LEGISLATIVE SUMMARY SHEET
Tracking No. 0315-18

DATE: September 21, 2018

AN ACTION RELATING TO HEALTH, EDUCATION AND HUMAN SERVICES; RECOMMENDING FOR APPROVAL OF THE NAABIK'IYATI' COMMITTEE THE DESIGNATION OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION AS A NAVAJO NATION "TRIBAL ORGANIZATION" FOR A PERIOD OF TWENTY-FIVE (25) YEARS, FOR THE PURPOSES OF CONTRACTING WITH THE UNITED STATES INDIAN HEALTH SERVICE AND AUTHORIZING IT TO NEGOTIATE AND ENTER INTO TITLE I, INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED) CONTRACTS AND TITLE V SELF GOVERNANCE COMPACTS PURSUANT TO THE INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED), SUCH DESIGNATION OF "TRIBAL ORGANIZATION" BEING REVOCABLE AND CONTINGENT ON COMPLIANCE WITH ALL TERMS AND CONDITIONS AS REQUIRED

PURPOSE: The purpose of this legislation is to renew the revocable designation of "Tribal Organization" to the Tuba City Regional Health Care Corporation for a period of twenty-five (25) years to contract to provide health services to the Navajo Nation under Public Law 638.

This written summary does not address recommended amendments as may be provided by the standing committees. The Office of Legislative Counsel requests each Council Delegate review the proposed resolution in detail.

PROPOSED STANDING COMMITTEE RESOLUTION

23rd NAVAJO NATION COUNCIL -- Fourth Year, 2018

INTRODUCED BY

(Lee Jr. Tolth)

(Prime Sponsor)

TRACKING NO. 0315-18

AN ACTION

RELATING TO HEALTH, EDUCATION AND HUMAN SERVICES; RECOMMENDING FOR APPROVAL OF THE NAABIK'IYATI' COMMITTEE THE DESIGNATION OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION AS A NAVAJO NATION "TRIBAL ORGANIZATION" FOR A PERIOD OF TWENTY-FIVE (25) YEARS, FOR THE PURPOSES OF CONTRACTING WITH THE UNITED STATES INDIAN HEALTH SERVICE AND AUTHORIZING IT TO NEGOTIATE AND ENTER INTO TITLE I, INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED) CONTRACTS AND TITLE V SELF GOVERNANCE COMPACTS PURSUANT TO THE INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED), SUCH DESIGNATION OF "TRIBAL ORGANIZATION" BEING REVOCABLE AND CONTINGENT ON COMPLIANCE WITH ALL TERMS AND CONDITIONS AS REQUIRED

BE IT ENACTED:

SECTION ONE. AUTHORITY

A. The Health, Education and Human Services Committee (Committee) is an established Committee of the Navajo Nation Council. 2 N.N.C. §400(A).

B. The Health, Education and Human Services Committee exercises oversight responsibility over all matters related to health on the Navajo Nation. 2 N.N.C. §400 (C)(1)

C. The Health, Education and Human Services Committee exercises authority to review and recommend the authorization and designation of a for-profit or non-profit health or social services organization as a tribal organization for the purposes of contracting or compacting under the Indian Self-Determination and Education Assistance Act. 2 N.N.C. § 401 (6)(e)

D. Navajo Nation Council Resolution CJY-33-10 authorized the previously existing Intergovernmental Relations Committee of the Navajo Nation Council to act as final approval authority, only upon a recommendation for approval by the Health, Education and Social Services Committee and each of the Navajo Nation Chapters to be served, for all additional designations of "tribal organizations". CJY-33-10

E. Upon reorganization of the Navajo Nation Council and Committees the Naabik'iyati Committee assumed, unless otherwise specified, all the responsibilities of the previous Navajo Nation Council's Intergovernmental Relations Committee and the Health, Education and Social Services Committee was renamed the Health, Education and Human Services Committee. CAP-10-11

F. The Naabik'iyati' Committee of the Navajo Nation Council, only upon the recommendation for approval by the Health, Education and Human Services Committee and the approval of each of the Navajo Nation Chapters to be served, is to act as the final authority for approving the revocable designation of "tribal organization" for purposes of contracting under the Indian Self-Determination Act (P.L. 93-638, as amended).

SECTION TWO. FINDINGS

A. The Tuba City Regional Health Care Corporation has requested to be designated a "tribal organization" for the purposes of contracting with the United States Indian Health Service and to negotiate and enter into Title I, Indian Self-Determination Act (P.L. 93-638, as amended) contracts and Title V Self Governance Compacts pursuant to the Indian Self-Determination Act (P.L. 93-638, as amended). See Exhibit A.

B. The Tuba City Regional Health Care Corporation serves the Navajo Nation Chapters of To'Nanees'Dizi Local Government, To Nihalii', K'ai'Bii'To', Coalmine, Cameron, Coppermine,Bodaway/Gap, LeChee Chapters.

C. The Tuba City Regional Health Care Corporation proposal for designation of "tribal organization" has been endorsed by separate resolutions adopted by all the named respective Chapters and the Upper Village of Moenkopi Village Council, the Hopi Tribal Council and the San Juan Southern Paiute Tribal Council. See Exhibit A, Tab No. 4.

D. The Health, Education and Human Services Committee of the Navajo Nation Council finds it to be in the best interest of the Navajo Nation to approve and recommend to the Naabik'iyati' Committee that the Tuba City Regional Health Care Corporation be given the revocable designation of "tribal organization" for a period of twenty-five (25) years, beginning October 1, 2020 and ending September 30, 2045, for the purposes of contracting with the United States Indian Health Service and to negotiate and enter into Title I, Indian Self-Determination Act (P.L. 93-638, as amended) contracts and Title V Self Governance Compacts pursuant to the Indian Self-Determination Act (P.L. 93-638, as amended), subject to the Terms and Conditions as found attached at Exhibit B.

Section Three. Approval

A. The Health, Education and Human Services Committee of the Navajo Nation Council hereby approves and recommends to the Naabik'iyati' Committee that the Tuba City Regional Health Care Corporation be given the revocable designation of "tribal organization" for a period of twenty-five (25) years, beginning October 1, 2020 and ending September 30, 2045, for the purposes of contracting with the United States Indian Health Service and to negotiate and enter into Title I, Indian Self-Determination Act (P.L. 93-638, as amended) contracts and Title V Self Governance Compacts pursuant to the Indian Self-Determination Act (P.L. 93-638, as amended), subject to the Terms and Conditions as found attached at Exhibit B.

B. The recommendation of the Health, Education and Human Services Committee is contingent on there being no changes to the Terms and Conditions as found at Exhibit B without the approval of the Health, Education and Human Services Committee.

EXHIBIT

tabbies

A

TITLE V

REAUTHORIZATION

TUBA CITY
Regional Health
Care Corporation

GREAT SEAL OF THE NAVAJO NATION

Tuba City
Regional Health Care Corporation

Table of Contents

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: JUN 15 2005

TUBA CITY REGIONAL HEALTH CARE
CORPORATION
PO BOX 600
TUBA CITY, AZ 86045-0000

Employer Identification Number:
04-3651340
DLN:
17053217024034
Contact Person:
SHAWNTEL R MCGUIRE ID# 31456
Contact Telephone Number:
(877) 829-5500
Accounting Period Ending:
September 30
Public Charity Status:
170(b)(1)(A)(iii)
Form 990 Required:
Yes
Effective Date of Exemption:
January 19, 2001
Contribution Deductibility:
Yes

Dear Applicant:

We are pleased to inform you that upon review of your application for tax exempt status we have determined that you are exempt from Federal income tax under section 501(c)(3) of the Internal Revenue Code. Contributions to you are deductible under section 170 of the Code. You are also qualified to receive tax deductible bequests, devises, transfers or gifts under section 2055, 2106 or 2522 of the Code. Because this letter could help resolve any questions regarding your exempt status, you should keep it in your permanent records.

Organizations exempt under section 501(c)(3) of the Code are further classified as either public charities or private foundations. We determined that you are a public charity under the Code section(s) listed in the heading of this letter.

Please see enclosed Information for Exempt Organizations Under Section 501(c)(3) for some helpful information about your responsibilities as an exempt organization.

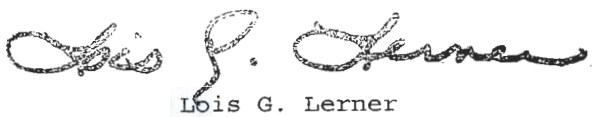
Letter 947 (DO/CG)

FILE

TUBA CITY REGIONAL HEALTH CARE

We have sent a copy of this letter to your representative as indicated in your power of attorney.

Sincerely,



Lois G. Lerner
Director, Exempt Organizations
Rulings and Agreements

Enclosures: Information for Organizations Exempt Under Section 501(c)(3)

TUBA CITY REGIONAL HEALTH CARE

INFORMATION FOR ORGANIZATIONS EXEMPT UNDER SECTION 501(c)(3)

WHERE TO GET FORMS AND HELP

Forms and instructions may be obtained by calling toll free 1-800-829-3676, through the Internet Web Site at www.irs.gov, and also at local tax assistance centers.

Additional information about any topic discussed below may be obtained through our customer service function by calling toll free 1-877-829-5500 between 8:30 a.m. - 5:30 p.m. Eastern time.

NOTIFY US ON THESE MATTERS

If you change your name, address, purposes, operations or sources of financial support, please inform our TE/GE Customer Account Services Office at the following address: Internal Revenue Service, P.O. Box 2508, Cincinnati, Ohio 45201. If you amend your organizational document or by-laws, or dissolve your organization, provide the Customer Account Services Office with a copy of the amended documents. Please use your employer identification number on all returns you file and in all correspondence with the Internal Revenue Service.

FILING REQUIREMENTS

In your exemption letter we indicated whether you must file Form 990, Return of Organization Exempt From Income Tax. Form 990 (or Form 990-EZ) is filed with the Ogden Submission Processing Center, Ogden UT 84201-0027.

You are required to file a Form 990 only if your gross receipts are normally more than $25,000.

If your gross receipts are normally between $25,000 and $100,000, and your total assets are less than $250,000, you may file Form 990-EZ. If your gross receipts are over $100,000, or your total assets are over $250,000, you must file the complete Form 990. The Form 990 instructions show how to compute your "normal" receipts.

Form 990 Schedule A is required for both Form 990 and Form 990-EZ.

If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. There are penalties for failing to timely file a complete return. For additional information on penalties, see Form 990 instructions or call our toll free number.

If your receipts are below $25,000, and we send you a Form 990 Package, follow the instructions in the package on how to complete the limited return to advise us that you are not required to file.

If your exemption letter states that you are not required to file Form 990, you

TUBA CITY REGIONAL HEALTH CARE

are exempt from these requirements.

UNRELATED BUSINESS INCOME TAX RETURN

If you receive more than $1,000 annually in gross receipts from a regular trade or business you may be subject to Unrelated Business Income Tax and required to file Form 990-T, Exempt Organization Business Income Tax Return. There are several exceptions to this tax.

1. Income you receive from the performance of your exempt activity is not unrelated business income.

2. Income from fundraisers conducted by volunteer workers, or where donated merchandise is sold, is not unrelated business income.

3. Income from routine investments such as certificates of deposit, savings accounts, or stock dividends is usually not unrelated business income.

There are special rules for income derived from real estate or other investments purchased with borrowed funds. This income is called "debt financed" income. For additional information regarding unrelated business income tax see Publication 598, Tax on Unrelated Business Income of Exempt Organizations, or call our toll free number shown above.

PUBLIC INSPECTION OF APPLICATION AND INFORMATION RETURN

You are required to make your annual information return, Form 990 or Form 990-EZ, available for public inspection for three years after the later of the due date of the return, or the date the return is filed. You are also required to make available for public inspection your exemption application, any supporting documents, and your exemption letter. Copies of these documents are also required to be provided to any individual upon written or in person request without charge other than reasonable fees for copying and postage. You may fulfill this requirement by placing these documents on the Internet. Penalties may be imposed for failure to comply with these requirements. Additional information is available in Publication 557, Tax-Exempt Status for Your Organization, or you may call our toll free number shown above.

FUNDRAISING

Contributions to you are deductible only to the extent that they are gifts and no consideration is received in return. Depending on the circumstances, ticket purchases and similar payments in conjunction with fundraising events may not qualify as fully deductible contributions.

CONTRIBUTIONS OF $250 OR MORE

Donors must have written substantiation from the charity for any charitable contribution of $250 or more. Although it is the donor's responsibility to obtain written substantiation from the charity, you can assist donors by

providing a written statement listing any cash contribution or describing any donated property.

This written statement must be provided at the time of the contribution. There is no prescribed format for the written statement. Letters, postcards and electronic (e-mail) or computer-generated forms are acceptable.

The donor is responsible for the valuation of donated property. However, your written statement must provide a sufficient description to support the donor's contribution. For additional information regarding donor substantiation, see Publication 1771, Charitable Contributions - Substantiation and Disclosure Requirements. For information about the valuation of donated property, see Publication 561, Determining the Value of Donated Property.

CONTRIBUTIONS OF MORE THAN $75 AND CHARITY PROVIDES GOODS OR SERVICES

You must provide a written disclosure statement to donors who receive goods or services from you in exchange for contributions in excess of $75.

Contribution deductions are allowable to donors only to the extent their contributions exceed the value of the goods or services received in exchange. Ticket purchases and similar payments in conjunction with fundraising events may not necessarily qualify as fully deductible contributions, depending on the circumstances. If your organization conducts fundraising events such as benefit dinners, shows, membership drives, etc., where something of value is received, you are required to provide a written statement informing donors of the fair market value of the specific items or services you provided in exchange for contributions of more than $75.

You should provide the written disclosure statement in advance of any event, determine the fair market value of any benefit received, determine the amount of the contribution that is deductible, and state this information in your fundraising materials such as solicitations, tickets, and receipts. The amount of the contribution that is deductible is limited to the excess of any money (and the value of any property other than money) contributed by the donor less the value of goods or services provided by the charity. Your disclosure statement should be made, no later than, at the time payment is received. Subject to certain exceptions, your disclosure responsibility applies to any fundraising circumstances where each complete payment, including the contribution portion, exceeds $75. For additional information, see Publication 1771 and Publication 526, Charitable Contributions.

EXCESS BENEFIT TRANSACTIONS

Excess benefit transactions are governed by section 4958 of the Code. Excess benefit transactions involve situations where a section 501(c)(3) organization provides an unreasonable benefit to a person who is in a position to exercise substantial influence over the organization's affairs. If you believe there may be an excess benefit transaction involving your organization, you should report the transaction on Form 990 or 990-EZ. Additional information can be

found in the instructions for Form 990 and Form 990-EZ, or you may call our toll free number to obtain additional information on how to correct and report this transaction.

EMPLOYMENT TAXES

If you have employees, you are subject to income tax withholding and the social security taxes imposed under the Federal Insurance Contribution Act (FICA). You are required to withhold Federal income tax from your employee's wages and you are required to pay FICA on each employee who is paid more than $100 in wages during a calendar year. To know how much income tax to withhold, you should have a Form W-4, Employee's Withholding Allowance Certificate, on file for each employee. Organizations described in section 501(c)(3) of the Code are not required to pay Federal Unemployment Tax (FUTA).

Employment taxes are reported on Form 941, Employer's Quarterly Federal Tax Return. The requirements for withholding, depositing, reporting and paying employment taxes are explained in Circular E, Employer's Tax Guide, (Publication 15), and Employer's Supplemental Tax Guide, (Publication 15-A). These publications explain your tax responsibilities as an employer.

CHURCHES

Churches may employ both ministers and church workers. Employees of churches or church-controlled organizations are subject to income tax withholding, but may be exempt from FICA taxes. Churches are not required to pay FUTA tax. In addition, although ministers are generally common law employees, they are not treated as employees for employment tax purposes. These special employment tax rules for members of the clergy and religious workers are explained in Publication 517, Social Security and Other Information for Members of the Clergy and Religious Workers. Churches should also consult Publications 15 and 15-A. Publication 1828, Tax Guide for Churches and Religious Organizations, also discusses the various benefits and responsibilities of these organizations under Federal tax law.

PUBLIC CHARITY STATUS

Every organization that qualifies for tax-exemption as an organization described in section 501(c)(3) is a private foundation unless it falls into one of the categories specifically excluded from the definition of that term [referred to in section 509(a)(1), (2), (3), or (4)]. In effect, the definition divides these organizations into two classes, namely private foundations and public charities.

Public charities are generally those that either have broad public support or actively function in a supporting relationship to those organizations.

Public charities enjoy several advantages over private foundations. There are certain excise taxes that apply to private foundations but not to public charities. A private foundation must also annually file Form 990-PF, Return of Private Foundation, even if it had no revenue or expenses.

Tuba City Regional Health Care Corporation
2016 Annual Report to the Health, Education and Human Services Committee
23rd Navajo Nation Council

Monday, October 24, 2016
Vermillion Cliffs Conference Room, TCRHCC, Tuba City, AZ

A G E N D A

10:00 AM	**Welcome/Invocation/Introduction**
TAB 1 10:15 AM	**Annual Message from Christopher Curley, President, Board of Directors** **Lynette Bonar, RN, BSN, MBA, Chief Executive Officer** • Establishing the Health Care Delivery Foundation for Transforming Generations • 2016 Annual Report
TAB 2 10:30 AM	**Annual Financial Report Card** **Christine Keyonnie, CPA, MSA, Chief Financial Officer** • FY 2016 Financial Report and Investment • FY 2016 Financial Operations and Capital Budget
TAB 3 11:00 AM	**Community Health Division** **Dollie Smallcanyon, MSN, Chief Community Health Services Officer** • Division Overview: Services to Elders and Youth
TAB 4 11:30 AM	**Quality Management Division** **William Dey, RN, MHA, Chief Quality Officer** • The Joint Commission Accreditation
Working Lunch	
TAB 5 12:00 PM	**Patient Care Services** **Dr. James Kyle, II, Chief Medical Officer** **Alvina Rosales, RN, MSN, MBA, Chief Nurse Officer** **Joette Walters, RN, Deputy Chief Nurse Officer** • Medical Staff Challenges and Improvements • Nursing Services Challenges and Improvements • Clinical Education Program and Partnership
TAB 6 12:30 PM	**Projects Update** **Julius Young, II, MBA, Chief Support Services Officer** **Shawn Davis, MIS, Chief Information Officer** • Facilities Capital Improvements • Elder Care Projects: Kaibeto Independent Living Center and Long Term Care • IT Overview: Disaster Recovery and IS Security Initiatives
TAB 7 1:00 PM	**Human Resources Division** **George Hunter, SHRM, MBA, Interim Chief Human Resources Officer** • Employee Workforce Update
TAB 8	**Resources** • **FY 2017 Strategic Priorities: Capital and Operations**
1:30 PM	**Discussion and Closing Summary**

Navajo Nation Council Health, Education and Human Services Committee

- Honorable Jonathan Hale, Chairperson
- Honorable Norman Begay, Vice Chairperson
- Honorable Nelson S. BeGaye, Member
- Honorable Nathaniel Brown, Member
- Honorable Amber Kanazbah Crotty, Member
- Honorable Peterson B. Yazzie, Member
- Ron Haven, Legal Counsel
- Beverly Martinez, Legislative Advisor
- Karen Thompson, Legislative Recorder

Board of Directors, Tuba City Regional Health Care Corporation

- Christopher Curley, BA, President, Tonalea Chapter
- Tincer Nez, Sr., Vice-President Coalmine Canyon Chapter
- Kimberlee Williams, BA, Treasurer, Kaibeto Chapter
- Dolly Lane, MBA, Bodaway/Gap Chapter
- Dr. Alan Numkena, Member, Moenkopi Village
- Laura Gon, Member, Cameron Chapter
- Herman Tso, BS, Member, LeChee Chapter
- Justice Merle Beard, M. Ed., Member, To'Nanees'Dizi Chapter
- Millie Brockie, PA, Retired, Member, Coppermine Chapter

Senior Leadership Council and Staff, Tuba City Regional Health Care Corporation

- Lynette Bonar, RN, BSN, MBA, Chief Executive Officer
- James Kyle, II, MD, Chief Medical Officer
- Holly VanDyk, MD, Deputy Chief Medical Officer
- Alvina Rosales, RN, MSN, MBA, Chief Nurse Officer
- Joette Walters, RN, BSN, MBA Candidate, Deputy Chief Nurse Officer
- Christine Keyonnie, CPA, MSA, Chief Financial Officer
- Gerard Diviney, CPA, Sr. Financial Advisor
- William Dey, RN, MHA, Chief Quality Officer
- George Hunter, SHRM, MBA, Interim Chief Human Resource Officer
- Lorraine Begay, BSBA, Deputy Chief Human Resource Officer
- Sharr Yazzie, MBA, HR Specialist
- Shawn Davis, MIS, Chief Information Officer
- Dollie Smallcanyon, RN, MSN, Chief Community Health Resources Officer
- Julius Young, II, MBA, Chief Support Services Officer
- Sara Jager, MD, Chief of Staff
- Alvina Tunney-Patterson, MBA, CHC, Chief Compliance Officer

