PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO
277 East Town Street, Columbus, Ohio 43215

MEMORANDUM June 30, 2005

TO: Ohio Retirement Study Council
Ohio House Financial Institutions, Real Estate and Securities Committee
Ohio House Retirement and Pensions Subcommittee
Ohio Senate Health, Human Services and Aging Committee

FROM: Laurie Fiori Hacking, Executive Director

RE: Reporting requirements under ORC Section 145.22(E)

The following document fulfills the requirements of the Ohio Public Employees Retirement System as outlined in Ohio Revised Code Section 145.22, Section E. The section and the System's responses follow:

(E) The board shall have prepared annually a report giving a full accounting of the revenues and costs relating to the provision of benefits under sections 145.325 and 145.58 of the Revised Code. The report shall be made as of December 31, 1997 and the thirty-first day of December of each year thereafter. The report shall include the following:

(1) A description of the statutory authority for the benefits provided

Attachments A and B are copies of ORC Sec. 145.325 (Medicare benefits for members of Ohio Public Employees Retirement System), and ORC Sec. 145.58 (Group Hospitalization coverage; ineligible individuals; service credit; alternative use of HMO).

(2) A summary of benefits

Following is an outline of the current OPERS health care benefits:

The Health Care Preservation Plan

This memorandum reflects the OPERS plan as it was in 2004. As of January 1, 2007, changes will be made to the OPERS benefit structure. These changes are reflective of an overall strategy to preserve the solvency of the OPERS Health Plan for as far into the future as possible. While this has no material impact on the data herein, it is offered to present the reader with a more complete understanding.

The Health Care Preservation Plan identifies a roadmap for being able to offer meaningful health care benefits well into the future. Strategies include tying health care benefit levels to OPERS service credit, a cafeteria-style plan from which retirees will be able to make choices, and a health care spending account. The Preservation Plan is expected to be implemented beginning January 2007.

The 2004 OPERS Health Care Plan

The 2004 OPERS health plan utilized a Preferred Provider Organization (PPO). PPO networks are based on a partnership between doctors, hospitals, health plan administrators and benefit recipients. Doctors and medical facilities that belong to the PPO network agree to perform services at discounted rates. Because these providers of service provide a cost savings to OPERS, the 2004 plan design encouraged the use of these providers. While benefit recipients were able to choose any provider and still receive benefits, they received a higher level of reimbursement if they chose network providers of service. Once a recipient became eligible for Medicare, he or she was able to choose any provider of service, regardless of network status, without a decrease in benefits. The OPERS health plan is secondary to Medicare.

The 2004 OPERS health plan utilized the PPO networks of Aetna and Medical Mutual, the two administrators of the OPERS health plan.

In 2004, all states in the United States were in the OPERS PPO network. Benefit recipients living outside of the United States were able to choose any provider of services (regardless of Medicare status) without a decrease in benefits.

How 2004 Benefits Were Paid

For benefit recipients eligible for Medicare, those living outside of the United States and those using network providers of service, the following benefits were available in 2004 (subject to medical necessity and the reasonable and customary rate):

Most Medical Benefits	80%	
Certain Preventative Benefits	100%	No deductible
Inpatient Hospital Benefits	100%	

In 2004, the calendar year deductible was $150 per person and $300 for a family.

The maximum out-of-pocket amount (the amount after which the plan paid at 100% for the remainder of the calendar year) was $750 for an individual and $1500 for a family.

The lifetime maximum benefit was $2,500,000 per covered person.

Benefit recipients who lived in a network state and who were not eligible for Medicare received the following benefits if they did not use network providers of service (subject to medical necessity and the reasonable and customary rate):

Most Medical Benefits	60%	
Certain Preventative Benefits	100%	No deductible
Inpatient Hospital Benefits (For elective admissions)	70%	

A calendar year deductible of $200 per individual or $400 per family applied. The maximum out of pocket amount (after which the plan paid at 100% for the remainder of the calendar year) was $1500 for an individual and $3000 for a family. The lifetime maximum benefit was $2,500,000 regardless of network usage.

Alternate Health Care Coverage

Alternative health coverage was available to 2004 OPERS benefit recipients who resided in certain counties in Ohio (and a few border counties in Indiana, Kentucky and Michigan). HMO products included Kaiser Permanente, Paramount and United Health Care. HMO products offered hospital and medical services through participating physicians and facilities.

In general, coverage under an HMO program was more comprehensive than coverage provided by PPO plans. OPERS benefit recipients were responsible for the cost difference in HMO coverage if that cost was more than the cost of the OPERS health care plan.

