

DATE: FEB 27 2003

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

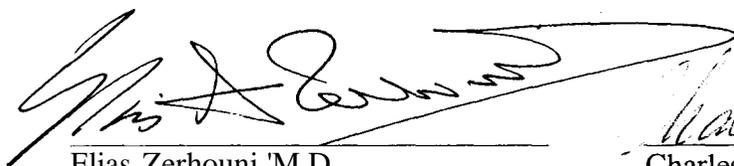
FROM: Director, NIH
Deputy Director for Management, NIH

SUBJECT: FY 2002 Chief Financial Officer Act (CFO) and Government
Management Reform Act (GMRA) Audit

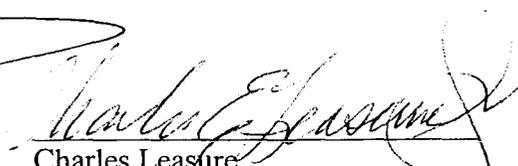
Attached are the results of our CFO/GMRA audit for FY 2002. We earned an unqualified opinion from our independent auditors, Clifton Gunderson, on our financial statements. This is the fourth year in a row that we have earned an unqualified opinion and is a distinguished accomplishment.

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 sb29kCa@nih.gov.



Elias Zerhouni, M.D.
Director, NIH



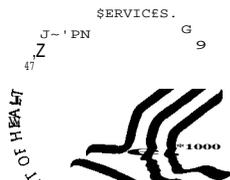
Charles Leasure
Deputy Director for Management, NIH

Attachment

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 2002



JANET REHNQUIST
Inspector General

JANUARY 2003
A-17-02-00009

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Washington, D. C.

INDEPENDENT AUDITOR'S REPORTS
AND FINANCIAL STATEMENTS
September 30, 2002 and 2001

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

INDEPENDENT AUDITOR'S REPORTS AND
FINANCIAL STATEMENTS
September 30, 2002 and 2001

TABLE OF CONTENTS

Independent Auditor's Report
Independent Auditor's Report on Compliance with Laws and Regulations
Independent Auditor's Report on Internal Control

- Material Weakness
- Reportable Conditions
- Status of Prior Year Comments

Financial Statements
Supplementary Information
Appendix:

- A - Management Response to Auditor's Internal Control Report
- B - Management Discussion and Analysis



Independent Auditor's Report

To the Inspector General of the
U. S. Department of Health and Human Services
and the National Institutes of Health

We have audited the accompanying consolidated balance sheet of the National Institutes of Health (NIH), an operating division of the U. S. Department of Health and Human Services (HHS) as of September 30, 2002, and the related consolidated statement of net cost, consolidated statement of changes in net position, combined statement of budgetary resources, and consolidated statement of financing for the year then ended (collectively the financial statements). These financial statements are the responsibility of NIH's management. Our responsibility is to express an opinion on these financial statements based on our audit. The balance sheet as of September 30, 2001 and the related consolidated statement of net cost for the year then ended were derived from the financial statements of NIH as of September 30, 2001, which were audited by other auditors whose report dated January 31, 2002, expressed an unqualified opinion on those financial statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to the 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*. Those standards require that we plan and perform the audit 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 audit provides 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 NIH as of September 30, 2002, its net cost, changes in net position, budgetary resources, and reconciliation of net cost to budgetary resources for the year then ended, in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our reports dated December 6, 2002 on our consideration of 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.

Our audit was performed for the purpose of forming an opinion on the basic financial statements taken as a whole. The required supplementary stewardship information and required supplementary information listed in the table of contents is not a required part of the basic financial statements but is supplementary information required by OMB Bulletin No. 01-09, *Form and Content of Agency Financial Statements*. We have applied certain limited procedures to such information, which consisted principally of inquiries of NIH management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

Clifton Gunderson LLP

Calverton, Maryland
December 6, 2002



Independent Auditor's Report on Compliance with Laws and Regulations

To the Inspector General of the
U. S. Department of Health and Human Services
and the National Institutes of Health

We have audited the financial statements of the National Institutes of Health (NIH), an operating division of the U. S. Department of Health and Human Services (HHS), as of and for the year ended September 30, 2002 and have issued our report thereon dated December 6, 2002. We conducted our audit in accordance with auditing standards generally accepted in the United States of America, 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 NIH is responsible for complying with laws and regulations applicable to NIH. As part of obtaining reasonable assurance about whether 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 affect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin No. 01-02, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to NIH.

The results of our tests of compliance with laws and regulations described in the preceding paragraph, exclusive of FFMIA, disclosed no instances of noncompliance with laws and regulations that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 01-02.

Under FFMIA, we are required to report whether NIH's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government 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, where NIH's financial management systems did not substantially comply with certain requirements in all three areas discussed in the preceding paragraph. The instances of noncompliance identified below are described in more detail in our Report on Internal Control, items 1 and 7.

Preparation of Financial Statements – As indicated in our Report on Internal Controls, NIH's accounting system lacks integration with its subsidiary systems and is not designed for financial reporting purposes. NIH's process for preparing the financial statements in the Central Accounting System (CAS) includes "controlled" transaction code 399 adjusting entries. These entries include certain accounting transactions, such as month end accruals and financial statement presentation related entries that are not reflected in the general ledger and must be repeated year after year. Forty-seven topside adjustments aggregating approximately \$6 billion were needed as of September 30, 2002 to prepare the initial adjusted trial balance for use in the preparation of the final financial statements required by OMB Bulletin No. 01-09. These adjustments were not recorded in CAS.

NIH made over seven thousand "controlled" transaction code 399 adjustments, which are nonstandard accounting entries, aggregating over \$194 billion to a variety of budgetary and net position accounts in the general ledger to ultimately complete the combined statement of budgetary resources and consolidated statement of financing, and consolidated statement of changes in net position. These entries are necessary to correct certain budgetary accounts, which are either not being used correctly or posted when required throughout the year. In addition to these adjustments, NIH generated approximately twelve thousand entries totaling \$192 billion during the closing process to close proprietary and budgetary accounts, such as revenues and expenses.

Use of Standard General Ledger (SGL) – NIH does not use its general ledger to capture all accounting transactions at a level necessary to meet OMB or Department of Treasury reporting requirements. In addition, the majority of the day-to-day transactions made during the year and at year-end did not follow the SGL posting rules set forth by the Department of Treasury and the HHS accounting manual. For example, transactions involving advances, payables and disbursements do not post to the 4801/4802/4901/4902 series of budgetary accounts. Transactions involving non-appropriated funds are generally recorded using accounts that are for appropriated funds. NIH does not populate the SGL 5700 account throughout the year and must create the account during the closing process. Conversely, NIH incorrectly uses the 3211 and 3400 accounts during the year, which then necessitated the clearing of these accounts during the closing process.

Data Processing Control Environment – During our review of Electronic Data Processing (EDP) controls, we identified several weaknesses in internal EDP controls. Such weaknesses are collectively considered a Reportable Condition in our Report on Internal Controls. These matters relate to the lack of contingency plans, contingency test plans, risk assessments and security program plans for NIH's financial systems.

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 NIH, HHS, the HHS Office of the Inspector General, OMB and Congress, and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Henderson LLP

Calverton, Maryland
December 6, 2002



Independent Auditor's Report on Internal Control

To the Inspector General of the
U. S. Department of Health and Human Services
and the National Institutes of Health

We have audited the financial statements of the the National Institutes of Health (NIH), an operating division of the U. S. Department of Health and Human Services, as of and for the year ended September 30, 2002, and have issued our report thereon dated December 6, 2002. We conducted our audit in accordance with auditing standards generally accepted in the United States of America, the standards applicable to the 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*.

In planning and performing our audit, we considered NIH's internal control over financial reporting by obtaining an understanding of NIH's internal control, determined whether internal controls 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 No. 01-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act (31 U.S.C. 3512), such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

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 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 controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. We noted certain matters discussed in the following section involving the internal control and its operation that we consider to be reportable conditions and a material weakness.

In addition, we considered NIH's internal control over Required Supplementary Stewardship Information by obtaining an understanding of NIH's internal control, determined whether these internal controls 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 these internal controls. Accordingly, we do not provide an opinion on such controls.

Finally, with respect to internal control related to performance measures reported in NIH's Management's Discussion and Analysis, we obtained an understanding of the design of significant internal controls relating to the existence and completeness assertions, as required by OMB Bulletin No. 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.

Our consideration of internal control would not necessarily disclose all matters in internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that we also considered to be material weaknesses as defined above. We have described the reportable conditions below; item 1 is considered a material weakness as defined above. The material weakness (item 1) is further supported by the potentially material collective effect of the reportable conditions (items 2 to 7) noted later.

HHS's Assistant Secretary for Budget, Technology, and Finance (ASBTF) office provides the Department-wide accounting policy oversight to NIH. The NIH Office of Financial Management (OFM) maintains the centralized financial systems, and performs the accounting and fiscal services, including the preparation of annual financial statements. The Division of Payment Management (DPM) of the Program Support Center (PSC) provides grant accounting services to NIH, including grant disbursement, expenditure, and advance processing functions. Accordingly, DPM is considered part of NIH's operations and is responsible for carrying out many of the grant accounting procedures on behalf of NIH.

MATERIAL WEAKNESS

FINANCIAL SYSTEMS AND PROCESSES DO NOT SUPPORT THE PREPARATION AND ANALYSIS OF FINANCIAL STATEMENTS (Repeat Condition)

Condition: Pursuant to OMB directives, beginning in fiscal 2002, the U. S. Department of Health and Human Services (HHS) must obtain an audit of its September 30th financial statements by February 1st of the following fiscal year. Further acceleration of this time frame is expected in the future. In addition, interim financial statements at March 31st (unaudited) were required beginning in fiscal 2002, and then quarterly in fiscal 2003. Such interim statements must be submitted to OMB within 60 and 45 days, respectively, of the period end.

Each operating division of HHS must have systems in place to provide HHS with timely financial statements so that it can comply with the stringent reporting requirements referred to above. Even though we noted some improvement in NIH's financial preparation and analysis process in fiscal 2002, NIH's Central Accounting System (CAS) lacks integration with its subsidiary systems as noted in other comments throughout this report and procedures continue to be inadequate to assist HHS in complying with these new reporting requirements in fiscal 2003 and beyond.

Reconciliations of certain accounts were not done in a timely manner, which required extensive research and analysis of various account balances before NIH's fiscal 2002 financial statements were considered complete. Financial statements should result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal controls, and reliable data. Once implemented, this financial management system should allow an entity to prepare reliable financial statements in a timely and efficient manner. NIH's current accounting system and processes are not prepared to achieve this goal.

Summary: Improvements Made But More Are Needed - The financial reporting systems and processes used by NIH were inadequate and not capable of producing reliable financial statements in a timely manner. This deficiency was defined as a material weakness. Such material weakness focused primarily on the following matters:

- the inability to properly account for expended appropriation transactions;
- the volume of differences in the fund balance with Treasury accounts throughout the year;
- the lack of subsidiary details in deferred revenue, grants advance, eliminations, undelivered orders. For example, NIH does not maintain a subsidiary ledger for grant advances and was, therefore, unable to perform a complete reconciliation of this account; for undelivered orders, NIH does not post transactions indicating unpaid vs. paid;
- the volume of adjustments needed for budgetary and net position accounts via controlled transaction code 399s during and at the end of the year;
- the use of manual transaction code 399 entries to reflect certain account balances, such as for inventory, accrued leave, as well as to correct the accounting for the receipt of donations and other revenue;
- the use of manual self-checking worksheets to aid in identifying incorrect amounts for FACTS II reporting;
- the lack of proper accounting and reporting for intra-governmental elimination entries throughout the year;
- the lack of timely cooperation by NIH Institutes and Centers (IC) to provide NIH OFM with timely accounting information related to grants. For example, NIH IC did not provide timely feedback to OFM concerning the release/revision of restrictions on grant awards and the submission of grantee Financial Status Reports (FSR). We noted during our testing of grants synchronization reconciliation that 8 restrictions had been lifted by the ICs, but the release/revision of the restriction had not been communicated to OFM to release the restriction in PMS;

- the lack of adequate and timely account reconciliations by the United States Government Standard General Ledger (SGL) account and by intra-governmental and governmental classification throughout the year for property, accounts receivable, non-grant advances, accounts payable and undelivered orders;
- an overall general lack of financial analysis on the financial statements once prepared, i.e., analytical review of financial statement line items to prior periods. For example, given that NIH's appropriations have steadily increased in the past few years, there was an unexpected and unexplained decrease in accounts payable in NIH's first draft financial statements. No analysis was provided to explain this relationship. An overall financial analysis would have spotted this unusual trend. Subsequent adjustments were prepared to correct the understatement; and
- the manually intensive nature of the monthly reconciliations and financial statement preparation process.

The following matters provide additional details of these deficiencies:

Account Reconciliations Not Performed Consistently During the Year - Even though most accounts were ultimately reconciled as of September 30, 2002, many were not done during the year or were done several months after the month-end. Although some accounting system reconciliations are performed periodically, additional routine manual reconciliations are needed to completely reconcile the accounting records at month-end to the supporting subsidiary ledgers. In addition, the process used to perform account reconciliations was not adequately documented for all accounts as of September 30, 2002.

The following summarizes the main accounts where reconciliations are required by the DHHS Department policy, but that were not complete as of or for the year ended September 30, 2002, either as to completeness (i.e., by SGL account and by intra-governmental and governmental classification), frequency or timeliness:

- Fund Balance with Treasury - Although reconciliations of Fund Balance with Treasury were performed for each month, NIH personnel did not perform reconciliations of all of NIH's Treasury fund symbols. Specifically, the two-year Management Fund appropriations were not reconciled every month;
- Accounts Receivable - Reconciliations for the months of October, November and December were not prepared timely. Additionally, accounts receivable is not reconciled at the SGL level or by intra-governmental and governmental classification;
- Property - Reconciliations were performed by asset category instead of by SGL;
- Grant Advances - Grant advance reconciliations were performed only at the appropriation level, as NIH does not record or reconcile grant advances at the document level. Reconciliations between PMS and the CAS at the appropriation level were not performed timely for four months of fiscal year 2002. The October 01 reconciliation was not completed until December 01; the November 01 reconciliation was not completed until February 02, and the December 01 and January 02 reconciliations were not completed until March 02;

- Accounts Payable - Reconciliations for October, November and December were not prepared timely;
- Payroll - NIH reconciled payroll disbursements reported to Treasury on the SF-224, Statement of Transactions, to the general ledger SGL 1013, Payroll Disbursements account, but the agency did not reconcile payroll disbursements to the SGL 6100 account, Operating/Program Expense. Both of these reconciliations were required by Departmental policy;
- Undelivered Orders - UDOs were reconciled only at the account summary level, rather than by the paid and unpaid amounts. Further, the October, November and December reconciliations were not prepared timely; and
- Net Position and other Budgetary accounts - These accounts are not reconciled during the year.

Some of the delays in reconciliations are the result of NIH's accounting system not properly recording accounting events consistent with the US SGL. For the budgetary accounts, NIH does not perform periodic reconciliations due to the system weaknesses previously discussed. To compensate, NIH uses the controlled 399 transactions whenever financial statements are prepared to correct these deficiencies. For example, the NIH systems do not separate undelivered orders paid and unpaid or expended appropriations paid or unpaid when recording day-to-day transactions; instead transactions are posted to a summary account (4800 or 4900). NIH uses the transaction code 399 entries to properly reflect at the general ledger level the paid vs. unpaid amounts that comprise the summary accounts.

Further, the NIH accounting system does not maintain subsidiary ledgers for intra-governmental and governmental transactions, unearned revenue, earned revenue, intra-governmental transactions, or payroll expense.

These delays and lack of complete reconciliations resulted in more time needed to research discrepancies that had occurred several months prior, and at times resulted in adjustments to the general ledger later in the year.

Review and Analysis of Budgetary and Net Position Accounts Need Improvement - NIH recorded a significant number of transaction code 399 adjustments in various budgetary and net position accounts during the year because NIH's Central Accounting System (CAS) was not originally designed to record the numerous types of budgetary accounts. The expended appropriations account was not recorded in CAS throughout the year and must be recreated during the closing process. NIH has developed a somewhat systematic method (the controlled 399 closing process) in compensating for this system deficiency. However, the budgetary and certain proprietary accounts are not being recorded properly during day-to-day transactions, and therefore, are not SGL compliant. That made the reconciliation of these accounts to amounts reflected in the financial statements difficult and time consuming to perform at September 30th. Furthermore, NIH was unable to perform periodic analysis of these accounts during the year. These "controlled 399" adjustments (approximately 19,000 entries at \$386 billion) record both the impact of current year day-to-day entries on budgetary and expended appropriations accounts at year-end.

Financial Statement Preparation and Analysis Process Need Improvement - NH's process for preparing the financial statements from CAS is manually intensive and provides for limited resources being available for financial analysis and related research of unusual account relationships. It includes downloading necessary data from CAS, and using Excel spreadsheets to process adjusting entries and to prepare financial statements. Even though NIH has met the timeline of delivering its financial statements as of and for the year ended September 30, 2002, this process continues to be time consuming; has a high risk for error and does not include procedures to ensure the completeness of the final data used to prepare the financial statements. Also, the frequent use of 399 entries increases the potential for errors, as nonstandard accounting entries increase the risk of bypassing accounting controls. In addition to the "controlled 399" adjustments, NIH posted approximately 1,500 transactions with an absolute value of \$3.2 billion during the year using a transaction code 399. Accordingly, the need for additional financial analysis and timely reconciliations is critical to reduce the likelihood of errors from these risks. NIH's financial managers should be participating in the financial analysis of such statements before the financial statements are presented for audit.

NIH was unable to provide complete explanations of fluctuations with balances at June 30, 2002, or fluctuations with balances at September 30, 2001. Once the financial statements were prepared for September 30, 2002, NIH did not prepare a complete analysis of the specific results reflected in its accrual based financial statements (i.e. grants related balances), nor for certain significant functional expenses (i.e. GPRA costs). The overall approach taken in analyzing the fluctuations at September 30, 2002 was general in nature and it lacked comprehensive and definitive explanations for fluctuations. We were ultimately able to conclude that the fluctuations were reasonable only after additional analysis to supplement what NIH initially provided and no adjustments to the financial statements were necessary.

We also noted that NIH had difficulty in gathering "Trading Partner" information for inclusion in the financial statements as required supplementary information required by OMB Bulletin No. 01-09. The lack of utilizing the Employer Identification Numbers (EINs), and Governmental *Form and Content of Agency Financial Statements (G)* and Non-governmental (NG) classifications did not facilitate the identification of the specific trading partners involved in transactions with NIH. During the interim phase, NIH was unable to provide any trading partner information for intra-governmental assets and liabilities; for example, the intra-governmental account receivable balance was \$98 million. NIH made approximately \$3.4 billion of topside adjustments to correct its intra-governmental and governmental misclassifications at year-end. We noted four instances of differences greater than \$3 million between NIH and other DHHS operating divisions. The final status on some of the reconciling differences was not provided. Absent this information, NIH was not able to timely and accurately eliminate trading partner information.

FACTS II PREPARATION PROCESS NEEDS TO BE LINKED TO FINANCIAL STATEMENT PREPARATION PROCESS

- The U. S. Treasury requires that cash and budgetary information reported via the FACTS 11 system on a quarterly basis. The report should be prepared using the same trial balance used by those preparing the basic financial statements. In comparing amounts reflected in NIH's fiscal 2002 FACTS II transmission and its September 30, 2002 trial balance of accounts used to prepare its financial statements, we noted differences with an absolute value of \$13 billion relating to the following accounts:

- Fund Balance with Treasury
- Other Appropriations Realized
- Total Actual Resources - Collected
- Unfilled Customer Orders
- Reimbursements and Other Income Earned - Collected
- Other Actual Business Type Collections from Non-Federal Sources
- Rescission - New Budget Authority
- Authority Permanently Unavailable for Obligation Pursuant to Public Law
- Allotments - Realized Sources
- Unobligated Funds Not Subject to Apportionment
- Allotments - Expired Authority
- Undelivered Orders - Paid and Unpaid
- Delivered Orders - Paid and Unpaid

Some of the differences resulted from the limitation of NIH's accounting system not processing transactions in accordance with the US SGL; however, most were caused by entries to adjust account balances from the trial balance to create the financial statements manually.

