CREATING A LEGACY OF HONOR AND TRUST: STRIVING FOR HEALTH PARITY FOR ALL AMERICAN INDIANS AND ALASKAN NATIVES

THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET

- RECOMMENDATIONS IN BRIEF[1] -

March 8, 2013

INTRODUCTION

President Obama has demonstrated that he understands the unique government-to-government relationship between the United States and sovereign Tribal Nations and has strived to live up to his promise to restore adequate funding across Indian Country. Under the Obama Administration, the Indian Health Service (IHS) has seen its first year-over-year budget increases in decades with a historical increase of 29% over the past four years. However, funding for Indian health care services and programs still falls significantly short of what is required to bring health parity to Indian health.

> *"So let me be clear, I believe treaty commitments are paramount law, I will fulfill those commitments as President of the United States. That's why I've co-sponsored the Indian Health Care Improvement Act and that's why I am fighting to ensure full funding for Indian Health Care Service"*
>
> *Then-Senator Barack Obama*
> *Crow Agency, Montana*
> *May 19, 2008*

The Obama Administration has the historic opportunity *to not only reduce*, but *also eliminate* the vast chasm between the health conditions of Native peoples and other Americans. The target for the IHS budget of $27.6 billion over twelve years contained in this brief offers a path forward and clear direction, countering those who argue this cannot be done. In defying this cynicism, we are reminded of the timeless wisdom of Abraham Lincoln, where we "*…determine the thing that must and shall be done, and then we find the way.*" As a first step, the National Tribal Budget Formulation Workgroup (Workgroup) recommends that the administration requests a 19.7% increase for a total of $5.3 billion for the IHS Fiscal Year (FY) 2015 budget. This is both fair and reasonable. Any lesser amount perpetuates the practice of pitting Tribe against Tribe for what little health care dollars are available. If those served by the IHS were funded at the same level as federal employees, medical services would receive a $13.0 billion budget versus the $3.0 billion received in FY 2012.

This administration, in partnership with Tribes, can truly be the change that moves health care in Indian Country toward a brighter future. Nothing can undo the damage done in the past, but we can use the

[1] The Recommendations in Brief is a summary document highlighting the National Tribal Budget Formulation Workgroup's for the IHS FY 2015 budget and is being presented at the United States Department of Health and Human Services Annual Tribal Budget Consultation on March 8, 2013. A full written recommendation report will be released in Mary 2013.

lessons to guide our future. Together, we can ensure our children have the opportunity to have healthy and productive lives while our elders can leave this life with dignity. Today, we can restore the **legacy** of **honor, trust**, and **parity** between the United States and the First Peoples of this great nation.

Honor

To Indian people, the federal budget is not just a fiscal document, but also a moral and ethical commitment. The budget request for Indian health care services reflects the extent to which the United States honors its promises of justice, health, and prosperity to Indian people. For the Tribes to recommend a budget that falls short of providing even the most basic of health care services to all our people is no different from asking a parent to decide which child to feed and which should go hungry.

"I understand the tragic history. Our government has not always been honest or truthful in our deals."

Then-Senator Barack Obama
Crow Agency, Montana
May 19, 2008

Washington must not continue to neglect or ignore its trust responsibility to Tribal Nations. Instead, Congress and this administration must begin a new era of honoring its promise to Indian Country. These are not duties to be grudgingly accepted, but must be embraced in a way that defines the character of this great nation. It is a matter of honor.

Trust

The provision of federal health care services to American Indians and Alaska Natives (AI/ANs) is the direct result of treaties that were made between the United States and Tribes and reaffirmed by Executive Orders, Congressional actions and two centuries of Supreme Court case law. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. This federal trust responsibility is the foundation for the provision of federally funded health care to all members of the 566 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States.

