-making activities and help ration scarce research funding across competing priorities. As grant funding continues to increase at NIH, appropriate monitoring of grants as the research is performed can be challenging. It requires sharing of responsibility among grants management officials, the Office of Financial Management, the technical advisor and scientists in the sponsoring ICs, principal investigators, and others within the grantee institution to work together to set expectations, monitor compliance, and facilitate reporting of results obtained for comparison to resources applied.

During FY 2000, we noted significant issues related to grants management and the oversight of grants. As a result, we identified grants management oversight as a material weakness. During FY 2001, certain actions were taken to improve the grants financial management and oversight processes including:

Resolution of significant issues at the Division of Payment Management (DPM) related to the systems conversion.

Some improvements in analysis by NIH of its obligations, expenditures, and advances.

- Improvement in the research and resolution of differences at the individual grant level between information reported by the DPM and the NIH.

Although improvements were noted, we still identified weaknesses affecting the grants management process as discussed below.

Reconciliation and Analysis Activities Continue to Merit Improvement

Although DPM is responsible for processing grant related transactions for authorizations, advances, and disbursement amounts, in many respects DPM functions as a bank and a service bureau and is not well positioned to detect anomalies in its customers' data. As a result, increased emphasis on NIH's grant financial management controls are needed. During our review of grants, we noted several concerns related to the reconciliation and analysis of grant information between the various systems, as follows:

During our review of reconciliations between advances and expenditures reported by NIH and those reported by DPM, we noted that although comparisons were performed throughout the year noting large differences, ranging from \$217 million to \$1.5 billion, formal investigation of those differences did not take place until after September 30, 2001. Because NIH analysis techniques are continuing to be refined, the NIH is not well positioned to assess whether information reported by DPM is reasonable.

NIH has developed and implemented historical analyses of its grant authorizations, expenditures, and advance information as reported from its general ledger. However, when fluctuations were identified, NIH did not formally document reasons surrounding such fluctuations.

- During FY 2001, we noted limited communications between NIH and the DPM regarding adjustments recorded by DPM against NIH appropriations. DPM charged two of NIH's appropriations for more than \$400 million in overages and shortages identified in its grant allocation processes.

Grant / Contract Close-Out Documents

According to NIH policy, grantees are required to submit closeout documentation within 90 days after termination of the grant. If the information is not received at this time, a follow-up memo is sent out requesting the information within 30 days. If the information is still not sent in, the IC will notify the grantee that they will no longer receive additional funds until the proper information is received. During our tests of grants, we found one instance where the closeout documents, such as the Financial Status Report (FSR), Progress Report, and Invention Statements, were not received from the grantee. NIH indicated that it is expecting to implement new systems and new processes to better monitor the receipt of closeout documentation.

IC Policies and Procedures

Generally, the grant and contract processes are similar between ICs. However, we noted that many ICs do not have written policies and procedures to document the award, accounting, and monitoring processes. When standard forms are used in the process, the information captured is consistent, although the procedures applied and the authorizing officials vary between ICs. For example, there are no written procedures on how checklists, progress review forms, or the grants management worksheets are to be prepared. We noted in certain ICs, where an automated process had been implemented, no authorizing signature was captured on the forms. For two sample items, we noted a lack of final approval for funding by authorized officials. Some of the ICs have moved away from manual signatures to electronic approval; however, we were not provided with any documentation of this policy.

Inconsistent Budget and Project Dates

During FY 2001, we identified two instances where the budget and project dates were inconsistent between documents or omitted entirely. If these dates are not consistent, grant recipients may have access to funds prior to the budget date of the project. For instance, if a grant budget period begins January 15, 2001 and is transferred to DPM on January 1, 2001, recipients could obtain money prior the budget begin date.

Chairman Grants

During our review of Chairman grants, a grant that is awarded to an individual for a specific scientific event, we noted one instance where the following exceptions were identified:

- The entity's identification number on the supplemental grant application does not match that of the corresponding Grants Management Worksheet. The Social Security Number of the Principal Investigator was used as the entity's identification number in the grants system that produces certain Grants Management Worksheets.
- The Budget Period for the grant ended June 30, 2000, but checks were written on the account in 2001. NIH subsequently corrected this condition by extending the budget period.

NIH indicated that the occurrence was due to oversight of personnel.

Missing Documentation

During our testing of grants we were unable to locate certain documentation in five of the 45 grant files reviewed. Although NIH indicated that the documents had been provided by the grantee, the documentation was not included in the file and not provided for our review.