Recommendation: The financial analysis and reconciliation procedures in place during fiscal 2002 were not effective in the production of reliable financial statements and in identifying errors prior to audit. NIH is in the process of developing the NIH Business System (NBS) that is intended to replace its current systems. In order to better prepare for the implementation of OMB Bulletin No. 01-09, we recommend that improvements be continued and be incorporated into its NBS in the following areas:

- a) Perform reconciliations for all accounts by SGL account with G/NG classification on a timely basis pursuant to HHS policy and make adjustments to the general ledger accounts as appropriate in the month the difference is resolved.
- b) Reevaluate the manual aspects of the financial statement preparation process currently in use and develop enhancements to streamline the process. The new interim reporting requirement for fiscal 2003 may be a good vehicle to test these new processes.
- c) Complete the preparation of the interim financial statements at December 31, 2002 and fine-tune the preparation and analysis process to comply with the new OMB requirements. These interim financial statements will require the recording of all

transactions in the general ledger, including accrual entries, and preparing a complete set of financial statements similar to those prepared at the end of the year. This will allow NIH to analyze all major accounts, including net position and budgetary accounts, and to compare account relationships with amounts reflected in the prior year audited financial statements and the prior year interim financial statement, if available. NIH management should investigate unusual changes from year to year in all financial statement categories and obtain explanations from appropriate program managers for significant deviations. In addition, consideration should be given to performing comparisons with expected expenditure amounts. After analyzing the results of the interim review process, NIH could then adjust its accounting procedures before the year-end financial statement preparation process to correct the cause of errors identified in such interim financial statements. This could reduce the time and adjustments needed to close the accounting records and prepare the financial statements at September 30^h.

- d) Evaluate accounting entries not currently posted in its accounting system and consider posting such entries in the general ledger, including those related to entries processed in the normal course of operations in the subsequent fiscal year that should be reversed.
- e) The subsidiary detail of the account balances for deferred revenue, grants advance, eliminations, and undelivered orders should be provided at the transaction/document level to facilitate its reconciliation to the general ledger.

Analyze and reconcile the net position general ledger accounts throughout the year to minimize this effort at year-end. We also continue to recommend that all audit and year-end closing adjustments be recorded in its accounting system to avoid reconciliation problems in net position accounts in future years.

- g) Reconcile current year operating and budgetary activity to the change in net position accounts during the year to ensure that the financial statements properly reflect net position activity at year-end. In addition, appropriate analysis and support for the composition of net position at September 30 and for the year then ended should be maintained. In order to avoid problems with this analysis at the end of the year, the analysis should be performed periodically during the year.
- h) Work with the Department and the Treasury to improve methods for accumulating "Trading Partner" information for inclusion in the financial statements and reconcile that information to its principal financial statements.
- i) Establish a function in NIH to perform critical analysis of financial statements generated by its staff to ensure objectivity and accuracy of reported amounts.
- J) Utilize the information in the accounting system to prepare the FACTS II transmission and compare results to that reflected in the financial statements.

REPORTABLE CONDITIONS

2. EFFECTIVENESS AND TIMELINESS OF FUND BALANCE WITH TREASURY (FBWT) RECONCILIATION PROCESS (Repeat Condition)

Condition: NIH is a large, diverse organization with approximately 180 Treasury fund symbols, 27 Institutes, over 60,000 grantees, and partnerships with PSC, other HHS operating divisions (OPDIVs) and research organizations. Each of these activities involves transactions that affect FBWT. In order to meet the new, more stringent reporting deadlines, NIH needs to improve its processes to eliminate/reduce the number of transactions requiring subsequent correction. During the period from May to September 2002, FBWT per the general ledger differed from that reported by Treasury by an average of \$65 million. NIH staff had to research and correct these differences each month.

Activities affecting NIH's FBWT, both internal and external to NIH result in a significant number of transactions that are in error at their inception and require subsequent correction. Many of these transactions originate from outside NIH's accounting division in the form of Intra-governmental Payment and Collection (IPACs) from other federal agencies that do not have the appropriate Treasury symbol, payroll transactions posted to the incorrect Treasury symbol, and unreconciled Intra-Departmental Delegations of Authority (IDDAs) from other HHS organizations. In addition to the workload caused by these transactions, the reconciliation process at NIH has resulted in various inaccuracies that were not detected and corrected in the course of normal activities. The following provides information on the types of FBWT errors noted at NIH:

IPA Cs With Unidentified Treasury Symbols - NIH receives numerous IPAC transactions from other Federal agencies each month that do not have an accurate Treasury symbol. Without this symbol, NIH's accounting unit cannot assign the transaction to the proper NIH Institute. NIH's practice has been to log onto the Treasury GOALS system to identify those transactions, which were shown on Treasury's records but not listed on the NIH SF-224. NIH then posted a summary level entry on their monthly SF224 to the Treasury suspense account (Treasury Fund Symbols 75-F-3875 and 75-F-3885) causing the total of the NIH activity on NIH's SF-224s to be equal to the total activity shown on Treasury's records. After NIH posted a summary level entry, they compared the listing of transactions per Treasury GOALS by schedule number to the schedules supporting the NIH SF224. Schedules, which did not agree between Treasury and NIH were listed on an internal printout entitled the Out-of-Balance report.

Unmatched IPAC transactions comprise the majority of the monthly manual adjustments to the suspense account. These manual adjustments averaged \$42 million a month but were not reflected in the NIH general ledger because the manual adjustments were made only on the SF-224 to Treasury to adjust Treasury's records at a summary level. As these unmatched IPAC transactions are researched and corrected, they are removed from the Out-of-Balance and posted to the proper general ledger accounts, posted to the proper NIH Treasury Fund Symbol, and removed from the Treasury suspense account.

Having IPAC transactions without the proper Treasury symbol and using an Out-of-Balance report means that on a monthly basis NIH's general ledger has a significant amount of accounting transactions which are not accurately posted and staff workload is devoted to correcting transactions

Intra-Departmental Delegations of Authority (IDDA) - NIH provides funding to other organizations within HHS by delegating authority for non-NIH charges to be posted against NIH appropriations. NIH, as the delegating organization, is responsible for external reporting and maintaining accounting. The receiving entity is responsible for monitoring, controlling, obligating and expending the funds as well as reporting to the delegating agency on the use of the funds. NIH's reconciliation of its FBWT frequently included assumptions that differences in the fund balances were the result of IDDA transactions. NIH did not have supporting documentation for these transactions.

Use of Inaccurate Treasury Symbols and Common Accounting Numbers (CANS) - NIH's efforts to reconcile its FBWT was increased because various transactions were posted to incorrect appropriations and CAN numbers by central payroll and NIH Institutes. Congressional changes to the duration of the appropriation for the Management Fund were not implemented by Central Payroll. As a result, payroll transactions were posted to an incorrect Treasury symbol, requiring monthly correcting entries to Treasury. On the September 2002 SF 224 (Statement of Transactions), NIH manually adjusted payroll transactions of \$40 million to correct the posting by Central Payroll to non-existing appropriation symbols. In addition, changes in CAN numbers used by NIH Institutes were not communicated between the Institutes, the NIH accounting group, and Central Payroll in a timely manner. These changes resulted in numerous cash differences between the NIH general ledger and Treasury.

In addition to the additional effort required to correct transactions originating outside NIH, NIH's processes do not lend themselves to timely and accurate correction of the FBWT account. We noted that NIH did not have written procedures for reconciling FBWT. We also noted errors in spreadsheets that NIH employees prepared to reconcile the NIH FBWT Treasury Fund Symbols, and numerous manual adjustments to temporarily adjust differences pending research. We also found that the information downloaded from Treasury to support the manual adjustment for unmatched IPACs included IPAC transactions not pertaining to month being adjusted but belonging, instead to the following month's business. As such, the manual adjustment posted to Treasury was not supported by the Out-of-Balance report. NIH attributed many of these difficulties to staff turnover and inexperience. The supervision process, however, did not discover and correct errors in the reconciliation process in the normal course of activity.

The more stringent deadlines for financial reporting commencing in FY 2003 will make it more difficult for NIH to continue to make adjustments and corrections to its accounts. Increased efforts are needed to assure that FBWT transactions are handled appropriately at their inception rather than subsequently corrected.

Recommendation: We recommend the following:

- a) Work with HHS Departmental officials and the Department of Treasury to reduce or eliminate IPACs received from other Federal organizations that are received without the appropriate Treasury fund symbol.
 - b) Discontinue use of the out-of-balance report process and make use of the controls in place with Treasury by researching transactions listed on the TFS 6652 (Statement of Differences) and make the necessary corrections in the general ledger and on the SF-224 (Statement of Transactions).
 - c) Continue to work with HHS Departmental officials to improve controls over IDDA's by requiring the necessary reports and reconciliations.
 - d) Improve communications with NIH Institutes and Central Payroll to assure the use of the correct appropriation symbols and CAN numbers.
 - e) Document the FBWT reconciliation process.
 - f) Provide the necessary training to new staff to enable them to prepare accurate reconciliations of the FBWT accounts.
3. GRANT TRANSACTION PROCESSING AND ANALYSIS (Repeat Condition)

Condition: During our review of NIH's grant accounting systems and procedures, including tests of a sample 45 NIH grant synchronization transactions during the year, we note the following conditions in NIH's grant accounting systems, which collectively are considered a Reportable Condition, as defined:

Grant Financial Analysis - The analytical review for grants related accounts was not adequately performed by NIH throughout the year and at year-end. Per the Departmental Policy on Periodic Management Analytical Reviews of Grant Accounting Information, NIH is required to have the following process implemented: "...involved program managers, budget and grant managers, as well as financial managers and the DPM in the periodic analytical review process... Document in writing the results of each component of the analytical review process throughout the year." This analysis is critical to ensure that proper account balances are reflected in the financial statements. NIH's Policies and Procedures for Monitoring and Analyzing Financial Activities did not specifically address the financial analysis aspect that related to grants balances reflected in the financial statements, e.g. the GPRA cost, etc. NIH did not provide an adequate analysis regarding the grant fluctuations. The overall approach taken in analyzing the fluctuations at September 30, 2002 was general in nature and it lacked comprehensive and definitive explanations for fluctuations. In addition, regression analysis estimated disbursements for the four quarters contained variances between the regression model and actual SF 272 expenditures reported by the grantees. NIH management did not initially provide any explanation of these results.

Grant Transaction Processing, Monitoring and Reconciliation – The following matters were noted during our tests of transactions during the year:

- Approximately 15,283 grant documents with over \$3.6 billion in authorization eligible for grant closeout were not closed out by NIH as of September 30, 2002. Most of these grant documents were related to fiscal year 1997 and prior appropriations.
- Approximately 1,300 grant documents with negative obligations remained unresolved as of year-end. NIH had approximately \$54 million in negative obligations at September 30, 2002. The open documents report containing grants transactions was not periodically reviewed by NIH to ensure that grant documents with negative balances were resolved promptly and adjusted periodically.

Grant Synchronization Reconciliation – The following summarizes the results of our review of 45 grant synchronization transactions during the year and at year-end. There were 617 unsynchronized transactions as of September 30, 2002. Our examination of the 45 documents included the review of the grant source documentation.

- 31 out of the 45 grant documents examined contained grant restrictions which were ordinarily communicated by the IC to OFM through an e-mail or a memorandum specifying the grant document and the amount to be restricted. OFM prepares the restrictions in an electronic template, which is only uploaded into the Payment Management System (PMS) to de-obligate grant funds. This process is not integrated with CAS. Differences in the authorization amounts between CAS and PMS exist when financial transactions are not reflected in CAS.
- We noted 24 grant documents with grant restrictions for more than one year. 15 of the 24 had restrictions for over two years, which indicates that NIH did not review the outstanding restrictions and follow up with the grantees promptly. Per discussion with OFM personnel, it is the Grant Management Office's (GMO's) responsibility to review grant restrictions. The GMOs have acknowledged that the restrictions were not resolved in a timely manner. The GMOs work with the grantee to obtain the information, which sometimes allows the grantees an extended time period to submit required documentation. The GMOs did not perform the proper follow up with the grantees, thus resulting in the untimely resolution of restrictions. The Code of Federal Regulations (CFR) states that the awarding agency may temporarily withhold cash payments pending the correction of the deficiency by the recipient. Restricting the grant funds for over a year is not considered "temporary".
- In 8 grant documents examined, grants restrictions were either removed or partially removed by the IC. However, OFM was not informed of the restriction removal in order to re-obligate funds in PMS. In order for a restriction to be lifted or revised, the restriction must be lifted via grant awards by the IC and funds released in PMS by OFM. If the IC fails to notify OFM that the restriction has been lifted via grant

award, the restriction will continue to remain in PMS. Additionally, in 1 grant document examined, the IC removed the restriction in April 2000 and communicated the restriction removal to OFM. However, the restriction remained in PMS as of September 30, 2002.

- In 1 grant document examined, the IC issued additional funding in the current budget period without resolving the prior period budget restrictions. Per CFR, the agencies shall not renew or extend covered transactions (other than no-cost time extensions) with any person. Additional funding should not be awarded to the grantee without resolving the condition related to the restriction first.
- In 3 grant documents examined, source documentation related to grant restrictions was not provided by the IC.
- In 7 grant documents examined, differences existed between PMS and CAS due to the improper processing of the grant closeout transactions by the IC. The IC processed the grant closeout transaction in CAS and PMS. However, the document in PMS could not be closed out because of the differences between the authorization, disbursement and advance amounts. PMS in some instances continued to charge the open documents for subsequent advances and thus created the synchronization issue.

Recommendation: We recommend the following:

- a) Continue to test the reasonableness of the Regression Model (RM) accrual methodology. This test should include comparing RM accrual estimates with actual SF 272 expenditure reports submitted by grantees after the end of the relevant quarter. Analytical procedures should be developed to assess the results of this test in light of management's expectations and knowledge about their grant programs, in partnership with DPM. Historical trend analysis can also assist management in demonstrating the reasonableness and reliability of the accrual developed by the RM.

The importance of this testing and analysis is further magnified by the accelerated due dates of the agency financial statements in future fiscal years. Under these compressed schedules, actual expenditure data will not be available during the audit process to support and/or adjust many of the accruals in the financial statements, including the grant accrual. Therefore, increased management attention and analysis must be focused on periodic analytical reviews of the reported grant financial data throughout the year.

- b) Prepare a complete set of financial statements on a quarterly basis, compare amounts reflected on the statements to those reflected in prior periods, and determine reasonableness of current period amounts given management's expectations of operating results. The study of fluctuations from year to year can facilitate an understanding of why the balances are as reported. ASBTF issued a policy memorandum in November 2001 outlining various analytical review procedures for use in the grants area. We recommend that NIH implement the provisions of this memorandum, as appropriate, immediately.

- c) The following recommendations should be considered by management to improve the accuracy and efficiency of grants transaction processing:
- 1) NIH should continue to perform periodic review of grant transactions to ensure unusual transactions, especially over-advance and negative obligation situations, needing corrective action are identified during the review process and resolved with the grantee immediately, thus ensuring management's efficient and effective management of government assets.
 - 2) Develop procedures to ensure that grants are closed out in a timely manner when the grant has met all of the requirements for grant completion. NIH should utilize the quarterly report received from DPM, which lists grant documents that will expire at the end of the fiscal year, to closeout those documents. In addition, NIH grants management should perform final grant document reconciliations with DPM via PMS queries prior to closeout of the grant in Payment Management System.
 - 3) NIH should work with DPM to identify a process to record the grant restrictions and ensure their consistent recordation in PMS and CAS. Utilizing the same transaction code in both systems will help prevent synchronization reconciliation issues between CAS and PMS when a restriction is issued.
 - 4) Establish and implement procedures to ensure outstanding grant restrictions are reviewed periodically throughout the year to ensure grantees' full compliance to the terms and conditions of the grant program. Prompt follow up action on delinquent grantees should be taken to ensure the program's mission is properly accomplished.
 - 5) Develop and implement procedures to ensure the removal of the grant restriction is performed timely and properly by OFM upon the issuance of the new grant award by the IC.

4. ACCOUNTING AND RECONCILIATION FOR PROPERTY (Repeat Condition)

Condition: The subsidiary systems for Property, Plant and Equipment (PP&E) are not integrated and automatically reconciled to the general ledger to account for all property activities. For example, NIH does not fully utilize Foundation Information for Real Property Management (FIRM), a real property subsidiary program, to maintain its real property records because it does not maintain sufficient detail to support amounts reported for construction-in-progress and new building projects. To compensate for this, NIH implemented a three-step process that tracked each individual asset related transaction to ensure its validity. The reconciliation performed was by the asset category and not by the SGL account. The process is manually intensive, extremely time consuming, and prone to human errors. NIH staff devoted a great deal of time researching, resolving, and documenting differences. A significant number of property transactions is processed on a monthly basis. The manual transaction code "399" adjustments (approximately 226 entries at \$460 million) were utilized to record prior period adjustments and reclassify property from the operating expenses to the property capitalization account throughout the year. In addition, NIH's property reconciliation procedures contained general descriptions of the

procedures performed for reconciliation of subsidiary detail balances to the general ledger, resolution of differences identified, physical inventory of property, and analytical review for property related accounts.

Analytical review for the property accounts was not adequately performed by NIH throughout the year. The analysis provided was general in nature and did not compare to prior periods at the account level.

We also noted the following matters regarding the transaction processing for property:

- Property transfer to other federal entities was recorded as gain or loss based on the asset's net book value.
- Depreciation expense was not calculated for 2 out of 5 fixed asset additions examined. In addition, in 4 out of 5 additions examined, the assets were not decaded in the Property Management Information System (PMIS) timely (within 5 days of the asset receipt).
- One asset was acquired in December 2001 but was not recorded in PMIS as of September 30, 2002.
- Supplemental agreements with General Service Administration (GSA) were not obtained and maintained by NIH. These supplemental agreements adjust square footage, rates and other factors surrounding the original lease agreement. As a result, NIH paid GSA based on the GSA billing rather than based on the supplemental lease agreements, which could result in errors.

Recommendations: We recommend the following to improve the efficiency of the property transaction processing:

- a) Maintain all capitalized property in one subsidiary system that can provide activity and SGL based reporting and can integrate a process of calculating depreciation for ease of reconciling to the general ledger and recording depreciation. The property subsidiary system should include the system requirements established by Joint Financial Management Improvement Program (JFMIP), OMB Circular A-127, FASAB standards and other applicable guidance.
- b) Perform the analytical review for property related SGL accounts at least quarterly to ensure the general ledger account balances' validity.
- c) Continue to refine the property reconciliation process to include procedures for detail reconciliation, difference resolution, physical property inventory adjustment, and analytical review procedures.
- d) Statement of Federal Accounting Standard No. 6 requires that the cost of PP&E be recorded by the transferring entity for the PP&E net of accumulated depreciation or

amortization. If the receiving entity cannot reasonably ascertain those amounts, the cost of the PP&E shall be the fair value at the time transferred. NIH should implement this requirement for transferred assets.

e) Maintain a copy of the GSA supplemental agreements to ensure proper lease payments.

5. **REVIEW AND RECONCILIATION OF ACCOUNTS PAYABLE AND UNDELIVERED ORDERS (Repeat Condition)**

Condition: NIH was unable to provide a detailed listing of undelivered orders by paid and unpaid SGL accounts as of September 30, 2002. The current system was not programmed to generate such a report. The reconciliation prepared by OFM between the Undelivered Orders and the amount recorded in the general ledger at September 30, 2002, was performed at the summary account level (Account 4800). Accordingly, the basic internal control of reconciling general ledger accounts to subsidiary records was not performed properly throughout the year.

NIH implemented its year-end accounts payable accrual process based on subsequent disbursements that occurred through October 25, 2002. Due to the accelerated deadline required for financial reporting, NIH did not have the necessary time to include all disbursements made beyond that cut-off day. In addition, NIH's process accrued only disbursement transactions greater than \$500,000. Consequently, the accounts payable amount included in the first draft of NIH's balance sheet was understated. During the audit process, \$232 million of adjustments were determined to be adequate to bring the accounts payable close to its actual amount. NIH ultimately concluded that the fluctuation of the accounts payable reported on their financial statements in fiscal 2002 and fiscal 2001, were reasonable only after exhaustive research and analysis of the account activities in those fiscal years.

We also noted the following matters regarding the transaction processing for accounts payable and undelivered orders:

- It appears that NIH has a number of inactive documents open at September 30, 2002. The chart below shows the total number of Undelivered Orders and Accounts Payable by age and their total dollar amounts at September 30, 2002 (excluding Grants and Payroll documents).

Age (yrs)	# UDO Documents	Amount (in thousands)	# A/P Documents	Amount (in thousands)
5	3	\$ 38	-	\$ -
4	314	14,596	53	661
3	760	25,197	171	4,381
2	1,337	89,926	332	4,418
1	<u>4,200</u>	<u>295,312</u>	<u>1,920</u>	<u>13,221</u>
Total	— <u>6,614</u>	\$ <u>425,069</u>	<u>2,476</u>	\$ <u>22,681</u>

The age indicates the number of years since the last transaction, whether it represents a collection or accrual. NIH investigates the validity of these documents at least yearly and many may, in fact still be valid; however, the overall totals warrant additional investigation by NIH.