AultCare was offered in 2004 as an alternative preferred provider organization. It was made available to qualifying benefit recipients who lived in Stark and surrounding counties in Ohio.

Prescription Drug Coverage

For 2004, prescription drug coverage was available for all benefit recipients eligible for OPERS health care and their covered dependents. When covered persons used retail pharmacies, they were able to receive a 34- day supply of medication. When benefit recipients chose the mail service plan, they were able to receive up to 90 days of medication at one time.

2004 co-payments were designed to encourage use of generic products, formulary products and the mail service. The following co-payments applied to a 34- day supply at retail:

$5.00	Generic Medication
$10.00	Single Source Brand (formulary drug)
$25.00	Single Source Brand (non-formulary drug)

When a brand was chosen even though a generic was available, the retiree paid the difference in cost up to $100, plus the generic co-pay.

The following co-payments applied to a 90-day supply at mail:

$10.00	Generic Medication
$20.00	Single Source Brand (formulary drug)
$50.00	Single Source Brand (non-formulary drug)

When a brand was chosen even though a generic was available, the retiree paid the difference in cost up to $100, plus the generic co-pay.

Medicare

The following requirements regarding Medicare were in place in 2004:

If an OPERS benefit recipient was eligible for Medicare Part A (hospital) at no cost OPERS required enrollment in Medicare coverage (if covered by OPERS health care). If Medicare Part A was not available to the benefit recipient without cost, OPERS provided comparable substitute coverage.

Benefit recipients who turned age 65 (and who are enrolled in OPERS health care) were required to enroll in Medicare Part B (medical).

When a benefit recipient or covered spouse reached the age of 65, OPERS requested a copy of the Medicare card. If the covered individual was not eligible for free Medicare A, OPERS requested a copy of his or her card showing part B coverage or a letter from Social Security, stating there would be a charge assessed for Medicare A.

Medicare Direct

Benefit recipients who were enrolled in Medicare B (medical) and who were enrolled in the OPERS health plan (not HMOs) were eligible to use Medicare Direct.

The Medicare Direct program was available in certain states and covered Medicare B charges only. The Medicare Direct program allowed the health care provider of services to mail a claim to the Medicare paying agency. The agency made a payment and forwarded the remainder of the bill (along with a Medicare explanation of benefits) to the OPERS health plan administrator.

Medicare Reimbursement

If our benefit recipient was enrolled in OPERS health care and was not being reimbursed for his or her Medicare B premium, he or she was eligible for OPERS reimbursement. In order to receive this reimbursement, the benefit recipient was required to send a copy of his or her Medicare card, showing enrollment in Part B. As long as the benefit recipient remained enrolled in part B coverage, the full reimbursement was added to the recipient's monthly retirement check.

Medicare Deduction

If a benefit recipient was required to pay the Medicare B premium to the Social Security Administration directly, he or she was able to ask OPERS to make a payment to Social Security, rather than having the amount added to his or her pension check.

The Dental Plan

During 2004, dental coverage was made available to all OPERS benefit recipients and their eligible dependents regardless of whether or not they were covered by the OPERS health plan. The dental plan was intended to help defray the costs of dental care, including oral examinations, diagnostic services, and extractions, as well as crowns, bridges, and dentures. If a recipient chose to be covered under the dental plan, a premium payment was deducted from each monthly benefit check. OPERS subsidized 25% of the benefit recipient's cost of dental coverage.

The Vision Plan

Vision coverage was offered to all OPERS benefit recipients and their eligible dependents regardless of whether or not they were covered by the OPERS health plan. The vision plan covered services provided by an ophthalmologist, optometrist, or optician for examinations, frames, and lenses. A premium payment was deducted from each monthly benefit check for those recipients who chose to participate. OPERS subsidized 25% of the benefit recipient's cost of vision coverage.

The Long Term Care Plan

The long term care plan was a program in which any OPERS benefit recipient, his or her spouse, adult children, parents and parents-in-law were able to apply for protection from the expense of long term care.

This plan was designed to cover those long-term care expenses not covered by the basic hospital/medical coverage (e.g. custodial care), including Medicare. Its intent was to provide daily cash benefits when the insured is no longer able to independently perform the activities of daily living.

(3) A summary of the eligibility requirements for the benefits

Following are the eligibility requirements for the OPERS health care plan. These requirements were in effect during 2004:

Age and Service Retirement

When applying for age and service retirement, a benefit recipient must have 10 years of Ohio service credit to qualify for the OPERS health care plan. These 10 years may not include out-of-state or military service purchased after January 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992.

