National Indian Health Board

National Budget Formulation Behavioral Health Recommendations

National Tribal Advisory Committee on Behavioral Health (NTAC) Albuquerque, New Mexico
October 25-26, 2018

FY 2020 Tribal Budget Formulation Workgroup Recommendations relating to Behavioral Health

+$1.5 billion for program increases for the most critical health issues (~36% above FY 2017 Enacted). Top priorities for program expansion include:

1.	Hospital & Clinics	+$409.0 Million
2.	Purchased/Referred Care	+$407.0 Million
5.	Dental Services	+$ 98.3 Million
6.	Health Care Facilities Construction/Other Authorities	+$ 81.4 Million
7.	Sanitation Facilities Construction	+$ 72,5 Million
8.	Urban Indian Health	+$ 32.7 Million
9.	Maintenance & Improvement	+$ 32.5 Million
10.	Equipment	+$ 24.1 Million
11.	Public Health Nursing	+$ 21.9 Million
12.	Health Education	+$ 20.0 Million
13.	Community Health Representatives (CHRs)	+$ 18.9 Million
14.	Indian Health Professions	+$ 16.2 Million
15.	Direct Operations	+$ .6 Million

MENTAL HEALTH +$157,245 MILLION

Tribal leaders report Mental Health as a significant priority for FY 2020 and recommend a $157.245 million increase above the FY 2017 budget enacted. This increase would mean a 167% increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of Tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that are so greatly needed in Tribal communities. AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. However, Tribal health continues to receive inadequate funding resources to address these issues.

Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, studies are suggesting that

American Indians and Alaska Natives are not receiving the services they need to help reduce the disparate statistics.[1]

Funds are needed to support infrastructure development and capacity in tele-behavioral health, workforce development and training, recruitment and staffing, integrated and trauma-informed care, long-term and after-care programs, screening, and community education programs. Mental Health program funding supports community-based clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities.

After-hours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. Group-homes, transitional living services and intensive case management are sometimes available, but generally not as IHS programs. The IHS Mental Health Program is currently focused on the integration of primary care and behavioral health services, suicide prevention, child and family protection programs, tele-behavioral health, and development and use of the RPMS Behavioral Health Management Information System.

Stabilization services are needed to addresses short and long term care that provides access to a multi-disciplinary team of nurses, psychiatrists, and other behavioral health providers 24/7 to ease pressures on emergency and urgent care services and to free equally and critically needed hospital space, which is often not necessarily the most appropriate environment for behavioral health patients. The goal is to stabilize patients before further treatment, assessment(s), evaluation(s), or referrals are completed. There is also another crucial need for protective transition center(s) for homeless women & children, and homeless men & children as they lose employment due to illness or otherwise. Adults and children fleeing their home due to domestic violence situations also need temporary shelter that offers safety, and counseling services that will assist and support them in stabilizing their crises. Once stabilized, they can be assessed for appropriate referrals that need to be completed to promote healing while empowering him or her to proactive life decisions.

Suicide continues to plague American Indians and Alaska Natives throughout Indian Country. Suicidality is often in combination with other behavioral and mental health issues including depression, feelings of hopelessness, history of trauma, substance abuse, domestic violence, sexual abuse and other negative social issues.

According to the Office of Minority Health, suicide was the second leading cause of death for AI/ANs between the ages 10 and 34 in 2014. Suicide was the leading cause of death for AI/AN girls between ages of 10 and 14; in AI/AN females from ages 15 to 19, rates of completed suicides were almost 4 times higher than in white females. In 2014, approximately 9% of AI/ANs ages 18 and up had co-occurring

[1] Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., &Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry, 162,* 1723-1732. Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with first nations women in group counseling. *Canadian Journal of Counseling.*)

mental illness and substance use disorder in the past year—almost 3 times that of the general population.

Lack of behavioral resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. In the California Area, for example, the lack of funding is reflected in the 2017 Government Performance and Results Act (GPRA) Data. Over 2,500 youth and almost 10,000 AI/AN patients were not screened for depression at tribal programs in the California Area. Of patients that were diagnosed with depression, only 30% received a prescription for antidepressants with enough medication (with refills) to last 12 weeks, and only 10% received enough medication (with refills) to last 6 months. Additionally, over 4,000 women were not screened for domestic violence and over 13,000 patients were not screened for alcohol use. An increase in funding and subsequent staffing would allow a greater percentage of the population to be screened, seen by behavioral health specialists and most importantly, treated.