Approximately 260 accounts payable and 530 undelivered order documents with negative obligations remained unresolved as of year-end. NIH had approximately \$9 million in negative obligations and \$2.3 million in negative accounts payable at September 30, 2002. This condition is mainly caused by NIH's inconsistent use of the document numbers or lack of timely adjustments between the original estimated and the actual disbursement amounts. The open documents report containing disbursement related transactions was not periodically reviewed or analyzed by NIH to ensure that disbursement documents with negative balances were resolved promptly and adjusted periodically.

- In 6 of the 10 subsequent disbursements examined, transactions in the total amount of over \$12 million that should have been included in NIH's year-end accounts payable balance were not included. NIH subsequently included these disbursements in a revised accrual amount.
- In 3 of the subsequent disbursements related to 5 reimbursable agreements examined, the modification suffix in the agreement number did not correspond to the modification identified in the agreement number recorded in the general ledger.

Recommendation: We recommend NIH the following:

- a) Develop a subsidiary system that can properly account for budgetary activities at the transaction and SGL account level. As reaffirmed by HHS's Deputy Chief Financial Officer in a memorandum dated July 29, 1999, the subsidiary records must be reconciled to the general ledger balances monthly. Reviews must be conducted to ensure the validity of accounts payable and undelivered orders, with corrections being made to the general ledger accounts on a current basis. We recommend NIH fully comply with the Department policy.
- b) The Statement of Federal Financial Accounting Standard No. 5 states that an entity should recognize and report on its financial statements, a liability for any unpaid amounts due as of the reporting date. We recommend that NIH develop a methodology to properly estimate the accounts payable liability that had been incurred but not recorded as of the reporting date. The estimation process developed should be adequately documented, analyzed and supported by historical trends.
- c) Review the accounts payable and undelivered orders balances that contain negative amounts and extend past one year on a quarterly basis. Budget offices should perform a similar review for undelivered orders to ensure inactive documents are liquidated promptly.

d) Standardize the modification numbering system for reimbursable agreements to ensure their correspondence with the general ledger.

6. ACCOUNTS RECEIVABLE, DEFERRED REVENUE AND REVENUE ACCOUNTING PROCEDURES (Repeat Condition)

Condition: NIH was unable to provide adequate subsidiary detail to support transactions recorded in its deferred revenue and earned revenue accounts as of and for the year ended September 30, 2002. This is because the NIH accounting system does not contain a subsidiary ledger for unearned revenue and earned revenue. To compensate for this, NIH used the account 1417 (intra-governmental advance) subsidiary ledger to support the deferred revenue balance. Subsidiary detail for Intra-governmental advance and deferred revenue could not be provided during the fiscal year because reconciliations for the intra-governmental advance account were not performed. After extensive research and analysis of the aforementioned type transactions, NIH eventually was able to gather enough documentation to support the amount of deferred revenue at September 30, 2002. The amounts of the deferred revenue and earned revenue prior to intra-NIH eliminations were \$277 million and \$1.6 billion, respectively, as of September 30, 2002.

NIH's accounts receivable reconciliation procedures contained limited descriptions of the procedures performed for reconciliation of subsidiary detail balances to the general ledger at the transaction and SGL account level by G/NG classification, resolution of differences identified, and analytical review for accounts receivable accounts. Analytical review for the accounts receivable, deferred revenue, and earned revenue accounts was not adequately performed by NIH throughout the year. The analysis provided was general in nature and did not provide definitive explanations at the account level.

The NIH accounting system tracks the G/NG classification based on the disbursement/accrued transactions. Since the accrued costs and their corresponding revenue and billing occurred simultaneously and a transaction can have only one G/NG designation, certain revenue transactions were misclassified in the system. Certain accounts receivable transactions (in the amount of \$875 million) were misclassified between intra and non-governmental accounts in the general ledger at September 30, 2002. Correction of these errors was not posted to the general ledger, but instead was used to support a manual adjustment to NIH's financial statements.

NIH had over \$79 million in outstanding accounts receivable from intra-governmental and non-governmental entities. Approximately \$48 million of the balance was recorded in the intra-governmental accounts receivable-unbilled account. Amounts in this account were not reconciled at the document level from the subsidiary detail to the general ledger. In addition, the methodology used by NIH to establish an allowance for uncollectible accounts was not adequately supported by any historical trend analysis.

We also noted the following matters regarding the transaction processing for accounts receivable and revenue:

- Certain transactions (in the amount of \$2 billion) were misclassified between intra and non-governmental accounts in the general ledger. Correction of these errors were not posted to the general ledger, but instead were used to support a manual adjustment to NIH's financial statements.

In 3 out of 13 of inter-agency transactions examined, the correct EIN was either not properly recorded in the system or recorded as Not Applicable (N/A) in CAS. In addition, 24 subsequent transactions related to these agreements examined contained N/A EINs in CAS. This resulted in the difficulty NIH encountered in identifying the trading partner information included in the Required Supplementary Information.

- In 2 out of 6 revenue cut-off transactions examined, revenues that were earned and should have been recorded in fiscal 2002 were not recorded until fiscal 2003.

Recommendation: We recommend NIH the following:

- a) Develop and document formal procedures for recording deferred revenue and earned revenue at the transaction level throughout the year. Such recording should be based upon when and what funds are received. The recording of revenue (i.e. reduction of deferred revenue) from these transactions should be recorded as goods or services are provided. We recommend that the NIH accounting system include a subsidiary ledger for the deferred revenue balance at September 30, 2002, record fiscal 2003 transactions at the transaction level and perform monthly reconciliation to subsidiary records during fiscal 2003.
- b) The subsidiary detail for the deferred revenue balance should be prepared at the project/agreement level and reconciled to the general ledger control accounts on a monthly basis throughout the year. As reaffirmed by HHS's Deputy Chief Financial Officer in a memorandum dated July 29, 1999, account analysis and reconciliations should be performed throughout the year, as well as maintaining adequate supporting documentation for transactions and reconciling items.
- c) Continue to establish/refine the accounts receivable, deferred revenue and earned revenue reconciliation process to include procedures for detail reconciliation, difference resolution, and analytical review procedures.
- d) Perform the analytical review for accounts receivable, deferred revenue and earned revenue related SGL accounts at least quarterly to ensure the general ledger account balances' validity.
- e) Formally document (with proper review and approval) the methodology used for estimating the uncollectible accounts receivable. Reevaluate relevance of the

methodology annually. Amounts reported as such should be reviewed and approved by management for financial statement reporting.

Implement policies and procedures provided by the Department to properly record (i.e. use the appropriate EIN and G/NG classification) when transactions are not recorded in the accounting system and timely identify trading partner transactions. Reconciliation with trading partners should be periodically performed throughout the year to ensure balances are reasonable.

- g) Implement a policy to perform cut-off procedures quarterly to ensure that revenue is recorded in the fiscal year services are provided. Billing procedures should also be performed in a timely manner to facilitate accrual accounting.

7. ELECTRONIC DATA PROCESSING CONTROLS

Condition: OMB Circular No. A-130, Appendix III, "*Security of Federal Automated Information Resources*," as revised in February 1996 established a minimum set of controls for federal agencies including risk assessments, assigning responsibility for security, security planning, periodic review of security controls, and management authorization of systems to process information. Our review of NIH's Security Program Plans as they relate to the Administrative Database (ADB), CAS, and Information for Management, Planning Analysis, and Coordination (IMPAC-II) Applications highlighted the following:

There are no risk assessments or security program plans for the ADB and CAS systems, and the security plan for IMPAC-II is out of date.

- Management has not identified or classified IMPAC-II, ADB, and CAS applications or information stored in these applications according to their criticality and sensitivity.
- There are no current contingency plans or contingency test plans for the ADB, CAS, or IMPAC-II systems.

Recommendation: For the ADB IMPAC-II CAS applications, we recommend that NIH develop risk assessment and security plans and classify applications and data contained in the applications according to their criticality and sensitivity. We also recommend that management develop and test contingency plans for the ADB, CAS, and IMPAC-II applications.

STATUS OF PRIOR YEAR COMMENTS

As required by *Government Auditing Standards* and OMB Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*, we have reviewed the status of NIH's corrective actions with respect to the findings and recommendations from the previous year's report on internal controls. For those items not addressed in various sections of our Independent Auditor's

Report on Internal Control, summarized above, the following discusses the current status of resolutions for those matters raised.

Condition - Investments in Management Systems:

- In FY 2001, it was recommended that NIH develop and implement policies and procedures with an appropriate internal control to ensure authorized, cost-effective and efficient systems implementation. During our audit, we noted that NIH has policies and procedures in place along with documentation of procedures performed.

NIH controls their Investments in Management Systems in accordance with the GAO publication "Assessing Risks and Returns: A Guide for Evaluating Federal Agencies' IT Investment Decision-making" GAO/AIMD-10.1.13. The guide addresses compliance with other laws and regulations such as the Paperwork Reduction Act (PRA), the Clinger-Cohen Act, the Government Performance and Results Act (GPRA), and the Chief Financial Officers (CFO) Act. As a result, we have not included the issue as a material weakness in our report.

Condition - Payroll:

- The FY 2001 report stated that 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 audit, we did not identify significant issues in this area. As a result, we have not included the issue as a reportable condition in this report.

Condition - Personnel Actions:

- NIH in its 2001 corrective action plan stated that it would perform periodic review to ensure its compliance with Title 42. In addition, NIH would develop specific procedures to ensure the appropriation authority for new hires is in writing and properly maintained in its personnel records. No exceptions were noted during our payroll internal control and sensitive payment testing. All personnel actions were supported by SF-50s. As a result, we have not included the issue as a reportable condition in our report.

Condition - Reimbursable Agreement Overhead Calculation:

- NIH's corrective action plan stated that it has a policy and procedure for when they charge indirect cost on reimbursable agreements. In addition, in our testing of the reimbursable agreements, we noted consistent overhead charge rates of 2 percent and 2.5 percent stated in the agreements. As a result, we have not included the issue as a reportable condition in our report.

As required by OMB Bulletin No. 01-02, we have compared the material weakness and material nonconformances reported by management in NIH's Federal Managers' Financial Integrity Act (FMFIA) Report to our report on the NIH's internal control. We determined that the material

weakness in our report, which also impacts NIH's ability to substantially comply with the Federal Financial Management Improvement Act of 1996, was not reported in NIH's FMFIA report including the Enclosures C and D. However, we do not believe that the failure to report this material weakness constitutes a separate reportable condition or material weakness. Management has reported, in general terms, some of the material weakness relating to financial systems and reporting processes as part of the lack of compliance with all financial system's standards in Section 4 of their report. However, management did not specifically identify that the "Financial Systems and Processes Do Not Support the Preparation and Analysis of Financial Statements" as a material weakness in their fiscal year 2002 FMFIA certification.

Management's response to the information summarized above is included in Appendix A. We have reviewed Management's response and have concluded that no change is needed to our original findings or recommendations. We will work closely with management to help them fully understand the key points of our recommendations.

In addition to the reportable conditions described above, we noted certain matters involving internal control and its operations that we reported to the management of NIH in a separate letter dated December 6, 2002.

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

Clifton Henderson LLP

Calverton, Maryland
December 6, 2002

FINANCIAL STATEMENTS

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

FINANCIAL STATEMENTS
September 30, 2001 and 2002

TABLE OF CONTENTS

Consolidated Balance Sheet

Consolidated Statement of Net Cost

Consolidated Statement of Changes in Net Position

Combined Statement of Budgetary Resources

Consolidated Statement of Financing

Notes to Financial Statements

Required Supplementary Stewardship Information:

- Investment in Research and Development
- Investment in Human Capital

Required Supplementary Information:

- Condensed Balance Sheet, Franchise and Intragovernmental Support Revolving Fund
- Condensed Statement of Net Cost, Franchise and Intragovernmental Support Revolving Fund
- Deferred Maintenance
- Intragovernmental Assets
- Intragovernmental Liabilities
- Intragovernmental Revenues & Expenses
- Management Discussion and Analysis (Appendix B)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED BALANCE SHEET
As of September 30, 2002 and 2001
(Dollars in Thousands)

	2002	2001
Assets		
Intragovernmental:		
Fund balance with Treasury (Note 3)	\$ 22,455,128	\$ 19,721,462
Investments, net (Note 5)	26,957	21,200
Accounts receivable, net (Note 6)	51,626	107,996
Other (Note 10)	<u>10,741</u>	<u>25,695</u>
Total intragovernmental	22,544,452	19,876,353
Accounts receivable, net (Note 6)	14,316	2,835
Cash and other monetary assets (Note 4)	104	104
Inventory and related property, net (Note 8)	12,939	12,095
General property, plant and equipment, net (Note 9)	1,378,257	1,150,508
Other (Note 10)	2,201	1,876
Total Assets	\$ 23,952,269	\$ 21,043,771
Liabilities		
Intragovernmental:		
Accounts payable	\$ 47,240	\$ 12,167
Accrued payroll and benefits (Note 14)	25,632	19,648
Deferred revenue (Note 15)	699	-
Other (Note 16)	<u>9,600</u>	<u>9,593</u>
Total Intragovernmental	83,171	41,408
Accounts payable	203,589	178,715
Environmental and disposal costs (Note 13)	8,100	10,700
Accrued grant liability (Note 7)	1,083,059	991,064
Federal employee and veterans' benefits (Note 12)	60,904	64,271
Accrued payroll and benefits (Note 14)	268,151	249,401
Deferred revenue (Note 15)	30,774	28,513
Other (Note 16)	53,162	70,513
Total liabilities	1,790,910	1,634,585
Net position		
Unexpended appropriations	20,763,940	18,268,835
Cumulative results of operations	<u>1,397,419</u>	<u>1,140,351</u>
Total net position	<u>22,161,359</u>	<u>19,409,186</u>
Total liabilities and net position	\$ 23,952,269	\$ 21,043,771

The accompanying notes are an integral part of these financial statements.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED STATEMENT OF NET COST
For the Years Ended September 30, 2002 and 2001
(Dollars in Thousands)

	Combined Total	<u>2002</u> Intra-NIH Eliminations	Consolidated Total	<u>2001</u> Consolidated Total
Research Program				
Costs:				
Intragovernmental	\$ 2,453,298	\$ (1,373,426)	\$ 1,079,872	\$ 855,379
With the public	<u>18,216,479</u>		<u>18,216,479</u>	<u>15,370,550</u>
Total costs	20,669,777	(1,373,426)	19,296,351	16,225,929
Less earned revenues:				
Intragovernmental	1,537,473	(1,373,426)	164,047	167,005
From the public	<u>74,433</u>		<u>74,433</u>	<u>51,578</u>
Total earned revenues	1,611,906	(1,373,426)	238,480	218,583
Net research costs	19,057,871	-	19,057,871	16,007,346
Training/Career Development Program				
Net training/career development costs	1,247,219	-	1,247,219	1,118,276
Facilities Program				
Net facilities costs	269,527	-	269,527	178,609
Net Cost of Operations	<u>\$ 20,574,617</u>	<u>\$ -</u>	<u>\$ 20,574,617</u>	<u>\$ 17,304,231</u>

The accompanying notes are an integral part of these financial statements.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2002
(Dollars in Thousands)

	Cumulative Results of <u>Operations</u>	Unexpended <u>Appropriations</u>	Totals
Beginning balances	\$ 1,140,351	\$ 18,268,835	\$ 19,409,186
Prior period adjustments (Note 18)	<u>8,354</u>		<u>8,354</u>
Beginning balances, as adjusted	1,148,705	18,268,835	19,417,540
Budgetary Financing Sources:			
Appropriations received		23,435,853	23,435,853
Appropriations transferred (out)		(91,120)	(91,120)
Other adjustments (recissions and cancelled)		(162,385)	(162,385)
Appropriations used	20,687,243	(20,687,243)	-
Donations and forfeitures of cash and cash equivalents	40,593	-	40,593
Other Financing Sources:			
Imputed financing from costs absorbed by others	88,812	-	88,812
Other	<u>6,683</u>	-	<u>6,683</u>
Total Financing Sources	20,823,331	2,495,105	23,318,436
Net Cost of Operations	20,574,617	-	20,574,617
Ending Balances	\$ 1,397,419	\$ 20,763,940	\$ 22,161,359

The accompanying notes are an integral part of these 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, 2002
(Dollars in Thousands)

	<u>Budgetary</u>
Budgetary Resources:	
Budget Authority	
Appropriations Received	\$ 23,488,258
Net transfers	(91,120)
Unobligated Balances - Beginning of Period	
Beginning of Period	469,635
Spending Authority from Offsetting Collections	
Earned	
Collected	1,663,401
Receivable from Federal sources	(62,123)
Change in unfilled customer orders	
Advance received	86,526
Without advance from Federal sources	<u>125,571</u>
Subtotal	1,813,375
Permanently not available	<u>(162,385)</u>
Total Budgetary Resources	\$ <u>25,517,763</u>
Status of Budgetary Resources:	
Obligations Incurred	
Direct	23,123,373
Reimbursable	<u>1,625,750</u>
Subtotal	24,749,123
Unobligated Balances - Available	
Apportioned	464,376
Exempt from apportionment	58,888
Unobligated Balances - Not Available	<u>245,376</u>
Total Status of Budgetary Resources	\$ <u>25,517,763</u>
Relationship of Obligations to Outlays:	
Obligated Balance, Net- Beginning of Period	\$ 19,250,315
Obligated Balance, Net - End of Period	
Accounts receivable	(67,324)
Unfilled customer orders from Federal sources	(403,986)
Undelivered orders	20,609,219
Accounts payable	1,578,936
Outlays	
Disbursements	22,219,145
Collections	<u>(1,749,927)</u>
Subtotal	20,469,218
Less: Offsetting receipts	<u>12,267</u>
Net Outlays	\$ <u>20,456,951</u>

The accompanying notes are an integral part of these financial statements.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
CONSOLIDATED STATEMENT OF FINANCING
For the Year Ended September 30, 2002

Change in Budgetary Resources Obligated for Goods, Services and Benefits Ordered but Not Yet Provided	2,228,372
Resources that fund expenses recognized in prior years	6,182
Resources That Finance the Acquisition of Assets or Liquidation of Liabilities	<u>325,400</u>
Total Resources Used to Finance Items Not Part of the Net Cost of Operations	<u>2,559,954</u>
 Total Resources Used to Finance the Net Cost of Operations	 <u>20,459,022</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	8,707
Increase in Exchange Revenue Receivable from the Public	<u>(10,291)</u>
 Total Components of Net Cost of Operations That Will Require or Generate Resources in Future Periods	 (1,584)
Components Not Requiring or Generating Resources:	
Depreciation and Amortization	65,214
Losses or (Gains) from Reevaluation of Assets and Liabilities	130
Other	<u>51,835</u>
 Total Components of Net Cost of Operations That Will Not Require or Generate Resources	 <u>117,179</u>
 Total Components of Net Cost of Operations That Will Not Require or Generate Resources in the Current Period	 115,595
 NET COST OF OPERATIONS	 \$ 20,574,617

The accompanying notes are an integral part of these financial statements.

U. S. Department of Health and Human Services
National Institutes of Health
Notes to the Financial Statements
September 30, 2002 and 2001

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

TABLE OF CONTENTS

Note 1:	Significant Accounting Policies
Note 2:	Non-entity Assets
Note 3:	Fund Balance with Treasury
Note 4:	Cash and Other Monetary Assets
Note 5:	Investments
Note 6:	Accounts Receivable
Note 7:	Accrued Grant Liability
Note 8:	Inventory and Related Property
Note 9:	General Property, Plant and Equipment, Net
Note 10:	Other Assets
Note 11:	Liabilities
Note 12:	Federal Employees and Veterans' Benefits
Note 13:	Environmental and Disposal Liabilities
Note 14:	Accrued Payroll and Benefits
Note 15:	Deferred Revenue
Note 16:	Other Liabilities
Note 17:	Leases
Note 18:	Prior Period Adjustment

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(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. 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 transactions 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 Statement of Budgetary Resources. This statement is labeled combined rather than consolidated.

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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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.