"We shall continue to fulfill the federal trust responsibility for the physical and financial resources we hold in trust for the tribes and their members. The fulfillment of this unique responsibility will be accomplished in accordance with the highest standards"

President Ronald Reagan
1983 Statement on Indian Policy

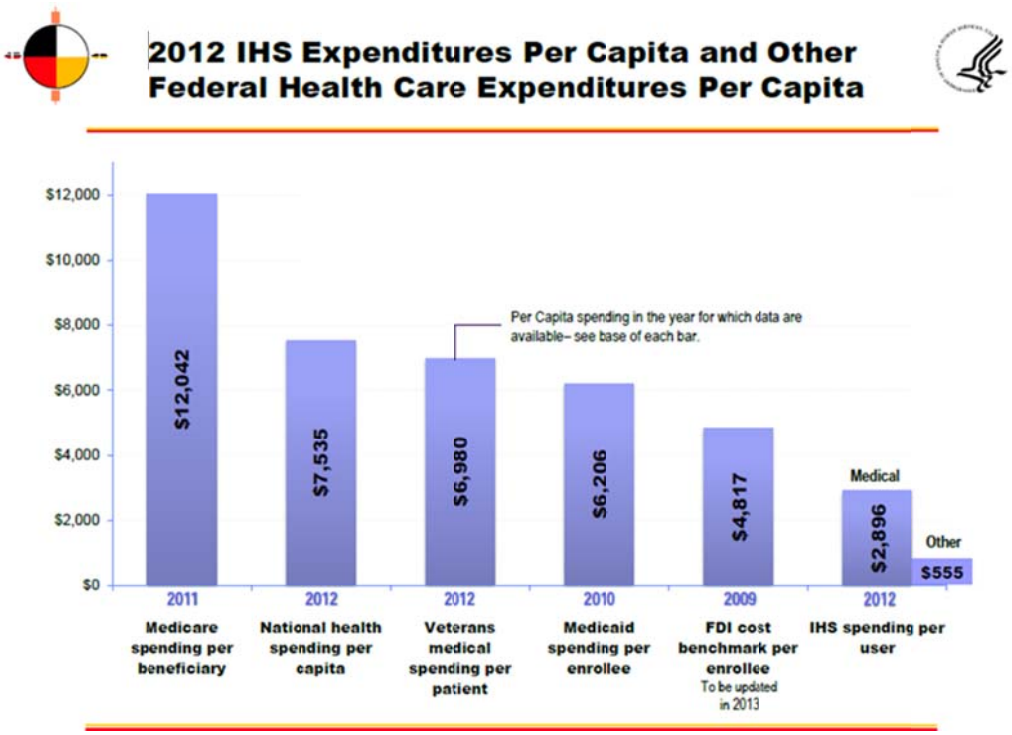
Parity

Although the Indian health care system has made significant improvements in mortality and morbidity rates for AI/ANs, serious health disparities persist. More needs to be done to finally end long-standing inequities in health status for First Americans. It remains true that AI/ANs die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (514% higher), diabetes (177% higher), unintentional injuries (140% higher), homicide (92% higher), and suicide (82% higher).

The Indian health care delivery system, in addition to significant health disparities, also faces significant funding disparities, both in per capita spending between the IHS and other federal health care programs and within IHS, among IHS Areas and among sites within IHS Areas. In 2012, the IHS per capita expenditures for patient health services were just $2,896, compared to $7,535 per person for health care spending nationally. The Federal Employee Health Benefits program (FEHB) serves as the benchmark for the Federal Disparity Index (FDI). While the benchmark is scheduled to be updated in 2013, IHS total per person spending for 2012 represented only 60% of FEHB per capita spending for calendar year 2009. If you compare just medical spending, this percentage drops to 20%.

"We are going to keep working together to make sure that the promise of America is fully realized for every Native American"

President Barack Obama
White House Tribal Nations Summit
December 2012



In addition, in FY 2010, the latest year for which data is currently available, the average Level of Need Funded (LNF) for IHS as a whole was just 56% of identified need. Among the 12 IHS Areas, the LNF ranged from a low of 50% for the Bemidji Area to a high of 62.2% for the Alaska Area. Developing and successfully executing a plan to achieve funding parity is critical to addressing devastating and growing health disparities in Indian country and essential to fulfilling the United States' trust responsibility to AI/ANs.