Annual Report

to Navajo Nation Health, Education and Human Services Committee

Resources on jump drive

October 24, 2016

1. Navajo Nation Certificate of Good Standing
2. Articles of Incorporation
3. TCRHCC Bylaws Approved 4-21-16
4. CJY-33-10 Title V Compacting Legislation
5. NN Health Compact between NN Tribal Organization and the Federal Government
6. Funding Agreement FY 2013-2018
7. TCRHCC Single Audit Reporting Package
9. TCRHCC List of Licensing, Certifying and Oversight Authorities
10. TCRHCC The Joint Commission Certificates
11. Tuba City Investment Policy
12. TCRHCC Annual Report
13. TCRHCC Annual Report Presentations to HEHSC

TUBA CITY REGIONAL HEALTH CARE CORPORATION

167 North Main Street, P.O. Box 600
Tuba City, Arizona 86045-0600
(928) 283.2501

Tuba City Regional Health Care Corporation
Orientation to the Health Education and Human Services Committee
Of the 23rd Navajo Nation Council

Tuesday, July 7, 2015 at 9:00 am (DST)
Coral Conference Room, Navajo Nation Quality Inn, Window Rock, AZ

AGENDA

TCRHCC Mission & Vision History & Partnership Integrated Health System Board of Directors Governance	Lynette Bonar, Chief Executive Officer
Presentation topics:	Lynette Bonar, Chief Executive Officer Senior Leadership Council & Staff

- TCRHCC Accomplishments and Priorities (Added) (Slide 10)
  - Operations Priorities (Slide 11)
  - Five Facilities I.H.S. Construction Priorities (Slide 12)
- TCRHCC Patient Financial Service (Added)
  - Revenue Cycle Overview (Slide 13)
  - All Inclusive Reimbursement (Slide 33)
- Human Resources (Slide 53)
- Nurse Division (Slide 63)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Program (73)
- Sacred Peaks Health Center (Slide 83)
- Community Health Center Mobile Health Program (Slide 91)
- Community Health Assessment (Slide 101)
- Quality Division
  - TCRHCC & Northern Arizona VA Health Care System (Slide 120)
  - Case Management (Slide 131)
  - Registered Nurse – Southern Arizona Branch (Slide 135)
  - Risk Management & Patient Advocate (Slide 139)
  - Purchase Referred Care (Added) (Slide 147)
- Information Technology Division (Slide 171)

Closing Remarks	Dolly Lane, Board Treasurer Tincer Nez, Sr., Board Vice-President Christopher Curley, Board President

July 7, 2015 Participants

Navajo Nation Council Health Education and Human Services Committee

- Honorable Jonathan Hale, Chairperson
- Honorable Norman Begay, Vice Chairperson
- Honorable Nelson S. BeGaye, Member
- Honorable Nathaniel Brown, Member
- Honorable Amber Kanazbah Crotty, Member
- Honorable Tuchoney Slim, Jr., Member
- Ron Haven, Legal Counsel
- Christine Schwamberger, Legal Counsel
- Beverly Martinez, Legislative Advisor
- Valcita Thompson, Legislative Recorder

Senior Leadership Council and Staff, Tuba City Regional Health Care Corporation

- Lynette Bonar, RN, BSN, MBA, Chief Executive Officer
- James Kyle, II, MD, Chief Medical Officer
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- Joette Walters, RN, BSN, Deputy Chief Nurse Officer
- Christine Keyonnie, MSA, (CPA Candidate) Deputy Chief Financial Officer
- Melverta Barlow, BA, Director of Patient Financial Services
- Bill Dey, RN, MHA, Chief Quality Officer
- Lorraine Begay, BSBA, Deputy Chief Human Resource Officer
- Tim Newland, RN, MHA, Chief Support Services Officer
- Shawn Davis, MIS, Chief Information Officer
- Dollie Smallcanyon, RN, MSN, Chief Community Health Resources Officer
- Tammy Trujillo, MPH Intern, University of Arizona
- Veronica Hardy-Becenti, BA, Sr. Executive Assistant
- Lisa Butler, BSW, Executive Assistant

Board of Directors, Tuba City Regional Health Care Corporation

- Christopher Curley, BA, President, Tonalea Chapter
- Tincer Nez, Sr., Vice-President Coalmine Canyon Chapter
- Dolly Lane, MBA, Treasurer, Bodaway/Gap Chapter
- Dr. Alan Numkena, Member, Moenkopi Village
- Esther Tsinigine, LPN, MLT, Member, Coppermine Chapter
- Laura Gon, Member, Cameron Chapter
- Herman Tso, BS, Member, LeChee Chapter
- Kimberlee Williams, BA, Kaibeto Chapter
- Merle Beard, M. Ed., Member, To'Nanees'Dizi Chapter

Navajo Nation Council Health Education and Human Services Committee

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- Tim Newland, RN, MHA, Chief Support Services Officer
- Shawn Davis, MIS, Chief Information Officer
- Dollie Smallcanyon, RN, MSN, Chief Community Health Resources Officer
- Kathryn Magee, MD, Director of Outpatient Services
- Kathleen Harner, MD, MPH, FACOG, Chief of Staff
- John Wright, MD, Deputy Chief of Staff
- Alvina Tunney-Patterson, MBA, CHC, Chief Compliance Officer
- Zane Kelly, DO, FACOS
- Diana Hu, MD
- Aurelia Yazzie, BA, Community Relations Director
- Dominika Heusinkveld, MD, MPH, Director, Diabetes Treatment and Prevention Services
- Shannon Johnson, RN, BSN, Trauma Director
- Violet Skinner, RN, BSN, Director, Utilization Review
- Lynnette Gilmore, MPT, DPT, Director, Physical Rehabilitation
- Everlee McCabe, BS, DMEPOS Manager
- Roselyn Riggs, BSB/M, Manager, Mobile Health Program
- Shannon Newland, RN, MHA, Risk Manager
- Maredith Thomas, MPA, Patient Advocate
- Yolanda Burke, RN, BSN, Nurse Consultant
- Veronica Hardy-Becenti, BA, Sr. Executive Assistant
- Lisa Butler, BSW, Executive Assistant

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TUBA CITY REGIONAL HEALTH CARE CORPORATION

167 North Main Street, P.O. Box 600
Tuba City, Arizona 86045-0600
(928) 283.2501

Tuba City Regional Health Care Corporation
Orientation to the Health Education and Human Services Committee
Of the 23rd Navajo Nation Council

Wednesday, June 3, 2015 at 10:00 am (DST)
Vermillion Cliffs Conference Room, TCRHCC, Tuba City, AZ

AGENDA

TCRHCC Mission & Vision History & Partnership Integrated Health System Board of Directors Governance	Lynette Bonar, Chief Executive Officer
Presentation topics:	Lynette Bonar, Chief Executive Officer Senior Leadership Council & Staff

- Management, Strategic Priorities and Finance (Slide 10)
- Human Resources (Slide 21)
- Trauma Designation (Slide 31)
- Nurse Division (Slide 41)
- Adolescent Health (Slide 51)
- Diabetes Treatment & Prevention Services (Slide 59)
- TCRHCC & Northern Arizona VA Health Care System (Slide 79)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Program (89)
- Sacred Peaks Health Center (Slide 99)
- Community Health Center Mobile Health Program (Slide 107)
- Community Health Assessment (Slide 114)
- Case Management Division: RN Consultant, Risk Management & Patient Advocate
- LeChee Health Facility (Slide 149)
- Multi-Family Housing Complex (Slide 153)
- Kaibeto Independent Living Center (Slide 156)
- Tuba City Long Term Care (Slide 159)
- Support Services Division (Slide 165)
- Information Technology Division (Slide 171)

Tour of Facility	Aurelia Yazzie, Community Relations Director
Closing Remarks	Dolly Lane, Board Treasurer Tincer Nez, Sr., Board Vice-President Christopher Curley, Board President

TUBA CITY REGIONAL HEALTH CARE CORPORATION (TCRHCC)
TUBA CITY, ARIZONA
Board of Directors Policy

SUBJECT: TUBA CITY INVESTMENT POLICY	
REVISION DATE: 17 April 2014	**SUPERSEDES DATE:** 19 December 2013

I. Purpose:

A. To generate the best possible return while protecting the real purchasing power of its financial assets, Tuba City Regional Health Care Corporation (TCRHCC) carefully considers calculated financial risks through authorized investment strategies. Safety of principal is the foremost objective of the investment policy. Investments will be undertaken in a manner that seeks to ensure the preservation of capital in the overall portfolio. The idea of safety is to mitigate credit risk and interest rate risk. All investments shall follow the prudent investor rule.

B. This policy does not apply to pension funds.

II. Policy:

A. Whenever cash funds exceed the cash needs, the TCRHCC Board of Directors has directed that such excess funds should first be used to pay down indebtedness where applicable or be deposited into interest bearing money market funds. Board Designated Funds shall be defined by the Finance Committee and approved by the Board of Directors. At a minimum, the days cash on hand should exceed 100 days.

B. From time to time investments will be managed through external programs, facilities and professionals. To constitute compliance all investments must be managed in a manner consistent with this policy. The Finance Committee shall select the investment adviser/broker and the money market account in which the funds will be placed.

III. Procedure:

A. With the approval of the TCRHCC Board of Directors, the investment portfolio will be managed by the Chief Financial Officer, or other officer to act as Investment Officer, who will strive to invest with the judgment and care that prudent individuals would exercise in the execution of their own affairs, to maintain the safety of principal, maintain liquidity to meet cash flow needs, and to provide competitive investment returns.

B. Investment objectives include:

1. Safety of principal;
2. Minimize risk; *and*
3. Liquidity of investment.

C. Following the primary objective of preservation of capital, investments should be actively managed to take advantage of market opportunities. In so doing, negotiable securities may be sold prior to their maturity to provide liquid funds as needed for cash flow purposes, to enhance portfolio returns, or to restructure maturities to increase yield and/or reduce risk. In accordance with this investment policy assets may be sold at a loss only if it is felt that the sale of the security is in the best long-term interest of the TCRHCC.

D. The Finance Committee should periodically establish benchmark allocations and target yields for portfolio growth and diversification. Currently:

Investment	Maximum Allocation	Minimum Allocation	Current Allocation	Target Allocation Next Year	Target Return
Short Term (MMA)	90% of Short Term	0% of Short Term	65%	50%	.05%
Short Term Bonds	50% of Short Term	0% of Short Term	35%	50%	.2%
Long Term Bonds	60% of Long Term	40% of Long Term	49%	50%	2%
Long Term Equities	60% of Long Term	40% of Long Term	51%	50%	4-8%

All investment decision must be approved by the Finance Committee and the Board of Directors.

E. The Bank of Arizona shall prepare a bi-annual investment report that will provide an analysis of the status of the current investment portfolio and transactions made over the reporting period. It will be prepared in a manner to allow the Board to draw a comparison between the portfolio's total return and the established investment objectives and goals, and to ascertain whether investment activities during the reporting period have conformed to the investment policy and appropriate risk levels. The report will include the following:

1. Listing of individual investments held at the end of the reporting period.
2. Listing of investments by maturity date.
3. Average weighted yield to maturity on investments as compared to the target yields.
4. Percentage of total portfolio that each type of investment represents.
5. Realized and un-realized gains or losses resulting from appreciation or depreciation by calculating the market value of securities in accordance with Generally Accepted Accounting Principles (GAAP).

IV. Distribution:

A. All Board of Directors Policy Manual located in the Quality Management Office;
B. TCRHCC Intranet Site for Board of Directors Policies;
C. Email to all Finance Department Heads and TCRHCC Staff; and
D. Legal Counsel.

SUBJECT: TUBA CITY INVESTMENT POLICY
This is an approved policy, the signed copy is on file with Quality Management.

SIGNATURE PAGE

Chief Quality Officer	DATE
Chief Financial Officer	DATE
Associate Executive Officer	DATE
Chief Executive Officer	DATE
President, Board of Directors	DATE

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
1.	The Health Care Self-Governance Tribal Organization must qualify as a participant under the Indian Self-Determination Act (P.L. 93-638, as amended) by: **A.** completing, to the satisfaction of the Navajo Nation Council, a planning phase as described under the Act and which includes: (1) legal and budgetary research; and (2) internal and tribal government planning and organizational preparation relating to the administration of health care programs. **B.** requesting participation in Title V, Self-Governance, by resolution by the governing body of the Navajo Nation; and **C.** demonstrating financial stability and financial management capability for the 3 fiscal years immediately preceding the application for Title V, Self-Governance.	TCRHCC adheres to the requirements of P.L. 93-638 by: **A.** Completion of the legal and budgetary planning and negotiation of a full Compact of Self-Governance and annual funding agreement; the current multi-year funding agreement covers 2013-2018. **B.** TCRHCC is a 501 (C)(3) non-profit Tribal Health Care Organization pursuant to the Indian Self-Determination Act (P.L. 93-638, as amended) enacted by the Navajo Nation Council on July 21, 2010 through Resolution CJY 33-10; compliance with "Exhibit A" was reaffirmed by Legislation #HEHSC CMY-014-12 on May 23, 2012. **C.** TCRHCC has maintained annual audits through REDW in accordance with generally accepted accounting principles ("GAAP"). Annual Financial Audits are submitted to our oversight committee; the Health, Education and Human Service Committee (HEHSC) of the Navajo Nation Council, the Navajo Nation President and Vice President and the Executive Director of the Navajo Department of Health at the annual report to HEHSC which is normally scheduled October through December. **TAB 1 Attachments:** • Navajo Nation Council Resolution CJY-33-10 • Multi-year Funding Agreement 2013-2018 • Audit Report; 2017, 2016, 2015 • Department of Health and Human Services Office of Audit Services letter from May 18, 2018
2.	The Health Care Self-Governance Tribal Organization shall maintain its eligibility for third party payments under the	TCRHCC maintains accreditation with The Joint Commission and compliance with the Centers for Medicare and Medicaid Service (CMS) in

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
	Centers for Medicare and Medicaid Service (CMS).	order to receive third party revenue. The following services are accredited with The Joint Commission: Hospital Accreditation Program, Home Care Program and Laboratory Accreditation Program. **TAB 2 Attachments:** • The Joint Commission certificates
3.	The Health Care Self-Governance Tribal Organization shall maintain continued accreditation by a nationally recognized accreditation program.	TCRHCC, a Joint Commission accredited health center, is a tribal organization authorized by the Navajo Nation Council under Title V of the Indian Self Determination and Education Assistance Act, P.L. 93-638 ("ISDEAA"). Under an ISDEAA compact with the Indian Health Service ("IHS"), TCRHCC provides Joint Commission Accredited health care services to Navajo, Hopi and San Juan Southern Paiute tribal members at its hospital campus in Tuba City, Arizona and LeChee Health Facility in LeChee, Arizona, located on the Navajo Nation, Cameron Dental Clinic in Cameron, Arizona, surrounding Community sites and schools via Telehealth, and our Health Resource Service Administration ("HRSA") Community Health Center Mobile Medical and Dental Vans, and at its Sacred Peaks Health Center sites (2) located off the Navajo Nation in Flagstaff, Arizona. TCRHCC serves as a specialty referral center for the western part of the Navajo and Hopi Reservations. **TAB 2 Attachment:** • List of Licensing, Certifying and Oversight Authorities • Level III Trauma Center Certificate of Verification from the American College of Surgeons and the Arizona Department of Health • Baby Friendly hospital through the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) • Level II Nursery Certification through Arizona Perinatal Trust

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
		• Prepared Care Emergency Department certification through the Arizona Chapter of American Academy of Pediatrics
4.	The Health Care Self-Governance Tribal Organization shall operate and administer their Self-Governance Compact programs under the oversight of the Health and Social Services Committee and pursuant to the authority of the Navajo Nation. The Health Care Self-Governance Tribal Organization shall appear and report to the Health and Social Services Committee and the Navajo Nation Council when requested to do so.	TCRHCC reports to the Health, Education and Human Services Committee (HEHSC) of the Navajo Nation Council annually. Reports cover patient services, case management and utilization services, care coordination, quality management, safety and performance improvement, risk management and customer services, community partnership and activities for health promotion and revenue cycle and finance. **TAB 3 Attachments:** • TCRHCC Annual Reports 2017, 2016, 2015
5.	The Health Care Self-Governance Tribal Organization shall maintain compliance with all monitoring and reporting requirements duly established by the Health and Social Services Committee-, including: **A.** The Health Care Self-Governance Tribal Organization shall submit copies of all final Federal Single Audit Act audit reports, including Audited Financial Statements, and final survey reports issued by its nationally recognized accreditation organization(s) and all associated corrective action plans to the Health and Social Services Committee with copies to the Navajo Nation Division of Health. **B.** The Health Care Self-Governance shall provide copies of the Self-Governance Compact and all Funding Agreements to the Navajo Division of Health.	TCRHCC complies with monitoring and reporting requirements as established by the HEHSC. **A.** TCRHCC Federal Single Audit Reports are submitted to the HEHSC, Navajo President and Vice President and the Executive Director for Navajo Health Department annually at the annual report to the HEHSC. **B.** TCRHCC Self-Governance Compacts and funding agreements are submitted with the annual report and financial audits to the HEHSC, Navajo President and Vice President and the Executive Director for Navajo Health Department annually at the annual report to the HEHSC. **C.** TCRHCC submits copies of its HEHSC Annual Report to HEHSC, Navajo President and Vice President and the Executive Director for Navajo Health Department annually at the annual report to the HEHSC. **TAB 4 Attachments:**

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
	C. The Health Care Self-Governance Tribal Organization shall provide copies of its Annual Report to the Health and Social Services Committee with copies to the Navajo Nation Division of Health. The format, criteria, and due date of the Annual Report shall be determined by the Health and Social Services Committee.	• Agendas from 2017, 2016, 2015 Annual Report to HEHSC and contents listed on jump-drive • Board of Director Resolution requesting Title V Reauthorization • Chapter Resolutions and Resolution from the San Juan Southern Paiute Tribal Council and Resolution from the Moenkopi Village supporting TCRHCC's request for Title V Reauthorization
6.	The Health Care Self-Governance Tribal Organization shall maintain continued compliance with all applicable Navajo Nation laws and regulations, including, but not limited to, the Navajo Preference in Employment Act.	TCRHCC maintains compliance with Navajo Nation laws and regulations including the Navajo Preference in Employment Act (NPEA) in recruitment, employment and retention. Workforce analysis reports are submitted quarterly to the Navajo Nation Labor Office. Employment statistics on current workforce, promotions and career mentorships are provided in the annual report to HEHSC. **TAB 5 Attachments:** • Navajo Nation Corporation Code - Certificate of Good Standing
7.	The Health Care Self-Governance Tribal Organization shall maintain compliance with all applicable Navajo Nation health care policies and priorities duly adopted by the Health and Social Services Committee.	TCRHCC is able to provide technical assistance to the Nation and of course welcomes advocacy from Navajo Nation officials to sustain and improve quality health services for our communities. TCRHCC advocates for health care programs and funding. TCRHCC has completed a design for a long term care facility and we are interested in moving forward in partnership with the Nation to provide long term care services. On Western Navajo there are no Long Term Care services. We are also excited to see the development of a Navajo Cancer Prevention Program. We are working to establish cancer care services. Planning a partnership with the Nation to add to the betterment of cancer education, prevention, detection and treatment is a laudable goal, and within reach if we work together. **TAB 6 Attachments:**

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
		• TCRHCC Comments to Navajo Nation Legislation on health care • TCRHCC letters to Navajo Nation President, Navajo Nation Council, Sihasin Sub-Committee on proposals for health care priorities, reports and talking points submitted to Council Delegates on health care
8.	The Health Care Self-Governance Tribal Organization will consult and cooperate with the Navajo Nation Division of Health concerning the public health needs and programs of the Navajo Nation.	TCRHCC strives to strengthen partnerships and build on a strong foundation for comprehensive health care services and public health needs. TCRHCC invites members of the Health, Education and Human Services Committee, the Navajo Nation Council, Executive Director of the Department of Health, area Chapter Officials and dignitaries and community members to the TCRHCC Quarterly Updates. These updates focus on building healthier communities through collaboration with community programs including programs of the Navajo Nation. Quarterly Update invitation, presentation list and presentation packets are sent to invitees via email, FAX and postal. TCRHCC Board of Directors resolutions show TCRHCC's support on public health needs and **TAB 7 Attachments:** • TCRHCC Board of Directors Resolution list • Quarterly Update agendas, sign in sheets and packets from 2017, 2018
9.	The Health Care Self-Governance Tribal Organization and the Navajo Division of Health shall timely develop an on-going written policy for the consultation on matters of public health and have such policy approved by the Health and Social Services Committee.	A draft consultation policy is developed and TCRHCC welcomes discussion on with the Navajo Department of Health to further develop this policy for public health matters. TCRHCC collaborates with programs that strengthen public health needs such has with the Navajo Birth Cohort program for environmental

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
		influences on child health outcomes (ECHO). Research projects demonstrate compliance with all Navajo Nation Human Research Review Board (NNHRRB). TCRHCC supports projects for the development of healthcare policies on Navajo. **TAB 8 Attachment:** • Draft Consultation Policy
10.	The Health Care Self-Governance Tribal Organization and the Navajo Nation Division of Health and Navajo Nation Department of Emergency Medical Service shall enter Memorandum of Understandings for the Navajo Nation's use and occupancy of Health Care Self-Governance Tribal Organization facilities as long as such use and occupancy does not interfere with direct care services.	Tuba City EMS is stationed at the TCRHCC. Under the Memorandum of Agreement, TCRHCC provides the office space and supplies for the ambulance service. Tuba City EMS provides coverage to Tuba City, Cameron, Grey Mountain, Bodaway/Gap, Tonalea, Rocky Ridge, Coalmine Canyon and Coppermine. TCRHCC ER Provider Dr. Edward Chu serves as the Navajo Nation EMS Director for Tuba City and Inscription House. Other Navajo Nation programs that are located with TCRHCC: • TB Control • Health Education • HIV Health Educator • STD Tech **TAB 9 Attachment:** • Memorandum of Understanding with Navajo Nation Programs
11.	The Health Care Self-Governance Tribal Organization in its dealings with the federal and state government, be it lobbying, advocacy, litigation, or negotiating efforts, shall only take	TCRHCC engages in programs, projects and services designed to improve, protect and/or restore individual, community and public health in order to achieve outcomes for improvement in access to, and the quality of

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as mentioned), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principals of Ke' to ensure that the health care needs of all Navajo Citizens are fully met.