Furthermore, one of the main risk factors known to contribute to psychological distress and behavioral health concerns among the AN/AI population is historical trauma which continues to manifest through this population and specifically today's generations through intergenerational trauma. Intergenerational effects of historical trauma on long-term health have been documented among American Indian and Alaska Native populations through adverse childhood events (ACEs) studies. These studies assess prevalence of personal experiences —physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect and family experiences--an alcoholic parent; a mother who has been a victim of domestic violence; a family member in jail; a family member with a mental illness; and the loss of a parent through divorce, death or abandonment. Higher scores are correlated with poorer long-term outcomes. As generations of families transmit the damage of trauma throughout the years, it becomes a cumulative, collective exposure to traumatic events that not only affect the individual exposed, but continue to affect the following generations, thus compounding the trauma even further.

The Attorney General's Advisory Committee on AI/AN Children Exposed to Violence, comprised of experts in the area of AI/AN children exposed to violence recently released a report that describes the foundation that must be put in place to treat and heal AI/AN children who have experienced trauma: We must transform the broken systems that re-traumatize children into systems where Tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed.

Another significant factor reinforcing these mental health concerns is economic. The poverty rate among American Indian and Alaska Natives was 28.3% among single-race American Indians and Alaska Natives in 2014, the highest rate of any race group. For the nation as a whole, the poverty rate was 15.5 percent, according to the Census Bureau. On many reservations, economic development is much lower than in surrounding cities. There are far fewer jobs, and unemployment is much higher in the reservation communities. On some reservations, unemployment is as high as 80 or 90%, leading to a sense of hopelessness and despair. The inability to provide for one's family often leads to a sense of loss of

identity, despair, depression, anxiety and ultimately substance abuse or other social ills such as domestic violence.

Transitional Housing

Displaced or homeless veterans returning home from active duty service, and/or individuals returning home after a long period of incarceration, will benefit from a transitional living environment that assists them while they readjust to their environment and surroundings. Such individuals may suffer from Traumatic Brain Injury and/or Post Traumatic Stress Disorder, and may need short or long term care with access to multi-disciplinary levels of care. There is a need to enable the I/T/U programs to expand access to multiple programs for services and implement a comprehensive, coordinated network of care. Without a significant increase in funds for FY 2020, IHS and Tribal programs will continue to experience difficulty with properly staffing outpatient community based mental health treatment facilities. Likewise, despite the need for mental health services throughout AI/AN communities, limited resources restrict the ability to hire qualified, culturally competent and licensed providers to relocate to rural areas. With behavioral health issues striking the crisis point in many Tribal communities, as evidenced by testimonials at local, regional and national meetings, the TBFWG has made behavioral health services a major budget priority for FY 2020. This category summarizes the need for additional funds to support many programs that share the common goals of moving our people from crisis to healthy lifestyles and improving quality of life. This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral health issues.

ALCOHOL & SUBSTANCE ABUSE +$123,754 MILLION

Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities continue to be afflicted with the epidemic of alcohol and other drug abuse. Tribal leaders agree that this topic remains a high priority for FY 2020. The Workgroup recommends a program increase of $123,754 million above the FY 2017 enacted budget. Alcohol and substance abuse has grave impacts that ripple across Tribal communities causing upheaval and adverse experiences that begin or perpetuate a cycle of abuse breaking the social fabric of our traditions and ties to one another. Stigmatization and lack of understanding of the disease of addiction make addressing the challenge even more difficult. The problems range from individual, social, and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide. Increasing resources to combat Alcohol and Substance Abuse is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities. The purpose of the Indian Health Service Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent.

Current alcohol and substance abuse treatment approaches (offered by both the IHS and Tribal facilities) employ a variety of treatment strategies consistent with evidenced-based approaches to

the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity.

IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming through the exploration and development of partnerships with stakeholder agencies and by establishing and supporting community alliances. New approaches are also needed to reduce significant health disparities in motor vehicle death rates, suicide rates, rates of new HIV diagnoses, binge drinking and tobacco use. There is also a need for funds to provide alternative treatment modes such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to the overused and abused medications along with development and support of regional treatment centers. Currently, waiting lists are indicative of our treatment programs for alcohol, illegal and prescription drug use.