❖ 1st Recommendation: Phase In Full Funding of IHS - Total Needs Based Budget of $27.6 Billion Over 12 Years

Early in 2003, the Workgroup met to develop the national Tribal budget recommendations for FY 2005. Tribal leaders were disheartened that the planning base for the IHS budget was $2.85 billion, less than 15% of the total funding required to meet the health care needs for AI/ANs. This level of funding was not even sufficient to maintain current services in the face of inflation and the increase in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and IHS's efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribal and Urban programs worked together to develop for the first time a true Needs Based Budget (NBB) and for FY 2005, proposed a IHS NBB totaling $19.5 billion.

That Workgroup proposed a 10-year phase-in plan, with substantial increases in the first two years and more moderate increases in the following years even though that Workgroup understood that meeting the NBB of $19.5 billion in one fiscal year was unlikely, due to the importance of balancing the Federal budget and other national priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at one time. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and Administration to improve the health status of AI/ANs.

That was 10 years ago. In the intervening years and with failure to produce necessary funding to fulfill this 10-year plan, the health disparities between AI/ANs and other populations continued to widen, and the cost and amount of time required to close the funding disparity gap has grown. The NBB has been updated every year, using the most current available population and per capita health care cost information. The *IHS need-based funding aggregate cost estimate for FY 2015* is now **$27.6 billion**, based on the FY 2012 estimate of 2.6 million eligible AI/ANs served by IHS, Tribal and Urban health programs. With the lack of adequate increases over the years, the phase-in of the NBB at $27.6 billion would need to occur over the next 12 years.

❖ 2nd Recommendation: Increase FY 2015 IHS Budget to $5.3 Billion

While the Workgroup's primary recommendation remains full funding of the IHS NBB, Tribes in each Area were asked to prepare budget recommendations at specific funding levels. Taking the Area recommendations, the Workgroup recommends an increase of **19.7%** or **$871.0 million** over the FY 2013 President's proposed IHS Budget. This increase includes **$163.9 million** for *Current Services*, **$178.8 million** for *Binding Agreements* with Tribes and **$528.4 million** in *Program Increases Expansion*. Current Services and other Binding Agreements provide the base for program increases designed to expand services. These base costs, which are necessary simply to maintain the status quo must be accurately estimated and fully funded before any real program expansion can begin. Whereas,

the Program Increases Expansion are the additional funding needed to address critical health services and new facility authorities aimed at slowing the growing health disparity rates in Tribal communities.

Full Funding of Current Services

Current Services are fixed costs that are necessary to maintain services at the same level as the previous year. If increased funding is not appropriated to cover these fixed costs, programs will have to absorb these mandatory cost increases within their existing programs by reducing services or by investing other Tribal resources that take away from education, elder services or other important Tribal programs. We recommend *full funding for Current Services* at an estimated **$163.9 million**.

The FY 2013 President's Budget request projected a 1.7% pay raise for federal commissioned officers, whom are part of the military, at a cost of $2.4 million. No funds were budgeted for federal civil service or Tribal employees, who remain under a pay freeze enacted by Congress. Civil service employees have access to bonus and performance pay as incentives to recruit or retain staff, while Tribes do not. Certainly, Tribal employees should have access to some form of incentive pay during a recession and difficult budget times to encourage staff retention similar to commissioned corp and civil service employees. The Workgroup feels strongly that not only commissioned officers, but also Tribal and federal IHS employees, should be exempted from any federal employee pay freeze that may be imposed in FY 2014 or 2015. The FY 2015 Tribal budget request includes an additional **$15.9 million** for *Federal Pay Costs* and **$18.7 million** for *Tribal Pay Costs*.

The Current Services request also includes **$14.3 million** for *Non-Medical Inflation* and **$65.9 million** for *Medical Inflation* above the $34 million included in the FY 2013 President's Budget, which was proposed to address a 1.5% non-medical inflation rate and a 3.6% medical inflation rate identified by the Office of Management and Budget and aimed primarily at increases in Contract Health Services (CHS) costs.