The following are institutes, centers and funds for which NIH is responsible:

Institutes and Centers

75-0807	National Library of Medicine
75-0819	John E. Fogarty International Center
75-0838	Buildings and Facilities
75-0843	National Institute on Aging
75-0844	National Institute of Child Health & Human Development
75-0846	Office of the Director
75-0848	National Center for Research Services
75-0849	National Cancer Institute
75-0851	National Institute of General Medical Sciences
75-0862	National Institute of Environmental Health Sciences
75-0872	National Heart Lung and Blood Institute
75-0873	National Institute of Dental & Craniofacial Research
75-0884	National Institute of Diabetes & Digestive & Kidney Diseases
75-0885	National Institute of Allergy & Infectious Diseases
75-0886	National Institute of Neurological Disorders & Stroke
75-0887	National Eye Institute
75-0888	National Institute of Arthritis & Musculoskeletal & Skin Disorders
75-0889	National Institute of Nursing Research
75-0890	National Institute on Deafness & Other Communication Disorders
75-0891	National Human Genome Research Institute
75-0892	National Institute of Mental Health
75-0893	National Institute on Drug Abuse
75-0894	National Institute on Alcohol Abuse and Alcoholism
75-0896	National Center for Complementary & Alternative Medicine
75-0897	National Center for Minority Health & Health Disparities
75-0898	National Institute of Biomedical Imaging & Bioengineering

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Revolvinjz, Management, and Commercial Activities

- 75-3966 Management Fund and Royalties
- 75-4554 NIH Service and Supply Fund
- 75-5145 Cooperative Research & Development Agreements

The Center for Information Technology, Center for Scientific Review, Warren Grant Magnuson Clinical Center, Office of Reward Services and certain Office of the Director functions are accounted for in either the Management Fund, Service and Supply Fund.

Trust Fund Activities

- 75-8248 Unconditional Gift Fund
- 75-8253 Conditional Gift Fund
- 75-8888 Patient Emergency Fund

The NM has the authority to accept gifts donated to the Gift Trust Funds from donors to support the mission of medical research.

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, certain 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 monies for our operations.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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 U.S. 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 the U.S. 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.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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. Internal use software with development costs of \$500,000 or more in a revolving fund, or \$1,000,000 or more in an appropriated account, is capitalized and depreciated over a useful life of three years. Personal property items with an initial acquisition cost of \$25,000 or more and estimated useful lives of two years or greater are capitalized and depreciated over useful lives ranging from 2 to 20 years. Real property is depreciated over a useful life of 30 years.

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 Note 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 8.51 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 10.7 percent of pay. Most employees hired after December 31, 1983 are covered by

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
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of Changes in Net Position and the FY 2002 Consolidated Statement of Financing.

Accrued Payroll and Benefits

Accrued payroll represents the estimated liability for salaries, wages, funded annual and sick leave that have been earned but are unpaid at the end of the year. 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 will ultimately be reported 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, 2002 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 90 days and multiplying by 10 days to derive the estimated liability.

Revenues and Other Financing Sources

Funding for the NH₁ 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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE I - SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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, transfer 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

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 \$233 million and \$205 million for fiscal year 2002 and 2001, 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.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 1 - SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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 to 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. The NIH decided to consolidate the budgeting, accounting, and tracking of these systems in its Service and Supply Fund account rather than have the costs spread among 28 - 30 different appropriations. See Deferred Revenue Note 15 on Deferred Revenue for a description of how NIH is budgeting and accounting for the costs for these four enterprise IT systems.

NOTE 2 - NON-ENTITY ASSETS

	<u>2002</u>	<u>2001</u>
Intragovernmental:		
Fund balance with Treasury	\$ <u>3,526</u>	\$ <u>3,037</u>
Total intragovernmental	<u>3,526</u>	<u>3,037</u>
Accounts receivable	<u>3,226</u>	<u>2,036</u>
Total non-entity assets	<u>6,752</u>	<u>5,073</u>
Total entity assets	<u>23,945,517</u>	<u>21,038,698</u>
Total assets	<u>23,952,269</u>	<u>21,043,771</u>

Non-entity Fund Balance with Treasury reflects amounts due to inventors. Non-entity accounts receivable pertain to National Research Service Awards (NRSAs) training grants and fellowships.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 3 - FUND BALANCE WITH TREASURY

The NIH's undisbursed account balance with the Department of the Treasury at September 30, 2002, and 2001, is \$22,455,128 and \$19,721,462, respectively. The Trust Funds balance is comprised of the Unconditional, the Conditional, and the Patient Emergency Fund. 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, 2002</u>			<u>September 30, 2001</u>		
	Entity Assets	Non- entity Assets	Total	Entity Assets	Non- entity Assets	<u>Total</u>
Appropriated Funds	\$ 21,919,662	\$ -	\$21,919,662	\$19,324,634	\$ -	\$19,324,634
Trust Funds	54,250	-	54,250	40,719	-	40,719
Revolving Funds	- 195,385	-	195,385	126,647	-	126,647
Other Funds	<u>282,305</u>	<u>3,526</u>	<u>285,831</u>	<u>226,425</u>	<u>3,037</u>	<u>229,462</u>
Total	<u>22,451,602</u>	3 526	<u>22,455,128</u>	19,718,425	3 037	<u>19,721,462-62</u>

Status of Fund Balance with Treasury:

	September 30, 2002	September 30, 2001
Unobligated Balance:		
Available	\$ 523,264	\$ 255,137
Unavailable	245,376	214,918
Obligated Balance Not Yet Disbursed	<u>21,686,488</u>	<u>19,251,407</u>
Total	<u>\$2_2,455,128</u>	<u>19,721,462</u>

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 3 - FUND BALANCE WITH TREASURY (CONTINUED)

Obligated Balance Not Yet Disbursed (above) corresponds to obligations (unfilled customer orders without advance, accounts receivable, undelivered orders, and accounts payable) reported on the Statement of Budgetary Resources. Also included in Obligated Balance Not Yet Disbursed (above) are marketable securities at par and amounts in NIH suspense cash accounts, which are not reported on the SBR. Please see Note 5 for a discussion on NIH's Investment account.

Obligated Balance Not Yet Disbursed:

	September 30, 2002	September 30, 2001
Unfilled customer orders without advance	\$ 403,986	\$ 282,059
Accounts receivable	67,324	129,446
Undelivered orders	(20,609,219)	(18,240,946)
Accounts payable	(1,578,936)	1,416,716
Marketable securities	27,082	21,685
Suspense Acct(s) cash not reported on SBR	<u>3,275</u>	<u>(26,935)</u>
Total	\$ 21.686.488	<u>\$19.251.407</u>

NOTE 4 - CASH AND OTHER MONETARY ASSETS

	September 30, 2002	September 30, 2001
Cash (Imprest funds)	104	<u>\$104</u>
Total Cash and Other Monetary Assets	<u>104</u>	<u>104</u>

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 5 - INVESTMENTS

		<u>September 30, 2002</u>				
	Cost	Unamortized Amortization Method	(Premium) Discount	Investments Net	Other Adis	Market Value Disclosure
A. Intragovernmental Securities:						
(1) Marketable	\$27,082	Interest	\$125	\$26,957		\$26,957
		<u>September 30, 2001</u>				
	Cost	Unamortized Amortization Method	(Premium) Discount	Investments Net	Other Adis	Market Value Disclosure
B. Intragovernmental Securities:						
(1) Marketable	\$21,685	Interest	\$485	\$21,200	-	\$21,200

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.

NOTE 6 - ACCOUNTS RECEIVABLE, NET

Accounts receivable from Federal agencies consists of sales of research goods and services from the NIH to other Federal agencies. No allowance is established for Federal receivables because they are deemed fully collectible. Amounts due from the public are presented net of an allowance for uncollectible accounts. The allowance is based on past collection experience and is presently calculated at a rate of 80 percent of outstanding amounts.

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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 6 - ACCOUNTS RECEIVABLE, NET (CONTINUED)

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 Service Awards.

	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net Receivables	Intra NIH Eliminations	Net Receivables Consolidated
September 30, 2002:							
Intragovernmental							
Entity	\$ 59,075	\$ -	\$ 59,075	\$ -	\$ 59,075	7,449	\$ 51,626
Total Intragovernmental	\$ 59,075	\$ -	\$ 59,075		59,075	7,449	51,626
With the Public							
Entity	\$ 11,090	\$ -	\$ 11,090		\$ 11,090	-	\$ 11,090
Non-Entity	9,056	7,074	16,130	(2,904)	3,226	-	3,226
Total, With the Public	\$ 20,146	\$ 7,074	\$ 27,220	(12,904)	\$ 14,316		\$ 14,316
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

NOTE 7 - ACCRUED GRANT 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 Department-wide procedures used by NIH to estimate and accrue amounts due grantees for their expenses, both realized and accrued, through September 30.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 7 - ACCRUED GRANT LIABILITY (CONTINUED)

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 PMD 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.

	2002	2001
Grant Advances Outstanding (before year-end grant accrual)	\$ 3,644,782	\$ 2,918,955
Less: Estimated Accrual for Amounts Due to Grantees	<u>4,727,841</u>	<u>3,910,019</u>
Net Grant Liability	<u>(1,083,059)</u>	<u>(991,064)</u>

NOTE 8 - INVENTORY AND RELATED PROPERTY

The NH's Inventory and Related Property consist of tangible personal property. Inventory and Related Property are items within the Service and Supply Fund (SSF) that are for sale and used 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, 2002, and 2001, is \$12,939 and \$12,095, respectively. Inventory is held for current sale.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 9 - GENERAL PROPERTY, PLANT AND EQUIPMENT

The following table summarizes property, plant and equipment balances as of September 30, 2002. Useful lives are assigned based on input from the NIH Office of Logistics Management and consultation with the end user of the asset. Depreciation is calculated on a straight-line basis.

	Depreciation Method	Est. Useful Lives	Acquisition Cost	Accumulated Depreciation	9/30/2002 Net Book Value	9/30/2001 Net Book Value
Land & Land Rights			\$ 14,336	\$ -	\$ 14,336	\$ 14,336
Construction in Progress			551,559	-	551,559	390,260
Buildings, Facilities & Other Structures	Straight Line	30 yrs	1,044,063	(541,456)	502,607	514,397
Internal Use Software Under Development	Straight Line	3 yrs	44,506	-	44,506	9,607
Equipment	Straight Line	5-20 yrs	<u>489,358</u>	<u>(224,109)</u>	<u>265,249</u>	<u>221,908</u>
Total			2	<u>\$ (765,565)</u>	1	<u>\$ 150,508</u>

NOTE 10 - OTHER ASSETS

	2002	2001
Intragovernmental Advances (Travel and to Others)	\$ 10,741	\$ 25,695
	<u>2,201</u>	<u>1,876</u>
Total Other Assets	\$ <u>12,942</u>	\$ <u>27,571</u>

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.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 11 - LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

	<u>2002</u>	2001
Intragovernmental:		
Accrued Unfunded FECA liability	\$ 10,384	\$ 10,573
Other (Custodial Liability)	<u>9,587</u>	<u>9,587</u>
Total Intragovernmental	19,971	20,160
Accrued leave	98,704	90,023
Environmental and disposal liabilities	8,100	10,700
Actuarial FECA Liability	60,904	64,271
Other (Amounts Due To Inventors)	<u>3,526</u>	<u>3,037</u>
Total liabilities not covered by budgetary resources	191,205	188,191
Total liabilities covered by budgetary resources	<u>1,599,705</u>	<u>1,446,394</u>
Total liabilities	\$ 1,790,910	<u>634,585</u>

NOTE 12 - FEDERAL EMPLOYEE AND VETERANS BENEFITS

These amounts represent 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. Contribution rates in effect as of September 30, 2002 for CSRS and FERS are 8.51 percent and 10.7 percent.

The actuarial amount allocated to NIH for FY 2002 and FY 2001 is based upon the actual payments made to the DOL for fiscal years 1993 through 2002 and 1992 through 2001 respectively. The amounts of \$60,904 and \$64,271, at September 30, 2002 and 2001 respectively, are classified as not covered by budgetary resources since the payments will be made from future appropriations.

NOTE 13 - ENVIRONMENTAL AND DISPOSAL LIABILITIES

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

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 13 - ENVIRONMENTAL AND DISPOSAL LIABILITIES (CONTINUED)

which they have assumed responsibility. The NIH management has determined that the active projects probably will result in an environmental cleanup. 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 — Assign np_Cost</u>	<u>Total Estimated Cleanup Cost</u>	<u>Liabilities With the Public Not Covered by Budgetary Resources</u>
September 30, 2002:			
Bitterroot Valley Sanitary Landfill	Estimated Cost of Similar Remediation	\$ 3,600	\$ 3,600
Caribbean Primate Research Center	Estimated Cost of Similar Remediation	500	500
Lexington, KY Tract V	Estimated Cost of Similar Remediation	<u>4,000</u>	<u>4,000</u>
Total		\$ = <u>8,100</u>	\$ = <u>8,100</u>

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 13 - ENVIRONMENTAL AND DISPOSAL LIABILITIES (CONTINUED)

Project or Activity	Method for Assigning Cost	Total Estimated Cleanup Cost	Liabilities With the Public Not Covered by Budgetary Resources
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	5,700
Lexington, KY Tract V	Estimated Cost of Similar Remediation	<u>2,000</u>	<u>2,000</u>
Total		\$ <u>10,700</u>	\$ <u>10,700</u>

NOTE 14 - ACCRUED PAYROLL AND BENEFITS

Accrued payroll and benefits represent 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. Accumulated annual leave is based on current year pay rates. Intragovernmental accrued payroll and benefits consists of employer contributions and payroll taxes payable and the accrued unfunded FECA liability. Governmental accrued payroll

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 14 - ACCRUED PAYROLL AND BENEFITS (CONTINUED)

and benefit liabilities consist of funded payroll, unfunded annual leave, and unfunded compensatory leave. Accrued payroll and benefits as of September 30, 2002 and September 30, 2001 are summarized below.

	September 30, 2002					
	IntraGovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Accrued Leave	\$ -	\$ -	\$ -	\$ 169,447	\$ 98,704	\$268,151
Payroll						
Withholding	15,248	-	15,248	-	-	-
Accrued Workers						
Compensation						
(including FECA)	=	<u>10,384</u>	<u>10,384</u>	=	=	=
Total	<u>15,248</u>	<u>\$ 10,384</u>	25 632	169 447	<u>\$ 98,704</u>	268 151
	September 30, 2001					
	Intragovernmental			With the Public		
	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Liabilities Not Covered by Budgetary Resources	Total
Accrued Leave	\$ -	\$ -	\$ -	\$ 159,378	\$ 90,023	\$249,401
Payroll						
Withholding	9,075	-	9,075	-	-	-
Accrued Workers						
Compensation						
(including FECA)	=	<u>10,573</u>	<u>10,573</u>	=	=	=
Total	<u>9,075</u>	<u>\$ 10,573</u>	19 648	159 378	<u>\$ 90,023</u>	249 401

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 15 - DEFERRED REVENUE

Unearned or deferred 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 fund 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.

The systems include the (1) NIH Business System, which is replacing the legacy administrative database (ADB) and central accounting system (CAS), the (2) Electronic Research Administration system, which is replacing the legacy grants management systems and supporting the federal government-wide Federal Commons, the (3) Clinical Research Information System, which is replacing the legacy Clinical Center's Medical Information System, and the (4) NIH-specific costs associated with the DHHS' Enterprise Human Resources Project, which is replacing the DHHS' legacy human resources and payroll systems.

The NIH Director and the NIH IC Directors established and approved a multi-year plan for these enterprise IT systems. Also approved was the authorization to collect additional amounts for 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 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.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 15 - DEFERRED REVENUE (CONTINUED)

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 carryout 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.

The NIH Institutes provide advances to the Service and Supply Fund and the Service and Supply Fund treats these advances as unearned revenue or deferred 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 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 deferred revenue account is the advance received from the Institutes that the Service and Supply Fund has not expensed. The balance in the unearned or deferred 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 deferred amounts advanced from the Institutes and treated as deferred revenue on the NIH Management Fund's books.

At September 30, 2002 and 2001, the intra-NIH elimination amounts are \$276,711 and \$187,341, respectively. At September 30, 2002 and 2001, these amounts are comprised of \$129,526 and \$88,634, respectively, related to IT software development reflected in the NIH Service and

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 15 - DEFERRED REVENUE (CONTINUED)

Supply Fund and \$147,185 and \$98,707, respectively, related to goods or services provided to the Institutes by the NIH Management Fund.

	Intra governmental		<u>With the Public</u>	
	Liabilities Covered by Budgetary Resources	Total	Liabilities Covered by Budgetary Resources	Total
September 30, 2002:				
Deferred Revenue	\$ 277,410	\$ 277,410	\$ 30,774	\$ 30,774
Less: Intra-NIH Eliminations	(276,711)	276,711		
	699	\$ 699	\$ 30,774	\$ 30,774
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

NOTE 16 - OTHER LIABILITIES

	Liabilities Covered By Budgetary Resources	Liabilities Not Covered By Budgetary Resources	Total
September 30, 2002:			
A.1. Intragovernmental			
(1) Custodial liabilities		9,587	\$ 9,587
(2) Other	13		13
Total Intragovernmental	13	9,587	9,600
2. Other Accrued Liabilities	49,636	3526	53,162
Total Other Liabilities	\$ 49,649	13,113	\$ 62,762
September 30, 2001:			
A.1. Intragovernmental			
(1) Custodial liabilities		9,587	\$ 9,587
(2) Other	6		6
Total Intragovernmental	6	9,587	9,593
2. Other Accrued Liabilities	67,476	3,037	70,513
Total Other Liabilities	-1- -f7.48_2	12_ 624	\$ - 106

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 16 - OTHER LIABILITIES (CONTINUED)

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.

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, 2002 and 2001. 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. Other Liabilities referenced above exclude Deferred Revenue, discussed in more detail in Note 15.

NOTE 17 - 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:

Fiscal Year	2002
Year 1	\$ 81,363
Year 2	88,711
Year 3	91,313
Year 4	91,083
Year 5	92,166
After 5 years	<u>616,655</u>
Total Future Lease Payments	<u>1,061,291</u>

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 1 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 18 - PRIOR PERIOD ADJUSTMENT

The prior period adjustments on the FY 2002 financial statements net to \$8,354. These adjustments include:

Adjustment to Construction in Progress	\$ 9,213
Transfers of leave balances	(706)
Other miscellaneous corrections	<u>(153)</u>
Total	<u>8,354</u>

During FY 2002, NIH identified transactions totaling \$9,213 that had been recorded as expenditures in prior years but should have been recorded as construction in progress. NIH also recorded net transfers of leave balances of \$706 associated with employees coming to or leaving NIH, and miscellaneous other adjustments of \$153.

Notes Disclosures Related to the Statement of Budgetary Resources

- Note 20: Apportionment Categories of Obligations Incurred
- Note 21: Adjustments to Beginning Balance of Budgetary Resources
- Note 22: Legal Arrangements Affecting Use of Unobligated Balances
- Note 23: Explanation of Differences Between the Statement of Budgetary Resources and the Budget of the Unites States

Note Disclosures Related to the Statement of Financing

- Note 24: Explanation of Differences Between Liabilities Not Covered by Budgetary Resources and Components Requiring or Generating Resources in Future Periods

Note Disclosures Not Related to a Specific Statement

- Note 25 Unified Financial Management System (UFMS)
- Note 26 Grant Awards

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 2 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

Note Disclosures Related to the Statement of Net Cost

NOTE 19 - EXCHANGE REVENUES

The National Institutes of Health provides services to federal agencies in conjunction with interagency agreements. NIH's pricing policy strives to neither generate a profit or a loss.

Notes Disclosures Related to the Statement of Budgetary Resources

NOTE 20 - APPORTIONMENT CATEGORIES OF OBLIGATIONS INCURRED

Obligations incurred by apportionment categories are as follows:

Direct

Category A	\$	22,813,077
Category B		282,839
Exempt from apportionment		27-458
Total Direct	\$	<u>23,123,374</u>

Reimbursable

Category A	\$	1,623,303
Category B		<u>2,446</u>
Total Reimbursable	\$	<u>1,625,749</u>
Total Obligations Incurred	\$	<u>24,749,123</u>

NOTE 21 - ADJUSTMENTS TO BEGINNING BALANCE OF BUDGETARY RESOURCES

The net adjustment during the reporting period to budgetary resources available at the beginning of the year was \$420. The adjustments were due to:

- a) Correction of fiscal year 2001 FACTS II entries
- b) Correction to bring balance reported on the September 30, 2001 Statement of Budgetary Resources and SF 133, "Report on Budget Execution and Budgetary Resources," in agreement with the carry forward balance reported to OMB on the SF 132, "Apportionment and Reapportionment Schedule."