	CJY 33-10 Exhibit "A" Conditions	Tuba City Regional Health Care Corporation (TCRHCC)
	positions or make arguments consistent with official published Navajo Nation positions.	health care and the overall health of individuals and communities. TCRHCC engages in, funding, carrying on, conducting or taking part in educational and training programs and courses of instruction I the field of medicine and preventative medicine and in nursing and in the regulation, diagnosis, treatment of care of diseases, disorders, maladjustments and abnormalities of the human body. TCRHCC engages in, funding, carrying out, conducting or taking part in any and all of the foregoing to promote or assist in promoting the good health of the community and the encouragement of providing means and facilities for such purpose. (from FA)
12.	The Health Care Self-Governance Tribal Organization shall not directly charge any tribal member for health care services nor charge the Navajo Nation Employee Benefit Plan or Worker's Compensation Plan for health care services provided to a covered tribal member unless the Indian Health Service would be able to charge the tribal member for the same service under the same circumstances unless otherwise authorized by the Navajo Nation Council.	TCRHCC does not charge the Navajo Nation Benefit plan for healthcare services and does not charge the Navajo Nation Worker's Compensation Plan for any Navajo Nation - Navajo employee or their beneficiaries.
13.	The Health Care Self-Governance Tribal Organization shall provide direct patient care to all Native American eligible users unless otherwise authorized by the Navajo Nation Council.	TCRHCC provides direct patient care to all Native Americans.

CJY-33-10

**RESOLUTION OF THE
NAVAJO NATION COUNCIL**

AN ACTION

RELATING TO HEALTH AND INTERGOVERNMENTAL RELATIONS; AUTHORIZING EXISTING AND FUTURE QUALIFYING TITLE I, INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED) CONTRACTORS, TO ENTER INTO TITLE V SELF GOVERNANCE COMPACTS PURSUANT TO THE INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED), SUCH CAPACITY BEGINNING OCTOBER 1, 2010 AND ENDING SEPTEMBER 30, 2020, AND ESTABLISHING A PROCEDURE FOR ADDITIONAL TITLE I CONTRACTORS TO ENTER INTO TITLE V SELF GOVERNANCE COMPACTS PURSUANT TO THE INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED)

BE IT ENACTED:

1. The Navajo Nation Council hereby authorizes the Winslow Indian Health Care Center, Inc., the Tuba City Regional Health Care Corporation and the Utah Navajo Health Systems Inc., as tribal organizations for the purpose of managing and operating under Title V, the Indian Self-Determination Act (P.L. 93-638, as amended), all programs, functions, services and activities (PFSAs) for which those tribal organizations currently contract or are eligible, including planning, design and construction projects within each tribal organizations' service area, under Title I of the Indian Self-Determination Act (P.L. 93-638, as amended), beginning October 1, 2010 and ending September 30, 2020, provided, however, that the decision whether and when to enter Title V Self-Governance shall be within the sole discretion of each tribal organization's Board of Directors and nothing in this resolution shall affect the tribal organizations' existing authority to operate under Title I, the Indian Self-Determination Act (P.L. 93-638, as amended), contracts if they choose to continue under Title I. Nothing in this Resolution shall affect or amend Resolutions CAP-35-02 and CJN-35-05.

2. The Navajo Nation Council further conditions the revocable authorizations set forth herein and the revocable authorization, and authority for approval of participation in Title V, the Indian Self-Determination Act (P.L. 93-638, as amended), Self Governance, of additional tribal organizations as set forth herein upon the complete and continuing compliance of the tribal organizations with all conditions set forth in the form of Exhibit "A".

3. In authorizing Winslow Indian Health Care Center, Inc., Tuba City Regional Health Care Corporation, Inc., and Utah Navajo Health Systems, Inc. to participate in Title V Self-Governance, the Navajo Nation Council finds that each of these tribal organizations has satisfactorily completed a planning phase, which has included legal and budgetary research, internal tribal government planning and organizational preparation relating to the administration of the health care programs each tribal organizations operates.

4. The Navajo Nation Council hereby specifically delegates to the Intergovernmental Relations Committee, the authority to approve of additional tribal organizations' participation in Title V, the Indian Self-Determination Act (P.L. 93-638, as amended), upon a recommendation for approval by the Health and Social Services Committee, and each of the Navajo Nation Chapters which will be served under the Title V, Indian Self-Determination Act (P.L. 93-638, as amended), Compact and Funding Agreement; provided, that no additional tribal organizations shall be approved by the Intergovernmental Relations Committee, to operate under Title V in the absence of a recommendation for approval by the Health and Social Services Committee, and each of the Navajo Nation Chapters which will be served under the Title V agreement. The Navajo Nation Chapter Resolutions from the Chapters served by the Winslow Indian Health Care Center Inc., Tuba City Regional Health Care Corporation Inc., and Utah Navajo Health Systems Inc., are attached as Exhibit "B".

5. Nothing in this Resolution shall affect or amend Resolutions CAP-35-02 and CJN-35-05 in the form of Exhibit "C".

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Navajo Nation Council at a duly called meeting at Window Rock, Navajo Nation (Arizona), at which a quorum was present and that same was passed by a vote of 67 in favor and 0 opposed, this 21st day of July, 2010.

Lawrence T. Morgan, Speaker
Navajo Nation Council

26 July '10
Date

Motion: GloJean Todacheene
Second: Amos Johnson

EXHIBIT "A"

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as amended), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principles of Ke' to ensure that the health care needs of all Navajo citizens are fully met.

1. The Health Care Self-Governance Tribal Organization must qualify as a participant under the Indian Self-Determination Act (P.L. 93-638, as amended) by:
   (A) completing, to the satisfaction of the Navajo Nation Council, a planning phase as described under the Act and which includes:
      (1) legal and budgetary research; and
      (2) internal tribal government planning and organizational preparation relating to the administration of health care programs.
   (B) requesting participation in Title V, Self-Governance, by resolution by the governing body of the Navajo Nation; and
   (C) demonstrating financial stability and financial management capability for the 3 fiscal years immediately preceding the application for Title V, Self-Governance.

2. The Health Care Self-Governance Tribal Organization shall maintain its eligibility for third party payments under the Centers for Medicare and Medicaid Services (CMS).

3. The Health Care Self-Governance Tribal Organization shall maintain continued accreditation by a nationally recognized accreditation program.

4. The Health Care Self-Governance Tribal Organization shall operate and administer their Self- Governance Compact programs under the oversight of the Health and Social Services Committee and pursuant to the authority of the Navajo Nation. The Health Care Self-Governance Tribal Organization shall appear before and report to the Health and Social Services Committee and the Navajo Nation Council when requested to do so.

5. The Health Care Self-Governance Tribal Organization shall maintain compliance with all monitoring and reporting requirements duly established by the Health and Social Services Committee, including:

(A) The Health Care Self-Governance Tribal Organization shall submit copies of all final Federal Single Audit Act audit reports, including Audited Financial Statements, and final survey reports issued by its nationally recognized accreditation organization(s) and all associated corrective action plans to the Health and Social Services Committee with copies to the Navajo Nation Division of Health.

(B) The Health Care Self-Governance Tribal Organization shall provide copies of the Self-Governance Compact and all Annual Funding Agreements to the Navajo Nation Division of Health.

(C) The Health Care Self-Governance Tribal Organization shall provide copies of its Annual Report to the Health and Social Services Committee with copies to the Navajo Nation Division of Health. The format, criteria, and due date of the Annual Report shall be determined by the Health and Social Services Committee.

6. The Health Care Self-Governance Tribal Organization shall maintain continued compliance with all applicable Navajo Nation laws and regulations, including, but not limited to, the Navajo Preference in Employment Act.

7. The Health Care Self-Governance Tribal Organization shall maintain -compliance with all applicable Navajo Nation health care policies and priorities duly adopted by the Health and Social Services Committee.

8. The Health Care Self-Governance Tribal Organization will consult and cooperate with the Navajo Nation Division of Health-concerning the public health needs and programs of the Navajo Nation.

9. The Health Care Self-Governance Tribal Organizations and Navajo Nation Division of Health shall timely develop an on-going written policy for consultation on matters of public health and have such policy approved by the Health and Social Services Committee.

10. The Health Care Self-Governance Tribal Organizations and Navajo Nation Division of Health and Navajo Nation Department of Emergency Medical Service shall enter Memorandum of Understandings for the Navajo Nation's use and occupancy of Health Care Self-Governance Tribal Organization facilities as long as such use and occupancy does not interfere with direct care services.

11. The Health Care Self-Governance Tribal Organization in its dealings with the federal and state government, be it lobbying, advocacy, litigation, or negotiating efforts, shall only take positions or make arguments consistent with official published Navajo Nation positions.

12. The Health Care Self-Governance Tribal Organization shall not directly charge any tribal member for health care services nor charge the Navajo Nation Employee Benefit Plan or Workers Compensation Plan for health care services provided to a covered tribal member unless the Indian Health Service would be able to charge the tribal member for the same service under the same circumstances unless otherwise authorized by the Navajo Nation Council.

13. The Health Care Self-Governance Tribal Organization shall provide direct patient care to all Native American eligible users unless otherwise authorized by the Navajo Nation Council.

[redacted]

EXHIBIT "A"

Navajo Nation Conditions for Health Care Self-Governance Tribal Organizations

The conditions set forth below are intended to be ongoing. Full compliance with the conditions set forth below is a pre-requisite for continuing authorization from the Navajo Nation for participation in Title V, The Indian Self-Determination Act (P.L. 93-638, as amended), Self-Governance. Notwithstanding the above, the Navajo Nation and the Health Care Self-Governance Tribal Organizations shall cooperate under the principles of Ke' to ensure that the health care needs of all Navajo citizens are fully met.

1. The Health Care Self-Governance Tribal Organization must qualify as a participant under the Indian Self-Determination Act (P.L. 93-638, as amended) by:
   (A) completing, to the satisfaction of the Navajo Nation Council, a planning phase as described under the Act and which includes:
   _____ (1) legal and budgetary research; and
   _____ (2) internal tribal government planning and organizational preparation relating to the administration of health care programs.
   (B) requesting participation in Title V, Self-Governance, by resolution by the governing body of the Navajo Nation; and
   (C) demonstrating financial stability and financial management capability for the 3 fiscal years immediately preceding the application for Title V, Self-Governance .

2. The Health Care Self-Governance Tribal Organization shall maintain its eligibility for third party payments under the Centers for Medicare and Medicaid Services (CMS).

3. The Health Care Self-Governance Tribal Organization shall maintain continued accreditation by a nationally recognized accreditation program.

4. The Health Care Self-Governance Tribal Organization shall operate and administer their Self- Governance Compact programs under the oversight of the Health and Social Services Committee and pursuant to the authority of the Navajo Nation. The Health Care Self-Governance Tribal Organization shall appear before and report to the Health and Social Services Committee and the Navajo Nation Council when requested to do so.

5. The Health Care Self-Governance Tribal Organization shall maintain compliance with all monitoring and reporting requirements duly established by the Health and Social Services Committee~~-~~, including:

   (A) The Health Care Self-Governance Tribal Organization shall submit copies of all final Federal Single Audit Act audit reports, including Audited Financial Statements, and final ~~audit~~ survey reports issued by its nationally recognized accreditation organization(s) and all associated corrective action plans to the Health and Social Services Committee with copies to the Navajo Nation Division of Health.

   (B) The Health Care Self-Governance Tribal Organization shall provide copies of the Self Governance Compact and all Annual Funding Agreements to the Navajo Nation Division of Health.

   (C) The Health Care Self-Governance Tribal Organization shall provide copies of its Annual Report to the Health and Social Services Committee with copies to the Navajo Nation Division of Health. The format, ~~and~~ criteria, and due date of the Annual Report shall be determined by the Health and Social Services Committee~~.~~

6. The Health Care Self-Governance Tribal Organization shall maintain continued compliance with all applicable Navajo Nation laws and regulations, including, but not limited to, the Navajo Preference in Employment Act.

7. The Health Care Self-Governance Tribal Organization shall maintain ~~-~~compliance with all applicable Navajo Nation health care policies and priorities duly adopted by the Health and Social Services Committee.

8. The Health Care Self-Governance Tribal Organization will consult and cooperate with the Navajo Nation Division of concerning the public health needs and programs of the Navajo Nation~~.~~

9. The Health Care Self-Governance Tribal Organizations and Navajo Nation Division of Health shall timely develop an on-going written policy for consultation on matters of public health and have such policy approved by the Health and Social Services Committee.

10. The Health Care Self-Governance Tribal Organizations and Navajo Nation Division of Health and Navajo Nation Department of Emergency Medical Service shall enter Memorandum of Understandings for the Navajo Nation's use and occupancy of Health

Care Self-Governance Tribal Organization facilities as long as such use and occupancy does not interfere with direct care services.

11. The Health Care Self-Governance Tribal Organization in its dealings with the federal and state government, be it lobbying, advocacy, litigation, or negotiating efforts, shall only take positions or make arguments consistent with official published Navajo Nation positions.

12. The Health Care Self-Governance Tribal Organization shall not directly charge any tribal member for health care services nor charge the Navajo Nation Employee Benefit Plan or Workers Compensation Plan for health care services provided to a covered tribal member unless the Indian Health Service would be able to charge the tribal member for the same service under the same circumstances unless otherwise authorized by the Navajo Nation Council.

13. The Health Care Self-Governance Tribal Organization shall provide direct patient care to all Native American eligible users unless otherwise authorized by the Navajo Nation Council.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

AUG 2 8 2012

Mr. Grey Farrell
Chairperson
Tuba City Regional Health Care Corporation
P.O. Box 600
Tuba City, AZ 86045

Dear Chairperson Farrell:

I am writing to provide you a copy of an amendment to the Tuba City Regional Health Care Corporation Multi-Year Funding Agreement covering fiscal years 2013-2018, which was signed under the authority of Title V of the Indian Self-Determination and Education Assistance Act. Copies of this amendment will be sent to the Indian Health Service (IHS) Navajo Area Director and the Agency Lead Negotiator for the Navajo Area as well as to the Tuba City Regional Health Care Corporation Self-Governance Coordinator.

We wish you continued success as you strive to provide the highest level of health care services to your members and others that you serve. It is our primary goal to work in partnership to continue to make Self-Governance a successful elected choice for the Tuba City Regional Health Care Corporation.

Sincerely,

P. Benjamin Smith
Acting Director
Office of Tribal Self-Governance

Enclosure

TUBA CITY REGIONAL HEALTH CARE CORPORATION
167 North Main Street, P.O. Box [illegible]
Tuba City, Arizona 86045-0[illegible]
(928) 283.2[illegible]

July 2, 2012

Floyd Thompson, Executive Officer/ALN Navajo Area Office
Navajo Area Indian Health Service
P.O. Box 9020
Window Rock, AZ 86515-9020

Dear Mr. Thompson:

Please find enclosed the final Funding Agreement between Tuba City Regional Health Care Corporation, Inc. (TCRHCC) and the Secretary of the Department of Health and Human Services for fiscal years 2013-2018. This is the final Funding Agreement agreed upon by all parties. We have filled in the blank with the appropriate date and attached the appropriate Attachments noted in Section 5.

Attached are two (2) original Funding Agreements signed by the TCRHCC Board President. Please ensure that the Funding Agreement is properly executed and an original fully-executed copy is returned to TCRHCC. Please contact me should there be any questions.

Thank you for your assistance and cooperation in this matter.

Sincerely,

Joseph Engelken
Chief Executive Officer

cc: Alva Tom
Therese Hickey
Chris Manydeeds
Dave Mather
Elliott Milhollin

FUNDING AGREEMENT

BETWEEN

TUBA CITY REGIONAL HEALTH CARE CORPORATION

AND

THE SECRETARY OF THE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEARS 2013 - 2018

SECTION 1- AUTHORITY AND PURPOSE. This Title V Funding Agreement (FA or Agreement) is executed by and between the Tuba City Regional Health Care Corporation (TCRHCC), a non-profit corporation organized pursuant to the laws of the Navajo Nation and designated as a tribal organization by the Navajo Nation Council, and the Secretary of the Department of Health and Human Services, acting through the Indian Health Service (IHS), pursuant to Title V of the Indian Self-Determination and Education Assistance Act (PL. 93-638, 25 U.S.C. Section 450 et seq), as amended, (ISDA or the Act) and is incorporated into and governed by the Navajo Nation Health Compact between authorized Navajo Nation Tribal Organizations and the United States of America, effective May 18, 2011 ("Compact"). Pursuant to the terms of the Compact and this Agreement, TCRHCC is authorized to plan, conduct, operate, and administer the programs, services, functions and activities ("PSFAs") identified in Attachment A to this FA. All terms of this Agreement shall be governed by ISDA, its implementing regulations and, to the extent expressly agreed to by the parties hereto, applicable IHS policies. To the extent that any term in this Agreement may be construed as being inconsistent with the Compact or as exceeding the authority granted by the Compact, the provisions of the Compact shall govern. The attachments listed and denoted as Attachments appearing at the end of this Agreement are incorporated by reference as part of this Agreement as if fully set forth herein.

The Compact between TCRHCC, a Navajo Nation corporation and tribal organization, and the Secretary of the Department of Health and Human Services ("the Secretary") and this FA, obligates the Secretary to provide funding for and both parties to perform PSFAs identified herein.

SECTION 2 - EFFECTIVE DATE AND TERM. This Agreement shall become effective upon execution by both parties or October 1, 2012, whichever is later, and shall extend through September 30, 2018.

SECTION 3 - PROGRAMS, FUNCTIONS, SERVICES, AND ACTIVITIES TO BE PROVIDED BY TCRHCC. TCRHCC will operate and administer the PSFAs identified in Attachment A, except that TCRHCC reserves the right to rebudget funds among the programs and services currently provided under this FA and to use rebudgeted funds and income generated

directly through the operation of these PSFAs to fund additional programs and services to the extent that any such programs and services are PSFAs that the Secretary could otherwise contract with TCRHCC to plan, conduct or administer under Sections102(a)(1) and 505 of the ISDA, 25 USC §§ 450f(a)(1), 458aaa-4. TCRHCC may redesign PSFAs and reallocate funds in accordance with Section 506(e) of the ISDA, 25 U.S.C. § 458aaa-5(e). To the extent the PSFA descriptions in the Compact or FA conflict with the new descriptions or definitions provided in the Indian Health Care Improvement Act ("IHCIA"), as amended, the IHCIA shall prevail unless they conflict with the ISDA, and in such case, the ISDA descriptions shall prevail.