When our programs are not able to receive patients when an addict is ready, this is where he or she falls through the cracks. We need these funds to increase the number of residential substance abuse treatment beds to increase access to care. Adult and youth residential facilities and placement contracts with third party agencies are funded through the IHS budget for alcohol and substance abuse treatment. However, as a result of diminishing resources, placement and treatment options, decisions are often attributed more to funding availability than to clinical findings. Providing this treatment is costly to the community and program funding is not consistent or stable. While a number of Tribes have been successful in finding grants and other non-IHS resources to manage alcohol and substance abuse outpatient programs, the long-term sustainability of these programs are questionable. IHS is in a unique position to assist the Tribes plan, develop and implement a variety of culturally responsive treatment options to help individuals become sober and prevent from relapse. Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability several culturally responsive in-patient treatment centers have had to close their doors leaving a major gap in service availability and more specifically availability of detox beds with the rising number of heroin and opioid addictions.

Methamphetamine, opioid and heroin use is high in many IHS regions, with limited treatment facilities available. Tribes and Tribal entities across the nation are developing initiatives to combat the epidemic that is causing harm and has a devastating impact on families and communities. Tribal leaders in the Bemidji Area have declared a “state of emergency” with the growing epidemic of increases abuse of alcohol and drugs, including meth and opioids; Tribes in Washington are taking a stand against opioid addictions and Tribal entities in Alaska have declared a ‘war on alcohol and drugs’; The combined effect of alcohol and drugs is devastating. The average age of death for those dying due to alcohol addictions at the Wind River reservation is 38; for those addicted to alcohol and drugs the average age of death is 33.

In FY 2008, Congress appropriated $14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, that funding continues to be allocated through competitive grants, despite Tribal objections. For over a decade, Tribes have noted that IHS reliance on grant programs is counter to the federal trust responsibility, undermining self-determination tenets. Some Tribes receive some funding, others don't. Grants create a "disease du jour" approach, where funding is tied to only one identified hot topic issue. If an area for example is suffering more from alcohol addictions than from meth or opioids, that area cannot redesign the available programs to meet the needs of that area.

And, because grant funding is never guaranteed, vulnerable people and communities often slip through the cracks and fall back into drug habits when grant resources run out. The needed increase must be applied to IHS funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and care to our struggling Tribal members and their families.

Breaking the cycle means that we must prevent and offer early intervention with our at-risk youth and expand the scope of treatment in Youth Regional Treatment Centers. Alcohol and Substance Abuse funds are needed to hire professionals and staff intermediate adolescent services such as group homes, sober housing, youth shelters and psychiatric units. Our communities need increased adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care. The science is starting to catch up, but there is a need for a paradigm shift in thinking in order to break down the stigmas that are a barrier to addressing the disease of addiction. One Tribal leader said it most plainly and simply, alcoholism is a terminal disease. In fact, if left untreated, addiction places considerable burden on the health system in unintentional injuries, chronic liver disease, cirrhosis, and facilitates the transmission of communicable diseases such as HIV and Hepatitis C, both having catastrophic effects on our health system. Effects from historical trauma, poverty, lack of opportunity, and lack of patient resources compound this problem. AI/ANs have consistently higher rates relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues

According to a study in 2009-2010 American Indian and Alaska Natives were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people. The study found that AI/ANs needed treatment at a rate of 17.5% compared to the national average of 9.3%. The Great Plains area has the highest alcohol-related death rate in the country. This death rate is 13.9 times the United States all-races rate and 1.3 times higher than the second highest rate, which is the Albuquerque area (Indian Health Service, 2001). According to SAMHSA (2007a), South Dakota, North Dakota, Nebraska, and Iowa had the highest rates of underage (aged 12 to 20) binge alcohol use (29.5%) and binge alcohol use among persons 18 to 25 years (58%). These states had the highest percentage of persons with dependence on or abuse of alcohol and needing treatment services. National data indicates that Alaska and New Mexico have the largest percentage of AI/AN

treatment admissions for illicit drug use in the country. Additionally, we now know that inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources, such as overloading the agency's outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections). The increased number of patient visits to private sector emergency departments also puts an increased burden on Purchased/Referred Care Services.

In addition to funding needed to support detox and rehabilitation services, Tribes have also reported a critical need for aftercare services. Time and again, Tribal members are re-entering the community or reservation without access to professional support services to prevent them from falling into the same crowds and behaviors that led to the past abuse. Additional funding would be directed to support groups, sober-living opportunities, job placement and other resources to encourage a clean and drug-free lifestyle.