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 2 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 22 - LEGAL ARRANGEMENTS AFFECTING USE OF UNOBLIGATED BALANCES

The unobligated balances consist of appropriated funds, revolving fund, Management Fund, trust funds, Cooperative Research and Development Agreement fund and royalties fund. The annual appropriations are available for sponsoring and conducting medical research. The annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for five subsequent years. The Revolving and Management Funds are available for centralized research support services and administrative activities of NIH. The Revolving Fund is a no year fund without any time limit. The Management Fund is available for two fiscal years. The trust funds consist of the Conditional, Unconditional, and Patient Emergency Funds. These are also no year funds without time limits. The Patient Emergency Fund is intended solely for the benefit of the patients. The Unconditional Gift Fund is available for any authorized purpose in the performance of NIH functions. The Conditional Gift Fund is restricted to a specific purpose determined by the donor. NIH is not authorized to spend the funds to support functions not encompassed within the terms of the conditions. However, for conditional monetary gifts, upon completion of the stipulated conditions or circumstances rendering completion of the conditions impossible, any remaining unobligated conditional funds are transferred to the unconditional gift account for the support of any other objectives of the recipient organization. The funds received for a CRADA agreement are available for the performance of the contractual agreement. Funds are available for the term of the agreements. The royalty funds are available for obligations for two fiscal years after the fiscal year the funds are received. The funds are available for a variety of purposes such as reward to scientific, engineering, and technical employees of the laboratory, to educate and train employees and to pay expenses incidental to the administration of intellectual property by the entity.

NOTE 23 - EXPLANATION OF DIFFERENCES BETWEEN THE STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES

A reconciliation of budgetary resources, unobligated balance, obligations incurred and outlays, as presented in the Statement of Budgetary Resources (SBR), to amounts included in the Budget of the United States Government (President's Budget) for the year ended September 30, 2001 is shown below. A reconciliation is not presented for the period ended September 30, 2002 since the information is not yet available. The NIH FY 2002 Annual Report will be published in December 2002 and the President's Budget is expected to be published in January 2003. The 'actual' President's Budget for fiscal 2002 is available on OMB website under Budget of U. S. Government, Fiscal Year 2004-Appendix.

The net difference between the budgetary resources available for obligations on the P&F schedule and the fiscal year 2001 Statement of Budgetary Resources is \$32,000. This is due to the following:

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 2 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 23 - EXPLANATION OF DIFFERENCES BETWEEN THE STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES (CONTINUED)

New Budget Authority;

Appropriations:

There is a net difference in appropriations of \$46,000 between the P&F and the SBR. This is due to:

- a. Authority for Federal Retiree costs of \$79,000 included on the P&F Schedule that are not on the SBR and
- b. Gift fund collections of \$33,000 included on the SBR that are not on the P&F.

Spending Authority for Offsetting Collections:

There is a difference of \$19,000 between the P&F and SBR. This is due to topside adjustments to the trial balance after the submission of FACTS II.

Other:

The other differences are recoveries of \$5,000 and cancelled appropriations totaling \$91,000 that are not on the P&F.

Unobligated Balance Carried Forward Start of Year:

There is a difference of \$183,000 between the P&F and the SBR. The P&F includes carry forward balances only for no year accounts where as the SBR also includes carry forward balances in expired and gift fund accounts.

Status of Resources:

The net difference between the status of resources between the P&F schedule and the fiscal year 2001 SBR is \$32,000. This is due to the following:

New Obligations :

There is a difference of \$84,000 in the new obligations between the P&F and the SBR. The P&F includes obligations of \$79,000 for Federal retiree costs not included on the SBR. The remaining difference of \$5,000 is due to other adjustments to the P&F schedule.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 2 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

NOTE 23 - EXPLANATION OF DIFFERENCES BETWEEN THE STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES (CONTINUED)

Unobligated Balance Carried Forward at End of Year:

There is a difference of \$259,000 between the P&F and the SBR. The P&F does not include unobligated balances in expired and gift funds accounts.

Other Adjustments:

SBR includes negative adjustments in expired accounts of \$160,000 and obligations in gift funds of \$20,000 not included on the P&F.

Outlays:

There is a difference of \$20,000 in the outlays between the P&F and the SBR. This is due to gift fund outlays that are included on the SBR but not on the P&F.

Note Disclosures Related to the Statement of Financing

NOTE 24 - EXPLANATION OF DIFFERENCES BETWEEN LIABILITIES NOT COVERED BY BUDGETARY RESOURCES AND COMPONENTS REQUIRING OR GENERATING RESOURCES IN FUTURE PERIODS

The liabilities not covered by budgetary resources on the balance sheet include the unfunded FECA liability, environmental and disposal liabilities, accrued leave, and other liabilities. The unfunded FECA liability and environmental and disposal liabilities decreased from FY 2001 to FY 2002 and are reported as resources that fund expenses recognized in prior years rather than component requiring resources in future periods. The accrued leave consists of unfunded annual leave, unfunded compensatory leave and unfunded credit hours. The unfunded compensatory leave decreased from FY2001 to FY2002 and is reported as resources that fund expenses recognized in prior years. The component requiring resources in future period on the Statement of financing represents the increase in annual leave and unfunded credit hours.. The other liabilities include the amount due to inventors and to the general trust funds and are not components on the Statement of Financing.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
NOTES TO THE FINANCIAL STATEMENTS (Part 2 of 2)
September 30, 2002 and 2001
(Dollars in Thousands)

Note Disclosures Not Related to a Specific Statement

NOTE 25 - UNIFIED FINANCIAL MANAGEMENT SYSTEM (UFMS)

As part of the Department of Health and Human Services (DHHS) modernization effort, on June 14, 2001, the Secretary directed that the number of financial systems be reduced from five to two modern accounting systems. This project is collectively known as the Unified Financial Management System (UFMS). The purpose of this endeavor is to achieve greater economies of scale, eliminate duplication and provide better service delivery.

The NIH provides accounting and contracting services for a portion of the total Department-wide UFMS initiative. The NIH has established separate accounts within its Service and Supply Fund for the UFMS project. In FY 2002 and FY 2001, NIH incurred obligations of \$11,704 and \$1,100, respectively, related to the UFMS project. Amounts credited to the NIH Service and Supply Fund are treated as unobligated balances and are available for obligation until the purpose is achieved. The NIH has reimbursable agreements with other DHHS components to provide funds for reimbursement of costs related to the UFMS.

NOTE 26 - GRANT AWARDS

The Single Audit Act of 1984, as revised, provides that recipients receiving \$300 or more in Federal financial assistance have an annual audit of its activities performed by an independent non-federal auditor. The result of these audits furnish information to awarding agencies about the validity of their financial assistance award expenditures, adequacy of internal controls over Federal assistance, and the extent of compliance with grant rules and regulations. Disallowed costs identified pursuant to these audits are used to reduce future years' grant awards, or returned to the awarding agency or general receipt funds, as required by appropriation law. Such reduction or returned awards are reported in the year the determination is made.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 NOTES TO THE FINANCIAL STATEMENTS (Part 2 of 2)
 September 30, 2002 and 2001
 (Dollars in Thousands)

NOTE 26 - GRANT AWARDS (CONTINUED)

The final determination of allowable costs relating to grants and letter of credit contracts provided by NIH in FY 2002 and FY 2001, has not been completed. Accordingly, awards issued and expensed may ultimately be adjusted for recipients' costs determined disallowed pursuant to the audit. As a result, later reviews may identify disallowances of FY 2002 and FY2001 expenditures after the financial statements have been issued. Even though the periods are not compatible, it should be noted that the FY 2002 and FY 2001 audit disallowances are summarized as follows:

	FY2002	FY2001
Disallowances	\$ 548	\$ 556
Total Grants	<u>\$ 14,773,332</u>	<u>\$ 13,971,426</u>
Percent	.0037%	<u>.0040</u> %

This information is an integral part of the accompanying financial statements.

REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION
(RSSI)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION
 INVESTMENT IN RESEARCH AND DEVELOPMENT
 For the Years Ended September 30, 1998 - 2002
 (Dollars 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>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>Total</u>
Basic Research	\$ 6,622,750	\$ 8,148,239	\$ 8,814,197	\$ 9,604,408	\$ 11,434,723	\$ 44,624,317
Applied Research	4,415,167	5,432,160	5,876,132	6,402,938	7,623,148	29,749,545
Total	\$ 11,037,917	\$ 13,580,399	\$ 14,690,329	\$ 16,007,346	\$ 19,057,871	\$ 74,373,862

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION
 INVESTMENT IN HUMAN CAPITAL
 For the Years Ended September 30, 1998 - 2002
 (Dollars 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.

	1998	1999	2000	2001	2002	Total
Research Training & Career Development	\$ 660,465	\$ 820,483	\$ 870,728	\$ 1,118,276	\$ 1,247,219	\$ 4,717,171

REQUIRED SUPPLEMENTARY INFORMATION (RSI)

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 REQUIRED SUPPLEMENTARY INFORMATION
 CONDENSED BALANCE SHEET
 FRANCHISE AND INTRAGOVERNMENTAL SUPPORT REVOLVING FUND
 As of September 30, 2002
 (Dollars in Thousands)

Assets		
Fund Balance with Treasury	\$	195,385
Accounts receivable		12,886
General property, plant and equipment, net		68,735
Other assets		<u>16,650</u>
Total Assets	\$	293,656
Liabilities		
Accounts payable	\$	54,553
Deferred revenue		129,526
Other liabilities		<u>16,569</u>
Total Liabilities		200,648
Net Position		
Cumulative results of operations		<u>93,008</u>
Total Net Position		93,008
Total Liabilities and Net Position	\$	293,656

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 REQUIRED SUPPLEMENTARY INFORMATION
 CONDENSED STATEMENT OF NET COST
 FRANCHISE AND INTRAGOVERNMENTAL SUPPORT REVOLVING FUND
 For the year ended September 30, 2002
 (Dollars in Thousands)

Program/Business Line	Intra- governmental	With the Public	Total Gross Cost	Less: Earned Revenue	Net Costs (Revenue)
Administrative Services	\$ 84,311	\$ 288,747	\$ 373,058	\$ 409,029	\$ (35,971)
Information Technology	33,461	114,596	148,057	156,195	(8,138)
Instrumentation Services	2,217	7,593	9,810	9,400	410
Animal Services	<u>9,221</u>	<u>31,579</u>	<u>40,800</u>	<u>42,972</u>	<u>(2,172)</u>
Total	\$ 129,210	\$ 442,515	\$ 571,725	\$ 617,596	\$ (45,871)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 REQUIRED SUPPLEMENTARY INFORMATION
 DEFERRED MAINTENANCE
 For the Year Ended September 30, 2002

The National Institutes of Health estimates that its deferred maintenance is approximately \$163,900. 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.

Category	Asset Condition	Cost to Return to Acceptable Condition
General PP& E		
Land	1	\$ 0
Buildings	3	163,900
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.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
REQUIRED SUPPLEMENTARY INFORMATION
INTRAGOVERNMENTAL ASSETS
September 30, 2002
(Dollars in Thousands)

<u>Agency</u>	Fund Balance w/ Treasury	Investments	Accounts Receivable	<u>Other</u>
Dept of Commerce			\$ 71	
Dept of Defense			1,070	
Dept of Education			380	
Dept of Energy			381	
Dept of Housing & Urban Development			8	
Dept of Health & Human Services			6,450	
Dept of Justice			766	
Dept of Labor			31	
Dept of Transportation			214	
Dept of the Treasury	\$ 22,455,128	\$ 26,957	40,576	\$ 10,741
Agency for International Development			51	
Environmental Protection Agency			537	
General Services Admin			9	
National Aeronautics & Space Admin			817	
National Science Foundation			139	
Social Security Admin			43	
All other Federal agencies			83	
Total	\$ 22,455,128	\$ 26,957	\$ 51,626	\$ 10,741

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 NATIONAL INSTITUTES OF HEALTH
 REQUIRED SUPPLEMENTARY INFORMATION
 INTRAGOVERNMENTAL LIABILITIES
 September 30, 2002
 (Dollars in Thousands)

Agent	Accounts Payable	Accrued Payroll & <u>Benefits</u>	Other
Dept of Defense	\$ 5,839		
Dept of Energy	2,681		
Dept of Health & Human Services	15,158	\$ 148	
Dept of the Interior	9,424		
Dept of Labor		10,384	
Dept of the Treasury		4,122	\$ 9,587
Dept of Veterans Affairs	4,057		
Environmental Protection Agency	379		
General Services Admin	9,659		6
Office of Personnel Mgmt	33	10,978	7
All other Federal agencies	10		699
Total	\$ 47,240	\$ <u>25,632</u>	\$ <u>10,299</u>

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
REQUIRED SUPPLEMENTARY INFORMATION
INTRAGOVERNMENTAL REVENUES & EXPENSES
For the Year Ended September 30, 2002
(Dollars in Thousands)

Agency -	Earned Revenue	Gross Cost
Dept of Agriculture	\$ 370	\$ 1,593
Dept of Commerce	1,533	15,186
Dept of Defense	29,404	53,490
Dept of Education	2	750
Dept of Energy	7,426	26,100
Dept of Health Human Services	92,744	437,608
Dept of Interior	15	26,208
Dept of Justice	855	-
Dept of Labor	188	8,432
Dept of State	258	3,555
Dept of Transportation	182	27
Dept of the Treasury	44	1,046
Dept of Veterans Affairs	127	22,005
Dept of International Development	796	750
Environmental Protection Agency	23,489	3,490
Federal Emergency Mgmt Agency	7	-
General Services Admin	572	216,831
National Aeronautics & Space Admin	1,595	1,223
National Science Foundation	1,086	13,607
Nuclear Regulatory Commission	1,117	13
Office of Personnel Mgmt	-	247,029
Social Security Admin	1,832	15
All other Federal agencies	405	914
Total	\$ <u>164,047</u>	\$ <u>1,079,872</u>

APPENDIX A
MANAGEMENT RESPONSE TO AUDITOR
INTERNAL CONTROL REPORT



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

www.nih.gov

December 20, 2002

TO: Clifton Gunderson

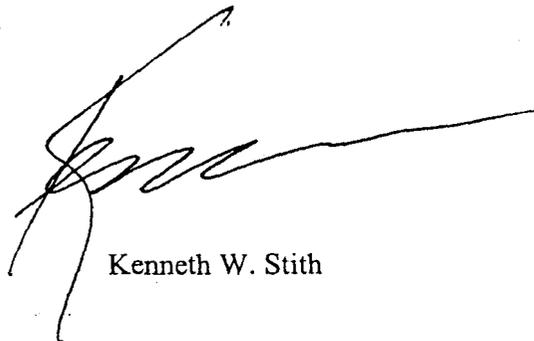
FROM: Deputy Chief Financial Officer, NIH

RE: Review of Draft Report

Thank you for the opportunity to comment on the draft Independent Auditor's Report on Internal Control. We concur that our current financial systems and the processes that we have developed to compensate for our financial system weaknesses are extremely labor intensive and require heroic efforts to achieve an unqualified audit opinion. We are hopeful that with the full rollout of the NIH Business System, many of these financial system weaknesses will disappear. Also, we appreciate that you have recognized that we have made many improvements in our processes to compensate for financial system weaknesses, and we agree that more improvements are necessary.

We concur with virtually all of your recommendations. Toward that end, we will be devoting more resources to bolster our analysis and reconciliation activities as we begin to roll out the NIB Business System. With the advent of quarterly comparative financial statements and the accelerated timeline to produce final financial statements, we concur that these analysis and reconciliation efforts will become more critical. Moreover, we will continue to enlist the aid of Institute and Center staff in reviewing supporting documentation.

Several of the recommendations will need to wait until the NIH Business System is fully operational, and we will work to ensure that these recommendations are considered in the full rollout of the NIH Business System.



Kenneth W. Stith

APPENDIX B
MANAGEMENT DISCUSSION AND ANALYSIS
September 30, 2002



**U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH**

**Audited Annual Financial Statements
September 30, 2002 and September 30, 2001**

NIH Audited Annual Financial Statement for FY 2002

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Appendix B

Audited Annual Financial Statement
September 30, 2002 and September 30, 2001

Table of Contents

INTRODUCTION	i
<i>General Purpose and Requirements</i>	<i>i</i>
MANAGEMENT DISCUSSION & ANALYSIS	1
<i>General Description</i>	<i>1</i>
THE NIH MISSION AND OBJECTIVES.....	1
NIH ORGANIZATIONAL STRUCTURE	2
<i>NIH Institutes</i>	2
<i>NIH Centers</i>	4
NIH CORE PROGRAMS	6
<u><i>Research Program</i></u>	8
<u><i>Research Training and Career Development Program</i></u>	9
<u><i>Research Facilities Program</i></u>	11
SUMMARY OF FY 2001 AND FY 2002 PERFORMANCE GOALS.....	14
<u><i>Research Program</i></u>	15
Research	15
Communication of Results	18
Technology Transfer.....	21
Research Leadership and Administration	22
<u><i>Research Training and Career Development Program</i></u>	24
Training Support.....	24
<u><i>Research Facilities Program</i></u>	25
Intramural Modernization and Maintenance.....	25
OTHER ACCOMPANYING INFORMATION.....	26
<u><i>Operations and Broad Strategy</i></u>	26
<u><i>President's Management Agenda</i></u>	28
Competitive Sourcing	28
Improved Financial Performance.....	28
Budget and Performance Integration.....	29
<u><i>Compliance with the Federal Managers' Financial Integrity Act of 1982</i></u>	30
<u><i>Results of Operations</i></u>	30
<u><i>Partnerships and Coordination</i></u>	31
<u><i>Collaboration with Other Federal Agencies</i></u>	32
<u><i>Relationships with Private Industry</i></u>	33
<u><i>NIH Anti-Bioterrorism</i></u>	34
<u><i>NIH Business System</i></u>	36
<u><i>NIH Security Program</i></u>	36
<u><i>NIH Infrastructure Security Initiative</i></u>	38
LIMITATIONS OF THE FINANCIAL STATEMENTS.....	40

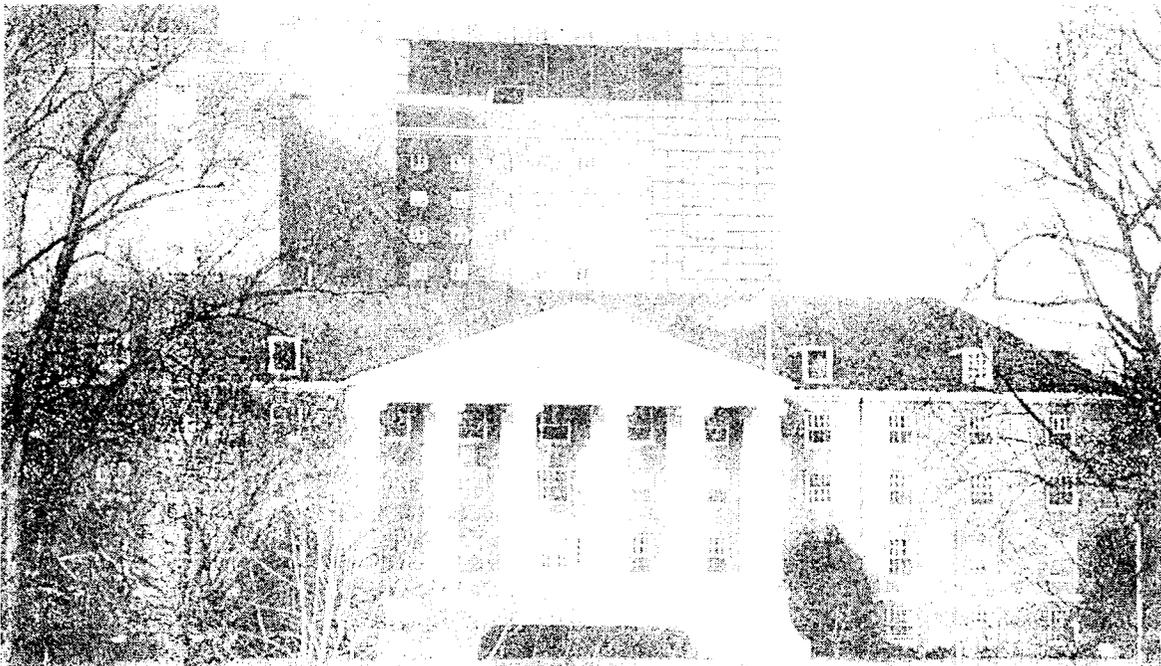
INTRODUCTION

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 (MD&A) and its audited financial statements for fiscal year 2002.

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, the Office of Management and Budget (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 (GMRA). The format of this document meets the requirements of 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 the Form and Contents of Agency Financial Statements, OMB Bulletin No. 01-09, and subsequent amendments. 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 of 1993 (GPRA), 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 OBJECTIVES

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 \$23.28 billion in 2002.

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 that will lead to better health for everyone.

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.

NIH mission is expressed in the following objectives:

- 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.

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 composed of 27 Institutes and Centers (ICs, or "Institutes") that work individually and in partnership performing research activities that extend from basic research that explores the fundamental workings of biological systems and behavior, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs. The following is a list of all 20 Institutes and seven Centers. These ICs are under the NIH Office of Director (OD).

NIH Institutes



National Cancer Institute (NCI) – Established in 1937

NCI leads a national effort to reduce the burden of cancer morbidity and mortality. Its goal is to stimulate and support scientific discovery and its application to achieve a future when all cancers are uncommon and easily treated. Through basic and clinical biomedical research and training, NCI conducts and supports programs to understand the causes of cancer; prevent, detect, diagnose, treat, and control cancer and disseminate information to the practitioner, patient, and public.