Disability Retirement

If a person was receiving a disability benefit from OPERS, health care coverage was provided regardless of years of service credit.

Coverage for Surviving Spouses

If a member retired, chose a joint and survivor annuity plan of payment (Plan A, C or D) and died, the beneficiary was entitled to health care coverage if the deceased retiree was eligible.

If a member died before retirement, health care coverage was available to survivors receiving monthly benefits regardless of the member's years of service credit.

Eligible Dependents

Eligible dependents included the member's spouse; unmarried child(ren) under age 18, or under age 22 if attending school (on at least a two-thirds full time basis) and dependent on the benefit recipient's support. Also eligible were dependent children, regardless of age, who had physical or mental handicaps, were unable to earn their living, and who became incapacitated prior to age 18 (or 22 if attending school).

(4) A statement of the number of participants eligible for the benefits

As of December 31, 2004, there were 134,527 benefit recipients and 55,167 dependents covered under the OPERS health care plan. There were an additional 6,945 who receive a pension but do not have OPERS health care plan. Of this number, 6,001 did not have enough service credit to qualify. These persons do have the option of participating in the OPERS dental and vision plans.

(5) A description of the accounting, asset valuation, and funding method used to provide the benefits

OPERS utilizes an accrual basis of accounting under which expenses are recorded when the liability is incurred and revenues are recorded in the accounting period they are earned and become measurable. Under this method, OPERS estimates health care claims which have been incurred at year end, but which are not yet known to the Retirement System. Investment purchases and sales are recorded as of their trade date. Investment expenses are financed exclusively through investment income.

Plan investments are reported at fair value. Fair value is, "the amount that a plan can reasonable expect to receive for an investment in a current sale between a willing buyer and a willing seller that is, other than in a forced liquidation sale." All investments, with the exception of real estate and private equity, are valued based on closing market prices or broker quotes. The fair value of real estate and private equity investments is based on estimated current values and independent appraisals.

Employer contributions and investment earnings are used to fund health care expenses. Under this method, employer contributions equal to 4 percent of covered payroll were used to fund health care liabilities in 2003. Based upon our most recent actuarial projections, these contributions along with investment income on allocated assets and periodic adjustments in health care provisions are expected to be sufficient to sustain the program through approximately 2016 using an intermediate health care inflation assumption. This also assumes that OPERS continues to earn its actuarial assumption rate of eight percent on investment assets, and 4% of employer contributions continue to be allocated toward health care funding. Other less optimistic assumptions show solvency extending only through 2013.

(6) A statement of the net assets available for the provision of the benefits as of the last day of the fiscal year

Please see Attachment C, "Statements of Plan Net Assets - Health Care".

(7) A statement of any changes in the net assets available for the provision of benefits, including participant and employer contributions, net investment income, administrative expenses, and benefits provided to participants, as of the last day of the fiscal year.

Please see Attachment D, "Statements of Changes in Plan Net Assets - Health Care".

(8) For the last six consecutive fiscal years, a schedule of the net assets available for the benefits, the annual cost of benefits, administrative expenses

incurred, and annual employer contributions allocated for the provision of benefits.

Please see Attachment D, "Statements of Changes in Plan Net Assets - Health Care".

(9) A description of any significant changes that affect the comparability of the report required under this division.

No significant changes affect these reports.

Attachment A

§ 145.325. Medicare equivalent benefits.

(A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395c, as amended. This coverage shall also be made available to the spouse, widow, or widower of such retirant or disability benefit recipient provided such spouse, widow, or widower has attained age sixty-five and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage only if he or she is the recipient of a monthly allowance or benefit from this system. One-half of the cost of the premium for the spouse shall be paid from the appropriate funds of the public employees retirement system and one-half by the recipient of the allowance or benefit.

The cost of such coverage, paid from the funds of the system, shall be included in the employer's rate provided by section 145.48 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and shall contract for such coverage as provided in section 145.58 of the Revised Code.

(B) The board need not make the hospital insurance coverage described in division (A) of this section available to any person for whom it is prohibited by section 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance.

HISTORY: 132 v H 402 (Eff 12-14-67); 136 v H 1 (Eff 6-13-75); 137 v H 1 (Eff 8-26-77); 139 v H 126 (Eff 6-13-81); 144 v S 346 (Eff 7-29-92); 148 v H 628. Eff 9-21-2000.

Attachment B

§ 145.58. Group hospitalization coverage for retired persons and survivors; ineligible individuals.