(A) **Generally.** The services funded by this Agreement are to be provided at facilities within, or reasonably accessible to, the Tuba City Service Unit. Funding is provided under this Agreement for Navajo tribal members and other eligible IHS beneficiaries. Services will also be provided to members of the San Juan Southern Paiute Tribe and members of the Hopi Tribe who reside in the upper and lower Moenkopi villages, to the extent authorized by each respective tribe's resolution and supported by funding provided under this Agreement.

TCRHCC will be responsible for the provision and operation of all PSFAs listed in Attachment A, which may change from time to time as provided for in this Section and in Section 21 below, at such time as additional PSFAs are assumed by TCRHCC. TCRHCC anticipates that these services will be provided either directly by TCRHCC or by subcontract, with overall policy direction and coordination of all health programs and services to be provided by TCRHCC. Some of these services may be provided through contracts or agreements with outside providers, including, but not limited to, sharing of specialized health resources, and personal services contracts with entities (either individuals or organizations) under Section 310A of the Indian Health Care Improvement Act. The TCRHCC Chief Executive Officer is responsible for the day-to-day management and administration of PSFAs by TCRHCC according to the policies and procedures established by the TCRHCC Board of Directors.

(B) **Liability.**

1. Federal Tort Claims Act. Pursuant to Article V, Section 3, "Federal Tort Claims Act Coverage; Insurance" of the Compact, the Federal Tort Claims Act ("FTCA") applies to TCRHCC's PSFAs under this Agreement as provided in Section 516(a) of Title V, which incorporates Section 102(d) of Title 1 of ISDA and Section 314 P.L. 101-512. The extent of FTCA coverage is described more particularly in 25 CFR §§ 900.180 - 900.210.

2. TCRHCC and its employees carrying out statutorily mandated grants programs added to the FA are subject to the FTCA as the above-cited statutes may allow.

3. Insurance. There is no requirement that TCRHCC purchase liability insurance to protect or indemnify the federal government. TCRHCC may purchase liability insurance to supplement FTCA coverage and such purchase is an allowable cost under this Agreement.

(C) Payor of Last Resort. Whether providing, purchasing, or authorizing health care services described in the Compact and this FA, in accordance with Section 2901(b) of Pub. L. 111-148 [25 U.S.C. § 1623(b)], and as otherwise provided in law, TCRHCC shall be the payer of last resort subject to availability of IHS funding.

SECTION 4 - SERVICES TO NON-BENEFICIARIES. Services may be provided by TCRHCC to otherwise ineligible persons as provided under Section 813(c) of the IHCIA, as amended, 25 U.S.C. § 1680c(c), and other applicable law. The TCRHCC Board of Directors has made a determination, consistent with, and in consideration of, the requirements stated in 25 U.S.C. § 1680c(c)(2), that the provision of services to individuals who are not otherwise eligible for health services provided by IHS will not result in a denial or diminution of health services to eligible Indians. This determination is memorialized in a resolution of the Board entitled, "Reaffirming the Provision of Healthcare Services to Non-Beneficiaries" dated March 27, 2012, which is attached as Attachment I. Consequently, TCRHCC is authorized to provide services to non-beneficiaries to the extent set forth in this Section 4 and in compliance with the requirements of 25 U.S.C. § 1680c(c)(2).

SECTION 5 - AMOUNT OF FUNDS. The Fiscal Year's (FY 2013) Funding Tables, attached as Attachments B through D and Attachment F, summarize the annual amounts by IHS budget category available to TCRHCC in the current fiscal year as of the most recent amendment dated June 1, 2012. These amounts reflect program base funding for the transferred PSFAs identified in this Agreement in the Attachment A, Headquarters and Area Office tribal shares and associated contract support costs. These amounts may be adjusted consistent with section 5(F) and 5(I) of this agreement. These annual amounts will be adjusted to reflect any additional FY 2013-2018 funding amounts after enactment of the FY 2013-2018 appropriations. For FY 2014-2018, the parties will negotiate subsequent FA Tables, which will accordingly be incorporated into this FA and will supercede the prior FY's FA Tables. Funds will be transferred to TCRHCC under this FA to the extent that the TCRHCC assumes the associated PSFAs during the associated fiscal year covered by this FA. The IHS funding allocations shown in Attachment B are not binding on TCRHCC, and TCRHCC may redesign program and/or rebudget funds between and among activities according to its priorities to the extent otherwise permitted by the ISDA and applicable federal appropriations laws, as set forth in Section 3 of this Agreement.

(A) Stable Base Budgets. In accordance with 25 U.S.C. § 505(g), the TCRHCC has requested budgets reflecting stable base funding for (five) 5 years including Headquarters and Area Office tribal shares based on current fiscal year final annual recurring funding amounts. Adjustments by IHS to the base funding amounts will be permitted in direct proportion to changes in appropriated amounts due to congressional actions. Funding adjustments will also be made by IHS when TCRHCC chooses to take a previously retained tribal share PSFA. TCRHCC will also be eligible for funding for service increases, new services, mandatories, population growth, Indian Health Care Improvement Fund, Contract Support Cost and the increases in resources on the same basis as all other tribes. TCRHCC will also remain eligible for distribution of year end funds from any other source of funds that the IHS may from time to time determine it will distribute to operating units.

(B) IPA/MOA Costs. IPA/MOA costs will be determined, funded, and processed as detailed in the Buyback Agreement between IHS and TCRHCC.

(C) Area Office Resources. Area Office resources are identified in the table entitled "Navajo Area Office Tribal Shares Table," attached as Attachment C. All funds for Sanitation Facilities Construction, PL 86-121, are determined based on program formula and have been retained by Area Office. See Attachment C. The Area Office will also retain funds for other PSFAs that TCRHCC will not be assuming under this FA.

The total amount of Area Office resources that support or benefit TCRHCC PSFAs annually is shown on Attachment C. This amount is for TCRHCC only and does not include resources benefitting or supporting other tribes or PSFAs under contract by the Navajo Nation or PSFAs retained by the NAIHS.

(D) Buyback Agreement. TCRHCC may carry out its responsibility under Section 508(f) of the ISDA, 25 U.S.C. § 458aaa-7(f) to provide certain PSFAs included in this Agreement by purchasing services or other resources of the federal government under Article V, section 18 of the Compact, as permitted by law. Except as provided in this Agreement, funds will be retained from the funding available to TCRHCC and/or paid by TCRHCC to IHS to allow TCRHCC to purchase certain goods, equipment or services from IHS as specified in the Buyback Agreement.

(E) Headquarters and OEHE Resources. TCRHCC's IHS Headquarters annual tribal shares and the funds available during the term of this agreement are shown in Attachment D. These amounts are for the TCRHCC only and do not include resources benefiting or supporting other tribes or programs operated by the Navajo Nation under its separate ISDA contract(s) with IHS, or PSFAs retained by IHS. TCRHCC shall use these funds in support of the PSFAs in this FA.

TCRHCC will receive a share of the balance of funds remaining in the "Emergency Fund," and "Management Initiatives" line items (as shown on Attachment D). Any such balance shall be distributed in accordance with the "Tribal Size Adjustment" methodology or such other methodology or program formula that is utilized to make funding available to other tribes and tribal organizations. Any such funds shall be distributed within ten (10) calendar days after they are adviced to IHS, or at the end of the fiscal year, whichever is sooner.

(F) Contract Support Funds. The parties agree that the CSC funding under this FA will be calculated and paid in accordance with Section 508(c), 519(b), and 106(a) of the Act; IHS CSC Policy (Indian Health Manual — Part 6, Chapter 3); and any statutory restrictions imposed by Congress. In accordance with these authorities and available appropriations for CSC, the parties agree that under this FA, TCRHCC will receive direct CSC and indirect CSC in the amounts set forth in Attachment F. These amounts were determined using the current IHS CSC appropriation and TCRHCC's direct cost base, and may be adjusted as set forth in the IHS CSC Policy (IHM 6-3) as a result of changes in program bases, Tribal CSC need, and available CSC appropriations. Any adjustments to these amounts will be reflected in future modification to this FA. Notwithstanding the foregoing, TCRHCC does not waive any claims it may have

regarding the amounts of direct and indirect CSC it is due pursuant to Section 106(a) of the Act, as amended.

(G) **Grants.** Section 505(b)(2) of Title V provides, among other things, that grants administered by the Department of Health and Human Services through the IHS may be added to the TCRHCC Funding Agreement after award of such grants. In accordance with this provision of Title V and its implementing regulations, the Secretary will add TCRHCC diabetes grants and any other statutorily mandated grant(s) administered by the Department through the IHS to this Funding Agreement after such grant(s) have been awarded. Grant funds will be paid to TCRHCC as a lump sum advance payment through the PMS grants payment system as soon as practicable after award of such grant. TCRHCC will use interest earned on such funds to enhance the purposes of the grant including allowable costs. The TCRHCC will comply with all terms of the grant award, including reporting requirements, and will not reallocate grant funds nor redesign the grant program, except as provided in the implementing regulations or the terms of the grant. TCRHCC and its employees carrying out statutorily mandated ISDA grant programs added to this FA are subject to the Federal Tort Claims Act (FTCA).

(H) **Competitive, Formula and Other Funds.** Funds for PSFAs assumed by TCRHCC, as reflected in Attachment A of this Agreement, not now included in this Agreement, which are available to area offices, service units, operating units, or tribes or tribal organizations on a competitive, formula, or other basis, including non-recurring funding, shall be determined by the relevant calculation. These funds shall be made available to TCRHCC on the same basis as such funds are available to IHS, service units, operating units, or other tribes and tribal organizations, and any such funds due TCRHCC during the term of this agreement shall be added to this Agreement. This does not include grant awards, which remain subject to the conditions or restrictions set forth in the awarding instrument and applicable laws.

(I) **Adjustments and Increases.** The funding amounts referenced in this FA and its attachments are subject to change based upon appropriations, the transfer of IHS PSFAs, and the actual date of assumption of PSFAs by TCRHCC. When funds due are not transferred by the Secretary as part of the initial lump sum payment, they must be transferred within ten (10) days after distribution methodologies and other decisions regarding payment of those funds have been made by IHS pursuant to 42 C.F.R. § 137.77. TCRHCC shall be eligible for funding for new services, service increases, inflation increases, and general increases on the same basis as IHS, service units, operating units, or all other tribes and tribal organizations. Amendments reflecting payment of these funds shall be provided to TCRHCC after any such funds are added to the FA. TCRHCC retains the right to reject the addition of the funds to the FA and return the funds to IHS, as provided in Section 21 below.

The parties recognize that the total amount of the funding due under this Agreement is subject to adjustment due to Congressional appropriations or other laws affecting availability of funds to the IHS and the Department of Health and Human Services. Upon enactment of any such law, the amount of funding provided to TCRHCC in this Agreement will be adjusted as necessary after TCRHCC has been notified of such pending adjustment and subject to any

rights which TCRHCC may have under this FA, the Compact, or the law.

The funding in this Agreement is subject to adjustment in the event that the San Juan Southern Paiute ("SJSP") provide a resolution authorizing TCRHCC to provide additional PSFAs. The amount of such adjustment will be negotiated between TCRHCC and the IHS.

(J) **Reconciliation.** For the term of this FA, reconciliations will be held between the TCRHCC and Area Office on a quarterly basis, or more often as needed. The parties agree that, within ten (10) calendar days of each reconciliation, the IHS will transfer any funds due to TCRHCC.

(K) **Collections, Credits or Refunds After the Transition Dates**. The parties agree that any collections, credits or refunds received by the IHS, an IHS service unit or TCRHCC after the effective date of this Agreement will be credited to the facility that generated the collection. These collections will be reconciled at the reconciliation provided for under Subsection (J) of this Section 5.

(L) **Maintenance and Improvement (M&I) and Biomedical Equipment Funding Pools**. TCRHCC is included in the IHS M&I and Biomedical Equipment pools. TCRHCC shall participate in these pools and receive funds based on the same procedures and distribution methodologies and formulas as are applicable to all other IHS facilities.

SECTION 6 - PROGRAMS, SERVICES, FUNCTIONS AND ACTIVITIES, RETAINED BY IHS.

(A) **Residual Administrative Functions and Resources**. IHS shall remain responsible for "inherently federal" services and functions with the resources identified by the IHS as "residual" in Attachment E.

(B) **Retained Functions and Resources**. The IHS retains responsibility and the TCRHCC may compact for all non-residual PSFAs that TCRHCC did not assume and for which TCRHCC is eligible to assume. The TCRHCC reserves the right to negotiate with IHS to assume PSFAs retained by IHS.

(C) **Access to Training and Technical Assistance**. To the extent funds are retained by the IHS, or the cost of such assistance reimbursed by TCRHCC, TCRHCC shall have access to training, continuing education, and technical assistance in the manner and to the same extent TCRHCC would have received such services if it were not a Self-Governance Compactor.

SECTION 7 - ACCESS TO FEDERAL INSURANCE. Subject to guidance established by Office of Personnel Management, the TCRHCC may exercise its right under Section 409 of the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. § 1647b, to provide federal life and health insurance to its employees.

SECTION 8 - PAYMENT OF FUNDS. Except as otherwise provided in this Agreement, any and all funds due TCRHCC under this Agreement, as specified by Section 5 and listed in Attachments A, B, C and D, that are recurring to IHS shall be included in an advance lump sum payment to TCRHCC as provided in Article II, Section 5 of the Compact. Specifically, the IHS shall provide annual recurring funding due under this Agreement in one lump sum payment within twenty (20) calendar days of the apportionment of such funds, or within ten (10) calendar days of the effective date of this Agreement, whichever is later. Competitive, formula, and other funds that require further calculation shall be paid within ten (10) calendar days of the date on which the IHS reaches a final allocation decision following tribal consultation, or within ten (10) calendar days of the effective date of this Agreement, whichever is later. IHS shall pay to the TCRHCC any interest that may be due under the Prompt Payment Act, (31 U.S.C. § 3901 et seq.) for late payments under this Agreement.

SECTION 9 - REPORTS. Pursuant to the Single Audit Act, as amended, 31 U.S.C. §§ 7501-7507, ISDA, 25 U.S.C. § 450c(f)(1), § 458aaa-5, and 42 C.F.R. § 137.200- 137.207, the TCRHCC shall provide to the IHS, the Federal Audit Clearinghouse and National External Audit Review, its annual A-133 Single Agency Audit Report. The TCRHCC shall provide such other reports as agreed upon by the parties from time to time.

SECTION 10 - RECORDS. Except as provided by law, the records generated and maintained by TCRHCC shall not be treated as federal records under Chapter 5 of Title 5 of the United States Code, except that:

(A) **Patient Records Disclosure.** Patient medical records may be disclosed only in accordance with the applicable provisions of 5 U.S.C. § 552a(b) and the HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164; and

(B) **Patient Records Storage.** Pursuant to Section 105(o) of the ISDA, the medical records generated by TCRHCC shall, at the option of TCRHCC, be stored with the National Archives and Records Administration to the same extent and in the same manner as other Department of Health and Human Services patient records.

SECTION 11— CONSOLIDATION OF ANNUAL FUNDING AGREEMENT.—All previous Annual Funding Agreements will be modified or terminated, as appropriate, to transfer applicable funds into this Funding Agreement as of the effective date of this Agreement, for PSFAs, materials, and facilities provided to the Tribes represented by TCRHCC; provided that, if any Tribal government does not authorize TCRHCC to enter into the Compact and this Agreement, PSFAs will continue to be provided under TCRHCC's existing contract.

SECTION 12 - EARMARKED AND RESTRICTED FUNDS. TCRHCC shall comply with applicable federal appropriations law regarding use of earmarked and restricted funds.

SECTION 13 - NO REDUCTION IN PROGRAMS OR SERVICES TO OTHER TRIBES. The IHS has reviewed and determined that nothing in this Agreement diminishes any resources to other tribes.

SECTION 14 - MEDICARE/MEDICAID AND THIRD PARTY BILLING AND RECOVERIES. For health care services provided by TCRHCC, TCRHCC shall exercise its right pursuant to 25 U.S.C. § 1621e, to submit claims directly to and recover directly from Medicare and Medicaid and other third parties responsible for payment and these funds will be available as provided in Section 5(K) of this Agreement. All funds recovered from Medicare and Medicaid shall be used as allowed by applicable law.

a. Reimbursement of Funds. TCRHCC has elected to directly collect Medicare and Medicaid payments as provided in Section 401 of the IHCIA, 25 U.S.C. § 1641, as amended. TCRHCC is obligated and entitled to directly collect and retain reimbursement for Medicare and Medicaid and any other third party payer for services provided under this FA (and previous annual FAs) in accordance with Section 401 of the IHCIA, as amended, by Public Law 111-148, 25 U.S.C. 1641, and Section 206 and 207 of the IHCIA, as amended at 25 U.S.C. §§ 1621e and 1621f. Any amounts collected by the IHS that should have been paid to TCRHCC in accordance with Section 401 of such Act, 25 U.S.C. § 1641, either prior to or after the effective date of this FA shall be added to this FA by addendum.

b. Use of Third-Party Collections. All Medicare, Medicaid and other program income earned by TCRHCC shall be treated as supplemental funding to that negotiated in the FA. TCRHCC may retain all such income and expend such funds in the current year or in future years except to the extent that the IHCIA, as amended (25 U.S.C. § 1601 *et seq.*) provides otherwise for Medicare and Medicaid receipts. Such funds shall not result in any off-set or reduction in the amount of funds TCRHCC is authorized to receive under its FA in the year the program income is received or for any subsequent fiscal year, 25 U.S.C. § 458aaa-7(j).

c. Recovery Right. TCHRCC has the right to recover reimbursement from certain third parties of the reasonable charges for health services in accordance with section 206 of the IHCIA, as amended at 25 U.S.C. § 1621e.

SECTION 15 - RECOVERIES, PROGRAM INCOME AND REIMBURSEMENTS. To the extent that TCRHCC or IHS (including any IHS-operated service units) receive program income otherwise payable to either the IHS or TCRHCC, in accordance with 25 U.S.C. § 1621(e) and 1621(f) and other applicable law, Medicare and Medicaid and other third party collections, quarters reimbursements, and other reimbursements, the funds will be promptly transferred to the appropriate party, unless a specific deadline for transfer is stated in this Agreement, in which case the stated deadline shall apply.

SECTION 16 - USE OF FEDERAL REAL PROPERTY. The IHS hereby authorizes the TCRHCC to utilize all of the federally owned real property IHS previously utilized, including all lands, buildings, structures, quarters and related facilities, as evidenced by a facility inventory, presently owned by the U.S. Government/IHS, as provided in Section 105(f)(1) and 512(c) of the ISDA, as amended, to be used in connection with carrying out the terms, conditions, and provisions of this FA and any subsequent FA. The parties agree they will immediately begin to negotiate an appropriate agreement setting forth the terms and conditions for use of such federally-owned real property.

SECTION 17 - PERSONAL PROPERTY. The TCRHCC has elected to take title to all personal property furnished by the Federal government for use in its performance under this Agreement. The TCRHCC shall take title to all personal property purchased with funds under the TCRHCC Compact.

SECTION 18 - OPERATION AND MAINTENANCE OF QUARTERS.

(A) The TCRHCC shall be responsible for the planning, operation, management, and maintenance of all housing facilities, also referred to as quarters, within the Tuba City Service Unit. TCRHCC shall comply with TCRHCC housing policies regarding the management of quarters.

(B) TCRHCC shall be responsible for the day-to-day operations of these quarters including, but not limited to, routine maintenance and up-keep of heating systems, cooling systems, appliances, grounds, and the building structures.

(C) TCRHCC may establish rental rates and collect rents for federally-owned quarters within the Tuba City Service Unit in accordance with Section 309 of the IHCIA, 25 U.S.C. §1638. TCRHCC shall collect rent and utilities charges from TCRHCC employees (where utility charges are not paid directly to the utility provider by the employee) including from Federal employees who occupy the quarters as well as other tenants through payroll deductions and maintain said funds in a quarters return fund. These funds shall be used by TCRHCC for payment of utilities and maintenance and repair and operation of the quarters, as TCRHCC determines to be appropriate. TCRHCC will provide notices to the affected federal employees and the Secretary that TCRHCC has elected to directly collect from them under Section 309 of the IHCIA, 25 U.S.C. §1638. Upon receipt of such notice, the affected federal employees shall pay rent for occupancy directly to TCRHCC.

(D) Patients boarding in quarters may be billed at the established rate. TCRHCC shall not be required to charge beneficiaries who must occupy such quarters for medical reasons authorized by the attending physician. If a patient boarder has a third party source of reimbursement providing lodging coverage, the third party source of reimbursement may be billed for lodging. Patient boarding receipts shall be program income under this funding agreement.

SECTION 19 - PRIME VENDOR CONTRACT. Until such time as TCRHCC may establish agreements directly with the Veterans Administration (VA), TCRHCC will continue to purchase pharmaceuticals and medical supplies through the National Supply Service Center.