National Eye Institute (NEI) – Established in 1968

NEI conducts and supports research that helps prevent and treat eye diseases and other disorders of vision. This research leads to sight-saving treatments, reduces visual impairment and blindness, and improves the quality of life for people of all ages. NEI-supported research has advanced our knowledge of how the eye functions in health and disease.



National Heart, Lung, and Blood Institute (NHLBI) – Established in 1948

NHLBI provides leadership for a national program in diseases of the heart, blood vessels, lung, and blood; blood resources; and sleep disorders. Since October 1997, the NHLBI has also had administrative responsibility for the NIH Women's Health Initiative. The Institute plans, conducts, fosters, and supports an integrated and coordinated program of basic research, clinical investigations and trials, observational studies, and demonstration and education projects.



National Human Genome Research Institute (NHGRI) – Established in 1989

NHGRI supports the NIH component of the Human Genome Project, a worldwide research effort designed to analyze the structure of human DNA and determine the location of the estimated 30,000 to 40,000 human genes. The NHGRI Intramural Research Program develops and implements technology for understanding, diagnosing, and treating genetic diseases.

NIH Institutes



National Institute of Aging (NIA) - Established in 1974

NIA leads a national program of research on the biomedical, social, and behavioral aspects of the aging process; the prevention of age-related diseases and disabilities; and the promotion of a better quality of life for all older Americans.



National Institute on Alcohol Abuse and Alcoholism (NIAAA) - Established in 1970

NIAAA conducts research focused on improving the treatment and prevention of alcoholism and alcohol-related problems to reduce the enormous health, social, and economic consequences of this disease.



National Institute of Allergy and Infectious Diseases (NIAID) - Established in 1948

MAID research strives to understand, treat, and ultimately prevent the myriad of infectious, immunological, and allergic diseases that threaten millions of human lives.



National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) - Established in 1986

NIAMS supports research into the causes, treatment, and prevention of arthritis and musculoskeletal and skin diseases, the training of basic and clinical scientists to carry out this research, and the dissemination of information on research progress in these diseases.



National Institute of Biomedical Imaging and Bioengineering (NIBIB) - Established in 2000

NIBIB improves health by promoting fundamental discoveries, design and development, and translation and assessment of technological capabilities in biomedical imaging and bioengineering, enabled by relevant areas of information science, physics, chemistry, mathematics, materials science, and computer sciences.



National Institute of Child Health and Human Development (NICHD) - Established in 1962

NICHD research on fertility, pregnancy, growth, development, and medical rehabilitation strives to ensure that every child is born healthy and wanted and grows up free from disease and disability.



National Institute on Deafness and Other Communication Disorders (NIDCD) - Established in 1988

NIDCD conducts and supports biomedical research and research training on normal mechanisms as well as diseases and disorders of hearing, balance, smell, taste, voice, speech, and language that affect 46 million Americans.



National Institute of Dental and Craniofacial Research (NIDCR) - Established in 1948

NIDCR provides leadership for a national research program designed to understand, treat, and ultimately prevent the infectious and inherited Craniofacial-oral-dental diseases and disorders that compromise millions of human lives.



National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) - Established in 1948

NIDDK conducts and supports basic and applied research and provides leadership for a national program in diabetes, endocrinology, and metabolic diseases; digestive diseases and nutrition; and kidney, urological, and hematological diseases. Several of these diseases are among the leading causes of disability and death; all seriously affect the quality of life of those who have them.



National Institute on Drug Abuse (NIDA) - Established in 1973

NIDA leads the nation in bringing the power of science to bear on drug abuse and addiction through support and conduct of research across a broad range of disciplines and rapid and effective dissemination of results of that research to improve drug abuse and addiction prevention, treatment, and policy.

NIH Institutes



National Institute of Environmental Health Sciences (NIEHS) - Established in 1969

NIEHS reduces the burden of human illness and dysfunction from environmental causes by defining how environmental exposures, genetic susceptibility, and age interact to affect an individual's health.



National Institute of General Medical Sciences (NIGMS) - Established in 1962

NIGMS supports basic biomedical research that is not targeted to specific diseases. NIGMS funds studies on genes, proteins, and cells, as well as on fundamental processes like communication within and between cells, how our bodies use energy, and how we respond to medicines. The results of this research increase our understanding of life and lay the foundation for advances in disease diagnosis, treatment, and prevention. NIGMS also supports research-training programs that produce the next generation of biomedical scientists, and it has special programs to encourage underrepresented minorities to pursue biomedical research careers.

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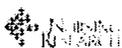
National Institute of Mental Health (NIMH) - Established in 1949

NIMH provides national leadership dedicated to understanding, treating, and preventing mental illnesses through basic research on the brain and behavior, and through clinical, epidemiological, and services research.



National Institute of Neurological Disorders and Stroke (NINDS) - Established in 1950

The mission of the NINDS is to reduce the burden of neurological diseases - a burden borne by every age group, every segment of society, and people all over the world. To accomplish this goal the NINDS supports and conducts research, both basic and clinical, on the normal and diseased nervous system, fosters the training of investigators in the basic and clinical neurosciences, and seeks better understanding, diagnosis, treatment, and prevention of neurological disorders.



National Institute of Nursing Research (NINR)- Established in 1986

NINR supports clinical and basic research to establish a scientific basis for the care of individuals across their life span-from the management of patients during illness and recovery to the reduction of risks for disease and disability; the promotion of healthy lifestyles; the promotion of quality of life in those with chronic illness; and the care for individuals at the end of life. This research may also include families within a community context, and it also focuses on the special needs of at-risk and under-served populations, with an emphasis on health disparities.



National Library of Medicine (NLM) -Established in 1956

NLM collects, organizes, and makes available biomedical science information to investigators, educators, and practitioners and carries out programs designed to strengthen medical library services in the United States. Its electronic data bases, including MEDLINE and MEDLINEplus are used extensively throughout the world by both health professionals and the public.

NIH Centers

C"01

Center for Information Technology (CIT formerly DCRT, OIRM, TCB) - Established in 1964

CIT incorporates the power of modern computers into the biomedical programs and administrative procedures of the NIH by focusing on three primary activities: conducting computational biosciences research, developing computer systems, and providing computer facilities.

Center for Scientific Review (CSR) - Established in 1946

CSR is the NIH focal point for conducting initial peer reviews, the foundation of the NIH grant and award process. The Center carries out peer review of the majority of research and research training applications submitted to the NIH. In addition, the Center serves as the central receipt point for all such Public Health Service (PHS) applications and makes referrals to scientific review groups for scientific and technical merit review of applications and to funding components for potential award. To this end, the Center develops and implements innovative, flexible ways to conduct referral and review for all aspects of science.

NIH Centers



John E. Fogarty International Center (FIC) - Established in 1968

FIC promotes and supports scientific research and training internationally to reduce disparities in global health.



National Center for Complementary and Alternative Medicine (NCCAM) - Established in 1992

NCCAM is dedicated to exploring complementary and alternative medical (CAM) practices in the context of rigorous science; training CAM researchers and disseminating authoritative information.



National Center on Minority Health and Health Disparities (NCMHD) - Established in 1993

The mission of NCMHD is to promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities. In this effort NCMHD will conduct and support basic, clinical, social, and behavioral research, promote research infrastructure and training, foster emerging programs, disseminate information, and reach out to minority and other health disparity communities.



National Center for Research Resources (NCRR) - Established in 1990

NCRR advances biomedical research and improves human health through research projects and shared resources that create, develop, and provide a comprehensive range of human, animal, technological, and other resources. NCRR's support is concentrated in four areas: biomedical technology, clinical research, comparative medicine, and research infrastructure.

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Warren Grant May-nuson Clinical Center (CC) - Established in 1953

CC is the clinical research facility of the National Institutes of Health. As a national resource, it provides the patient care, services, and environment needed to initiate and support the highest quality' conduct of and training in clinical research.

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 promote scientific innovation that transforms clinical practice and enhances the capabilities and quality of routine medical treatment.



NIH research community is divided between two major sub-communities. The extramural research community and the intramural research community.

The Extramural Research Community. More than 80 percent of the dollars appropriated to NIH flows out to the scientific community at large. The "extramural research community" contributes to training the next generation of researchers, enhancing the skills and abilities of established investigators, and renewing the infrastructure for NIH-sponsored research that

uncover new knowledge that leads to improvements in the prevention, detection, diagnosis, and treatment of disease and disability.

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 system is premised on several factors: *Independence*, embodied in "investigator- initiated" research; *Self Governance*, 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 10 percent of the dollars appropriated to NIH - supports a core program of basic and clinical research activities administered and staffed by NIH scientists, physicians, nurses, technicians, and administrators. 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 individuals provide scientific, clinical, and educational benefits to the citizens of the United States and the world through the conduct of biomedical research in NIH laboratories and clinical research with individuals 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 and disease-oriented laboratory research, 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.

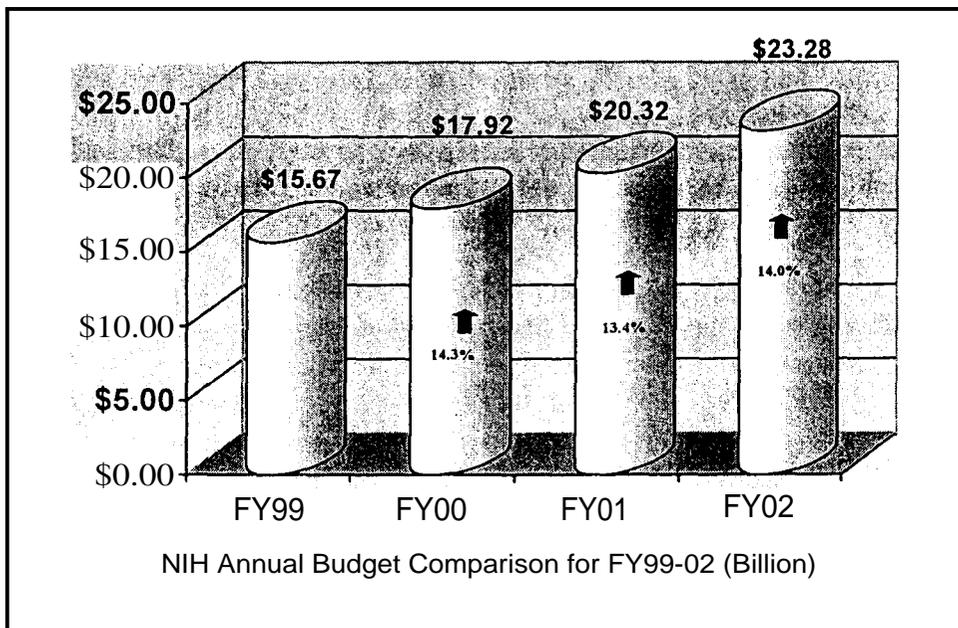
The Research Facilities Program focuses on ensuring that the scientists we support have suitable facilities in which to conduct their work. NIH recognizes that ensuring broad access to these technologies creates efficiencies that make the research dollar go farther. Appropriate research technologies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

OR ⁴¹ -A

The Core Programs are aggregates of the many specific programs and activities underway across 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
\$23.28 billion appropriated for FY 2002 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 Prevention and Control • Construction • Library of Medicine • Office of the Director • Buildings and Facilities 	Research	Research
			Communication of Results
			<u>Technology</u> Transfer
			Grants Administration and Peer Review
			Agency Management and Administrative <u>Support</u>
		Research Training and Career <u>Development</u>	Training Support and Outreach
			Research Facilities
		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 Research Program concentrates these topics into five functional areas: Research, Communication of Results, Technology Transfer, Grants Administration and Peer Review, and Agency Management and Administrative Support. (Table 2)

Research Program	
Major Functional Areas	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.
	Communication of Results - Communicate scientific results and health information to the medical research community, health care providers, patients, and the general public.
	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.
	Grants Administration and Peer Review - maintain effective and efficient grants administration and a high quality of peer review to ensure the most meritorious research projects are considered for funding.
	Agency Management and Administrative Support - ensure that management and administrative functions necessary to support the NIH mission are carried out effectively and efficiently.

Table 2. NIH Research Program

	FY99	FY00	FY01	FY02
\$25,000				
\$20,000	\$13,580	\$14,690	516,007	
\$15,000				19.0%
\$10,000		9.2%	9.0%	
\$5,000				
	FY99	FY00	FY01	FY02
NIH Research Program Actual Comparison for FY99-02 (Million)				

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. 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.

The NIH identifies goals and a budget strategy annually to maximize support for basic biomedical research and to better understand the biological and behavioral basis for disease to improve prevention and treatment of human disorders. In recent years, NIH has been able to report annually on advances that represent outstanding achievements in science. Achievements in research programs mean a continuing flow of high quality research, discoveries of new fundamental knowledge and advances in new therapies, diagnostics, prevention, and new research tools originating from extramural grantees and the intramural laboratories. They also mean timely dissemination of scientific results and research-based health information and expeditious transfer of the results of medical research for further development and commercialization of products of immediate benefit to improved health as an important mandate.

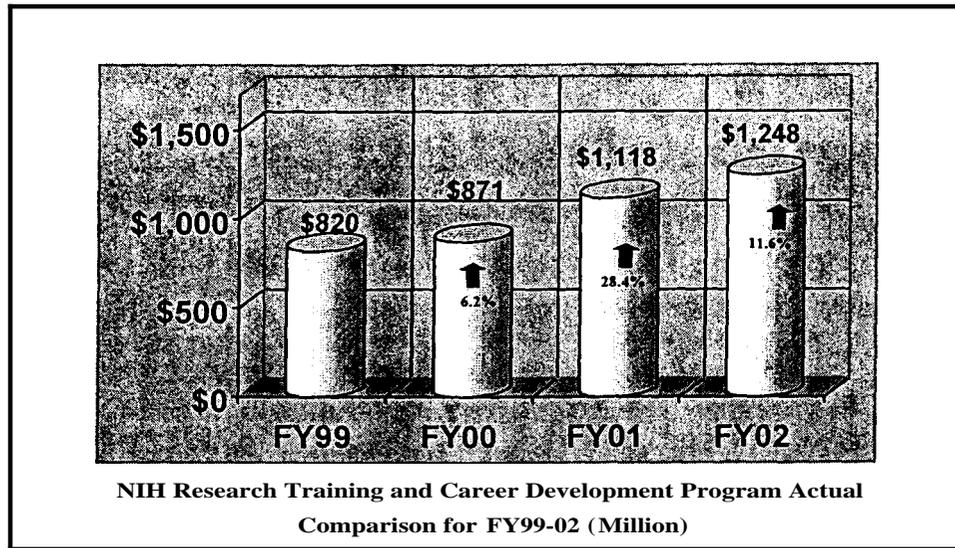
Scientific research probes and seeks to understand the scientific insights that provide a basis for solutions usually accumulate over many years, and often are derived from the efforts of diverse investigators working on and communicating about differing facets of the problem. Medical [discovery.is](#) marked by stops and starts and a vital interplay between theory, experimental evidence, and clinical observations. It is very hard - if not impossible - to predict what discoveries will arise or to anticipate the opportunities that such new knowledge will provide. Accordingly, NIH must support research along a broad, and of necessity, expanding front in order to achieve progress in key areas that reflect the agency's obligation to respond to public health needs, a commitment to support research of the highest scientific caliber, and judgment as to the scientific opportunities that offer the best prospects for new knowledge and better health.

Research Training and Career Development Program

The Research Training and Career Development Program addresses the NIH's 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)

Research Training and Career Development Program	
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 to encourage participants to pursue research careers and foster the recruitment and retention of underrepresented groups into careers as researchers.

Table 3. NIH Research Training and Career Development Program



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 health related 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.

Postdoctoral training - At the predoctoral level, students who are beginning graduate training need to learn the conceptual and theoretical aspects of the science they hope to practice. For individuals at this level, NIH supports broad, multidisciplinary training grants.

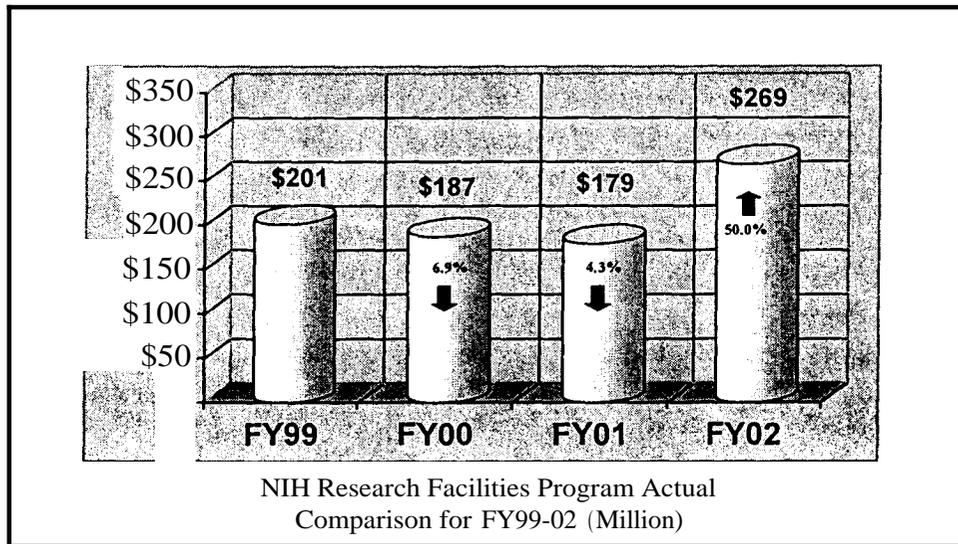
Postdoctoral training - At the postdoctoral level, NIH supports an extension and expansion of the apprenticeship approach. For individuals who continue their formal education in the biological or behavioral sciences, NIH offers training grants, fellowships, and research assistantships to fund this period of intense research activity. The primary focus at this level is on the acquisition of knowledge and skills necessary to launch an independent research career.

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: (1) Intramural Modernization and Improvements and (2) Extramural Assistance. (Table 4)

Research Facilities Program	
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 Research Facilities Program



Intramural Modernization and Improvements-NIH occupies federally owned facilities, which undergo refurbishment and expansion 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 other regional campuses and several off-campus field stations.

These include the following:

- o The NIH Animal Center in Poolesville, Maryland;
- o The Frederick Cancer Research and Development Center at Fort Detrick in Frederick, Maryland;
- o Leased and government owned facilities on the Bayview Campus, Baltimore, Maryland;
- o The Rocky Mountain Laboratory in Hamilton, Montana; and,
- o A laboratory in New Iberia, Louisiana.

NIH's Intramural Modernization and Improvements Program (IMIP) facilitates the development of annual facility planning, programming, budgeting and construction execution strategies, which include the energy reduction objectives of the National Energy Conservation Policy Act and Executive Order 13123, compliance with Executive Order 13148, Greening the Government Through Leadership in Environmental Management, as well as other facility management initiatives.

The IMIP is the product of a systematic process of interaction between the facility planning, programming, design, and construction components of NIH and the various ICs. Other program inputs include technologically-driven protocols and advancements; facility assessments and surveys; engineering studies; compliance with building, environmental and other regulatory requirements; accreditation guidelines of the Association of Assessment and Accreditation of Laboratory Animal Care International (AAALAC) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that identify the programmatic and operating requirements for the patient care and research environment; politically-driven research initiatives; physical security requirements; and recommendations of the approved NIH Facilities Master Plan.

Requirements of the Buildings and Facilities (B&F) program are reviewed and prioritized by a Facilities Planning Advisory Committee (FPAC), which includes senior executives from a cross-section of NIH. The committee's effort culminates in the development of NIH's Strategic Facilities Plan, which helps shape NIH's Buildings and Space Plan, the Agency Capital Plan, the Federal Capital Improvements Program, and a Six-Year Facility Budgeting Plan.

The B&F program encompasses six broad program areas that are linked to existing or emerging intramural research needs, regulatory or accreditation guidelines and standards, and/or the unique operating requirements, Federal mandates and government-wide security objectives, and age of the facilities in NIH's inventory. New facilities are programmed for construction or existing facilities are renovated or upgraded on a case-by-case basis, depending on the most viable option to support current and emerging research and technological advancements. The focus of the B&F program is to provide facilities that are in compliance with applicable physical security, safety, accreditation, and other regulatory requirements; efficient in terms of indoor

The <i>B&F</i> Program	
D	Safety & regulatory compliance
D	New construction
	Renovations
	Equipment & systems
D	Repair & improvements
D	Physical Security Improvements

and outdoor environment and energy consumption; and effective in meeting the needs of intramural researchers.