OMB Circular A-133 states, "The documentation for transactions, management controls, and other significant events must be clear and readily available for examination." In addition, NIH Policy Manual Chapter 5808, states that the Grants Management Officer is responsible for assuring that complete up-to-date program information files and official grant files for individual projects are established and maintained. Pertinent material should be filed in a timely manner and maintained chronologically through final closeout to ensure that all required documents are in hand and the file initialed by the reviewer and dated to signify completeness.

Recommendation

We recommend the NIH

Establish a task force to assess what enhancements are required at the DPM and NIH to ensure all grant related transactions generated are complete, valid, properly valued, and recorded appropriately. Additionally, NIH and the DPM should develop a process to enable improved communication so that unusual fluctuations identified through analyses are resolved on a timely basis.

Develop formal written policies and procedures by IC for the awarding, issuing, and monitoring of grant and contract awards. This will assist in identifying audit trails and the various electronic forms and approvals.

- Reinforce policies and procedures related to the closeout of grants, including providing guidance to grantees regarding their obligations to submit final reports. Improvements in maintenance and tracking of the closeout information should be made to ensure that ICs are receiving the necessary closeout information for terminated grants. The timely de-obligation of these funds would limit the availability of these funds to the grantee and its potential effect on the monthly charging of advances and the grant estimation models. Information should be centralized and available to all ICs in order to track the delinquent grantees and to ensure additional funds are not awarded until submission of the required reports.
- Enhance quarterly reconciliations for all grant related balances including obligations, advances, and expenditures, and develop supporting documentation that reflects management's understanding of the composition of those accounts.
- Enhance formalized procedures to perform periodic detailed reviews of transactions within the IMPAC (NIH's grant management system), NIH's general ledger, and the DPM.
- Develop a mechanism to identify specific grants and contracts from the IMPAC system that are administered by the DPM so that enhanced reconciliation procedures may be performed.
- Enhance high-level exception driven analysis techniques to include the follow-up on emerging trends and anomalies in reported balances.
- Direct Program Managers within the ICs to review subsidiary ledgers and Grantee submitted reports to ensure reasonableness of balances related to obligations, expenditures, and advances for the current and prior years, and obtain query access to DPM financial systems to identify and investigate unusual items. The critical role the IC executive officers, budget and grant managers, and financial community play in monitoring grants should be reinforced and reinvigorated as appropriate.
- Emphasize the need for the ICs to file pertinent material in a timely manner in the grant file to be maintained through the final closeout. In addition, the file should

be reviewed to ensure that all required documents are in hand and the file initialed by the reviewer and dated to signify completeness.

- Emphasize to the ICs that award budget periods, which are approved and contained within documents, the grants management system, and the general ledger should be consistent with those that are contained at DPM. This may involve limiting the dates a grant can be awarded or regularly updating the data in PMS. Furthermore, the synchronization report should be updated to identify discrepancies in the budget dates authorized at DPM and in the general ledger.

Fund Balance with Treasury (Repeat Condition)

Treasury regulations require that each federal entity ensure that it reconciles on a monthly basis its financial records with Treasury's records and that it promptly resolves differences. If this reconciliation is not adequately performed, loss, fraud, and irregularities may occur and not be promptly detected, and/or financial reports that are inaccurate may be prepared and used in decision-making. On a monthly basis, NIH is responsible for reconciling approximately 150 Treasury accounts. During our testing, we noted certain weaknesses, for example:

Two suspense accounts with unreconciled balances totaling \$25 million and \$6 million relating to September 30, 2001, had not been reconciled as of January 2002, and included reconciling items over a year old. The suspense accounts pose as a holding account for unidentified gift funds and royalties. When first received, NIH does not know details about money so it is held in suspense until it can be identified and then classified correctly. This is a continuous account; amounts that are deposited will not necessarily be the same amount that is cleared and so there is always a balance. Treasury does not appropriate these funds and so NIH manually submits them via the SF224 as they receive them.

Several reconciliations containing unresolved differences that in some cases were several months old. These reconciling items primarily resulted from OPAC vouchers, foreign disbursements, Inner-Office Transfer Vouchers (IOTV), and payroll differences and are due to the lack of supporting documentation that is received by NIH from other agencies.

- We noted one item in the amount of \$6.7 million listed on the November 2000 reconciliation as a FY 99 prior year difference. This PY difference is a part of the unconditional gift fund suspense account, which is a continuous account. At FY 01, NIH had a positive balance of \$6.7 million that was still waiting to be obligated to the right appropriation, depending on NIH receiving the information.
- We noted mathematical inaccuracies in the spreadsheets used to reconcile fund balances. The difference was approximately \$5 million and was not identified during NIH's supervisory review process.