However, the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), inpatient hospital care is currently at 4.1% and outpatient hospital care is at 5.6%. The Workgroup asserts that the rates of inflation applied to Hospitals & Clinics, Dental Health, Mental Health, and CHS in developing the IHS budget should correspond to the appropriate components in the CPI. Otherwise, the estimates developed by IHS underestimate the true level of funding needed to maintain current services.

Another **$49.1 million** is requested for *Population Growth* to fund the increased need arising from the growth in the AI/AN population, which in recent years has been growing at an average rate of 1.9% annually.

Funding for Binding Agreements

We recommend **$178.8 million** to meet the fiscal requirements of existing *Binding Agreements* with Tribes. Appropriated funding must be sufficient for the IHS to meet its binding obligations made with Tribes and Tribal organizations. This funding is critical to support the commitments made in prior years for Contract Support Costs (CSC), Health Care Facility Construction (HCFC), and staffing for new facilities through annual funding agreements.

Specifically, the Workgroup recommends **$31 million** for *Staffing and Operating Costs for New and Replacement Facilities*. This funding allows the IHS and Tribes to provide the necessary services associated with operating these facilities. In the case of Joint Venture projects, Tribes have taken on great risk in financing the construction of new or replacement facilities. This was done with a commitment from the IHS to fund necessary staffing and operating costs upon completion of facility construction. Failure to fund staffing and operating costs in a sufficient and timely manner leaves Tribes without the means to safely operate these facilities, compromising their ability to service loan agreements while jeopardizing the health and safety of entire communities.

The FY 2015 *CSC Shortfall* request of **$90 million** is needed to address the estimated shortfall associated with program increases and new and expanded programs already acquired by Tribes and Tribal organizations under more than 300 ongoing contracts and compacts.

The HCFC program plays an essential role in ensuring access to comprehensive health care for the most vulnerable AI/AN populations. These facilities investments lead to more care that is effective, improved health outcomes, and reductions in overall health care delivery costs. We recommend **$57 million** in FY 2015 funding to support projects currently on the HCFC program planned construction budget this is in addition to the Planning Base figure of $81.5 million.

Program Expansion Increases

Additional *Program Expansion Increases* totaling **$528.4 million** are needed to address the ever-widening AI/AN health disparity and funding gap. The Hospitals & Clinics (H&C) line item includes funding for the Indian Health Care Improvement Fund, Health Information Technology, and Long Term Care, as well as general H&C increases. Top Tribal priorities are reflected by the critical line item increases listed below.

- Increase the funding for *H&C* by **$119.6 million**.
- Increase funding for *Mental Health* by **$47.9 million** to address resource deficiencies at behavioral health programs that are providing outpatient and emergency crises services and community based prevention programs.
- Increase funding for *Contract Health Service (CHS)* by **$181.2 million**.
- Increase funding for *CSC* by **$37.3 million** for new and expanded programs.
- Increase funding for *Alcohol & Substance Abuse Services* by **$31.7 million**.
- Increase funding for new *HCFC* authorities above the planning base and what is needed to meet Binding Agreements by **$30.0 million**.

If the requested Program Expansion Increases are not funded, AI/ANs will continue to live sicker and die younger than other American citizens do and will continue to drain existing available resources for costly urgent, emergent and chronic care at higher rates than other populations. The prospect of a better future, the dream of healthy communities, and a fair shake at improving the health status of all AI/ANs will remain out of reach for most Tribal Nations.