Extramural Assistance-Biomedical research facilities are a critical component of the nation's science and engineering research infrastructure. The availability and condition of biomedical research space directly affects the scope and quality of the biomedical research conducted at the nation's colleges, universities, medical schools, hospitals, and other research organizations. Providing extramural assistance to institutions for the purpose of improving their research capabilities is integral to the success of the NIH extramural research program in achieving its research goals and the national health goals established by DHHS. 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. 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. 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.

Summary of FY 2001 and FY 2002 Performance Goals

This part of the Management Discussion and Analysis describes several of NIH's performance goals and targets for FY 2001 and FY 2002, and their respective outcomes as of September 30, 2002. 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, as follows:

- u Research Program
 - Research
 - Communication of Results
 - Technology Transfer
 - Grants Administration and Peer Review
 - Agency Management and Administrative Support
- o Research Training and Career Development Program
 - Training Support and Outreach
- o Research Facilities Program
 - Intramural Modernization and Improvement
 - ² Extramural Assistance

Research Program

Research

FY 2001 and FY 2002 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	FY 2001 Accomplishments
<p><i>Human Genome Project:</i></p>	
1. Worldwide effort completes "full shotgun" of human genome sequence (95% complete, 99.9% accurate).	1. The Human Genome Project public consortium succeeded in meeting its target to complete a "full shotgun" of the human genome sequence.
2. Finish one-third of human genome (accuracy of at least 99.99%).	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. Identify 2,500,000 human single nucleotide polymorphisms (SNPs).	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. Complete 2X depth of coverage toward the working draft of the mouse genome (90% coverage, 99% accurate).	4. 3X depth of coverage of the mouse DNA sequence has been achieved.
5. Complete 1 X depth of coverage toward the working draft of the rat genome (90% coverage, 99% accurate).	5. The Rat Sequencing Consortium has completed nearly 2X coverage of the rat genome in whole genome sequence reads.
<p><i>Genomes of Pathogenic Microbes:</i></p>	
6. Complete sequencing of five additional bacterial pathogens and five chromosomes of protozoan parasites.	<p>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. [Update: Performance on the sequencing of the five chromosomes of protozoan parasites advanced in FY 2002 with publication of the sequences for two more <i>P. falciparum</i> chromosomes. Sequencing of four other parasite chromosomes of protozoan parasites (<i>Giardia lamblia</i>, <i>Leishmania major</i>, <i>Trypanosoma brucei</i>, and <i>Trypanosoma cruzi</i>) is ongoing, and is expected to be completed in FY 2004.]</p>

FY 2001 Targets

7. Augment existing knowledge of pathogen genomes by initiating sequencing projects for at least six additional genomes

Complete worldwide sequencing effort of the entire genome of *Plasmodium falciparum*.

FY 2001 Accomplishments

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. [Update: The complete genome sequence of *P. falciparum* was published in October 2002.]

FY 2002 Targets***Human Genome Project:***

1. Finish two-thirds of the human genome (accuracy of at least 99.99%). NIH grantees will be responsible for half of this target, i.e., one-third of the human genome.
2. Obtain full-length clones and sequence data for 20,000 mammalian cDNAs.

FY 2002 Accomplishments

Human Genome Project.

1. By the end of FY 2002, The International Human Genome Sequencing Consortium surpassed this goal, by finishing over 88% of the human genome. NIH grantees have completed roughly half of this amount, i.e., over 42% of the human genome (considerably more than their goal of 33%). The essentially complete sequence of the human genome is expected to be achieved in FY 2003.
2. The goal of the Mammalian Gene Collection project is to provide a complete set of full-length (open reading frame) sequences and cDNA clones of expressed genes for human and mouse. The goal for FY 2002 was exceeded, with the centers participating in the project sequencing 23,000 clones. Over a two-year period, and accounting for redundancy, a total of 19,600 unique sequences with complete open reading frames have been submitted to public databases. A manuscript outlining the progress of the project has been submitted for publication.

FY 2002 Targets

3. Complete full shotgun coverage of the sequence of the mouse genome; finish 10% of the mouse genome.
4. Complete 3X sequence coverage of the rat genome.
5. Initiate pathogen genome sequencing projects for additional NIH priority areas based upon Blue Ribbon Panel Report
6. Establish a mechanism to facilitate access to resources, services, and technologies (bioinformatics, scanning, microarrays, genome chips) needed to investigate microbial gene function

FY 2002 Accomplishments

3. By the end of FY 2002, 10.9% of the mouse genome was finished. The mouse genome-sequencing project completed the whole genome shotgun phase of the project and achieved approximately 7X shotgun coverage, containing 96% of the mouse genome in an assembled sequence. The Mouse Genome Sequencing Consortium is about to publish a landmark paper that describes the first analysis of this data.
4. By the end of FY 2002, the rat genome sequencing project generated approximately 5.5X coverage through adding random whole genome shotgun reads to light shotgun coverage of a set of genomic clones.
5. In FY 2002, NIH initiated several pathogen-sequencing projects based on priorities articulated by Blue Ribbon Panels. NIH initiated sequencing of the genomes of the microbial pathogens *Trichomonas vaginalis* and *Bacillus anthracis*. The sequencing of *B. anthracis* is part of a larger comprehensive genome analysis. In addition NIH initiated the sequencing of a portion of the genome of *Aedes aegypti*, an invertebrate vector.
6. NIH met this target early when, at the end of FY 2001, a contract for a Pathogen Functional Genomics Research Center (PFGRC) was awarded to the Institute for Genomic Research to develop, provide and distribute to the broader research community a wide range of genomic and related resources and technologies for the functional analysis of microbial pathogens and invertebrate vectors of infectious diseases.
In FY 2002, NIH continued to facilitate access. For example, the National Institute of Allergy and Infectious Diseases, a component of NIH, issued a program announcement, to facilitate the application of innovative/emerging technologies (frequently genomic technologies) to currently funded NIAID research projects related to the study of infectious diseases,

FY 2002 Targets

7. Develop technologies that assess, display, and query human genome sequence data to facilitate investigation of how the immune system responds during different disease **conditions** (i.e., **infection**, transplantation, autoimmune disease, and other diseases).

FY 2002 Accomplishments

- diseases caused by category A agents of bio-terrorism, HIV/AIDS, basic immunology, and immune-mediated conditions. That same fiscal year, NIH funded 28 of 84 grant applications in response to the program announcement (PAS-02-160).
7. The Pathogen Functional Genomics Research Center (PFGRC) noted in the performance summary for Target #6 has several **functions**. Among them is development of emerging genomic technologies.

Communication of Results

<p>FY 2001 Goal. Establish a Clinical Trials Database, as required by the FDA Modernization Act.</p>	<p>Clinical Trials.gov</p>	
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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 received about 2 million hits per month and hosted approximately 5,300 visitors daily in FY 2001.
2. NIH completed the study in March 2001.
3. The number of industry sponsored clinical trials was increased by 109 in FY 2001. The number sponsored by Federal agencies tripled from 104 in FY 2000 to 383 in FY 2001. [Update: NIH worked closely with the FDA to develop guidance for companies to submit their clinical trial information to ClinicalTrials.gov and that guidance was issued in March 2002. By the close of FY 2002, the number of industry-sponsored clinical trials stood at over 1,200.

FY 2002 Goal (new for FY 2002): Increase awareness of NIH-sponsored research results among the general public. (Newly included in MD&A, but was in the GPRA Plan since FY 1999.)

FY 2002 Targets	FY 2002 Accomplishments
<p>1. Introduce an easily navigable site on the World Wide Web that can increase older adults' awareness of health information and, based on the National Institute on Aging-supported cognitive research findings, enhance the online learning experience for people age 60 and over.</p>	<p>1. "NIH Senior Health" is a web site that presents aging-related health information in a senior-friendly format. Developed by the National Institute on Aging (NIA) and the National Library of Medicine (NLM), the web site is based on NIA's cognitive aging research and has been tested with groups of older adults to ensure that they can easily use it. The site went up for beta testing on March 19, 2002. NLM is developing new technology to facilitate the expansion of the site before its launch, <u>scheduled for FY 2003.</u></p>
<p>2. Perform a process evaluation of the effectiveness of pap test information materials produced in FY 2001.</p>	<p>2. The National Cancer Institute (NCI) conducted a process evaluation of new and revised Pap test-related publications that are designed to raise awareness about the need for Pap tests, particularly among older women, and to increase awareness of the change in Medicare coverage from every 3 years to every 2 years. The evaluation included telephone surveys of health and tracking activities to measure use of the materials in print and online publications as well as targeted web sites. A formal final report summarizing the lessons learned regarding materials dissemination and usage was issued (Cervical Cancer Evaluation Support: Final Report - Process Evaluation of Health Professional Pap Test Packet, Press Release, and PSA; March 2002).</p>
<p>3. Develop campaign materials about the importance of calcium from milk and other sources for strong bones.</p>	<p>3. The NICHD website "Milk Matters," http://www.nichd.nih.gov/milk/, includes a page that allows visitors to view and order calcium education materials. Many of the materials can be downloaded and bulk quantities of the materials can be ordered from the NICHD Information Resource Center. In addition, NICHD partnered with the Powerful Bones Powerful Girls campaign to distribute calendars, stickers,</p>

FY 2002 Targets	FY 2002 Accomplishments
<p>4. Implement a stroke awareness campaign.</p>	<p>and other campaign materials concerning the role of calcium in building strong bones. _</p> <p>4. In May 2001, the National Institute of Neurological Disorders and Stroke (NINDS) launched the campaign, "Know Stroke. Know the Signs. Act in Time." This campaign includes community education materials, public service messages, and media outreach to educate those at risk for stroke, and those around them, to recognize the signs of stroke and call 911 immediately. Through a variety of voluntary organizations and Federal partners, NINDS has distributed hundreds of thousands of brochures and posters and more than 1,000 community education kits that are being used in education sessions at hospitals, senior centers, and other places that serve those at the highest risk for stroke. _</p>
<p>5. Increase awareness among university presidents, program planners, and policy makers about college drinking and related problems. [FY 2001 target that was not met until FY 2002]</p>	<p>5. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) Task Force on College Drinking released several publications on the effectiveness of current alcohol prevention strategies and recommendations on future research to improve college drinking prevention programs, including a report titled, "A Call to Action: Changing the Culture of Drinking at U.S. Colleges"; 24 commissioned papers; as well as brochures targeting specific audiences. The report and accompanying materials have been sent to all college and university presidents in the United States. Follow-up activities have included a series of workshops for college presidents, alcohol prevention staff, and local government officials. In addition, Senator Jack Reed (D-RI) hosted a Congressional breakfast on September 19, 2002, to share the report's findings with his colleagues.</p>

FY 2002 Targets

6. Increase awareness among young people of the importance of calcium in their diet. [FY 2001 target that was not met until FY 2002]

FY 2002 Accomplishments

6. The National Institute of Child Health and Human Development (NICHD) developed and promoted a new "Milk Matters" website with information about calcium and strong bones for children and their parents, <<http://www.nichd.nih.gov/milk/>>. The Website, launched early in FY 2002, has received considerable media coverage including a brief article in the Boston Globe. Later in FY 2002, NICHD also developed the Website in Spanish.

Technology Transfer

FY 2001 and FY 2002 Goal: Increase the number of scientists who have received training in technology transfer.

<u>FY 2001 Targets</u>	<u>FY 2001 Accomplishments</u>
1. Seek to have 15% of scientists complete the training module, and/or attend technology transfer seminars.	1. Approximately 2,450 of the 4,000 NIH scientists (63%) attended the training seminars. As a result, NIH surpassed its training targets for FY 2001, FY 2002, and FY 2003.

<p><u>FY 2002 Targets</u></p> <ol style="list-style-type: none"> 1. 200 scientists complete the web-based training module. 	<p><u>FY 2002 Accomplishments</u></p> <p>During FY 2002, over 1,000 scientists were trained using the NIH On-Line. Technology Transfer Training module. Specifically, 1231 scientists completed the web-based module, and the module was incorporated as a standard requirement for all new scientists at NIH. As a result, NIH surpassed its training targets for both FY 2002 and FY 2003. Furthermore, NIH also met the FY 2004 target of making completion of the NIH On-Line Technology Transfer Training an ongoing requirement for employees. With completion of all targets, this goal has been met and will be dropped from future GPRA plans.</p>
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Research Leadership and Administration

Grants Administration and Peer Review
FY 2001 and FY 2002 Goal: Improve electronic Research Administration (eRA) technology by developing capability for end-to-end electronic research administration by FY 2004.

FY 2001 <u>Tar'g'ets</u>	FY 2001 <u>Accom lishments</u>
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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. [Update: Pilot testing of the beta version of the e-SNAP module was completed. Recommendations from the pilot are being incorporated into the release of the new version of e-SNAP. NIH expects the electronic progress reporting system to open to the 65 FDP institutions in early 2003.] 2. When NIH reported on this target at the end of FY 2001, it expected pilot testing for the basic functionality involved in reporting complex mechanisms to I begin in FY 2002. All business process reengineering for the new system had been completed. The technological infrastructure necessary for development of the system in the new technological environment had been put in place. [Update: Electronic research administration projects have been reprioritized to align the NIH focus more closely with the Federal e-Grant emphasis on the competitive application process. This redirection necessitated a reallocation of resources. Accordingly, development of a system to accommodate progress reporting for multi-project mechanisms has been postponed until 2005.]

FY 2002 <u>Targets</u>	FY 2002 <u>Accomplishments</u>
1. Release NIH Commons modules in the <u>new architecture</u> .	1. NIH Commons modules were deployed in <u>the new architecture in August 2002</u> .
2. Scan all incoming competing R01 applications in preparation for pilot testing <u>receipt of R01 applications</u> in 2003.	2. All incoming applications are being scanned and made available electronically to NIH staff, as of January 2002.

Grants Administration and Peer Review
FY 2002 Goal (new for FY 2002): Ensure that the NIH peer review process keeps pace with current advances in research and that the expertise of peer reviewers is appropriate for the needs of modern science.

FY 2002 Targets-

1. Increase number of Steering Committees and Study Section Boundary (SSB) Teams to 10.
2. Complete the formation of all external Integrated Review Group (IRG) Advisory Groups.

FY 2002 Accomplishments

1. NIH exceeded the target by increasing the number of Steering Committees and their respective SSB Teams to 12.
2. Enhancements of study section operations were completed ahead of schedule, with the last 5 IRG Advisory Groups being formed in FY 2002. Reports from all 19 Advisory Groups, which are working groups of the CSR Advisory Committee, were developed and a summary was presented to the CSR Advisory Committee in January 2002.

Management and Administration
FY 2001 and FY 2002 Goal: Expand the use of Performance Based Contracting (PBC).

FY 2001 <u>Targets</u>	FY 2001 <u>Accomplishments</u>
1. Allocate \$21.2 million of the available NIH contracting dollars to PBC-eligible contracts.	1. The NIH allocated \$36.5 million of its available contracting dollars to PBC-eligible contracts during FY 2001.

FY 2002 Targets

1. Allocate \$207.0 million of the available NIH contracting dollars to PBC-eligible contracts.

FY 2002 Accomplishments

In FY 2002, NIH contracting offices obligated approximately \$418 million toward performance-based contracts, an amount more than twice the FY 2002 target. The size of the increase reflects a major shift in the way NIH writes contracts and a commitment to the Administration's PBC goals.

Management and Administration
 FY 2001 and FY 2002 Goal: Improve the efficiency of the simplified acquisition process by continuing to expand the Purchase Card Program.

<u>FY 2001 Targets</u>	<u>FY 2001 Accomplishments</u>
1. \$200 million in orders	1. The dollar volume of purchase orders was \$196 million in FY 2001.
<u>FY 2002 Targets</u>	<u>FY 2002 Accomplishments</u>
1. \$210 million in orders	1. The dollar volume of purchase card orders achieved in FY 2002 was \$225 million, which exceeds the targeted amount by \$15 million.
2. 365,000 orders/transactions	2. The number of purchase card orders/transactions for FY 2002, was 385,000, which exceeds the targeted amount by 20,000.

Research Training and Career Development Program

Training Support

FY 2001 and FY 2002 Goal. Increase the pool of clinical researchers trained to conduct patient-oriented research.

<u>FY 2001 Targets</u>	<u>FY 2001 Accomplishments</u>
1. Issue at least 80 awards each in the K23 and K24 categories over the course of the fiscal year.	1. The NIH made a total of 184 new K23 awards and 58 K24 awards in FY 2001.
<u>FY 2002 Targets</u>	<u>FY 2002 Accomplishments</u>
1. Issue at least 120 awards in the K23 category,	1. In FY 2002, NIH significantly exceeded the target by issuing 197 new K23s (Mentored Patient-Oriented Research Career Development Awards) to support young investigators.
2. Maintain a steady state level of awards in the K24 category.	2. In FY 2002, NIH issued 48 K24s (Midcareer Investigator Award in Patient-Oriented Research Awards), somewhat fewer than the expected steady-state. The K24 results suggest that the pool of mid-career patient-oriented

FY 20,02 <u>Targets</u>	FY 2002 <u>Accomplishments</u>
	research mentors may be reaching saturation. However, NIH still expects the K24 mechanism to continue to facilitate increases the number of productive scientists working in this important area.

Research Facilities Program

Intramural Modernization and Maintenance

FY 2001 and FY 2002 Goal: Complete the Mark O. Hatfield Clinical Research Center.

FY 2001 <u>Targets</u>	FY 20,01 <u>Accomplishments</u>
1. Complete the superstructure and exterior wall system. [FY 2000 target not met until FY 2001) 2. Complete 50% of construction.	1. During FY 2000, the construction project progressed on schedule until NIH encountered unforeseen conditions during placement of the utility distribution systems on the site. As a result, NIH completed only 65% of the superstructure by the end of FY 2000. Because construction of the exterior wall system depends on completion of the superstructure, its construction was delayed. [Update: The target was met in December 2001.] 2. Construction of the Mark O. Hatfield Clinical Research Center reached the 50% phase as scheduled in FY 2001.

FY 2002 <u>Targets</u>	FY 2002 <u>Accomplishments</u>
1. Complete 75% of construction.	1. NIH completed 75% of the construction for the Mark O. Hatfield CRC project, as scheduled, in FY 2002.

FY 2001 Goal: Complete the Louis Stokes Laboratories Building.

<u>FY 2001 Targets</u>	<u>FY 2001 Accomplishments</u>
1. Complete construction.	1. Construction of the Louis Stokes Laboratories Building was completed in FY 2001.

OTHER ACCOMPANYING INFORMATION

Operations and Broad Strategy

Sustained and diligent Federal stewardship is the touchstone for the planning and management activities carried out by each IC as they implement the core programs that embody the NIH mission. The fundamental principles that underpin this stewardship, and thus guide the utilization of resources for program purposes, are described below. These principles ensure the relevance, quality, and performance of NIH programs.

- o Provide scientific leadership and establish research priorities.* Establishing research priorities is essential to ensure that science meets national public health needs and efficiently uses limited resources. In general, NIH sponsors research that addresses burden of illness - ways to prevent, treat, or cure disease and to minimize pain and suffering. But addressing burden alone is not enough; there must also be some real opportunity for success.

NIH Operating Principles

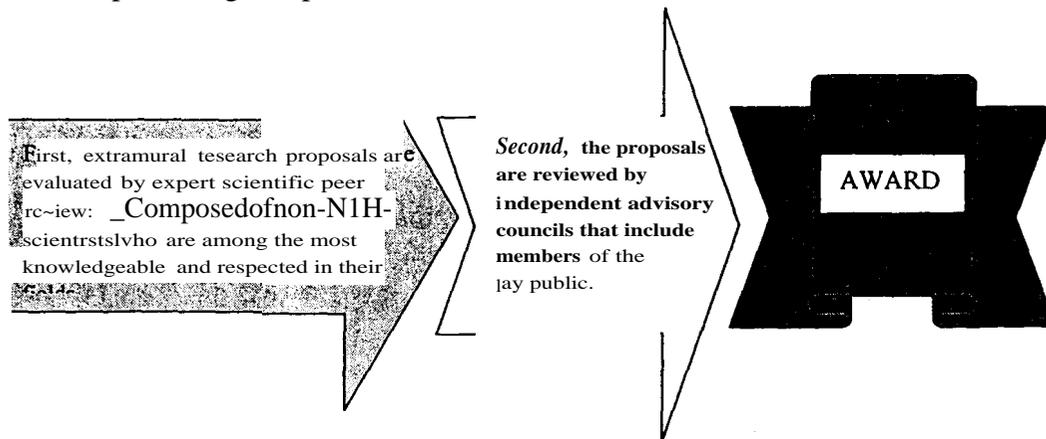
- D ***Provide scientific leadership and establish research priorities.***
- D ***Fund the best research.***
- D ***Conduct leading-edge research in NIH laboratories.***
- D ***Collaborate and coordinate with others.***

How do we identify areas of increased scientific opportunity? New knowledge comes from the pursuit of answers to gaps in knowledge. 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. 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 NIH capitalizes on such areas of scientific opportunity.