- We noted one item on the June 2001 reconciliation totaling \$13.9 million that was reported to Treasury under the wrong FY or appropriation. A manual adjustment to SF 224 is being prepared by NIH to report the transaction to Treasury, under the correct FY or appropriation. As of September 30, 2001, this item was still unresolved.

Three deposit slips included checks that were received up to three months prior to the date of the deposit. Management indicated that certain checks are sent to various departments within the IC prior to being forwarded to the Office of Financial Management for deposit.

Management indicated that lack of sufficient resources had hindered its ability to timely complete the reconciliation and resolution of all differences. Further, management believes that differences are primarily attributed to the Government-wide processes for which supporting documentation for disbursements can be delayed by several months.

Recommendation

We recommend that NIH improve its current procedures to ensure the timely reconciliation of the Fund Balance with Treasury and to identify, research, and resolve variances and amounts reported in the suspense accounts in a timely manner, to record adjustments to the general ledger on a timely basis, and to ensure supporting documentation is available and maintained. Further, efforts should continue to be focused on the older out-of-balance amounts in the 3875 account. Finally, the NIH should also monitor the timeliness of completion of cash reconciliations and related adjustments.

Real Property (Repeat Condition)

As reported in FY 2000, weaknesses in property systems and internal control related to NIH's real property totaling more than \$940 million, still exist. For example:

- Although NIH implemented DHHS's FIRM (Foundation Information for Real Property Management), a real property subsidiary program, in FY 2001, the program does not maintain sufficient detail to support amounts reported for construction in-process and new buildings.
- NIH does not obtain supplemental agreements to General Service Administration (GSA) leases. These supplemental agreements adjust square footage, rates and other criteria surrounding the lease agreement. As a result, NIH pays GSA based on the bill rather than the lease agreement, which could result in errors.

Recommendation

We recommend that the Division of Engineering Services, in coordination with the Office of Financial Management, enhance its subsidiary system to account for real property activity at the detail level, properly calculate depreciation, and interact with the general ledger to properly record property related transactions using DHHS approved transactions. Further, we recommend that formalized policies and procedures be developed and training be provided to the appropriate personnel to ensure proper accounting of real property additions and deletions.

Personal Property (Repeat Condition)

Weaknesses in internal control over safeguarding of and accounting for personal property are still being identified. We tested 45 sample items from a population of \$64.8 million in new acquisitions and noted the following:

- Due to lack of integration between the property system and the general ledger, NIH was required to record 322 transactions totaling \$371 million using a transaction code that supersedes the table driven entries supported by the DHHS.
- Depreciation expense for 9 out of 45 items tested was calculated incorrectly. This is due to incorrect useful lives, delay in the entry into property system (PMIS), and software-programming issues that were identified. Differences ranged from \$426 to \$8,245 per item.
- We noted 20 items totaling \$4.7 million where no depreciation had been calculated because they either had not been marked with a tracking number or a tracking number had not been entered into the property system.
- One item that was not recorded into the PMIS system within five working days as required by the HHS accounting policy.
30 items where documentation to support the date the item was identified with a tracking number was unavailable.
- 28 instances where NIH could not locate certain documentation, including purchase orders, sole source justifications, receiving reports, invoices, and purchase requisitions to support fixed asset purchases. In one instance the purchasing agent was unable to locate any procurement documentation.
- 21 instances where amounts could not be tracked between the originating documentation, the property system and the general ledger.
- 20 items that did not have a tracking number. When we inspected the asset, we noted that while 13 of 20 had a tracking number that had not been entered into the property system, the remaining six items had not been marked with the identifying tracking number.

One item where an error was made in recording the acquisition costs in the property system. Instead of recording the cost at \$2,600, the asset was recorded at \$26,000. The item should not have been capitalized under NIH's current capitalization policy.

Recommendation

We recommend that the NIH re-emphasize current policies and procedures, including the importance of complying with regulations to ensure that capitalized asset activity is properly recorded within the property management system and the general ledger and all items received are promptly entered to safeguard assets against loss. The NIH should ensure that formal policies address the assignment of acquisition dates. Finally, a detailed analysis of the current calculation of depreciation expense and accumulated depreciation should be performed.

Reimbursable Agreements (Repeat Condition)

During our review of 30 reimbursable agreements, we noted weaknesses that continue to affect the tracking of accounting records to the related agreements. For example:

For 13 items, the agreement was either missing data or the data were filled out incorrectly.

- For eight items, the modification suffix in the agreement number on the reimbursable agreement does not correspond to the modification identified in the agreement number in the general ledger.