SECTION 20 — SUBSEQUENT FUNDING AGREEMENTS. As provided in the Compact, negotiations for a subsequent funding agreement shall begin not later than 120 days prior to the conclusion of this FA. The amount of funds required to be provided by Sections 106(a) and

508(c) of the ISDA for each subsequent FA, which is subject to the availability of appropriations, shall only be reduced in compliance with the requirements of Sections 106(b) and 508(d) of the ISDA.

SECTION 21- AMENDMENT OF THIS AGREEMENT.

(A) **Form of Amendments**. Except as otherwise provided in this FA, the Compact or by applicable law, any amendment to this FA shall be in the form of a written amendment and signed by both TCRHCC and the IHS.

(B) **Amendment to Add Additional Programs**. The TCRHCC reserves the right to identify other PSFAs that it wishes to include in this Agreement by amendment during the term of this Agreement. If TCRHCC's proposal(s) to include additional activities is approved by IHS, this Agreement will be amended to include such PSFAs. Should the parties fail to reach agreement, TCRHCC may submit a final offer in accordance with the Title V procedures set out in Sections 507(b)-(d) of the Act.

(C) **Amendments to Add Additional Available Funding**. TCRHCC shall be eligible for any increases in funding or for funding for Maintenance and Improvement Funds, other reimbursements, and new programs established under the Indian Health Care Improvement Act or any other applicable law, as well as funds available to IHS Headquarters and the Area Office, whether those funds are recurring or non-recurring funds, on the same basis as the Area Office, service units, operating units, or other tribes and tribal organizations. This agreement shall be amended to provide for the timely payment of such funds to TCRHCC.

(D) **Funding Increases**. Written consent of TCRHCC shall not be required for issuing amendments which result from increases in actual appropriation levels or which represent an increase in funding for PSFAs identified in this FA. Such increases may include:

(1) Program/Area/HQ Mandatories;

(2) Program/Area/HQ End-of-year Distributions; Contract Health Emergency Fund (CHEF) and other related CHS Services; and any unused reserves as provided in this Agreement;

Amendments reflecting payment of these funds shall be provided to TCRHCC within ten (10) working days after any such funds are added to the FA. TCRHCC retains the right to reject the addition of the funds to the FA and return the funds to IHS.

SECTION 22 — DISPUTES

The parties to this Agreement may have failed to reach agreement on certain matters which remain unresolved and in dispute. Such matters may be addressed through the process set forth in Section 507(b)-(d) of Title V. TCRHCC does not waive any remedy it may have under the law with regard to these issues and any others not listed therein.

SECTION 23 - TITLE I DISCRETIONARY PROVISIONS APPLICABLE TO THIS AGREEMENT

As authorized in 25 U.S.C. §458aaa-15(b), TCRHCC exercises its option to include the following provisions of Title I of the ISDEAA as part of this Agreement; these provisions will have force and effect as if they were set out in full in Title V of that Act:

25 U.S.C. § 450b(e) (defining "Indian tribe");
25 U.S.C.§ 450h(b) (relating to grants);
25 U.S.C. § 450h(d)(1) (relating to duty of Secretary to provide technical assistance);
25 U.S.C. § 450j(a)(I) (relating to contracting or cooperative agreement law);
25 U.S.C. § 450k(b) (relating to conflicting laws and regulations);

16.6 25 U.S.C. § 4501(c), section 1(b)(8)(F) (relating to screener identification);
16.7 25 U.S.C. § 4501(c), section 1(b)(9) (relating to availability of funds);
16.8 25 U.S.C. § 4501(c), section 1(d)(1)(B) (relating to construction of the contract); and
16.9 25 U.S.C. § 4501(c), section 1(d)(2) (relating to good faith).

SECTION 24 – REASSUMPTION

Reassumption in General. As required under Section 507 of ISDA, the Secretary is authorized to reassume operation of a PSFA (or portions thereof) and associated funding pursuant to the specific criteria set forth therein.

SECTION 25 — SEVERABILITY

(A) Except as provided in this section, this Agreement shall not be considered invalid, void or voidable if any section or provision of this Agreement is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction.

(B) If any section or provision of this Agreement is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction, and if the parties mutually agree, the parties may at their option, treat this Agreement as invalid, void or voidable or terminate it in accordance with the provisions of this Agreement.

DATED this 29th day of June, 2012.

TUBA CITY REGIONAL HEALTH CARE CORPORATION

BY: _____
Grey Farrell, Jr., President, Board of Directors, TCRHCC

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
INDIAN HEALTH SERVICE

BY: _____

for Yvette Roubideaux, Director of Indian Health Service

Attachment A – TCRHCC FY2013-2018 Summary of Current PSFAs
Attachment B - TCRHCC Program Funding
Attachment C - Navajo Area Office Tribal Shares Table
Attachment C-A - Navajo Area Office Tribal Shares Area Wide Reserve/Contract Health Care
Attachment D - TCRHCC Headquarters Shares Table
Attachment E - Residual Table
Attachment F - CSC Funding Table

ATTACHMENT A

TUBA CITY REGIONAL HEALTH CARE CORPORATION
FY 2013-2018 Funding Agreement
Summary of Current PSFAs

Tuba City Regional Health Care Corporation (TCRHCC) is a Regional Medical Center offering a wide range of inpatient, outpatient, skilled nursing and chronic care services for the prevention, diagnosis, treatment, consultation, and rehabilitation of disease and conditions. Services include: Primary Care, Specialty Care, Rehabilitation, Preventative Care, Public Health Services, and providing Specialty and Consulting Support Services for Facilities in the TCRHCC Region. Services are offered in various locations including modalities such as direct inpatient and outpatient care, telemedicine consultation, field clinics, community support, home care and elder care. These services are provided to improve comprehensive care access, continuity of care, and health care outcomes for communities across our region and to ensure a full range of advanced primary and specialty health services.

This Attachment is a list of programs, services, functions and activities (PSFAs), and those reasonably inferred therefrom, which TCRHCC currently compacts and provides. TCRHCC will periodically supplement this list with notice to the Director as may be appropriate.

The programs, services, functions and activities, (PSFAs) TCRHCC administers under the terms of its Funding Agreement (FA) with the IHS are described below in accordance with 25 U.S.C. § 505(d).

I. HOSPITAL INPATIENT and OUTPATIENT AMBULATORY CARE SERVICES:

Patient care is provided in a 73-bed hospital and through ambulatory primary care and specialty clinics. The ambulatory clinics are located on the main campus within or in proximity of the hospital facility; satellite clinics are off site from the main campus and include clinics operated through memoranda of agreements that support the PSFAs covered by the FA. These services may be provided via telemedicine or on-site facilities, mobile health care vans and through on-site services provided at outside entities, school clinics or at school sponsored events. In addition, public health care is provided in the home. Both patient and health care provider training and educational services are provided in support of the PSFAs administered by TCRHCC and the health care needs of the patients.

In general, the services provided include, but are not limited to, the following:

A. Clinical Services: TCRHCC provides a comprehensive range of primary and specialty health care services, appropriate for a regional medical center and integrated health system, to prevent and treat disease and injury and to promote improvements in health status and outcomes.

B. Nursing Services: Nursing care is provided within the scope of standard nursing practices. Nursing Care includes both inpatient and outpatient medical and surgical services for adult, pediatric, prenatal, perinatal and childbirth patients.

C. Skilled Nursing Services: These services are intended to include post-hospital inpatient services needed for treatment of various medical and surgical services (e.g., swing beds, SNU or SNF).

D. Emergency Medicine, Trauma and Critical Care Services: Provides comprehensive multi-disciplinary management of any patient with an emergency or urgent disease or condition on a 24/7 basis. Services include, but are not limited to, care of any patient who presents for emergent or urgent care. Care includes, diagnosis and treatment, stabilization within the resources of TCRHCC and when necessary the transfer to facilities to continue the care not available at TCRHCC. Staff may be involved in transport of patients. Emergency services also includes the provision of disaster coordination and provision of health services at on scene sites in the event of a public health emergency or natural disaster within the capabilities of TCRHCC. TCRHCC also provides for medical direction for EMS land and air services, including transportation and air and ground ambulance services to and from TCRHCC, to include planning for helipad.

E. Family Medicine Services: Provides both outpatient and inpatient medical care for pediatric, adolescent and adult patients which includes the diagnosis, treatment, education, prevention, and consultation including, but not limited to, Primary Care and Subspecialty Services such as Geriatric, Rheumatology, Dermatology, Neurology, Infectious Disease, Hematology, Nephrology, Cardiology, Pulmonary Disease, Allergy, Immunology, Oncology, Nutritional Therapy, Endocrine and Metabolic and Nutritional Disorders, and the co-ordination of referral to outside services not available at TCRHCC.

F. Internal Medicine Services: Provides both outpatient and inpatient medical care for adolescent and adult patients which includes the diagnosis, treatment, education, prevention, and consultation including, but not limited to, Primary Care and Subspecialty Services such as Geriatric, Rheumatology, Dermatology, Neurology, Infectious Disease, Hematology, Nephrology, Cardiology, Pulmonary Disease, Allergy, Immunology, Oncology, Nutritional Therapy, Endocrine and Metabolic and Nutritional Disorders, and the co-ordination of referral to outside services not available at TCRHCC.

G. Pediatric Services: Provides both outpatient and inpatient medical care for newborn infants, children and adolescents patients which includes the diagnosis, treatment, education, prevention, and consultation including, but not limited to, Primary Care and Subspecialty Services such as Genetics, Rheumatology, Dermatology, Neurology, Infectious Disease, Hematology, Nephrology, Cardiology, Pulmonary Disease, Allergy, Immunology, Oncology, Nutritional Therapy, Endocrine and Metabolic and Nutritional Disorders, and the co-ordination of referral to outside services not available at TCRHCC.

H. Obstetric and Gynecological Services: Provides both outpatient and inpatient obstetrical and gynecological care which includes the diagnosis, medical and surgical treatment, education, prevention, and consultation including, but not limited to, Primary Women's Health care, prenatal care, Perinatal care, and post partum care, antenatal testing; amniocentesis, ultra-sound, support for high-risk deliveries, surgery for gynecological and uro-gynecological diseases and conditions.

I. Surgical Services: Provides both outpatient and inpatient services for Pediatric and Adult patients which includes the diagnosis, medical and surgical treatment, education,

prevention, and consultation including, but not limited to, General Surgery and Surgical Subspecialties such as, Orthopedics, Podiatry, Urology, Peripheral Vascular, Bariatric, Pediatric, Otolaryngology, Dental, Pediatric Dental, and Oral Surgery. It also includes Endoscopic diagnostic and treatment services. Facilities include ambulatory surgery units, operating rooms, endoscopy rooms, along with support services such as sterile processing services.

J. Anesthesia Services: Provides both outpatient and inpatient services for Pediatric and Adult patients which includes the diagnosis, medical and surgical treatment, education, prevention, and consultation including, but not limited to, General Regional and Local Anesthesia, post-anesthesia care and pain management.

K. Ophthalmology and Optometry Services: Provides both outpatient and inpatient services for Pediatric and Adult patients which includes the diagnosis, medical and surgical treatment, education, prevention, and consultation including, but not limited to, optometry and ophthalmologic medical and surgical treatment (e.g., minor and major surgery, laser therapy) and management of diseases and disorders of the visual system, and related structures as well as in the diagnosis of related systemic conditions (e.g., diabetes) visual acuity, visual field testing, and the prescribing and dispensing of glasses and contact lenses.

L. Dental Services: Provides both outpatient and inpatient services for Pediatric and Adult patients which includes the diagnosis, medical and surgical treatment, education, prevention, and consultation for dental health and dental disease through services including, but not limited to, General Dentistry, Pediatric Dentistry Oral Surgery, Orthodontics, and Endodontic, and Periodontal care.

M. Mental Health Services: Provides outpatient and inpatient counseling and psychiatric services to individuals and families, including, but not limited to, counseling, psychiatric services, evaluations, including court-ordered evaluations and evaluations pursuant to memoranda of agreement, telephone consultation to providers, 24-hour on-call services, outpatient and inpatient consultations. Provides social services including, but not limited to, assistance with psychosocial issues, consultation and training, developing care and placement plans, and coordinating patient case management with other patient services.

N. Alcohol and Substance Abuse Services: Provides services including, but not limited to, screening, assessment and referrals to appropriate inpatient/outpatient centers, and short-term counseling and group activities for patients.

O. Clinical Laboratory Services and Pathology Services: Provides a full range of laboratory services including, but not limited to, chemistry, hematology, pathology, microbiology, transfusion services, and clinical tests in support of patient diagnosis and treatment. Also serves as a referral laboratory, a reference laboratory and pathology service by contract for testing services not performed at TCRHCC.

P. Radiology Services: Provides both outpatient and inpatient services for Pediatric and Adult patients which includes, but is not limited to, providing diagnostic examinations that include general radiography, mammography, ultrasound, echo cardiogram, teleradiology, computed tomography (CT) scans, biopsy, vascular and interventional procedures, and MRI (Magnetic resonance imaging) and bone density studies.

Q. Pharmacy Services: Provides both outpatient and inpatient pharmaceutical services for Pediatric and Adult patients including, but not limited to, prescribing therapies (e.g., anti-coagulation clinics), recommending therapies, dispensing medications and monitoring of

medication treatment plans to assure appropriate, safe, cost effective therapies and provides patient education and information regarding pharmaceutical treatment to assure compliance and mediate against potential adverse effects (e.g., lipid clinic and other patient related counseling).

R. Respiratory Therapy Services: Provides both outpatient and inpatient diagnostic and treatment services for Pediatric and Adult patients including, but not limited to, ECG, Holter monitoring, event monitoring, arterial blood gases, pulmonary function testing, pulse oximetry, nebulizer and IPPB therapy, sleep disorder laboratory testing and treatment and ventilator support.

S. Physical Rehabilitation Services: Provides both outpatient and inpatient evaluation and treatment services for Pediatric and Adult patients including but not limited to,

- Physical Therapy Services: Provides both outpatient and inpatient services for Pediatric and Adult patients including evaluation, education, treatment, prevention, and consultation including, but not limited to, patients with acute and chronic neurological disease and disorders, musculoskeletal and joint disorders and diseases, pre and post operative evaluation and treatment, wound care, ongoing care for diabetic patients, self-care education and coordination with other patient services.
- Speech-Language Pathology and Occupational Therapy Services: Provides both outpatient and inpatient services for Pediatric and Adult patients including evaluation, treatment, education, prevention, and consultation including, but not limited to, speech-language therapy and occupational therapy, screening, diagnosis, rehabilitation and prevention with a wide variety of diagnoses, to patients who have conditions that are mentally, physically, developmentally, or emotionally disabling, to help them to develop, recover, or maintain daily living and work skills.
- Cardiac and Pulmonary Rehabilitation Services: Provides both outpatient and inpatient services for Adult patients including evaluation, treatment, education, prevention, and consultation including, but not limited to, cardiopulmonary rehabilitation which is a physician referred program offering both monitored, and non-monitored cardio-pulmonary physical training; education and training that, includes diet, stress management, and smoking cessation; and other interventions to promote a healthier lifestyle.

T. Nutrition and Dietetics Services: Provides both outpatient and inpatient services for Pediatric and Adult patients including evaluation, treatment, education, prevention, and consultation including, but not limited to, medical nutritional therapy, nutritional screening and assessment, nutritional education and monitoring, supplemental feedings, consultative assistance for selected patients, and the food service that is responsible for providing patient meals and cafeteria service for patients, visitors and employees.

U. Public Health Nursing Services: Provides public health nursing services.

V. Diabetes Clinical Treatment and Prevention Services: Provides primary, secondary and tertiary prevention services, including, but not limited to, diagnosis, treatment, education, prevention, research, screening, monitoring case management services, including peritoneal dialysis.

W. Health Promotion Program Services: Provides an integrated holistic approach that is directed at individual and community empowerment with positive, proactive approaches

to making healthy lifestyle changes. Includes, but is not limited to, employee health and community health and health promotion programs, sponsoring events to promote health services, disease prevention, healthy life style activities.

X. Telemedicine Services: Provides both outpatient and inpatient services for Pediatric and Adult patients including evaluation, treatment, education, prevention, and consultation including, but not limited to, the diagnosis and treatment, consultation, monitoring and management of patients through interactive audio, video and data modalities, through both Primary Care and Subspecialty Services are supported by telemedicine at TCRHCC and at satellite sites. Teleradiology services are also supported to provide interpretation of diagnostic images with contract providers.

Y. Contract Health Services: Authorizes funds within established medical priorities for certain services provided by non-IHS or non-tribal providers and facilities both inside and outside of the service area. Access by qualified beneficiaries to CHS may be obtained only by authorization of TCRHCC staff that has been delegated the authority to approve CHS. This requires that beneficiaries must be referred by a TCRHCC physician to the CHS program for consideration of their CHS request prior to approval, or must obtain required approval for care as provided by applicable federal regulations.

Z. Complementary and Alternative Medicine Services: Provides complementary and alternative medicine ("CAM") patient care services, which can be demonstrated to be reasonably safe and effective and are indicated for the patient's diagnosis or condition, and which are provided either (a) through a referral from a provider (defined as MD, DO, DDS, DMD, PA, APN, DPM) on the TCRHCC medical staff or (b) by a TCRHCC medical staff member who is credentialed and privileged as required by TCRHCC's accrediting or certifying body for the specific CAM services to be provided.

AA. Medical Gases: Provides liquefied, dissolved, vaporized and cryogenic compressed medical gases alone or in combination as defined in the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 321(g)(l).

BB. Traditional Healing: Provides services including, but not limited to, traditional Navajo, Hopi and Paiute healing practices and ceremonies. These services will be provided in accordance with Section 831 of the Indian Health Care Improvement Act, as amended at 25 U.S.C. § 1680u.

CC. TCRHCC Employee Health: Provides health services for TCRHCC employees including, but not limited to, health services under the TCRHCC employee assistance program, screenings and immunizations, and related services.

DD. Durable Medical Equipment: Provides durable medical equipment, supplies and related services.

EE. Itinerant Services: Provides periodic rotation of TCRHCC personnel at other IHS facilities, P.L. 93-638 facilities and Navajo Nation P.L. 93-638 programs for primary and specialty care.

FF. Transportation Services: TCRHCC provides patient (including escorts, in accordance with Section 213 of IHCIA, 25 U.S.C. § 1621, as amended,), lab and related courier transportation, and employee travel and travel management, including but not limited to,

airplanes, motor vehicles, boats, all terrain vehicles and other forms of transportation common to the TCRHCC region, including vehicles owned or leased by TCRHCC and privately owned vehicles used in the performance of the PSFAs under this Funding Agreement.

GG. EMS & Emergency Transportation Services: Provides both Pediatric and Adult patients either air or ground transportation that includes, but not limited to,

- TCRHCC Staff personnel participating in the transport of the patient for education and training or
- TCRHCC Staff personnel participating in the transport of the patient for patient services that EMS personnel are not permitted to perform, and
- provide medical direction for such emergency medical transportation by either air or ground medical transport services.
- Pre-hospital or inter-facility transportation between the TCRHCC main campus and satellite clinics and non-TCRHCC facilities for health care services.
- The maintenance and operation of facilities to house and service vehicles, including helipad facilities and related operations and services.

HH. Temporary Patient Housing: Provides temporary housing within TCRHCC facilities for patients in conjunction with health care services.

II. Organ and Tissue Harvesting Services: Provides services in support of the harvesting of organs for transplantation.

JJ. Blood Bank Services: Provides services for the screening, collection and storage of blood in support of periodic blood drives and blood-banking.

KK. Veteran's Administration and IHS dual-eligible services development at the Hospital and satellite clinics services in accordance with the IHCIA, 25 U.S.C. § 1680f.

LL. Residency Programs: Participates in residency programs through written agreements with various medical schools and health science programs under the appropriate accrediting organizations.

MM. Long term care: Provides planning for elder care, independent living care, and assisted living care and related services, including facility maintenance and operation.

II. SUPPORT SERVICES:

A. Administrative Services: Includes, but is not limited to, strategic and operational program planning; financial management; grant applications and management, personnel management, and ensuring that the executive direction meets or exceeds the requirements of regulatory programs.

B. Planning of New Services and Facilities: Includes, but is not limited to, planning of new facilities and PSFAs consistent with IHCIA.

C. Human Resources: Includes, but is not limited to, administering and implementing policies and procedures related to human resource programs. Includes all

organizational/employee training, education and development functions for all departments and services.

D. Health Information Management: Maintains a comprehensive medical record system that is manual and/or electronic that includes, but is not limited to, record storage and retrieval, review and analysis of medical records, transcription, inpatient and outpatient data collection and management, and managing release of medical information.