FY 2015 National Tribal Recommendation		
Planning Base - FY 2013 Pres. Budget		**$4,422,476,000**
Current Services & Binding Agreements		**$342,671,000**
Current Services		**$163,900,000**
Federal Pay Costs		15,900,000
Tribal Pay Costs		18,701,000
Inflation (non-medical)		14,300,000
Inflation (medical)		65,900,000
Population Growth		49,099,000
Binding Agreements		**$178,771,000**
New Staffing for New & Replacement Facilities		31,458,000
Contract Support Costs - Shortfall		90,000,000
Health Care Facilities Construction (Planned)		57,313,000
Program Expansion Increases - Services		**$470,296,000**
Hospitals & Health Clinics		119,644,000
Dental Services		20,376,000
Mental Health		47,898,000
Alcohol and Substance Abuse		31,752,000
Contract Health Services		181,229,000
Public Health Nursing		8,585,000
Health Education		8,920,000
Community Health Representatives		10,115,000
Alaska Immunization		2,000
Urban Indian Health		3,487,000
Indian Health Professions		880,000
Tribal Management Grants		8,000
Direct Operations		35,000
Self-Governance		11,000
Contract Support Costs - New & Expanded		37,354,000
Program Expansion Increases - Facilities		**$58,068,000**
Maintenance & Improvement		6,421,000
Sanitation Facilities Construction		16,447,000
Health Care Facilities Construction Authorities		30,000,000
Facilities & Environmental Health Support		1,400,000
Equipment		3,800,000
GRAND TOTAL		***$5,293,511,000***
% and $ Change over Planning Base	19.70%	$871,035,000

❖ 3rd Recommendation: Protect Prior Year Healthcare Gains and Advance Tribal Health

The Workgroup is thankful for the support of Congress and the Administration in recent years for significant increases to the IHS budget. However, the IHS budget has been subject to proposed budget cuts in the past. This was detrimental not only to the agency's budget, but to the lives and well-being of AI/ANs. Any budget cuts, in any form, will have harmful effects on the health care delivery to AI/ANs and its true cost will be measurable in lives as well as dollars.

Sequestration Impact

The Tribes are extremely concerned about the consequences of sequestration. Unlike federal programs that serve the health of our nation's populations with the highest need, such as Social Security, Medicare, Medicaid, the Children's Health Insurance Program, and the Veterans Administration, the IHS is not exempt from the looming automatic across the board cuts. Although the recently passed American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2% to 5.1%, these cuts must be achieved over seven months instead of twelve, making the effective percentage of reductions approximately 9%. Even at that revised level, the IHS budget will suffer a devastating cut of $220 million.

As projected by the Administration, the IHS and Tribal hospitals and clinics would be forced to provide 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits. In addition, the billions in cut to funding for other key health agencies, such as Centers for Disease Control & Prevention, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration will further increase the blow to health of AI/ANs, as these programs have become critical to the Indian Health Care System. In total, this cut translates into lost funding for primary health care and disease prevention services for AI/ANs, which is certain to produce tremendous negative health impacts.

Partnership w/ HHS Agencies

As we work to improve access and quality of care, we must leverage existing funding through partnerships, taking full advantage of proven strategies and promising practices. Extending self-governance to non-IHS programs within the HHS provides tremendous opportunities for collaboration, synergy and maximization of resources. When Congress enacted The Tribal Self-Governance Amendments of 2000, P.L. 106-260, it included a provision requiring the HHS to conduct a study to determine the feasibility of extending Tribal Self-Governance to non-IHS programs within DHHS. In the final study submitted to Congress in 2003, HHS concluded that it was feasible to extend Tribal Self-Governance to eleven select programs within the Department, and recommended that Congress do so. Assuming that Self-Governance, as a practice, provides a greater benefit than federally administered programs, supporting the expansion of this practice, via Title VI is a priority for Tribes. Some benefits of Title VI Self-Governance Amendments include:

- Expands Tribal Self-Governance; the most successful policy in the history of Tribal-Federal relations.

- Builds on the well-documented successes of Tribes and Tribal organizations in delivering IHS health care programs and services under Title V.
- Determined to be feasible and desirable by HHS in its 2003 study.
- Allows Self-Governance in HHS analogous to that in the Department of the Interior, where Title IV allows Tribes to compact non-Bureau of Indian Affairs programs and services.
- Provides an integrative, holistic approach to ensuring healthy communities by providing services that enhance individual and community well-being.
- Described by the Senate Committee on Indian Affairs as "the next evolution in Tribal self-governance."