For eight agreements selected, we noted handwritten changes to the interagency agreement without evidence of proper approval.

NIH management noted two reasons for the discrepancies—(1) the general ledger is not being updated with new modification numbers assigned and (2) the general ledger assigns a different modification number if there is more than one common account number on the agreement.

Recommendation

We recommend that NIH develop policies and procedures to:

- Ensure the traceability of agreements to the accounting documents by standardizing the numbering of agreements, reemphasizing existing policy, and rebuilding reimbursable record files, as necessary.
- Develop procedures to ensure that agreement files are complete and properly authorized and that modifications are properly tracked.

Provide additional training for personnel to ensure reimbursable agreements are prepared properly.

Payroll (Repeat Condition)

NIH needs to improve internal control to ensure that payroll and time and attendance transactions are properly authorized and supported by current files. During our testing of 45 payroll related transactions, we noted the following issues:

Discrepancies between the NIH time and attendance system (ITAS) and the DHHS central payroll system (IMPACT) were noted in 17 of 45 payroll transactions selected. Management indicated that several reasons contributed to the discrepancies between the IMPACT system and ITAS. During FY2000, the former time and attendance system was replaced with ITAS. During this conversion, NIH noted that certain issues arose causing some beginning balances per ITAS to be incorrect. Additionally, because of a lack of integration, authorized NIH officials must directly enter and update personnel information into both systems, increasing the risk for differences. Finally, due to inadequate communications between the timekeepers and the Office of Human Resource Management, leave amounts between systems could be incorrect and go unresolved for long periods of time.

Leave was not earned in accordance with NIH policy for three of 45 transactions selected.

- Various personnel documents, including a thrift savings plan form and a master payroll record display, were missing in three of 45 items selected.

We noted one item where an improper truncation on the Data Flowback report displayed the amount for the employer's contribution for retirement incorrectly.

Because of the 17 instances where NIH did not consistently reconcile leave from the employees timesheet to the leave and earnings statements to ensure that the appropriate balances were being reported, accrued leave amounts may be inaccurate. Total accrued annual leave at September 30, 2001, represents \$89.4 million. As a result, any misstatement to the accrued leave balance would not be material to the financial statements taken as a whole.

Recommendation

We recommend that NIH, in collaboration with DHHS' Central Payroll:

Periodically analyze time and attendance personnel files to ensure complete and accurate information is maintained in the time and attendance system, as well as ensure sufficient supporting documentation is maintained in the file,

- Direct timekeepers to review the leave information maintained in the ITAS system to ensure that leave being accrued is accurate and errors and corrections are communicated to the Office of Human Resource Management in a timely manner,
- Periodically audit the leave balances in order to ensure agreement between the ITAS and the Central Payroll systems, and
- Assess report formats generated from the ITAS and IMPACT systems to ensure amounts are properly stated on payroll reports used by management.

Personnel Actions

During fiscal year 2001, NIH canceled certain promotions for 44 administrative staff that are among 2700 individuals in its Administratively Determined Pay (AD) Classification. These individuals were determined by the DHHS not to meet the requirements of Title 42, *The Public Health Service Act*, because they are not scientists or “professionals.” Approximately 900 of the 2700 individuals are paid at levels greater than a GS-15, Step 1, or more than \$79,000 a year, with a ceiling of \$200,000 plus incentives annually. Under Title 42, NIH is provided authority to increase the pay with certain limitations of certain individuals who have the appropriate credentials, primarily doctorate degrees, to perform scientific research. In addition to a centralized approval process and conduct reviews of data to see how Special Experts are being used, NIH policy has also been rewritten.

Recommendation

We recommend that NIH, in conjunction with the Department of Health and Human Services, perform periodic reviews to ensure compliance with Title 42. Additionally we recommend that NIH, in promoting individuals to the Administratively Determined Pay category, develop specific processes in hiring individuals to ensure appropriate authority is obtained in writing.

Receipt and Acceptance Procedures (Repeat Condition)

During our review of cash disbursements and personal property, we noted that certain receiving documents contained inaccurate or incomplete information regarding the date, place, or individual who did the receiving and/or did not properly reflect what items had been actually received. This inaccurate or incomplete information was then entered into the Administrative Database. We noted the following:

Twelve items for which inadequate supporting documentation for proof of receipt and acceptance of personal property was provided.

One instance where goods were not promptly recorded into the general ledger. It required over seven months for receipt of personal property to be recorded into the property subsidiary.

- One instance where the date established within the property system was prior to the receiving date.
- One instance where the invoice was received but not recorded within the NIH receiving guidelines. Instances such as this may result in noncompliance with the Prompt Payment Act, particularly if services have been provided prior to invoice receipt.