E. Finance Services: Provides financial services including, but not limited to, organizing, coordinating and executing budget and financial operations for the organization.

F. Facilities Management: Includes, but is not limited to, performance and management of contracting activities and facility procurement, maintenance of related grounds, associated physical plant equipment, security, and renovation activities, including Maintenance & Improvement (M&I) funded projects and activities.

G. Housekeeping Services: Provides services including, but not limited to, waste, trash and infectious waste removal, linen management, routine and urgent cleaning for the facility.

H. Infection Control Services: Provides services including, but not limited to, management of the coordinated process to reduce the risks of endemic and epidemic nosocomial infections in patients, health care workers, and other employees that is accomplished through surveillance methodologies, education and reporting internally and when appropriate, to outside public health agencies.

I. Information Technology Resource Management Services: This function includes, but is not limited to, the provision of all aspects of technical (computerized) information management. The information and technology services support function provides hardware, software, applications development, telecommunications, remote data services, overall systems and operations management including senior leadership level information management.

J. General Services: This function includes, but is not limited to, providing technical and logistical management for all support services and operations for capitalized and non-capitalized equipment, vehicles, drugs, medical supplies and forms. Material support services range from management and distribution of supplies, equipment and mail, to inventory control of equipment assets.

K. Performance Improvement: This function includes, but is not limited to, monitoring and evaluating quality and value of services by providing education; coordination and support in the areas of continuous quality improvement, risk management, and issues related to complying with certifying and regulatory agencies such as those for the Joint Commission accreditation. Utilization review functions are also provided.

L. Safety Department: Provides services including, but not limited to, technical and professional consultation and directs services to all departments including, but not limited to, safety management programs; hazard surveillance monitoring; hazardous materials and waste management; monitoring of contracts for pest control, regulated medical waste and hazardous waste; and activities involved with the Joint Commission surveys and applicable OSHA requirements.

M. Business Office: Includes, but is not limited to, providing complete and accurate patient data for providers, collecting data on reimbursable expenses incurred by patients, generating bills for collection from other payers (primarily Medicare, Medicaid, and private insurance), conducting utilization review, insurance verification, and collection activities.

N. Educational Programs: Includes, but is not limited to, providing training, educational services and clinical rotations established in support of the PSFAs covered by the FA. Also includes providing programmatic consultations, proctoring and training of health care providers from other IHS facilities, P.L. 93-638 facilities and Navajo Nation P.L. 93-638 programs and non-IHS and Tribal Facilities. Also includes engaging in, funding, carrying out, conducting or taking part in programs, projects and services designed to improve, protect and/or restore individual, community and public health in order to achieve as outcomes improvements in access to, and the quality of, health care and the overall health both of individuals and communities as a whole in the area served by the TCRHCC.

Includes engaging in, funding, carrying on, conducting or taking part in educational and training programs and courses of instruction in the field of medicine and preventive medicine and in nursing and in the regulation, diagnosis, treatment and care of diseases, disorders, maladjustments and abnormalities of the human body.

Includes engaging in, funding, carrying out, conducting or taking part in any and all of the foregoing to promote or assist in promoting the good health of the community and the encouragement of providing means and facilities for such purposes.

O. Clinical Research: Research programs approved by the Board of Directors and the Navajo Nation IRB that supports the PSFAs covered by the FA.

P. Biomedical Services: Provides services including, but not limited to, biomedical engineering to repair and maintain medical and dental equipment and durable medical equipment.

Q. Housing Services and Quarters Management: Provides services including, but not limited to, management and maintenance of TCRHCC-controlled employee residences, if any.

R. Patients in custody: Provides inpatient and outpatient care.

S. Environmental Health Services: Provides services including, but not limited to, sanitation, vector control and building and code inspections.

SELF-GOVERNANCE FA TABLE **FOR FY 2013 NEGOTIATIONS**

Tribe: Tuba City Regional Health Care Corporation **Compact No. 63G110104** **Includes Tuba City, Moenkopi and San Juan Paiute**

	SUB-SUB ACTIVITY	PROGRAM FA Amount	PROGRAM Retained Services	PROGRAM Pgm Total Amount to Be Rec'd	AREA FA Amount	AREA Retained Services	AREA Area Total Amount to Be Rec'd	HEADQUARTERS FA Amount	HEADQUARTERS Retained Services	HEADQUARTERS HQ Total Amount to Be Rec'd	TOTALS FA Amount	TOTALS Retained Services	TOTALS FA Total Amount to Be Rec'd
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
(1)	Hospitals & Clinics	23,941,563	0	23,941,563	1,060,422	(61,630)	998,792	992,433	(597,297)	395,136	25,994,418	(658,927)	25,335,491
(2)	Dental	2,473,600	0	2,473,600	92,926	(92,926)	0	25,963	(25,963)	0	2,592,489	(118,889)	2,473,600
(3)	Mental Health	968,771	0	968,771	0	0	0	45,302	0	45,302	1,014,073	0	1,014,073
(4)	Alcohol & Subst Abuse	118,063	0	118,063	37,337	0	37,337	0	0	0	155,400	0	155,400
(5)	Public Health Nursing	1,019,128	0	1,019,128	0	0	0	0	0	0	1,019,128	0	1,019,128
(6)	Health Education	0	0	0	0	0	0	0	0	0	0	0	0
(7)	Community Health Reps.	0	0	0	0	0	0	0	0	0	0	0	0
(8)	Immunization AK	0	0	0	0	0	0	0	0	0	0	0	0
(9)	Direct Operations	0	0	0	188,797	(83,227)	105,570	332,820	(49,863)	282,957	521,617	(133,090)	388,527
(10)	Contr Supp Costs-Direct	1,860,091	0	1,860,091	0	0	0	0	0	0	1,860,091	0	1,860,091
(11)	Contr Supp Costs-Indirect	10,014,422	0	10,014,422	0	0	0	0	0	0	10,014,422	0	10,014,422
(12)	Self-Governance	0	0	0	0	0	0	0	0	0	0	0	0
(13)	Total, Services	40,395,638	0	40,395,638	1,379,482	(237,783)	1,141,699	1,396,518	(673,123)	723,395	43,171,638	(910,906)	42,260,732
(14)	Contract Health Services	8,694,435	0	8,694,435	134,993	0	134,993	55,366	0	55,366	8,884,794	0	8,884,794
(15)	Total, No-year Services	8,694,435	0	8,694,435	134,993	0	134,993	55,366	0	55,366	8,884,794	0	8,884,794
(16)	Environ Hlth Support	0	0	0	291,594	(137,729)	153,865	8,386	0	8,386	299,980	(137,729)	162,251
(17)	Facilities Support	2,389,929	0	2,389,929	149,561	(149,561)	0	35,593	0	35,593	2,575,083	(149,561)	2,425,522
(18)	OEHE Support	0	0	0	0	0	0	0	0	0	0	0	0
(19)	Maint & Improvement	0	0	0	0	0	0	0	0	0	0	0	0
(20)	Equipment	0	0	0	0	0	0	0	0	0	0	0	0
(21)	Total, Indian Hlth Facil	2,389,929	0	2,389,929	441,155	(287,290)	153,865	43,979	0	43,979	2,875,063	(287,290)	2,587,773
(22)	GRAND TOTAL, FA	51,480,002	0	51,480,002	1,955,630	(525,073)	1,430,557	1,495,863	(673,123)	822,740	54,931,495	(1,198,196)	53,733,299

Note: Adjustment made to reflect FY 2013 Table 4F
All amounts above reflect FY 2012 appropriations and these amounts will be adjusted based upon the enacted FY 2013 appropriations.

APPROVED: _____ DATE: _____
Director, Financial Management-Navajo Area IHS

ATom
OISD
Last Revision: 07-25-2012

ATTACHMENT B

TUBA CITY REGIONAL HEALTH CARE CORPORATION
106 (a) (1) Service Unit Base Funding
FY 2013

	FY-2012 Recurring Base	FY-2012 Return of GRSSC Operational Shares	FY-2012 Rescission (.0016) H&C - CHS & (.0016164) Facility Support	Tuba City	Moenkopi	SJSP	FY 2013 Funding Base
1. H/C	23,912,872	67,059	(38,368)	23,227,865	663,660	50,038	23,941,563
2. Dental	2,475,903	1,661	(3,964)	2,399,861	68,568	5,171	2,473,600
Mental Health	970,323		(1,553)	939,890	26,854	2,026	968,770
ASAP	118,252		(189)	114,542	3,273	248	118,063
PHN	1,020,761		(1,633)	988,747	28,260	2,131	1,019,128
Contract Health	8,708,368		(13,933)	8,435,255	241,009	18,171	8,694,435
Facilities Support	2,393,799		(3,870)	2,318,686	66,249	4,994	2,389,929
3. Environmental Health Support	0	0	0	0	0	0	0
TOTAL	39,600,278	68,720	(63,511)	38,424,847	1,097,862	82,777	39,605,487

NOTES:
All numbers above reflect FY-2012 appropriations.

1. FY-2011 3/4 of Hospital & Clinic Operational Shares $201,175 paid to TCRHCC and the remaining recurring base of $67,059 will be returned in FY-2012. Reference the September 30, 2010 memorandum and the October 1, 2010 letter from TCRHCC requesting to terminate Prime Vendor and Stores Stock services from the GRSSC.

2. FY-2011 3/4 of Dental Operational Shares $4,982 paid to TCRHCC and the remaining recurring base of $1,661 will be returned in FY-2012. Reference the September 30, 2010 memorandum and the October 1, 2010 letter from TCRHCC requesting to terminate Prime Vendor and Stores Stock services from the GRSSC.

3. All EHS funds are centrally managed at the Area Office. Service Unit and Area Office shares are shown in Attachment C.

E Begay
OISD
Original Date: 4/24/2012

ATTACHMENT C

TUBA CITY REGIONAL HEALTH CARE CORPORATION
FY 2013 Area Office Shares

	FY-2013 Funding Base	Less 2013 Residual	Area Office Shares Less Residual	% of 1998Total Users 253,822	Annualized Tuba City Share Amount @ 100 %	Moenkopi % of 1998 Total Users 253,822	Annualized Moenkopi Share Amount @ 100 %	SJSP % of 1998 Total Users 253,822	Annualized SJSP Share Amount @ 100 %	FY 2013 Shares Taken	FY 2013 Shares Retain
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Hospitals & Clinics					11.141%		0.318%		0.024%		
101 Office of the Area Director	72,066		72,066	11.141%	8,029	0.318%	229	0.024%	17	8,275	0
171 Attorney	401,381	(199,204)	202,177	11.141%	22,525	0.318%	643	0.024%	49	23,216	0
182 Office of Ind Self Deter.	390,347		390,347	11.141%	43,489	0.318%	1,241	0.024%	94	44,823	0
1A8 EEO	4,447		4,447	11.141%	496	0.318%	14	0.024%	1	511	0
123 Contract Health Services	154,246		154,246	11.141%	17,185	0.318%	491	0.024%	37	17,712	0
102 Financial Management	1,537,298	(503,036)	1,034,262	11.141%	115,227	0.318%	3,289	0.024%	248	118,764	0
105 Admin Services	366,423		366,423	11.141%	40,823	0.318%	1,165	0.024%	88	42,076	0
128 MIS	418,900	(197,573)	221,327	11.141%	24,656	0.318%	704	0.024%	53	0	25,415
107 Acquisition	833,851	(524,357)	309,494	11.141%	34,481	0.318%	984	0.024%	74	35,539	0
103 Human Resources	1,145,831	(128,949)	1,016,882	11.141%	113,268	0.318%	3,233	0.024%	244	116,746	0
117 Medical Records	5,004		5,004	11.141%	557	0.318%	16	0.024%	1	575	0
147 EMS	15,011		15,011	N/A	0	N/A	0	N/A	0	0	0
118 Nursing Admin	207,252		207,252	11.141%	23,090	0.318%	659	0.024%	50	23,799	0
109 Professional Stds & Recruit	315,375		315,375	11.141%	35,136	0.318%	1,003	0.024%	76	0	36,215
sub-total:	5,867,231	(1,553,119)	4,314,112		478,983		13,671		1,032	432,036	61,630
114 BIA/CSA	0		0	N/A	0	N/A	0	N/A	0	0	0
189 Health Board	47,124		47,124	11.141%	5,250	0.318%	150	0.024%	11	5,411	0
114 Assessments	0		0	N/A	0	N/A	0	N/A	0	0	0
134 Model Diabetes Prog	309,705		309,705	11.141%	34,504	0.318%	985	0.024%	74	35,563	0
284 HP/DP (SR)	199,680		199,680	11.141%	24,255	0.318%	693	0.024%	52	25,000	0
sub-total:	8,423,740	(1,553,119)	4,870,621		542,972		15,499		1,170	498,011	61,630
Pinon Support	200,000		200,000	N/A	0	N/A	0	N/A	0	0	0
Red Mesa Support	200,000		200,000	N/A	0	N/A	0	N/A	0	0	0
sub-total:	400,000	0	400,000		0		0		0	0	0
Dental Health											
268 Dental Program minus Flouride	555,690		555,690	11.141%	61,908	0.318%	1,767	0.024%	133	0	63,810
Dental OEH Flouridation	60,000		60,000	N/A	0	N/A	0	N/A	0	0	0
Jeddito (MOA - PHXIHS)	0		0	N/A	0	N/A	0	N/A	0	0	0
Biomedical Support	253,557		253,557	11.141%	28,249	0.318%	806	0.024%	61	0	29,116
sub-total:	869,247	0	869,247		90,158		2,573		194	0	92,926
Mental Health											
261 Mental Health Program	0	0	0	N/A	0	N/A	0	N/A	0	0	0
Alcohol & Subetance Abuse											
239 ASAP minus None for the Road	325,150		325,150	11.141%	36,225	0.318%	1,034	0.024%	78	37,337	0
None for the Road	9,828		9,828	N/A	0	N/A	0	N/A	0	0	0
sub-total:	334,978	0	334,978		36,225		1,034		78	37,337	0
Public Health Nursing											
284 Public Health Nursing	0	0	0	N/A	0	N/A	0	N/A	0	0	0

ATTACHMENT C

TUBA CITY REGIONAL HEALTH CARE CORPORATION
FY 2013 Area Office Shares

	FY-2013 Funding Base	Less 2013 Residual	Area Office Shares Less Residual	% of 1998Total Users 253,822	Annualized Tuba City Share Amount @ 100 %	Moenkopi % of 1998 Total Users 253,822	Annualized Moenkopi Share Amount @ 100 %	SJSP % of 1998 Total Users 253,822	Annualized SJSP Share Amount @ 100 %	FY 2013 Shares Taken	FY 2013 Shares Retain
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Direct Operations											
101 Office of the Area Director	918,911	(923,465)	(4,554)	11.141%	(507)	0.316%	(14)	0.024%	(1)	(523)	0
111 Office of the Area Director-Travel	24,891		24,891	11.141%	2,773	0.316%	79	0.024%	6	2,858	0
1A8 EEO	97,713		97,713	11.141%	10,888	0.316%	311	0.024%	23	11,220	0
106 Third Party Resources	134,180		134,180	11.141%	14,949	0.316%	427	0.024%	32	15,408	0
123 Contract Health Services	134,241		134,241	11.141%	14,956	0.316%	427	0.024%	32	15,415	0
102 Financial Management	248,262	(217,187)	31,075	11.141%	3,462	0.316%	99	0.024%	7	3,568	0
105 Admin Services	302,847		302,847	11.141%	33,740	0.316%	963	0.024%	73	34,776	0
104 Property Management	273,202	(217,187)	56,015	11.141%	6,241	0.316%	178	0.024%	13	6,432	0
128 MIS	317,182		317,182	11.141%	35,337	0.316%	1,009	0.024%	76	0	36,422
107 Acquisition	0		0	11.141%	0	0.316%	0	0.024%	0	0	0
103 Human Resources	351,814	(208,881)	142,953	11.141%	15,926	0.316%	455	0.024%	34	16,415	0
108 Program Planning & Evaluation	348,318		348,318	11.141%	38,806	0.316%	1,108	0.024%	84	0	39,997
109 Professional Stds & Recruit	59,283		59,283	11.141%	6,605	0.316%	189	0.024%	14	0	6,807
sub-total:	3,210,843	(1,566,700)	1,644,143		183,174		5,228		395	105,570	83,227
Facilities Support											
115 Bio-Med	636,117		636,117	11.141%	70,870	0.316%	2,023	0.024%	153	0	73,045
Pinon Support	69,301		69,301	N/A	0	N/A	0	N/A	0	0	0
Ft. Defiance Support	0		0	N/A	0	N/A	0	N/A	0	0	0
Red Mesa Support	157,214		157,214	N/A	0	N/A	0	N/A	0	0	0
sub-total:	862,632	0	862,632		70,870		2,023		153	0	73,045
104 Real Property	184,542		184,542	11.141%	20,560	0.316%	587	0.024%	44	0	21,191
Pinon Support	21,000		21,000	N/A	0	N/A	0	N/A	0	0	0
Ft. Defiance Support	0		0	N/A	0	N/A	0	N/A	0	0	0
Red Mesa Support	47,639		47,639	N/A	0	N/A	0	N/A	0	0	0
sub-total:	253,181	0	253,181		20,560		587		44	0	21,191
114 Facility Management	928,917	(447,120)	481,797	11.141%	53,677	0.316%	1,532	0.024%	116	0	55,325
Pinon Support	109,319		109,319	N/A	0	N/A	0	N/A	0	0	0
Ft. Defiance Support	0		0	N/A	0	N/A	0	N/A	0	0	0
Red Mesa Support	247,991		247,991	N/A	0	N/A	0	N/A	0	0	0
sub-total:	1,286,227	(447,120)	839,107		53,677		1,532		116	0	55,325
Quarters, SU Funded	97,543		97,543	N/A	0	N/A	0	N/A	0	0	0
Pinon Support	10,501		10,501	N/A	0	N/A	0	N/A	0	0	0
Ft. Defiance Support	0		0	N/A	0	N/A	0	N/A	0	0	0
Red Mesa Support	23,821		23,821	N/A	0	N/A	0	N/A	0	0	0
sub-total:	131,865	0	131,865		0		0		0	0	0
Total FS:	2,533,905	(447,120)	2,086,785		148,107		4,142		313	0	149,661

ATTACHMENT C

TUBA CITY REGIONAL HEALTH CARE CORPORATION
FY 2013 Area Office Shares

	FY-2013 Funding Base	Less 2013 Residual	Area Office Shares Less Residual	% of 1998Total Users 253,822	Annualized Tuba City Share Amount @ 100 %	Moenkopi % of 1998 Total Users 253,822	Annualized Moenkopi Share Amount @ 100 %	SJSP % of 1998 Total Users 253,822	Annualized SJSP Share Amount @ 100 %	FY 2013 Shares Taken	FY 2013 Shares Retain
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Environmental Health Support											
DOH -638 Contract	249,860		249,860	N/A	0	N/A	0	N/A	0	0	0
Area Office Support	626,147	(292,736)	333,411	11.141%	37,145	N/A	0	0.024%	80	0	37,225
S.U. Operation	1,378,103		1,378,103	11.141%	153,534	N/A	0	0.024%	331	153,865	0
Chinle/Pinon	35,030		35,030	N/A	0	N/A	0	N/A	0	0	0
Ft. Defiance	161,859		161,859	N/A	0	N/A	0	N/A	0	0	0
Shiprock/Red Mesa	77,135		77,135	N/A	0	N/A	0	N/A	0	0	0
Winslow	267,799		267,799	N/A	0	N/A	0	N/A	0	0	0
S.U. Non-Recurring	0		0	11.141%	0	N/A	0	0.024%	0	0	0
sub-total:	2,815,933	(292,736)	2,523,197		190,680		0		411	153,865	37,225
Occup. Health & Safety Manager	505,017		505,017	11.141%	56,264	0.316%	1,606	0.024%	0	0	57,870
sub-total:	505,017	0	505,017		56,264		1,606		0	0	57,870
			0								
Sanitation Fac. Const.											
Area Wide Operations	5,668,336	(514,933)	5,053,403	N/A	0	N/A	0	N/A	0	0	0
Chinle/Pinon	68,451		68,451	N/A	0	N/A	0	N/A	0	0	0
Ft. Defiance	354,502		354,502	N/A	0	N/A	0	N/A	0	0	0
Shiprock/Red Mesa	151,250		151,250	N/A	0	N/A	0	N/A	0	0	0
SFCB - 88-121	0		0	N/A	0	N/A	0	N/A	0	0	0
O&M Training (NTUA)	0		0	N/A	0	N/A	0	N/A	0	0	0
NECA contract	137,516		137,516	N/A	0	N/A	0	N/A	0	0	0
sub-total:	6,280,055	(514,933)	5,765,122		0		0		0	0	0
Injury Prevention											
Area & SU Projects	252,339		252,339	11.141%	28,113	N/A	0	0.024%	61	0	28,174
IP - NAO	129,516		129,516	11.141%	14,429	N/A	0	0.024%	31	0	14,460
IP - Ft. Defiance	23,711		23,711	N/A	0	N/A	0	N/A	0	0	0
IP - Chinle	43,139		43,139	N/A	0	N/A	0	N/A	0	0	0
IP - Sage	12,636		12,636	N/A	0	N/A	0	N/A	0	0	0
IP - GMC	51,423		51,423	N/A	0	N/A	0	N/A	0	0	0
IP - Crownpoint	25,803		25,803	N/A	0	N/A	0	N/A	0	0	0
IP - Winslow	25,820		25,820	N/A	0	N/A	0	N/A	0	0	0
Sub-total Injury Prevention	564,387	0	564,387		42,542		0		92	0	42,634
Total OEH:	10,165,392	(807,669)	9,357,723	0	289,486	0	1,606	0	502	153,865	137,729
Totals:	23,938,195	(4,374,608)	19,563,487		1,287,122		30,082		2,652	794,783	525,873

revised 5-1-2012

ATTACHMENT C-A

TUBA CITY REGIONAL HEALTH CARE CORPORATION
FY 2013 Area Wide Reserve Shares

	FY-2013 Funding Base	% of 1998Total Users 253,822	Annualized Tuba CitY Share Amount @ 100 %	Moenkopi % of 1998 Total Users 253,822	Annualized Moenkopi Share Amount @ 100 %	SJSP % of 1998 Total Users 253,822	Annualized SJSP Share Amount @ 100 %	FY 2013 Shares Taken
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Hospital and Clinics								
201 AW Reserve	4,361,068	11.141%	485,867	0.318%	13,868	0.024%	1,047	500,781
Contract Health Care								
523 CHS Reserve	1,175,587	11.141%	130,972	0.318%	3,738	0.024%	282	134,993
Totals:	5,536,655		616,839		17,607		1,329	635,774

revised 5-1-2012

Table 4F

Estimated Area and Headquarters Facilities Appropriation Funds for FY 2013 SD/SG Negotiations