(A) As used in this section, "ineligible individual" means all of the following:

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331 [145.33.1], 145.34, or 145.46 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years' service credit, exclusive of credit obtained pursuant to section 145.297 [145.29.7] or 145.298 [145.29.8] of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 [145.29.3] or 145.301 [145.30.1] of the Revised Code, and credit obtained after May 4, 1992, pursuant to section 145.28 of the Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code.

(B) The public employees retirement board may enter into agreements with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage of benefits in accordance with division (D)(2) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to ineligible individuals if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.325 [145.32.5] of the Revised Code for any ineligible individual.

The board may provide for self-insurance of risk or level of risk as set forth in the contract with the companies, corporations, or agencies, and may provide through the self-insurance method specific benefits as authorized by rules of the board.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or survivor benefit under the public employees retirement system who is eligible for medical insurance coverage under part B of Title XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended, an amount equal to the basic premium for such coverage, except that the board shall make no such payment to any ineligible individual.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 145.325 [145.32.5] of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

(E) The board shall make all other necessary rules pursuant to the purpose and intent of this section.

HISTORY: 128 v 308 (Eff 10-14-59); 129 v 1714(1740) (Eff 10-27-61); 131 v 170 (Eff 11-13-65); 135 v H 430 (Eff 11-20-73); 136 v H 268 (Eff 8-20-76); 137 v H 1 (Eff 8-26-77); 139 v H 126 (Eff 6-13-81); 139 v H 236 (Eff 2-2-82); 140 v H 631 (Eff 3-28-85); 141 v H 706 (Eff 12-15-86); 142 v S 124 (Eff 10-1-87); 144 v H 382 (Eff 6-30-91); 144 v H 383 (Eff 5-4-92); 144 v S 346 (Eff 7-29-92); 145 v H 151 (Eff 2-9-94); 146 v S 82 (Eff 3-7-97); 147 v S 67 (Eff 6-4-97); 148 v H 222 (Eff 11-2-99); 148 v H 535 (Eff 4-1-2001); 149 v S 247. Eff 10-1-2002.

Attachment C

Statement of Plan Net Assets
Health Care

	2004	2003	2002	2001	2000	1999
Assets						
Cash and Short Term Investment	$194,486,592	$417,214,283	$185,571,147	$152,283,582	$299,551,036	$193,521,934
Receivables:						
Employers Contributions	$64,664,924	$71,464,614	$46,467,195	$26,975,696	$20,915,187	$27,145,428
Retirement Incentive Plan	3,098,433	5,124,584	$18,188,956	$6,775,267	$3,721,569	$2,777,067
Investment Sales Proceeds	12,946,973	11,534,818	$39,388,483	$14,246,185	$26,467,886	$117,162
Accrued Interest and Dividends	30,981,282	29,499,116	$27,438,280	$29,271,211	$46,815,613	$46,415,084
Total Receivables	**$111,691,612**	**$117,623,132**	**$131,482,914**	**$77,268,359**	**$97,920,255**	**$76,454,741**
Investments, at fair value:						
Bonds	$1,658,033,259	$1,440,534,173	$1,147,148,273	$1,271,358,373	$2,134,491,585	$2,162,313,014
Mortgage & Mortgage Backed	942,546,523	823,734,334	$734,293,155	$757,309,894	$1,493,537,925	$1,429,145,862
Stocks	5,590,842,559	5,112,470,625	$4,129,397,805	$4,750,774,185	$3,850,714,985	$3,911,196,263
Real Estate	629,039,656	644,858,238	$866,566,452	$967,004,493	$1,046,691,262	$1,118,361,190
Venture Capital	69,834,553	57,113,048	$48,181,864	$12,933,389	$16,733,040	$18,111,104
International Securities	2,671,029,189	2,305,480,202	$1,776,052,122	$2,002,672,885	$2,045,814,900	$2,287,215,780
Collateral on Loaned Securities						
Total Investments	**$11,561,325,739**	**$10,384,190,620**	**$8,701,639,671**	**$9,762,053,219**	**$10,587,983,697**	**$10,926,343,213**
Collateral on Loaned Securities	$1,429,823,432	$960,517,368	$435,303,084	$593,251,558	$799,148,208	$865,608,588
Capital Assets:						
Land	$665,394	$1,473,754	$697,663	$691,687	$717,831	$724,575
Building and Building Improvements	$18,624,614	$40,554,734	$17,702,101	$12,387,633	$6,016,564	$3,868,237
Furniture, Fixtures, and Equipment	$7,366,060	$16,603,845	$8,335,682	$7,067,342	$5,357,308	$4,428,341
Total Capital Assets	$26,656,068	$58,632,333	$26,735,446	$20,146,662	$12,091,703	$9,021,153
Accumulated Depreciation	($5,553,881)	($10,444,551)	($4,668,983)	($3,946,684)	($3,644,071)	($3,384,156)
Net Capital Assets	**$21,102,187**	**$48,187,782**	**$22,066,463**	**$16,199,978**	**$8,447,632**	**$5,636,997**
Prepaid Expenses and Other	$0	$0	$22,941,138	$19,931,824	$18,677,709	$15,985,801
TOTAL ASSETS	**$13,318,429,562**	**$11,927,733,185**	**$9,499,004,417**	**$10,620,988,520**	**$11,811,728,537**	**$12,083,551,274**
Liabilities:						
Undistributed Deposits	$0	$0	$1,026,008	$6,313,108	$477,657	$251,682
Medical Benefits Payable	$116,024,321	$114,581,249	$95,374,085	$72,859,185	$41,684,800	$53,846,033
Investment Commitments Payable	$163,468,451	$38,150,816	$79,530,542	$10,355,578	$4,259,704	
Accrued Administrative Expenses	$0	$680,303	$1,488,612	$1,825,097	$728,799	$631,714
Obligations Under Securities Lending	$1,429,823,432	$960,517,368	$435,303,084	$593,251,558	$799,148,208	$865,608,588
TOTAL LIABILITIES	**$1,709,316,204**	**$1,113,929,736**	**$612,722,331**	**$684,604,526**	**$846,299,168**	**$920,338,017**
Net assets held in trust for pension and post-employment health care benefits	$11,609,113,358	$10,813,803,449	$8,886,282,086	$9,936,383,994	$10,965,429,369	$11,163,213,257