Recommendation

We recommend that the NIH strengthen its controls to ensure that receiving documentation is adequate, properly completed, and available on a timely basis to support the financial statements and audit requirements. NIH should enforce the regulations and policies set forth regarding receipt and acceptance of goods.

Reimbursable Agreement Overhead Calculation (Repeat Condition)

Consistent with our prior year finding, we noted during our audit procedures that NIH does not consistently apply overhead to its reimbursable agreements. Further, when overhead is applied, the overhead is based on judgmental percentages rather than an analysis of cost structures that would determine whether the percentage is reasonable. Statement of Federal Financial Accounting Standards (SFFAS) Number 4, *Managerial Cost*, requires reporting entities to report the full costs of outputs in general purpose financial reports. The full cost of an output produced is the sum of (1) the costs of resources consumed by the segment that directly or indirectly contributes to the output, and (2) the costs of identifiable supporting services provided by other responsibility segments with the reporting entity, and by other reporting entities.

Recommendation

We recommend NIH perform an analysis to (1) determine its compliance with SFFAS Number 4 and (2) determine a reasonable overhead rate, if applicable. The NIH should review current policies in the use of overhead on reimbursable agreements and work with each IC to determine its basis for its calculated overhead rate, if any, to ensure consistency throughout the NIH and compliance with Federal standards.

FACTS II Reporting Requirements (Repeat Condition)

The Treasury Financial Manual requires each federal entity to prepare, certify, and report to Treasury via the FACTS II process the adjusted trial balance for budgetary accounts that identifies the status of appropriated balances. Although the adjusted trial balance was prepared and submitted, a subsequent review identified several incorrect amounts totaling \$164 million.

Recommendation

We recommend that procedures used in the preparation of FACTS II be reviewed and updated, where applicable. In addition, we recommend that financial personnel who prepare the Form 2108 worksheets and supporting documents be provided additional training to ensure a full understanding of required procedures and accuracy in reporting.

STATUS OF PRIOR YEAR COMMENTS

In reports issued by Ernst & Young LLP and other prior auditors, a number of issues were raised relating to the internal control of NIH. For those items not addressed in our Report of Independent Auditors on Internal Control, summarized above, the following discusses the current status of resolutions for those matters raised.

Duplicate and Overpayments

In FY 2000, we recommended that NIH review payment procedures to ensure that they have been designed with adequate internal control to prevent over or duplicate payments. During FY 2001, we did not identify any instances of duplicate payments. As a result, we have not included the issue as a reportable condition in this report.

* * * * *

In addition, we considered NIH's internal control over Required Supplementary Stewardship Information (RSSI) by obtaining an understanding of the agency's internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on internal control or related controls, if any. Accordingly, we do not provide an opinion on such controls.

Finally with respect to internal control related to performance measures reported in the Management's Discussion and Analysis (MD&A), we obtained an understanding of the design of internal control relating to the existence and completeness assertions and determined whether they have been placed in operation, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

We noted other matters involving internal control over financial reporting, which we have reported to management in a separate letter dated January 31, 2002.

This report is intended solely for the information and use of the management of NIH and the DHHS, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst + Young LLP

January 31, 2002

Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services, and
the Director of the National Institutes of Health

We have audited the consolidated balance sheets of the National Institutes of Health (NIH), an operating division of the Department of Health and Human Services as of September 30, 2001 and 2000, and the related consolidated statements of net costs, for the fiscal years then ended and the consolidated statement of changes in net position and financing and combined statements of budgetary resources for the fiscal year ended September 30, 2001, and have issued our report thereon dated January 31, 2002. We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*.

The management of the NIH is responsible for complying with laws and regulations applicable to the NIH. As part of obtaining reasonable assurance about whether the NIH's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to the NIH. We caution that noncompliance may occur and not be detected by the tests performed and that such testing may not be sufficient for other purposes.

The results of our tests disclosed one potential instance of noncompliance with the laws and regulations discussed in the preceding paragraph exclusive of FFMIA that are required to be reported under *Government Auditing Standards* or OMB Bulletin 01-02, as follows:

Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services, and
the Director of the National Institutes of Health

We have audited the consolidated balance sheets of the National Institutes of Health (NIH), an operating division of the Department of Health and Human Services as of September 30, 2001 and 2000, and the related consolidated statements of net costs, for the fiscal years then ended and the consolidated statement of changes in net position and financing and combined statements of budgetary resources for the fiscal year ended September 30, 2001, and have issued our report thereon dated January 31, 2002. We conducted our audits in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*.