Current Funds Manager: NV, IHS-TUBA CITY SU | Serv Type: T5

Possible SG Tribe or Org: Navajo Tribe - Tuba City | For Fiscal Year: 2013

Tribes Served: Navajo

Comments:

HQ Line #		Activity Description	AREA FY2012 Actual	AREA FY2013 Avail106a1	AREA FY2013 Negotiated	AREA Base Thru	HEADQUARTERS - Facilities Appropriation Share Factor	HQ FY2012 Actual	HQ FY2013 Av 106a	HQ FY2013 Calcul	HQ FY2013 Negot	HQ Base Thru
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)
		Maintenance and Improvement (M&I)(2100)										
	1	Routine M&I IHS owned Facility	0	0	0							
	2	Routine M&I Tribally owned Facility	0	0	0							
	3	Project M&I IHS owned Facility	0	0	0							
	4	Project M&I Tribally owned Facility	0	0	0							
	a	Subtotal Non-base (28)	0	0	0							
	b	Subtotal base (26)	0	0	0							
2100		Total M&I (26)	0	0	0		Calculated on line 2405a					
	5	M&I Environmental Remediation Projects					Available with accepted proposal					
2200	9	Sanitation Facilities (P.L. 86-121 Proj) (00)	Available through amendment process									
2300	10	Health Care Facilities (NEW) (00)					With line item construction project					
		Facilities and Environ Health Support (2400)										
		Environ Health Support Account (EHSA)										
	11	San Fac Constr (SFC) Support - Proj Related	0	0	0							
	12	AO SFC Program Mgmt - Proj Related	0	0	0							
	13	SFC Support - Non-project Related	0	0	0							
	14	AO SFC Program Management-Non-project Related	0	0	0							
	15	Other:	0	0	0							
	a	Subtotal Non-Base (27)	0	0	0							
	b	Subtotal Base (27)	0	0	0							
	c	Subtot HQ-OEHE Support -SFC Non-Base (29)					0.0545	0	0	0	0	
	d	Subtotal HQ-OEHE Support -SFC Base (29)						0	0	0	0	
2401		Total HQ-OEHE Support - SFC Related (29)						0	0	0	0	
	16	Environ Health Services - Basic Program	0	153,864	0							
	17	Environ Health Services - Institutional Hlth	0	0	0							
	18	Environ Health Services - Injury Prevention	0	0	0							
	19	AO Environmental Health Services Support	0	0	0							
	20	Other:	0	0	0							
	a	Subtotal Non-Base (27)	0	153,864	0							
	b	Subtotal Base (27)	0	0	0							
	c	Subtot HQ-OEHE Support EHS Non-Base (29)					0.0545	0	8,366	0	0	
	d	Subtotal HQ-OEHE Support EHS Base (29)						0	0	0	0	0
2402		Total HQ-OEHE Support - EHS Related (29)						0	8,366	0	0	
		Facilities Support Account (FSA)										
	31	Service Unit Operations	0	2,389,929	0							
	32	Biomedical	0	0	0							
	33	AO FSA Support	0	0	0							
	34	AO Real Property Support	0	0	0							
	35	AO Biomedical Program	0	0	0							
	36	M&I Engineering Support	0	0	0							
	37	Other:	0	0	0							
		Total FSA (28)	0	2,389,929	0							
2403		HQ Facilities and Real Property Support										
	a	Total HQ - OEHE Support - FSA Related (29)					0.0149	0	35,593	0	0	
	b	HQ Real Property(based on net # of bldgs transferred to tribe) (29)		0	0		236.40	0	0	0	0	
2404		Facilities Planning and Construction Support					Available with line 2300					
2405		Engineering Services Support										
	a	M&I Contracting Services (29)					0.0088	0	0	0	0	
	b	New Health Care Facilities (29)					Available with line 2300					
2400		TOTAL Facilities and Environ Support (29)	0	2,543,793	0			0	43,979	0	0	
2500		Equipment Replacement (01)	0	0	0							
		SubTotal (Non-Base)	0	2,543,793	0			0	43,979	0	0	
		SubTotal (Base Budget Pilot)	0	0	0			0	0	0	0	
d:ver:h		GRAND TOTAL	0	2,543,793	0			0	43,979	0	0	

Table #4

HQ PFSAs for FY 2012 TSA and Program Formula Lines

$ in Pool, Allocable Shares, Shares for Contracted SUs, and Transfer Schedule

Based on FY 2011 Appropriation.

Tuba City

11.141% of Service Unit Contracted | *$12,650,236*

		TSA	PF	$ In Shares Pool	Tribes Allocable Shares	% SUs Contracted*	Shares for Contracted SUs & Rescission (.0016)	FY 2012 Taken	FY 2012 Retained by IHS
				(1)	(2)	(3)	(4)	(5)	(6)
Hospitals & Clinics				**$60,029,165**	**$8,815,435**		**$958,331**	**$381,829**	**$576,502**
101	Emergency Fund		X	$4,141,378	$0	11.1%	$0	$0	$0
105	Management Initiatives		X	$2,144,702	$0	11.1%	$0	$0	$0
106	A.C.O.G. Contract	X		$102,749	$17,256	11.1%	$1,919	$0	$1,919
107	H.P./D.P. Initiatives	X		$4,691,706	$313,340	11.1%	$34,853	$0	$34,853
110	N.E.C.J.	X		$1,154,300	$194,030	11.1%	$21,583	$21,583	$0
111	Nurse Initiatives	X		$1,336,319	$219,145	11.1%	$24,376	$0	$24,376
112	Nursing Costeps	X		$673,039	$113,127	11.1%	$12,584	$0	$12,584
113	Chief Clinical Consultant	X		$289,041	$48,592	11.1%	$5,406	$0	$5,406
118	Research Projects	X		$1,332,873	$222,919	11.1%	$24,796	$24,796	$0
119	A.A.I.P. Contract	X		$27,859	$4,684	11.1%	$521	$0	$521
120	Clinical Support Center-Phoenix	X		$1,805,135	$321,033	11.1%	$35,709	$0	$35,70
121	Costeps-Non Physicians	X		$84,792	$14,237	11.1%	$1,584	$0	$1,58
123	Physician Residency	X		$287,421	$48,319	11.1%	$5,375	$0	$5,375
124	Recruitment/Retention	X		$2,176,892	$365,907	11.1%	$40,701	$0	$40,701
125	U.S.U.H.S., etc.	X		$3,182,062	$534,939	11.1%	$59,504	$59,504	$0
126	D.I.R. Support Fund	X		$22,494,664	$3,782,194	11.1%	$420,710	$131,050	$289,660
127	Evaluation	X		$1,107,347	$186,179	11.1%	$20,709	$20,709	$0
128	National Indian Health Board	X		$478,485	$79,890	11.1%	$8,886	$8,886	$0
129	Albuq/HQ Administration	X		$928,174	$176,401	11.1%	$19,621	$19,621	$0
130	Nutrition Training Center	X		$359,610	$65,350	11.1%	$7,270	$7,270	$0
131	Diabetes Program-Albuq HQ	X		$1,340,034	$234,777	11.1%	$26,117	$25,862	$255
132	Cancer Prevention-Albuq HQ	X		$745,971	$131,513	11.1%	$14,628	$14,628	$0
133	Health Records	X		$142,025	$18,823	11.1%	$2,093	$2,093	$0
135	Handicapped Children	X		$360,403	$63,679	11.1%	$7,082	$0	$7,082
137	National DIR Support-Albuq HQ	X		$8,642,366	$1,459,101	11.1%	$162,302	$45,826	$116,476
Dental Health				**$6,507,639**	**$226,237**		**$25,166**	**$0**	**$25,166**
201	IHS Dental Program	X		$1,061,547	$226,237	11.1%	$25,166	$0	$25,166
202	IHS Dental Program-PgmFormula		X	$5,446,092	$0	11.1%	$0	$0	$0
Mental Health				**$2,319,860**	**$393,304**		**$43,749**	**$43,749**	**$0**
301	Technical Assistance	X		$1,562,661	$266,028	11.1%	$29,592	$29,592	$0
302	C.M.I. Grants	X		$646,528	$108,887	11.1%	$12,090	$12,090	$0
303	National Conference	X		$110,671	$18,588	11.1%	$2,068	$2,068	$0
Contract Health Care				**$10,539,603**	**$480,604**		**$53,459**	**$53,459**	**$0**
501	Fiscal Intermediary		X	$7,683,626	$0	11.1%	$0	$0	$0
504	C.H.S. Reserve & Undistributed	X		$2,855,977	$480,604	11.1%	$53,459	$53,459	$0

EBEGAY/OISD
Original Date: 10/12/2011
Last Revision: 06/20/2012

Table #4

HQ PFSAs for FY 2012 TSA and Program Formula Lines

$ in Pool, Allocable Shares, Shares for Contracted SUs, and Transfer Schedule

Based on FY 2011 Appropriation.

Tuba City				11.141% of Service Unit Contracted	*$12,650,236*	
	TSA	PF	$ in Shares Pool	Tribes Allocable Shares	% SUs Contracted*	Shares for Contracted SUs & Rescission (.0016)	FY 2012 Taken	FY 2012 Retained by IHS
Direct Operations			$17,195,246	$2,888,991		$321,355	$272,612	$48,743
1301 Direct Operations-Rockville	X		$17,195,246	$2,888,991	11.1%	$321,355	$272,612	$48,743
Facilities & Envr.Hlth.Support			$7,970,184	$45,665		$45,665	$45,665	$0
2401 San. Facilities Constr. Support		X	$2,355,881	$0	11.1%	$0	$0	$0
2402 Environ. Health Svcs. Support		X	$1,406,900	$8,510	11.1%	$8,510	$8,510	$0
2403 Facilities & Realty Support		X	$2,296,288	$37,155	11.1%	$37,155	$37,155	$0
2404 Facilities Engineering Support		X	$1,423,277	$0	11.1%	$0	$0	$0
2405 Engineering Services Support		X	$487,858	$0	11.1%	$0	$0	$0
Other:								
							$797,314	$650,411

TOTALS

TSA	Program Formula	$ in Shares Pool	Tribes Allocable Shares	Shares for Contracted Sus
$74,255,138	$30,306,559	$104,561,698	$12,650,236	$1,447,725

EBEGAY/OISD
Original Date: 10/12/2011
Last Revision: 06/20/2012

Table #4

HQ PFSAs for FY 2012 TSA and Program Formula Lines

ATTACHMENT D

$ in Pool, Allocable Shares, Shares for Contracted SUs, and Transfer Schedule

Based on FY -2011 Appropriation.

Moenkopi

0.318% of Service Unit Contracted *$12,604,571*

		TSA	PF	$ In Shares Pool	Tribes Allocable Shares	% Sus Con-tracted*	Shares for Contracted Sus & Rescission (.0016)	FY 2012 Taken	FY 2012 Retained by IHS
				(1)	(2)	(3)	(4)	(5)	(6)
Hospitals & Clinics				**$60,029,165**	**$8,615,435**		**$27,381**	**$10,919**	**$16,462**
101	Emergency Fund		X	$4,141,376	$0	0.3%	$0	$0	$0
105	Management Initiatives		X	$2,144,702	$0	0.3%	$0	$0	$0
106	A.C.O.G. Contract	X		$102,749	$17,268	0.3%	$55	$0	$55
107	H.P./D.P. Initiatives	X		$4,691,706	$313,340	0.3%	$996	$0	$996
110	N.E.C.I.	X		$1,154,300	$194,030	0.3%	$617	$617	$0
111	Nurse Initiatives	X		$1,336,319	$219,145	0.3%	$697	$0	$697
112	Nursing Costaps	X		$673,039	$113,127	0.3%	$359	$0	$359
113	Chief Clinical Consultant	X		$289,041	$48,592	0.3%	$154	$0	$154
118	Research Projects	X		$1,332,873	$222,919	0.3%	$708	$708	$0
119	A.A.I.P. Contract	X		$27,859	$4,684	0.3%	$14	$0	$14
120	Clinical Support Center-Phoenix	X		$1,805,135	$321,033	0.3%	$1,020	$0	$1,020
121	Costaps-Non Physicians	X		$84,792	$14,237	0.3%	$45	$0	$45
123	Physician Residency	X		$287,421	$48,319	0.3%	$153	$0	$153
124	Recruitment/Retention	X		$2,176,892	$365,907	0.3%	$1,163	$0	$1,163
125	U.S.U.H.S., etc.	X		$3,182,082	$534,939	0.3%	$1,700	$1,700	$0
126	D.I.R. Support Fund	X		$22,494,864	$3,782,194	0.3%	$12,021	$3,744	$8,277
127	Evaluation	X		$1,107,347	$186,179	0.3%	$592	$592	$0
128	National Indian Health Board	X		$478,485	$79,890	0.3%	$254	$254	$0
129	Albuq/HQ Administration	X		$928,174	$178,401	0.3%	$561	$561	$0
130	Nutrition Training Center	X		$359,610	$65,350	0.3%	$208	$208	$0
131	Diabetes Program-Albuq HQ	X		$1,340,034	$234,777	0.3%	$746	$746	$0
132	Cancer Prevention-Albuq HQ	X		$745,971	$131,513	0.3%	$419	$419	$0
133	Health Records	X		$142,025	$18,823	0.3%	$60	$60	$0
135	Handicapped Children	X		$360,403	$63,679	0.3%	$202	$0	$202
137	National DIR Support-Albuq HQ	X		$8,842,366	$1,459,101	0.3%	$4,638	$1,309	$3,329
Dental Health				**$6,507,639**	**$226,237**		**$718**	**$0**	**$718**
201	IHS Dental Program	X		$1,061,547	$226,237	0.3%	$718	$0	$718
202	IHS Dental Program-PgmFormula		X	$5,446,092	$0	0.3%	$0	$0	$0
Mental Health				**$2,319,860**	**$393,304**		**$1,250**	**$1,250**	**$0**
301	Technical Assistance	X		$1,562,661	$266,028	0.3%	$846	$846	$0
302	C.M.I. Grants	X		$646,528	$108,687	0.3%	$345	$345	$0
303	National Conference	X		$110,671	$18,588	0.3%	$59	$59	$0
Contract Health Care				**$10,539,603**	**$480,604**		**$1,528**	**$1,528**	**$0**
501	Fiscal Intermediary		X	$7,683,626	$0	0.3%	$0	$0	$0
504	C.H.S. Reserve & Undistributed	X		$2,855,977	$480,604	0.3%	$1,528	$1,528	$0
Direct Operations				**$17,195,246**	**$2,888,991**		**$9,182**	**$8,320**	**$862**
1301	Direct Operations-Rockville	X		$17,195,246	$2,888,991	0.3%	$9,182	$8,320	$862

EBEGAY/OISD
Original Date: 10/12/2011
Revision: 03/16/2012

Table #4

HQ PFSAs for FY 2012 TSA and Program Formula Lines

ATTACHMENT D

$ in Pool, Allocable Shares, Shares for Contracted SUs, and Transfer Schedule

Based on FY -2011 Appropriation.

Moenkopi				0.318% of Service Unit Contracted	***$12,604,571***	
	TSA	PF	$ In Shares Pool	Tribes Allocable Shares	% Sus Con-tracted*	Shares for Contracted Sus & Rescission (.0016)	FY 2012 Taken	FY 2012 Retained by IHS
			(1)	(2)	(3)	(4)	(5)	(6)
Facilities & Envr.Hlth.Support			$7,970,184	$0		$0	$0	$0
2401 San. Facilities Constr. Support		X	$2,355,881	$0	0.3%	$0	$0	$0
2402 Environ. Health Svcs. Support		X	$1,406,900	$0	0.3%	$0	$0	$0
2403 Facilities & Realty Support		X	$2,296,288	$0	0.3%	$0	$0	$0
2404 Facilities Engineering Support		X	$1,423,277	$0	0.3%	$0	$0	$0
2405 Engineering Services Support		X	$487,858	$0	0.3%	$0	$0	$0
Other:								
							$22,017	$18,043

TOTALS

TSA	Program Formula	$ In Shares Pool	Tribes Allocable Shares	Shares for Contracted Sus
$74,255,138	$30,306,559	$104,561,698	$12,604,571	$40,059

EBEGAY/OISD
Original Date: 10/12/2011
Revision: 03/16/2012

Table #4

HQ PFSAs for FY 2012 TSA and Program Formula Lines

ATTACHMENT D

$ in Pool, Allocable Shares, Shares for Contracted SUs, and Transfer Schedule

Based on FY 2011 Appropriation.