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 Administration, including the Department of Health and Human Services (DHHS), Congress, and the public. The NIH considers the research priorities identified through this process and makes resource allocation decisions that are intended to ensure that NIH commits federal resources to projects and programs that are relevant and are most [likely to](#) achieve the greatest yield from the nation's medical research investment.

In short, understanding burden of illness, identifying knowledge gaps, and deciding how to best capitalize on scientific opportunities are the primary drivers in the allocation of resources.

- o *Fund the best research.* NIH funds are awarded through a highly competitive process to the most promising and productive scientists.



This two-tiered independent review system is critical to ensuring that the best proposals are funded from the more than 40,000 research and training applications NIH receives each year.

- o *Conduct leading-edge research in NIH laboratories.* NIH also ensures that the research conducted in its own (intramural) laboratories is of the highest caliber. 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 NIH to respond rapidly to critical health problems and emergencies and to take advantage of emerging opportunities.
- o *Collaborate and coordinate with others.* 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 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 NIH's collaborative activities, both in the past and those contemplated for the future, is far wider. NIH partners include many other federal agencies, government bodies, non-governmental organizations, and industry.

President's Management AAzenda

Competitive Sourcing

In its President Management Agenda, Government Wide Initiatives, Competitive Sourcing section, the President stated that "Government should be market-based-we should not be afraid of competition, innovation, and choice. I will open government to the discipline of competition."

The NIH continues to strive and comply with the spirit of the PMA in the area of competitive sourcing. The NIH met its FY 2002 competition requirement of 5 percent, which represents 466 FTEs. For FY 2003 and FY 2004, the goal is to study 10 percent of the commercial competitive positions at NIH each year. The NIH's 10 percent goal for FY 2003 and FY 2004 represents 930 FTEs each year.

Communication has begun with all NIH employees to raise their awareness with this activity. This includes memorandums, all hands meetings, and union notification. Competitive sourcing co-chair teams have been formed for each functional area and data collection is underway. The functions affected by the FY 2003 and FY 2004 competitive sourcing effort are listed below.

- o Personnel management - employee development, EEO staff, benefits reviews, personnel administrative support, and negotiated dispute resolution;
- o Finance and accounting - administrative clerical support, voucher examining and customer billing;
- o Grants management - administrative and clerical support, grants technical review activities, receipt, processing and distribution functions, and grants close out functions;
- o Facilities and installation services, and,
- o IT and information services - information technology management; ADP equipment maintenance; system design development and programming services; client services management.

A transition plan has been developed to describe the impact of competitive sourcing and administrative restructuring programs and help address the needs of employees affected by those restructuring efforts.

Improved Financial Performance

In its President Management Agenda, Government Wide Initiatives, Improved Financial Performance section, the President stated that "Without accountability, how can we ever expect results? Under my Administration, we will bring this cycle of failure to an abrupt end. As President, I will hold all affected agencies accountable for passing their audits not later than 2002. I will say to those I put in place, get your audits right."

The NIH continues to strive and comply with the spirit of the PMA in the area of Improved Financial Performance. In the past three years NIH obtained an unqualified opinion on the annual financial statements, and we are currently at the final stage of the FY 2002 audit.

The NIH implemented processes to ensure that we produce accurate and timely information to support operating, budget, and policy decisions. We continue to improve the timeliness and accuracy of our financial reporting by:

- o re-engineering reporting processes and expanding use of web-based technologies;
- o improving reconciliation and analysis of various accounts;
- o instituting quarterly financial statements;
- o instituting an accelerating quarterly and year-end reporting;
- o implementing a corrective action plan to ensure the resolution of audit findings; and,
- o measuring systems compliance with agencies' ability to meet OMB and Treasury requirements accurately and timely.

In addition, the NIH is currently developing a new business system that will replace legacy systems and will produce information that is:

- o timely, to measure and effect performance immediately;
- o useful, to make more informed operational and investing decisions; and,
- o reliable, to ensure consistent and comparable trend analysis over time and to facilitate better performance measurement and decision making.

Budget and Performance Integration

In its President Management Agenda (PMA), Government Wide Initiatives, Budget and Performance Integration section, the President stated that "Government should be results-oriented - guided not by process but guided by performance. There comes a time when every program must be judged either a success or a failure. Where we find success, we should repeat it, share it, and make it the standard. And where we find failure, we must call it by its name. Government action that fails in its purpose must be reformed or ended."

The NIH continues to strive and comply with the spirit of the PMA in the area of Budget and Performance Integration. The NIH continues to provide a greater focus on performance and integrate performance review with budget decisions. For purposes of planning and performance assessment under GPRA, NIH organizes its activities into three core programs that correspond with the agency's objectives, which are outlined in the section NIH Mission and Objectives:

- o The *Research Program*, which corresponds with the first two objectives, encompasses the support of investigations across the full range of the medical research continuum, including basic research, which may be disease-oriented; observational and population-based research; behavioral research; health services research; and clinical research.

- o The *Research Training and Career Development Program*, which corresponds with the third objective, addresses the need for creative and capable personnel to conduct medical research.
- o The *Research Facilities Program*, which corresponds with the fourth objective, focuses on ensuring that NIH-supported scientists have adequate facilities in which to conduct their work.

This allows the NIH to achieve the following expected long-term results, as outlined in the PMA:

- o Better performance, based on an assessment of the expected outcomes relative to what is actually being achieved;
- o Better control over resources used and accountability for results by program managers;
- o Better service as a result of more competition based on full costing of resources used by working capital funds and other support service providers, and a simpler competitive process consistent with the President's competitive sourcing initiative;
- o Standard, integrated budgeting, performance, and accounting information systems at the program level that would provide timely feedback for management. This would facilitate the goals of the President's initiative to improve financial performance; and,
- o Integration of existing segregated and burdensome paperwork requirements for measuring the government's performance and competitive practices with budget reporting.

Compliance with_ the Federal Managers' Financial Integrity Act of 1982

The NIH is committed to ensuring effective management controls and clearly demonstrating and documenting them in our extramural, intramural, and administrative program areas. During FY 2002, the NIH continued to successfully integrate management controls into programs and administrative areas. This approach consists of Management Control Reviews, Alternative Management Control Reviews, General Accounting Office Reviews, Office of Inspector General Audits, Corrective Action Plans, and Program Evaluations conducted by both internal and external groups.

The NIH financial systems, taken as a whole, satisfy most, but not all, of the policies and standards prescribed for executive agencies to follow in developing, operating, evaluating, and reporting on financial management systems as defined in OMB Circular A-127, Financial Management Systems and OMB's Implementation Guidance for the Federal Financial Management Improvement Act of 1996.

Results of Operations

The NIH appropriation increased by approximately 14.6 percent in FY 2002, keeping NIH on the road to a doubled budget over the five-year period from FY 1998 to FY 2003.

The net cost of NIH operations for FY 2002 was \$20,575 million. Of this amount, \$19,058 million funded the Research Program, \$1,248 million funded the Research Training and Career Development Program, and \$269 million funded the Facilities Program.

Considering this data from the perspective of percentage increase, the Research Program increased 19.0 percent over FY 2001, the Research Training and Career Development Program increased by 11.6 percent, and the Facilities Program increased by 50.0 percent.

To further illustrate the three major programs that the NIH supported during FY 2002, the NIH funded 36,617 research project grants, 1,150 research centers, 2,191 other research grants (excluding research career awards), 1,324 research and development contracts, 3,654 research career awards, and 16,624 full-time training positions. In addition, the NIH employs staffs who conduct 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 2000, 2001, and 2002:

<i>ITEM</i>	<i>FY 2000 Actual</i>	<i>FY 2001 Actual</i>	<i>FY 2002 Actual -</i>
<u>Research</u>			
Research Project Grants	32,184	34,122	36,617
Research Centers	951	1,032	1,150
Other Research	1,739	1,890	2,191
R&D Contract	1,219	1,313	1,324
<u>Research Training and Career Development</u>			
Research Career Awards	2,898	3,234	3,654
Full-,Time Training Positions	15,830	16,486	16,624

By far the largest NIH asset is its fund balance with the U.S. Treasury. This balance of \$22,455 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, 2002.

The NIH provides research goods and services on a reimbursable basis to other Federal government agencies. As of September 30, 2002, the amount due NIH from these agencies was approximately \$52 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 \$1,378 million.

As of September 30, 2002, the PMS had advanced to grantees almost \$1,083 million more than we had advanced to PMS; thus we have an accrued grant liability of \$1,083 million.

Partnerships and Coordination

NIH collaborates with numerous organizations to pursue its longer-term objectives. Such partnerships include competitively funded grants to the universities, medical schools, and other research entities that comprise the extramural research community. Furthermore, NIH Institutes and Centers (ICs) collaborate regularly with one another, as well as with other DHHS

agencies, other Federal agencies and departments, private industry, international organizations, foundations, non-governmental organizations, and states.

The reasons for such collaboration are many. Where research and related interests intersect, joint efforts can enhance individual activities. Research benefits from the multiple perspectives and diverse expertise that can be brought to bear on a particular problem. Coordination works to produce the best possible science while making more economical use of the resources available. Importantly, collaboration can facilitate more rapid response to emerging opportunities. In addition, partnerships can greatly enhance the effective diffusion and dissemination of research-based health information.

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). Partnerships with other agencies have included the Department of Energy (DOE) and the National Aeronautics & Space Administration (NASA).

A small sampling of NIH's diverse research collaborations in recent years with other federal agencies is as follows:

- o ***Early Learning and School Readiness:*** The National Institute of Child Health and Human Development (NICHD) leads an initiative on Early Learning and School Readiness. This program evaluates the effectiveness of different models of early childhood education that consider both cognitive and social development. The program also will develop and evaluate curricula for children at risk of failure to learn to read and do mathematics. The studies are supported by NICHD, the National Institute of Mental Health (NIMH), the Administration for Children and Families (ACF), the National Science Foundation (NSF), and the Department of Education.
- o ***Ecology of Infectious Diseases Program:*** This program, a collaboration between the Fogarty International Center, NIAID, National Institute of Environmental Health Sciences (NIEMS), National Institute of General Medical Sciences (NIGMS), NSF, U.S. Geological Survey (USGS), NASA, and USDA's Agricultural Research Service (ARS), will develop new models to forecast risks of newly emerging and reemerging infectious diseases. Through these innovative programs the agencies provide funding and scientific support for each other's awards and advance such trans-disciplinary activities that none could advance on their own.
- o ***Underage Drinking Prevention:*** To combat drinking by children aged 9 to 15; NIH's National Institute on Alcohol Abuse and Alcoholism (NIAAA) has launched Leadership to Keep Children Alcohol Free. The Leadership initiative is led by an alliance of 33 governor's spouses and five emeritus spouses with funding from NIAAA, the Robert Wood Johnson Foundation, the NIH Office of Research on Women's Health, the NIH Center on Minority Health and Health Disparities, the Office of Juvenile Justice and Delinquency Prevention, the National Highway Traffic Safety Administration, and SAMHSA. In addition, representatives

of more than 25 national organizations support the initiative through participation on an advisory executive working group.

Relationships with Private Industry

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

A small sampling of NIH's diverse research relationships with private industry is as follows:

- o ***Early-Phase Cancer Clinical Trials Partnership:*** In July 2002, NCI and five pharmaceutical manufacturers - Aventis, Bristol-Myers Squibb, Eli Lilly and Company, GlaxoSmithKline, and Novartis - launched a public/private partnership to increase the percentage of newly diagnosed cancer patients who participate in Phase I and II clinical trials. These earliest phases of clinical research, which are designed to test the safety and efficacy of drugs and to determine the best way to administer them, are necessary for researchers to discover potential new treatments that emerge from laboratories and hold promise for cancer patients. This collaboration on cancer trials will serve as a model to help accelerate the pace of clinical trials research in other diseases. The partners will provide approximately \$6 million to cancer centers to design and implement new approaches to increase patient participation in early-stage trials. Other organizations that have actively promoted and supported the partnership include Friends of Cancer Research, the Association of American Cancer Institutes, and the Foundation for the National Institutes of Health.
- o ***HIV Vaccine Candidates:*** The National Institute of Allergy and Infectious Diseases (NIAID) entered into an agreement with Merck & [Co. to](#) team up on human testing of promising candidate HIV vaccines developed by the company. The vaccines will be evaluated in collaboration with NIAID's international HIV Vaccine Trials Network (HVTN), a group of more than two-dozen clinical sites worldwide established to rapidly move promising experimental HIV vaccines through all stages of human testing. Merck will continue its ongoing HIV vaccine development program, which includes a number of independent trials that are underway or planned. Merck will also provide HVTN with certain proprietary scientific tools and methodologies that can be adopted for use in the evaluation of other competing vaccines.
- o ***Osteoarthritis Initiative:*** NIH is engaged in a public-private partnership to develop clinical research resources that support discovery and evaluation of biomarkers and surrogate endpoints for clinical trials on osteoarthritis. The National Institute of Arthritis and Musculoskeletal and Skin Disease (NIAMS) and the National Institute on Aging (NIA), along with the Office of Research on Women's Health (ORWH), the National Center on Minority Health and Health Disparities (NCMHD), the National Center for Complementary and Alternative Medicine (NCCAM), and the National Institute of Dental and Craniofacial Research (NIDCR) have partnered with other Federal agencies and four pharmaceutical companies to support this newly launched initiative.

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. In addition, since the September 2001 events, NIAID has markedly expanded, intensified and accelerated its efforts to support and conduct basic, applied, and clinical research to develop: (1) vaccines, drugs, biologics, and immunotherapies for prevention and treatment, and (2) resources for the scientific community and industry. Highlights of scientific and programmatic accomplishments:

Strategic Planning

- o Convened three Blue Ribbon Panels of experts to provide objective scientific advice on NIH's biodefense research agenda by assessing current research; identifying goals for the highest priority areas; and making recommendations to achieve the goals.
- o Developed and implemented the *NIH Biodefense Research Strategic Plan* to build and sustain a robust and long-term biomedical research program to develop countermeasures to neutralize bioterrorist threats.
- o Developed and implemented the *NIH Biodefense Research Agenda for CDC Category A Agents*.

Scientific Accomplishments

- o Successfully completed a 680-person study that demonstrated that the current Dryvax smallpox vaccine can be effectively diluted (1:5). The impact of this study has been to expand the existing stockpile of vaccine from 15 million to 75 million doses.
- o Demonstrated in animal model systems that the antiviral drug, Cidofovir, is active against smallpox.
- o Expanded genomic sequencing of agents of potential bioterrorism, including anthrax and plague and many others.

- o Supported comparative genomic studies of different anthrax strains and anthrax isolates from victims of the anthrax attack last autumn and provided data to investigators.
- o Continued studies of basic mechanisms of poxvirus replication, including research on the use of vaccinia virus as a vaccine or as a vector to deliver antigens of medical importance.
- o Initiated a partnership with industry to develop a new, safer smallpox vaccine.
- o Initiated efforts to develop an alternative to vaccinia immune globulin (VIG) through research on viral neutralization with monoclonal antibodies and also by exploring alternative approaches to obtain neutralizing monoclonal antibodies, for example in chimpanzees.
- o Determined how anthrax toxin gains entry into a cell and then demonstrated, in a laboratory, how anthrax toxin can be blocked from entry into the cell, suggesting that the development of compounds to block the anthrax toxin could be a viable treatment for anthrax disease.
- a Expanded basic and clinical intramural research efforts on agents of importance in biodefense, such as anthrax and vaccinia.
 - o Discovered a genetic basis for transmission of plague, *Yersinia pestis*, by infected fleas to humans. This discovery has the potential to lead to strategies that could improve the treatment, diagnostic and preventive countermeasures against plague.
 - o Developed Interagency Agreement with U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) to conduct testing, research and development of high-priority products, such as therapeutics and vaccines for anthrax, plague and viral hemorrhagic viruses.
 - o Developed a mouse model of plague to be used for evaluating a new recombinant vaccine, developed by USAMRIID, for its ability to protect mice against flea-borne transmission of *Y. pestis*.

Completed and Planned Vaccine Clinical Trials

- o Expanded clinical trials infrastructure to support an increased number of clinical trials, including immunogenicity and toxicity testing for anthrax vaccine and initial smallpox vaccine dilution studies.
- o Phase I vaccine studies that are project to begin before the end of CY 2002 include:
 - Anthrax recombinant Protective Antigen (rPA) vaccine (2^d-generation vaccine)
 - 3^d-generation smallpox vaccine
- o Additional Dryvax (1st generation) smallpox vaccine dilution studies:
 - Enrollment completed for pilot study to test safety and acceptability in individuals previously immunized with vaccinia.
 - Clinical protocols for Dryvax studies in children are under review by Human Subjects Review Committees and FDA. Enrollment will be initiated by the end of CY 2002.
 - Expanded study to obtain an accurate "take" rate to be concluded by the end of CY 2002 or early 2003.
- a Aventis smallpox vaccine "wetvax":

- Completed first study to validate safety and efficacy of undiluted vaccine.
 - Started enrollment of 330 participants for the second study to evaluate the "take" rate of the vaccine at several levels of dilution.
- o West Nile Virus:

NIH-supported research at Acambis, a private company, has led to the development of a vaccine candidate that shows encouraging results in preclinical tests in mice, monkeys, and horses. Researchers are testing the vaccine candidate in monkeys and hope to begin Phase I human trials in early 2003.

Intramural NIH scientists recently developed a second vaccine candidate for West Nile virus. This vaccine candidate has been tested in monkeys with promising results.

NIH Business System

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 and plays a vital role in facilitating the NIH mission of uncovering new knowledge that will lead to better health for everyone. 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:

- o 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. NIH uses these tools to categorize and prioritize vulnerabilities, provide recommended actions, and submit reports to managerial and operational personnel.
- o Intrusion detection software - This identifies specific attacks levied on NIH systems by monitoring network traffic 240 for intrusion signatures. As possible vulnerabilities are identified, they are immediately reported to the appropriate local official and appropriate corrective action is recommended for each incident.
- o Firewalls - NIH has developed firewall policies that filter out malicious traffic while retaining the electronic services necessary for the NIH community to conduct research and communicate. 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.
- o 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. NIH also blocks e-mail attachments of high-risk file types that have no known legitimate uses.

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

- o Administering NIH-wide IT security awareness training program that provides and develops specialized IC awareness training and support. In FY 02, NIH initiated development of a new web-based, interactive training that includes a tracking system. As part of a professionalism initiative, NIH has also encouraged IT security personnel to take specialized IT security training such as the CISSP certification and SANS Institute network security training courses and certifications.
- o Coordinating the development of System Security Plans and Risk Assessments. In FY 02, NIH developed an NIH Enterprise Security Plan, providing an overview of the security requirements of NIH and describes the controls in place or planned for meeting those requirements. NIH also initiated a revised Security Plan of NIHnet.
- o Developing security policies, guidelines and procedures that protect sensitive and critical information with a level of security that is commensurate with the risk and magnitude of the harm that could potentially result from the loss, misuse, disclosure, or modification of the information.
- o Coordinating incident prevention and response with the Federal Computer Incident Response Capability (FedCIRC), Forum of Incident Response and Security Teams (FIRST), Department of Energy's Computer Incident Advisory Capability (CIAC), Carnegie Mellon Computer Emergency Response Team (CERT), Federal Computer Security Managers Forum, other organizations.
- o 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.
- o Maintaining inventories of IT assets, including networking, telecommunications and biomedical equipment.

- o **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.
- o **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.
- o **Continuency 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:

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

- o NIH facilities (owned and leased) are managed and operated to support mission activities.

- o NIH facilities are for the sole use of NIH staff, contractors, visitors, patient and patient visitors, and affiliates.
- o 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.
- o 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.
- o 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.
- o 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, a 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 Security Operations Advisory Committee (SOAC). Chaired by the NIH Deputy Chief Security Officer, the SOAC 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:

- o *NIH Facility Survey and Risk Assessment* (Confidential).
- o *NIH Interim Security*.
- o *Operating Procedures at Each of Five GSA Levels*.
- o *NIH Security Response Summary*.
- o *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 SOAC 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 Deputy Chief 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:

- o 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.

- o All vehicles entering parking garages under buildings on the NIH campus also are inspected.
- o NIH police and uniformed contract inspectors are engaged in securing the perimeter.
 - a All NIH personnel must display a valid NIH ID card.
- o Entrance to NIH buildings is either via proximity cards 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. Additionally, NIH is currently in the process of implementing the DHHS "12 Points" strategy intended to further enhance security for the use of select agents. Completion of implementation is expected by the end of this calendar year.

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.