In 2012, HHS Secretary Sebelius took another step toward expanding Tribal access to HHS programs by establishing the Self-Governance Tribal/Federal Workgroup (SGTFW) charged with identifying the barriers to Tribal Self-Governance within the DHHS. While the Workgroup's establishment is a step in the right direction, the work of the SGTFW must be allowed to be completed its recommendations to establish a Self-Governance Demonstration project to encourage greater Tribal participation in HHS programs. In addition, the Secretary's Tribal Advisory Group would serve as an excellent partner for this Workgroup to share recommendations and insights with, as well as serve to elevate the shared priorities of each group.

CONCLUSION

Health programs, services, functions and activities provided to AI/ANs through compacts, contracts and direct operations of the IHS are Tribal trust and treaty obligations grounded in the Constitution and numerous federal laws. This obligation to fund IHS administered program must be treated differently than any other federal program. To do this, the Tribal budget recommendation to fully fund health services at $27.6 billion is a reasonable and achievable phased-in approach to begin to address the true needs in Indian Country. The Tribal NBB, if fully funded, would be less than three percent of the HHS $941 billion budget.

The President's second term represents an opportunity to do so much more for our nation's First People and to truly reform and revolutionize the Indian Health System. For a long time, we have been working to repair a starved system - a system that continues to disappoint our people. While we celebrate the steps this Administration has taken to improve the health status of AI/ANs, these should not be the only steps. Now, this Administration's legacy could be one of true change towards how the promise of health care to AI/ANs is funded and delivered.

Legacy – Champion for Indian Health

President Obama has secured a legacy in reforming America's healthcare system. President Obama should not only be known as a champion of health, but as a champion of change in Indian health. However, the task of reforming the Indian health care system so our people can benefit on the same basis as other Americans can only be achieved by fully funding the Indian health care system. We understand that this presents a challenge, but we believe that the commitment this Administration has shown in working towards the American Dream for all can and should be applied to health care for AI/ANs.

> *"We haven't solved all our problems. We've got a long road ahead. But I believe that one day, we're going to be able to look back on these years and say that this was a turning point."*
>
> President Barack Obama
> White House Tribal Nations Conference
> December 2, 2011

We ask this Administration to stand up with us and move forward on a path toward health parity for our people, a turning point as envisioned by President Obama in his address to the 2011 White House Tribal Nations Conference. Let this second term be the turning point for Indian healthcare.

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About the Workgroup: The National Tribal Budget Formulation Workgroup Members include Tribal representatives from each of the 12 IHS Areas who are tasked with consolidating budget recommendations developed by tribal leadership and program staff of the 12 IHS Areas (regions) into a national set of budget and health priorities for a given fiscal year. The Workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year.

About the Indian Health Care Delivery System: The Indian health care delivery system consists of services and programs provided directly by the Indian Health Service; Indian Tribes and Tribal organizations who are exercising their rights of self-determination and self-governance; and services provided through urban organizations that receive IHS grants and contracts (collectively, the "Indian Health Care System"). This system is community-based and reflects a culturally appropriate approach to delivering health care to a population suffering severe health disparities and massive rates of poverty within the most remote and rural areas of America. The Indian Health Care System has a user population of 2.6 million individuals. Currently, the IHS FY 2012 budget is $4.3 billion, but remains at 50% of the level of needed funding system wide.

FY 2015 National Tribal Recommendation

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Revised Mar 5, 2013

INDIAN HEALTH SERVICE
FY 2015 Tribal Recommendation

(Dollars in Thousands)