Smoking and smokeless tobacco is often the first drug which individuals experiment; furthermore, research has demonstrated that it increases risk to using illegal drugs. Smoking rates are significantly higher among American Indian and Alaska Natives when compared to non-AI/AN populations. Moreover, cigarette smoking is linked to approximately 90% of all lung cancers in the U.S. and it is a leading cause of death among AI/AN people. Such chronic illnesses exacerbate individuals' mental well-being and overall health and wellness. Increased funding will support the need for prevention and education on this topic and particularly targeting youth while promoting non-tobacco using adults as role models for establishing social norms in Indian communities. As noted in the FY 2017 report, domestic violence rates are alarming, with 39% of AI/AN women experiencing intimate partner violence - the highest rate in the U.S. The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle. This is apparent in the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relationship to children's cognitive development. The National American Indian/Alaska Native Behavioral Health Strategic Plan provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. IHS, Tribal and urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture based prevention and treatment.

8TH RECOMMENDATION: SUPPORT FUNDING OF TRIBES OUTSIDE OF A GRANT-BASED SYSTEM

The health needs of Indian people are chronic and multi-faceted; such needs deserve to be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes receive assistance and benefit from somewhat consistent increases, while

other Tribes do not. This creates two pools of Tribes – those that have technical experience and financial resources receive funding, while many others without this capacity see no benefit in appropriated increases. The strings attached to federal grants in terms of reporting, limitations on use of funds, and timelines distract from patient care. This creates additional administrative burden for receiving Tribes which cannot be offset through means that would be available if IHS distributed the funds via regular programmatic increases. Finally, when grant programs are established, Contract Support Costs, which are administrative costs normally provided in addition to base funding, are not allowed. Instead, indirect costs are taken from within a grant award, resulting in less funding to provide direct project services. For these reasons, grant programs are counter to the federal trust responsibility.

Since 2008, 50% (about $40 Million) of the increases to the total Behavioral Health budget (Mental Health and Alcohol & Substance Abuse Programs) is due to a growth in special grant programs and initiatives rather than increases to existing Behavioral Health programs. Instead of project or disease specific grant funds, the IHS needs to prioritize flexible, recurring base funds. Grants create a "disease de jour" approach, where the funding is tied only to an identified hot topic issue. For instance, if a patient presents with an "unfunded" diagnosis that is not covered by grants for specific disease categories that patient is left without many alternatives. This does not bode well for the many chronic diseases from which AI/ANs disproportionately suffer. For example, a large focus on the methamphetamine epidemic 10 years ago may have distracted from the rise in patients addicted to prescription pain medicine, thus contributing to the opioid crisis in Indian Country today. While the United States generally is now facing an opioid crisis, a particular service unit in one IHS area may struggle most with alcohol addiction and under the grant making process cannot redesign the available programs and services to meet Tribal community needs. As such, IHS should never use a grant program to fund ongoing critical Indian Health needs.

Funding for ongoing health services in FY 2020 should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. Across Indian Country, the high incidence of chronic health conditions like heart disease, suicide, substance abuse, diabetes, and cirrhosis is well documented. Grant funding used to address any Indian health issue creates limited and restrictive funding and access to culturally appropriate care.

INDIAN HEALTH SERVICE

FY 2020 National Tribal Recommendaiton

February 20, 2018

(Dollars in Thousands)