The management of the NIH is responsible for complying with laws and regulations applicable to the NIH. As part of obtaining reasonable assurance about whether the NIH's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to the NIH. We caution that noncompliance may occur and not be detected by the tests performed and that such testing may not be sufficient for other purposes.

The results of our tests disclosed one potential instance of noncompliance with the laws and regulations discussed in the preceding paragraph exclusive of FFMIA that are required to be reported under *Government Auditing Standards* or OMB Bulletin 01-02, as follows:

Personnel Actions—During fiscal year 2001, NIH canceled certain promotions for 44 administrative staff that are among 2700 individuals in its Administratively Determined Pay (AD) Classification. These individuals were determined by the DHHS not to meet the requirements of Title 42, *The Public Health Service Act*, because they are not scientists or “professionals.” Approximately 900 of the 2700 individuals are paid at levels greater than a GS-15, Step 1, or more than \$79,000 a year, with a ceiling of \$200,000 plus incentives annually. Under Title 42, NIH is provided authority to increase the pay with certain limitations of certain individuals who have the appropriate credentials, primarily doctorate degrees, to perform scientific research.

At the request of the Office of Inspector General, we assessed whether the NIH’s financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements.

The results of our tests disclosed instances, described below, where the NIH’s financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph.

Analysis and Development of Financial Statements—NIH’s central accounting system lacks integration with certain subsidiary systems, does not facilitate the preparation of the financial statements, has not fully adapted the Treasury Standard General Ledger, and contains insufficient internal control to detect incorrect entries in a timely for its approximately 28 institutes and centers on a timely fashion. The process currently performed is substituting the central accounting system as an input to a work around systematic process to summarize trial balances from the institutes and centers and record thousands of adjusting, closing, and elimination entries — many of which represent entries to bring the subsidiary and general ledger accounts into balance or to correct errors. Subsequent to the work around process, we noted 64 entries totaling an absolute value of approximately \$28 billion to adjust account balances manually through a series of spreadsheets to generate amounts for financial statement purposes. Additionally, certain reconciliation processes were not adequately performed to ensure differences between subsidiary systems and the general ledger were properly identified, researched, and resolved and that account balances were complete and accurate.

Adjusting Journal Entries—During our audit, we noted several types of journal entries that are not supported by the standard general ledger guidance. Further, the automated system and manual processes allow for the posting of paired entries where one side of the entry posts to the proprietary accounts while the other side posts to the budgetary accounts resulting in imbalances between the budgetary and proprietary trial balances. Because NIH does not properly use all standard general ledger accounts, personnel are required to manually prepare numerous entries at year-end to balance and close accounts to be in accordance with Treasury’s closing procedures. During fiscal year 2001, NIH

recorded approximately 19,000 entries totaling an absolute value of over \$348 billion using a transaction code that is normally used when table driven entries, regulated by the Department of Health and Human Services, are not available.

Open Document File— NIH maintains its outstanding obligations for grants, accounts payable, and accounts receivable subsidiary files in the Open Document file. The Open Document file tracks transactions based on document number instead of vendor or grantee. As a result, if a change or error is made in the document number, the expenses and related obligations are sometimes classified as two entries, which results in (1) the appearance of overpayment or overstatement of accruals against obligations and outstanding obligations without activity, and (2) difficulty in properly analyzing the reported financial statement activity. In addition, we noted that the Open Document file does not facilitate the elimination of intra- or inter-governmental transactions.

The Report of Independent Auditors on Internal Control and our separate management letter includes information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from the NIH's management responsible for addressing the noncompliance are provided as an attachment to this report.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report is intended solely for the information and use of the management of the NIH and the DHHS, OMB and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

January 31, 2002



February 14, 2002

NOTE TO ERNST AND YOUNG

SUBJECT: Review of Draft Report

Thank you for the opportunity to comment on the draft Report of Independent Auditors on Internal Control. We concur with your recommendations, but we do not concur with the conclusion that your findings represent a material weakness related to Investments in Management Systems.

A material weakness in internal control is a reportable condition in which the design or operation of one or more of the specific internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned function. There are no findings included in your report that related to our IT system's account that rise to the level required for a material weakness.

Moreover, the conclusion that "such internal control deficiencies can increase the risk that resources may not be safeguarded against waste, loss, unauthorized use, and misappropriation" is not supported by the facts and findings identified in the report. There are no instances that you have identified that may result in waste, loss, unauthorized use, or misappropriation of resources.