Attachment D

Statements Of Changes In Plan Net Assets
Health Care

	2004	2003	2002	2001	2000	1999
Additions:						
Contributions:						
Members'						
Employers'	$464,096,679	$579,904,361	$573,038,298	$431,103,750	$452,867,242	$392,459,727
TOTAL CONTRIBUTIONS	**$464,096,679**	**$579,904,361**	**$573,038,298**	**$431,103,750**	**$452,867,242**	**$392,459,727**
Investment Income:						
Net Appreciation in Fair Value of Instruments & Other Invest. Inc.	$866,806,864	$1,888,247,396	($897,847,591)	($1,396,124,511)	($546,918,282)	$888,386,350
Bond Interest	122,129,931	107,738,517	135,276,163	361,752,777	284,384,050	254,543,745
Dividends	107,071,190	88,991,564	65,521,483	130,998,066	90,565,240	69,366,846
Internatinal	165,266,361	109,545,453	(189,310,970)			
Real Estate Operating Income, net	52,299,350	63,468,603	45,652,477	137,855,938	82,658,021	71,472,483
Securities Lending Net Income	1,861,915	677,601	1,104,834	47,293,017	37,328,394	29,062,059
	$1,315,435,611	$2,258,669,134	($839,603,604)	($718,224,713)	($51,982,577)	$1,312,831,483
Less: Investment Expenses	(18,143,728)	(603,059)	(3,462,304)	(45,351,114)	(37,183,505)	(28,561,474)
Net Investment Income	$1,297,291,883	$2,258,066,075	($843,065,908)	($763,575,827)	($89,166,082)	$1,284,270,009
TOTAL ADDITIONS	**$1,761,388,562**	**$2,837,970,436**	**($270,027,610)**	**($332,472,077)**	**$363,701,160**	**$1,676,729,736**
Deductions:						
Benefits	$963,384,400	$907,769,092	$776,006,852	$693,484,110	$559,606,294	$523,599,349
Refunds of Contributions						
Administrative Expenses	2,694,253	2,679,981	4,067,446	3,089,188	1,878,754	1,757,358
TOTAL DEDUCTIONS	**$966,078,653**	**$910,449,073**	**$780,074,298**	**$696,573,298**	**$561,485,048**	**$525,356,707**
Net Increase	$795,309,909	$1,927,521,363	($1,050,101,908)	($1,029,045,375)	($197,783,888)	$1,151,373,029
Net assets held in trust for pension and						
Postemployment health care benefits:						
Balance, Beginning of Year (as restated)	$10,813,803,449	$8,886,282,086	$9,936,383,994	$10,965,429,369	$11,163,213,257	$10,011,840,228
BALANCE, END OF YEAR	**$11,609,113,358**	**$10,813,803,449**	**$8,886,282,086**	**$9,936,383,994**	**$10,965,429,369**	**$11,163,213,257**