		Current Service (Fixed Costs)								Binding Obligations							
		Estimates								Estimates						**Comparison**	
		Pay			Inflation											Change over Planning Base	
Sub Sub Activity	FY 2017 Enacted (Planning Base)	Federal Pay	Tribal Pay	Pay Subtotal	Non-Medical	Medical	Inflation Subtotal	Population Growth	Current Services Subtotal	Staffing for New Facilities	Contract Support Costs Need	Healthcare Facilities Priority List	Binding Obligations Subtotal	Current Services & Binding Obligations Total	Program Increases	**FY 2020 National Recomm**	$	%
SERVICES																		
Hospitals and Health Clinics	1,935,178	6,642	10,156	16,798	2,423	23,213	25,636	34,854	77,288	75,000	0	0	75,000	152,288	409,042	**2,496,508**	561,330	29.0%
Dental Services	182,597	792	1,066	1,858	57	1,999	2,056	3,266	7,180	0	0	0	0	7,180	98,264	**288,041**	105,444	57.7%
Mental Health	94,080	286	530	816	20	1,048	1,068	1,521	3,405	0	0	0	0	3,405	157,245	**254,730**	160,650	170.8%
Alcohol & Substance Abuse	218,353	225	1,414	1,639	31	3,373	3,404	4,087	9,130	0	0	0	0	9,130	123,754	**351,237**	132,884	60.9%
Purchased/Referred Care	928,830	0	0	0	0	37,382	37,382	17,721	55,103	0	0	0	0	55,103	406,993	**1,390,926**	462,096	49.8%
Total, Clinical Services	3,359,038	7,945	13,166	21,111	2,531	67,015	69,546	61,449	152,106	75,000	0	0	75,000	227,106	**1,195,297**	**4,781,441**	1,422,403	42.3%
Public Health Nursing	78,701	302	494	796	27	2,031	2,058	1,432	4,286	0	0	0	0	4,286	21,881	**104,868**	26,167	33.2%
Health Education	18,663	41	134	175	2	596	598	344	1,117	0	0	0	0	1,117	19,951	**39,731**	21,068	112.9%
Comm. Health Reps	60,325	7	493	500	1	2,336	2,337	1,123	3,960	0	0	0	0	3,960	18,887	**83,172**	22,847	37.9%
Immunization AK	2,041	0	17	17	0	74	74	35	126	0	0	0	0	126	0	**2,167**	126	6.2%
Total, Preventive Health	159,730	350	1,138	1,488	30	5,037	5,067	2,934	9,489	0	0	0	0	9,489	**60,718**	**229,937**	70,207	44.0%
Urban Health	47,678	21	244	265	65	1,470	1,535	785	2,585	0	0	0	0	2,585	32,748	**83,011**	35,333	74.1%
Indian Health Professions	49,345	18	0	18	985	0	985	0	1,003	0	0	0	0	1,003	16,197	**66,545**	17,200	34.9%
Tribal Management	2,465	0	0	0	46	0	46	0	46	0	0	0	0	46	417	**2,928**	463	18.8%
Direct Operations	70,420	466	175	641	641	0	641	0	1,282	0	0	0	0	1,282	614	**72,316**	1,896	2.7%
Self-Governance	5,786	20	0	20	82	0	82	0	102	0	0	0	0	102	422	**6,310**	524	9.0%
Total, Other Services	175,694	525	419	944	1,819	1,470	3,289	785	5,018	0	0	0	0	5,018	50,396	**231,108**	55,414	31.5%
Total, Services	3,694,462	8,820	14,723	23,543	4,380	73,522	77,902	65,168	166,613	75,000	0	0	75,000	241,613	**1,306,412**	**5,242,487**	1,548,025	32.4%
FACILITIES																		
Maintenance & Improvement	75,745	0	0	0	1,872	0	1,872	1,604	3,476	0	0	0	0	3,476	32,531	**111,752**	36,007	47.5%
Sanitation Facilities Constr.	101,772	0	0	0	2,349	0	2,349	2,072	4,421	0	0	0	0	4,421	72,544	**178,737**	76,965	75.6%
Health Care Fac. Constr.	117,991	0	0	0	3,886	0	3,886	0	3,886	0	0	100,000	100,000	103,886	81,389	**303,266**	185,275	157.0%
Facil. & Envir. Hlth Supp.	226,950	1,313	1,127	2,440	1,910	1,012	2,922	4,084	9,446	0	0	0	0	9,446	9,426	**245,822**	18,872	8.3%
Equipment	22,966	0	0	0	33	825	858	424	1,282	0	0	0	0	1,282	24,058	**48,306**	25,340	110.3%
Total, Facilities	545,424	1,313	1,127	2,440	10,050	1,837	11,887	8,184	22,511	0	0	100,000	100,000	122,511	219,948	**887,883**	342,459	62.8%
CONTRACT SUPPORT COSTS																		
CSC Need	800,000	0	0	0	0	0	0	0	0	0	100,000	0	100,000	100,000	0	**900,000**	100,000	12.5%
Total, Contract Support Costs	800,000	0	0	0	0	0	0	0	0	0	100,000	0	100,000	100,000	0	**900,000**	100,000	12.5%
TOTAL, IHS	**5,039,886**	**10,133**	**15,850**	**25,983**	**14,430**	**75,359**	**89,789**	**73,352**	**189,124**	**75,000**	**100,000**	**100,000**	**275,000**	**464,124**	**1,526,359**	**7,030,369**	1,990,483	39.5%
$ Change over prior year									$189,124					$464,124		$1,990,483		
% Change over prior year									3.75%					9.21%		39.5%		