In fact, the multiple levels of review to which we subject our IT system's projects leads to a more effective and efficient approach to budgeting for and monitoring the execution of our IT systems projects. We are following the tenets of Clinger-Cohen by planning, presenting, and executing our development of these complex multiple project systems over a total project multi-year horizon. What we learned from our preliminary assessment of ERPs is that the line between success and failure is a function of how well we treat these complex projects as a multi-year undertaking. As such, we must have certainty as to having the resources to carry-out these projects.

Moreover, we notified the DHHS, the OMB, and the Congress of our plans to pursue Enterprise IT systems.

On page 12 of the report you indicate that the NIH found flexibility in using the Service and Supply Fund to consolidate the budgeting and accounting for our major enterprise IT systems and you identify several bullets that explains why the NIH found flexibility in this approach. These bullets are the advantages contained in the August 2000 report of the IT Enterprise Systems Funding Workgroup. This Workgroup was created by the NIH Deputy Director for

Management to identify options, with advantages and disadvantages, for funding our major enterprise IT systems. This pre-decisional document identified the advantages and disadvantages of various options as viewed by the members of the Workgroup. This pre-decisional document does not represent NIH policy or NIH views.

The NIH Deputy Director for Management has indicated that he discussed with the Acting NIH Director the memorandum of the discussion between Office of Financial Management and Office of General Counsel staff after the NIH Acting Director request a legal opinion when this topic was discussed with the IC Directors. According to the NIH Deputy Director for Management, the NIH Acting Director was satisfied that we consulted with the Office of General Counsel before we proceeded. In the January and February 2002 communications from the Office of General Counsel, they have reiterated their concurrence with our approach.

We received all of the necessary approvals to proceed with the NBS project. In the conference call with the DHHS Deputy CIO for which you participated, the DHHS Deputy CIO reiterated that NIH received DHHS approval to proceed. Although we did not receive a written document authorizing us to proceed after we receive written tentative approval, all of the circumstantial evidence supports the fact that the DHHS approved our proceeding. In addition, there is no law, rule, or regulation that indicates that we needed to receive a written document from the DHHS to proceed. We complied with all required laws, rules, and regulations. The DHHS accepted and processed OMB apportionments that included the funds for the NBS, the DHHS accepted and processed required 300b reports for the NBS, the DHHS was briefed on several occasions on our progress with the NBS, and the DHHS Secretary has recognized the NBS by adopting the financial portion of our NBS initiative to be used as a model for the DHHS-wide Uniform Financial Management System.

Regarding the written documentation from two Institutes with the Common Accounting Numbers (CANs) to use for the IT systems obligations, those two Institute provided us with the CANs over the telephone. There is no evidence that these Institutes did not give us the CANs or that we obligated the funds incorrectly against the two Institute CANs. To provide further assurances to you, we asked these two Institutes to send us a document confirming that they did indeed provide us with a CAN and that we obligated funds properly against those CANs. We have provided you with these two documents.

The OMB examiner initially requested more information from NIH about the IT systems before approving the Service and Supply Fund apportionment that included funds for the IT systems. By telephone the NIH provided the OMB examiner with this additional information, and the OMB then approved the apportionment. There is no law, rule, or regulation that suggests that our communication with OMB needed to be in writing.

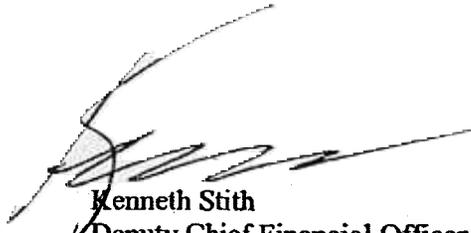
We disagree with the conclusion that NIH was unable to track activity, including obligations, advances, and costs related to the NIH Business System. The \$3.5 million error that the NIH identified in the unearned revenue account did not affect the Institute's obligations, advances, or costs recorded for the NIH Business System at the NIH entity. The major portion of this error was our failure to complete one of the top side adjustments to shift resources between the accounts receivable and the unearned revenue general ledger accounts. Revenues and costs were properly recorded in this instance. Regarding the \$2.2 million of accruals, the expenses are

correct at the NIH entity level. Neither of these two items has a significant effect on the NIH financial statements.

Each project manager reviews and monitors project plans and costs for their respective projects on an ongoing basis. We do modify tables that reflect out year costs as more current information and data become known. We do not agree with the implied conclusion that we should not modify our original implementation plans as conditions warrant our making changes based on more current information.