Revised 3-5-13

Sub Sub Activity	FY 2012 Enacted	FY 2013 President's Budget (Plng Base)	FY 2015 - CURRENT SERVICES Estimates: Federal Pay CO, CS	Tribal Pay	Inflation: Non-Medical	Inflation: Medical	Population Growth	Current Services Subtotal	FY 2015 - PROGRAM EXPANSION: Binding Agrmts: Staffing for New Facilities	Binding Agrmts: CSC Shortfall	Binding Agrmts: Health Care Facilities Constr	Other Increases	Program Expans. Subtotal	FY 2015 Recomm	Comparison: Change over FY 2013 PB $	Change over FY 2013 PB %
SERVICES																
Hospitals & Health Clinics	1,810,966	1,849,310	10,269	12,077	2,143	22,574	24,399	71,462	31,458	0	0	119,644	151,102	2,071,874	222,564	12.0%
Dental Services	159,440	166,297	1,042	1,226	79	1,656	2,123	6,126	0	0	0	20,376	20,376	192,799	26,502	15.9%
Mental Health	75,589	78,131	452	532	45	863	1,008	2,900	0	0	0	47,898	47,898	128,929	50,798	65.0%
Alcohol & Substance Abuse	194,297	195,378	1,182	1,390	35	2,939	2,630	8,176	0	0	0	31,752	31,752	235,306	39,928	20.4%
Contract Health Services	843,575	897,562	0	0	0	33,029	11,785	44,815	0	0	0	181,229	181,229	1,123,606	226,044	25.2%
Total, Clinical Services	3,083,867	3,186,678	12,945	15,225	2,301	61,061	41,946	133,478	31,458	0	0	400,899	432,357	3,752,513	565,835	17.8%
Public Health Nursing	66,632	69,868	429	505	28	653	877	2,492	0	0	0	8,585	8,585	80,945	11,077	15.9%
Health Education	17,057	17,450	102	119	4	233	226	683	0	0	0	8,920	8,920	27,053	9,603	55.0%
Comm. Health Reps	61,407	61,531	397	466	4	919	817	2,603	0	0	0	10,115	10,115	74,249	12,718	20.7%
Immunization AK	1,927	1,927	12	15	0	29	26	82	0	0	0	2	2	2,011	84	4.4%
Total, Preventive Health	147,023	150,776	940	1,105	35	1,834	1,946	5,860	0	0	0	27,622	27,622	184,258	33,482	22.2%
Urban Health	42,984	42,988	188	221	45	643	581	1,678	0	0	0	3,487	3,487	48,153	5,165	12.0%
Indian Health Professions	40,596	40,598	11	12	559	4	0	586	0	0	0	880	880	42,064	1,466	3.6%
Tribal Management	2,577	2,577	0	0	0	95	0	95	0	0	0	8	8	2,680	103	4.0%
Direct Operations	71,653	72,867	456	536	391	0	0	1,382	0	0	0	35	35	74,284	1,417	1.9%
Self-Governance	6,044	6,044	11	12	21	109	0	153	0	0	0	11	11	6,208	164	2.7%
Contract Support Cost	471,437	476,446	0	0	6,646	0	0	6,646	0	90,000	0	37,354	127,354	610,446	134,000	28.1%
Total, Other Services	635,291	641,520	665	782	7,660	851	581	10,540	0	90,000	0	41,775	131,775	783,835	142,315	22.2%
Total, Services	3,866,181	3,978,974	14,550	17,113	9,997	63,746	44,473	149,878	31,458	90,000	0	470,296	591,754	4,720,606	**741,632**	18.6%
FACILITIES																
Maintenance & Improvemen	53,721	55,470	0	0	735	0	709	1,445	0	0	0	6,421	6,421	63,336	7,866	14.2%
Sanitation Facilities Constr.	79,582	79,582	0	0	1,369	0	990	2,359	0	0	0	16,447	16,447	98,388	18,806	23.6%
Health Care Fac. Constr.	85,048	81,489	0	0	1,198	0	0	1,198	0	0	57,313	30,000	87,313	170,000	88,511	108.6%
Facil. & Envir. Hlth Supp.	199,413	204,379	1,350	1,587	971	1,355	2,621	7,884	0	0	0	1,400	1,400	213,663	9,284	4.5%
Equipment	22,582	22,582	0	0	31	799	307	1,137	0	0	0	3,800	3,800	27,519	4,937	21.9%
Total, Facilities	440,346	443,502	1,350	1,587	4,303	2,154	4,627	14,022	0	0	57,313	58,068	115,381	572,905	129,403	29.2%
TOTAL, IHS	4,306,527	4,422,476	15,900	18,700	14,300	65,900	49,100	163,900	31,458	90,000	57,313	528,364	707,135	5,293,511	**871,035**	**19.7%**
$ Change over prior year		115,949												$871,035		
% Change over prior year		2.69%												19.70%		