Regarding different projected costs identified on different documents, the OMB 300b reports reflect the total costs for both software development and post-development operations and maintenance for a much longer time period than the five-year multi-colored tables that we use to track and monitor costs; of course, the total reported cost for a project over a 10 year timeframe would be different from the cost for a project over a 5 year timeframe. This accounts for the total project costs ranging from \$350 million to over \$800 million on various documents that you reviewed. Moreover, as we obtain more refined cost data for future years of a project, we incorporate the more current data. This is not unusual for multi-year projects.

We concur with the recommendations and will institute a better record-keeping process for those documents for which we are responsible. Also, we will ensure that we examine during the current fiscal year the most current budget requirements to ensure that we have sufficient resources to fund each of the projects.



Kenneth Stith
Deputy Chief Financial Officer
National Institutes of Health

Mr. Charles Leasure
Chief Financial Officer
National Institutes of Health

In planning and performing our audits of the consolidated balance sheets of the National Institutes of Health (NIH), as of September 30, 2001 and 2000, and the related consolidated statements of net costs for the fiscal years then ended and the consolidated statement of changes in net position and financing and combined statements of budgetary resources for the fiscal year ended September 30, 2001, we considered the internal control of the NIH to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on internal control. We have separately reported in our report dated January 31, 2002, certain matters involving internal control and its operation that we consider to be reportable conditions and/or material weaknesses under standards established by the American Institute of Certified Public Accountants.

The following suggestions, which resulted from our consideration of internal control, are submitted to assist in improving procedures and controls.

Grants Logical Access Controls

We noted that security over NIH's grant management system's (IMPAC II) application password management controls need enhancement. We noted certain weaknesses, specifically in the implementation of password aging and expiration, history, complexity, checking, and account locking features. Weak password management controls increase the risk for unauthorized and inappropriate access to sensitive data.

Recommendation

We recommend that NIH implement stricter password management controls over the IMPAC II application to ensure that inappropriate and unauthorized access cannot be gained to the sensitive application.

Administrative Database Logical Access and Program Change Controls

Currently there are no controls in place to ensure that the Administrative Database (ADB) access rights are reviewed by the ADB Administrative Officers within the various Institutes and Centers. The ADB Administrative Officers are reminded on quarterly basis by the ADB Group of their responsibilities with respect to user access reviews. However, there is no formal process in place to ensure that the reviews are being performed, issues documented, and resolved.

Additionally, there is no automated tracking of changes to ADB production programs. Without a complete log of all modifications to ADB program files, unauthorized changes may not be detected in a timely manner.

Recommendation

We recommend that ADB management periodically obtain confirmation from ADB Administrative Officers to ensure that these reviews are being performed.

Additionally, we recommend that change management software be implemented to provide an automated record of all changes made to production programs. Once implemented, the log should be reviewed on a periodic basis to ensure that only authorized changes were made to the production environment.

Cash Collections

Our review of the cash collections process identified several weaknesses that affect the timeliness of deposit of funds and the accuracy of reported amounts. Weaknesses identified are as follows:

Two exceptions where data was incorrectly entered on supporting documentation to support the deposit and recording of cash receipts—the Agency Location Code and the check date on the Detail Deposit Schedule was incorrect. NIH indicated that the exceptions were due to oversight.

- One gift receipt for \$5000 where although the donor requested that the funds be used for a specific purpose and the acceptance letter from the Director of the recipient IC indicated that the contribution would be used towards the program, NIH recorded the funds as a gift for unconditional use. We noted from the IC transmittal that this gift receipt was classified as an unconditional gift fund.
- The deposit transmittal for royalty funds did not identify the appropriation breakdown. NIH indicated that the area of the transmittal was not completed due to an oversight of the personnel.

- Two instances where the deposit of the receiving IC was recorded to the general ledger prior to the disbursement of the funds from the other IC.

Recommendation

With respect to the processing of cash receipts, we recommend NIH:

- Ensure transactions are recorded appropriately to ensure receipts are recorded subsequent to the funds being disbursed from other ICs. Also, transactions should be posted timely to the general ledger.
- Ensure all required data is filled out on all schedules used at every point in the transaction process.
- Classify receipts into proper gift accounts and contact donors to clarify donor's intent as to the use of the gift fund.
- Ensure all required data on required documentation are filled out correctly.

* * * * *

The status of these matters will be reviewed as part of the fiscal year 2002 financial statement audit. Consequently, we encourage you and your staff to take the necessary corrective actions to address the conditions identified during the fiscal year 2001 audit.

This report is intended solely for the information and use of the management of NIH and the DHHS, OMB, and Congress, and is not intended to be and should not be used by anyone other than these specified parties.

We would be pleased to discuss the above matters or to respond to any questions, at your convenience.

Ernst & Young LLP

January 31, 2002