San Juan Palute

0.024% of Service Unit Contracted — *$12,604,571*

		TSA	PF	$ In Shares Pool	Tribes Allocable Shares	% Sus Contracted*	Shares for Contracted Sus & Rescission (.0016)	FY 2012 Taken	FY 2012 Retained by IHS
				(1)	(2)	(3)	(4)	(5)	(6)
Hospitals & Clinics				**$60,029,165**	**$8,615,435**		**$6,721**	**$2,389**	**$4,333**
101	Emergency Fund		x	$4,141,378	$0	0.024%	$0	$0	$0
105	Management Initiatives		x	$2,144,702	$0	0.024%	$0	$0	$0
106	A.C.O.G. Contract	x		$102,749	$17,256	0.024%	$14	$0	$14
107	H.P./D.P. Initiatives	x		$4,691,708	$313,340	0.024%	$218	$0	$218
110	N.E.C.I.	x		$1,154,300	$194,030	0.024%	$153	$153	$0
111	Nurse Initiatives	x		$1,336,319	$219,145	0.024%	$183	$0	$183
112	Nursing Costaps	x		$673,039	$113,127	0.024%	$90	$0	$90
113	Chief Clinical Consultant	x		$289,041	$48,592	0.024%	$38	$0	$38
118	Research Projects	x		$1,332,873	$222,919	0.024%	$175	$175	$0
119	A.A.I.P. Contract	x		$27,859	$4,884	0.024%	$4	$0	$4
120	Clinical Support Center-Phoenix	x		$1,805,135	$321,033	0.024%	$221	$0	$221
121	Costaps-Non Physicians	x		$84,792	$14,237	0.024%	$11	$0	$11
123	Physician Residency	x		$287,421	$48,319	0.024%	$38	$0	$38
124	Recruitment/Retention	x		$2,176,692	$365,907	0.024%	$289	$0	$289
125	U.S.U.H.S., etc.	x		$3,182,082	$534,939	0.024%	$423	$423	$0
126	D.I.R. Support Fund	x		$22,494,864	$3,782,194	0.024%	$2,995	$923	$2,072
127	Evaluation	x		$1,107,347	$186,179	0.024%	$146	$146	$0
128	National Indian Health Board	x		$478,485	$79,890	0.024%	$63	$63	$0
129	Albuq/HQ Administration	x		$928,174	$176,401	0.024%	$98	$0	$98
130	Nutrition Training Center	x		$369,810	$66,360	0.024%	$52	$0	$52
131	Diabetes Program-Albuq HQ	x		$1,340,034	$234,777	0.024%	$186	$186	$0
132	Cancer Prevention-Albuq HQ	x		$746,971	$131,513	0.024%	$103	$0	$103
133	Health Records	x		$142,025	$18,823	0.024%	$14	$0	$14
136	Handicapped Children	x		$360,403	$63,679	0.024%	$50	$0	$50
137	National DIR Support-Albuq HQ	x		$8,642,366	$1,459,101	0.024%	$1,155	$319	$836
Dental Health				**$6,507,639**	**$226,237**		**$79**	**$0**	**$79**
201	IHS Dental Program	x		$1,061,547	$226,237	0.024%	$79	$0	$79
202	IHS Dental Program-PgmFormula		x	$5,446,092	$0	0.024%	$0	$0	$0
Mental Health				**$2,319,860**	**$393,304**		**$303**	**$303**	**$0**
301	Technical Assistance	x		$1,562,861	$266,028	0.024%	$202	$202	$0
302	C.M.I. Grants	x		$648,528	$108,887	0.024%	$86	$86	$0
303	National Conference	x		$110,671	$18,588	0.024%	$15	$15	$0
Contract Health Care				**$10,539,603**	**$480,604**		**$379**	**$379**	**$0**
501	Fiscal Intermediary		x	$7,683,626	$0	0.024%	$0	$0	$0
504	C.H.S. Reserve & Undistributed	x		$2,855,977	$480,604	0.024%	$379	$379	$0
Direct Operations				**$17,195,246**	**$2,888,991**		**$2,283**	**$2,025**	**$258**
1301	Direct Operations-Rockville	x		$17,195,246	$2,888,991	0.024%	$2,283	$2,025	$258

EBEGAY/OISD
Original Date: 10/12/2011
Revision: 3/16/2012

Table #4

HQ PFSAs for FY 2012 TSA and Program Formula Lines

ATTACHMENT D

$ in Pool, Allocable Shares, Shares for Contracted SUs, and Transfer Schedule

Based on FY 2011 Appropriation.

San Juan Paiute					0.024% of Service Unit Contracted	***$12,604,571***	
	TSA	PF	$ In Shares Pool	Tribes Allocable Shares	% Sus Con-tracted*	Shares for Contracted Sus & Rescission (.0018)	FY 2012 Taken	FY 2012 Retained by IHS
			(1)	(2)	(3)	(4)	(5)	(6)
Facilities & Envr.Hlth.Support			**$7,970,184**	**$0**		**$0**	**$0**	**$0**
2401 San. Facilities Constr. Support		X	$2,355,861	$0	0.024%	$0	$0	$0
2402 Environ. Health Svcs. Support		X	$1,406,900	$0	0.024%	$0	$0	$0
2403 Facilities & Realty Support		X	$2,296,288	$0	0.024%	$0	$0	$0
2404 Facilities Engineering Support		X	$1,423,277	$0	0.024%	$0	$0	$0
2406 Engineering Services Support		X	$487,858	$0	0.024%	$0	$0	$0
Other:								
							$5,095	$4,670

TOTALS

TSA	Program Formula	$ In Shares Pool	Tribes Allocable Shares	Shares for Contracted Sus
$74,255,138	$30,306,559	$104,561,698	$12,604,571	$9,785

EBEGAY/OISD
Original Date: 10/12/2011
Revision: 3/16/2012

ATTACHMENT E

NAVAJO AREA INDIAN HEALTH SERVICE
FY 2013 TITLE I CORE RESIDUAL PLAN

OFFICE	TOTAL COST
OFFICE OF THE DIRECTOR	$1,122,669
FINANCIAL MANAGEMENT BRANCH	$720,223
DIVISION OF ADMINISTRATIVE SERVICES	$217,187
CONTRACTS & GRANTS BRANCH	$524,357
PERSONNEL MANAGEMENT BRANCH	$337,810
MANAGEMENT INFORMATION SYSTEM	$197,573
OFFICE OF ENVIRONMENTAL HEALTH & ENGINEERING	
Facilities Management:	$369,840
Office of OEHE Director:	$370,016
Sanitation Facilities Construction:	$514,933
TOTAL TITLE I RESIDUAL PLAN	$4,374,608

ATTACHMENT F

TUBA CITY REGIONAL HEALTH CARE CORPORATION
CONTRACT SUPPORT COST
FY 2013 AFA

	FY-2012 Funding	FY-2012 Rescission (.0016)	FY-2012 Shortfall Allocation	FY-2013 Funding Base
Indirect CSC (Non-Recurring)	$8,494,538	(13,591)	1,533,475	$10,014,422
Direct CSC (Recurring)	$1,863,072	(2,981)		$1,860,091
TOTAL	$10,357,610	($16,572)	$1,533,475	$11,874,513

NOTES

E BEGAY
OISD
Original Date: 4/26/2012

TUBA CITY REGIONAL
HEALTH CARE CORPORATION

Tuba City Regional Health Care Corporation and Subsidiary

Consolidated Financial Statements,
Independent Auditor's Report, and
Single Audit Reporting Package

September 30, 2017 and 2016

REDW LLC
CPAs | Business & Financial Advisors

Tuba City Regional Health Care Corporation and Subsidiary

Table of Contents

Independent Auditor's Report

Board of Directors
Tuba City Regional Health Care Corporation

Report on Financial Statements

We have audited the accompanying consolidated financial statements of Tuba City Regional Health Care Corporation and Subsidiary (TCRHCC), which comprise the consolidated statements of financial position as of September 30, 2017 and 2016, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of TCRHCC as of September 30, 2017 and 2016, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, and the consolidating statements presented as supplementary information, are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management, and was derived from, and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated March 20, 2018, on our consideration of TCRHCC's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering TCRHCC's internal control over financial reporting and compliance.

REDW LLC
Phoenix, Arizona
March 20, 2018

Tuba City Regional Health Care Corporation and Subsidiary
Consolidated Statements of Financial Position
September 30,

	2017	2016
Assets		
Current assets		
Cash and cash equivalents	**$ 28,911,334**	$ 10,934,175
Investments	**21,850,050**	26,168,909
Patient accounts receivable, net of allowance for doubtful accounts of $1,836,603 and $2,360,603 in 2017 and 2016, respectively	**9,427,873**	9,426,072
Grant receivable	**217,453**	301,972
Other receivables	**1,264,278**	188,466
Supplies	**1,693,741**	1,588,926
Prepaid expenses and other	**767,909**	738,510
Total current assets	**64,132,638**	49,347,030
Designated cash and cash equivalents	**21,445,370**	19,080,574
Restricted cash and cash equivalents	**-**	4,000,000
Property and equipment, at cost		
Buildings and equipment	**24,538,188**	24,324,843
Land	**902,292**	-
Furniture and fixtures	**491,023**	425,740
Equipment	**36,067,138**	29,695,362
	61,998,641	54,445,945
Less accumulated depreciation	**26,787,575**	21,861,216
Total property and equipment, net	**35,211,066**	32,584,729
Construction in progress	**11,357,779**	5,955,058
Total assets	**$ 132,146,853**	$ 110,967,391
Liabilities and Net Assets		
Current liabilities		
Accounts payable	**$ 6,946,117**	$ 3,717,191
Accrued liabilities	**11,333,320**	10,586,884
Purchased/referred care payable	**2,616,090**	2,246,673
Current portion of long-term debt	**2,331,473**	4,211,688
Total current liabilities	**23,227,000**	20,762,436
Deferred revenue	**277,937**	514,214
Long-term debt, less current portion	**7,247,564**	2,422,970
Total liabilities	**30,752,501**	23,699,620
Net assets		
Board designated net assets – capital activities	**15,103,402**	18,190,000
Undesignated net assets	**86,290,950**	69,077,771
Unrestricted net assets	**101,394,352**	87,267,771
Total liabilities and net assets	**$ 132,146,853**	$ 110,967,391

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

Tuba City Regional Health Care Corporation and Subsidiary

Consolidated Statements of Activities
For the Years Ended September 30,

	2017	2016
Operating Revenue		
Net patient service revenue	**$ 119,887,425**	$ 104,895,946
Indian self-governance compact revenue	**56,803,225**	55,691,396
Grant revenue	**2,699,084**	3,810,189
Rental income	**1,597,866**	1,464,943
Other	**2,563,389**	801,534
Total operating revenue	**183,550,989**	166,664,008
Operating Expenses		
Salaries and wages	**83,946,340**	83,192,783
Supplies and other	**25,232,488**	20,694,100
Employee benefits	**22,510,673**	22,505,359
Purchased services and professional fees	**11,002,429**	9,255,828
General services	**8,136,236**	8,178,503
Depreciation	**5,112,179**	4,820,273
Purchased/referred care	**4,588,818**	5,397,435
General and administrative	**9,118,807**	9,000,472
Total operating expenses	**169,647,970**	163,044,753
Operating income	**13,903,019**	3,619,255
Nonoperating Income (Expense)		
Interest expense	**(172,434)**	(207,337)
Investment income	**899,858**	871,396
Other	**(503,862)**	22,606
Settlement income	**-**	80,808
Nonoperating income, net	**223,562**	767,473
Change in net assets/revenues over expenses	**14,126,581**	4,386,728
Net assets, beginning of year	**87,267,771**	82,881,043
Net assets, end of year	**$ 101,394,352**	$ 87,267,771

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

Tuba City Regional Health Care Corporation and Subsidiary

Consolidated Statements of Cash Flows
For the Years Ended September 30,

	2017	2016
Cash flows from operating activities		
Change in net assets	**$ 14,126,581**	$ 4,386,728
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Provision for doubtful accounts	**(1,095,000)**	728,000
Depreciation	**5,112,179**	4,820,273
Unrealized gain on investments	**(389,901)**	(719,410)
Net changes in operating assets and liabilities		
Patient accounts receivable	**1,093,199**	98,555
Grant receivable	**84,519**	2,263,309
Accounts payable and accrued expenses	**3,975,362**	214,719
Purchased/referred care payable	**369,417**	1,200,843
Deferred revenue	**(236,277)**	(69,954)
Other current assets and liabilities	**425,178**	(62,913)
Cash provided by operating activities	**23,465,257**	12,860,150
Cash flows from investing activities		
Transfers (to)/from investments	**4,708,760**	(14,979,443)
Purchase of property and equipment	**(13,141,237)**	(7,985,981)
Cash used for investing activities	**(8,432,477)**	(22,965,424)
Cash flows from financing activities		
Proceeds from issuance of long-term debt	**7,445,908**	-
Payments on long-term debt	**(4,501,529)**	(3,657,413)
Cash provided by (used for) financing activities	**2,944,379**	(3,657,413)
Increase/(decrease) in cash and cash equivalents	**17,977,159**	(13,762,687)
Cash and cash equivalents, beginning of year	**10,934,175**	24,696,862
Cash and cash equivalents, end of year	**$ 28,911,334**	$ 10,934,175
Supplemental information		
Cash paid for interest	**$ 172,434**	$ 207,337

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

Tuba City Regional Health Care Corporation and Subsidiary

Notes to Consolidated Financial Statements
September 30, 2017 and 2016

1) Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Tuba City Regional Health Care Corporation (TCRHCC) operates an acute care hospital and related clinics. It primarily earns revenues and receives funding by providing inpatient, outpatient, and emergency care services, environmental health, public health nursing, school health, dental health services, telemedicine services, and public education to residents in and around Tuba City, Arizona.

In August 2002, the TCRHCC entered into an agreement with the Secretary of the Department of Health and Human Services under the Indian Self-Determination and Education Assistance Act, Public Law 93-638. As a result of this agreement, the federal government has transferred responsibility of all the programs, functions, services and activities (PFSA) relating to health care services, including all related administrative functions, to TCRHCC. Before the formation of TCRHCC in August 2002, the facility was operated by the United States Government Indian Health Service.

The Navajo-Hopi Health Foundation (the "Foundation") is a legally separate, tax-exempt organization under the Internal Revenue Code Section 501(c)(3) whose sole purpose is the support of TCRHCC by solicitation of gifts of financial resources and commitments of time from volunteers. Although TCRHCC does not control the timing or amount of receipts from the Foundation, the majority of the Foundation's resources and related income are restricted by donors for the benefit of TCRHCC. The financial statements of TCRHCC and the Foundation have been consolidated as required by accounting principles generally accepted in the United States of America. Significant intercompany balances and transactions have been eliminated in consolidation.

Basis of Presentation

Financial statement presentation follows the requirements of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Section 958-205, *Not-for-Profit Entities—Presentation of Financial Statements*. Under this section, TCRHCC is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. TCRHCC had no temporarily or permanently restricted net assets at September 30, 2017 and 2016.

Use of Estimates

Financial statement preparation in conformity with accounting principles generally accepted in the United States of America 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 financial statement date and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates contained in TCRHCC's financial statements

include the allowance for doubtful accounts, contractual allowances, purchased/referred care payable, and depreciation.

Cash and Cash Equivalents
For purposes of reporting cash flows, TCRHCC considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents, which at times may exceed the federally insured limits. TCRHCC has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on its cash balances. At September 30, 2017 and 2016, cash equivalents consisted primarily of money market accounts.

Designated and Restricted Cash and Cash Equivalents
Cash and cash equivalents classified as designated on the statements of financial position are to be used for future capital expansion projects as designated by the Board of Directors. The restricted cash and cash equivalents seen as of September 30, 2016 represents amounts held in a certificate of deposit (CD) to secure a bank loan. As of September 30, 2017, there was no restricted cash balances for TCRHCC.

Investments
TCRHCC carries investments in marketable equity securities with readily determinable fair values and all investments in debt securities at their fair values in the statements of financial position in accordance with applicable generally accepted accounting principles. Realized and unrealized gains and losses are included in investment income in the accompanying statements of activities.

Fair Value Measurements
TCRHCC follows FASB ASC Section 820, *Fair Value Measurements and Disclosures*, which applies to all assets and liabilities that are being measured and reported on a fair value basis. This section requires disclosures that establish a framework for measuring fair value in generally accepted accounting principles. FASB ASC Section 820 enables readers of the financial statements to assess the inputs used to develop those measurements by establishing a hierarchy for ranking the quality and reliability of the information used to determine fair values. Under FASB ASC Section 820, assets and liabilities carried at fair value are required to be classified in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets and liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are not corroborated by market data.

For the year ended September 30, 2017, the application of valuation techniques to similar assets and liabilities has been consistent with previous years. In determining the appropriate valuation levels, TCRHCC performed a detailed analysis of the assets and liabilities that are subject to FASB ASC Section 820.

Fair Value of Financial Instruments

For financial statement purposes, receivables, accounts payable, purchased/referred care payable, and debt are considered financial instruments. TCRHCC estimates that the fair value of these financial instruments at September 30, 2017 and 2016, does not differ materially from the aggregate carrying values of its financial instruments recorded in the accompanying statements of financial position.

Patient Accounts Receivable and Related Allowances

TCRHCC reports patient accounts receivable for services rendered at net estimated realizable amounts from third-party payors, patients, and others. As a service to the patient, TCRHCC bills third-party payors directly and bills the patient when the patient's liability, if any, is determined. Patient accounts receivable are due in full when billed. Accounts are considered delinquent and subsequently written off as bad debts based on individual credit evaluation and specific circumstances of the account.

Contractual allowances represent the amounts which reduce patient accounts receivable to amounts that are considered to be collectible from third-party payors based on existing contracts TCRHCC has with these payors. The contractual allowance percentages are based upon historical collection information by payor class. Contractual allowances are deducted from gross patient accounts receivable in the statements of financial position.

Periodic rate adjustments are made, sometimes resulting in retroactive settlements. Retroactive settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as more information is available to improve estimates or final settlements are determined. Based on information existing at September 30, 2017 and 2016, no material retroactive settlements were anticipated; therefore, no estimated settlements were accrued at September 30, 2017 or 2016.

The allowance for doubtful accounts is that amount which, in management's judgment, is considered adequate to reduce patient accounts receivable to an amount that is considered to be ultimately collectible. The net accounts receivable balance as of September 30, 2017 and 2016, represent actual subsequent cash collections and an estimated additional amount of cash to be received based on an analysis of historical collection trends.

Supplies

Supplies are stated at lower of cost (the first-in, first-out method), or market and consist primarily of medical supplies and medications.

Property and Equipment

Property and equipment are recorded at cost. Assets held under capital leases are recorded at the lower of the net present value of the minimum lease payments or the fair value of the leased asset at the inception of the lease. Additions, improvements, and other capital outlays that significantly extend the useful life of an asset and are greater than $5,000 are capitalized. Costs incurred for repair and maintenance are expensed as incurred.

Depreciation is computed using the straight-line method over the assets' estimated useful lives ranging from 3 to 20 years. Leasehold improvements are amortized over their useful lives not to exceed the term of the related lease.

Donations of property and equipment are reported at fair value as an increase in unrestricted net assets unless use of the assets is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service. No such restrictions existed in 2017 or 2016.

Under the terms of the Tribal Self-Governance Compact and Funding Agreement with the Department of Health and Human Services, TCRHCC has been authorized to use the federally owned real property comprising certain facilities in order to carry out its requirements under the compact. The real property is held by the Navajo Area Indian Health Service and title of said property may be transferred to TCRHCC during the term of the compact. Since the facilities would be substantially depreciated and the fair rental value is not determinable, in-kind rent expense and the offsetting contribution income have not been recorded in the accompanying financial statements.

Accrued Liabilities

The accrued liabilities on the statements of financial position consist primarily of accruals for vendor invoices, and employee paid time off and health insurance.

Net Assets and Changes Therein

Net assets and income, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of TCRHCC and changes therein are classified and reported as follows:

Unrestricted—Unrestricted net assets represent those resources that are not restricted by donors, or for which donor-imposed restrictions have expired. The board has chosen to designate some of its unrestricted net assets for specific purposes but since this designation is internally generated these amounts are still considered unrestricted.

Temporarily Restricted—Temporarily restricted net assets reflect donor-imposed restrictions that require TCRHCC to use or expend the related assets as specified. The restrictions are satisfied either by the passage of time or by the satisfaction of donor-specified use.

TCRHCC records contributions as temporarily restricted if they are received with donor stipulations that limit their use through either purpose or time restrictions. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is fulfilled, temporarily restricted net assets are reclassified to unrestricted net assets. Temporarily restricted contributions received and expended in the same accounting period are recorded in the unrestricted net asset category. Temporarily restricted revenues and reclassifications were not significant to TCRHCC for the years ended September 30, 2017 and 2016, and are therefore not presented separately in the accompanying statements of activities.

Permanently Restricted—Permanently restricted net assets reflect donor-imposed restrictions which stipulate that the related resources be maintained in perpetuity, but which permit TCRHCC to expend part or all of the income and capital appreciation derived from the donated assets for either specified or unspecified purposes. Permanently restricted revenues and reclassifications were not significant to TCRHCC for the years ended September 30, 2017 and 2016, and are therefore not presented separately in the accompanying statements of activities.

Tax Status

TCRHCC is exempt from state and federal income taxes on related income under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(3). TCRHCC is classified as other than a private foundation. Accounting principles generally accepted in the United States of America require TCRHCC to evaluate and disclose uncertain tax positions. TCRHCC does not believe any such positions exist at September 30, 2017 and 2016, that would require accrual or disclosure in the financial statements. TCRHCC's policy, when applicable, is to classify interest and penalties, if any, as miscellaneous expense.

Indian Self-Determination Compact Revenue

Effective April 30, 2011, TCRHCC executed a compact with the Department of Health and Human Services, Indian Health Service (IHS) under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638. Title V compacting allows self-governance and enables TCRHCC to redesign programs, merge or reallocate funds.

Under Title V, TCRHCC receives annual lump-sum payments based on negotiations between IHS and TCRHCC, as provided in the Funding Agreement (FA), for services

provided during the annual compact period. The cost of providing these services to IHS-eligible beneficiaries approximates the funding received under the FA over time.

Purchased/referred care are services provided to IHS-eligible beneficiaries by private sector health care providers, such as hospitals and physicians, under contract with TCRHCC. Purchased/referred care expense was approximately $4.5 million and $5.4 million in 2017 and 2016, respectively. TCRHCC reported purchased/referred care payable for estimated services provided by private sector health care providers but not yet paid by TCRHCC, of $2.6 million and $2.2 million in the accompanying statements of financial position as of September 30, 2017 and 2016, respectively. Because of the uncertainty regarding payments made to private sector health care providers, the amounts ultimately paid may materially differ from purchased/referred care payable recorded in the accompanying statements of financial position.

Uncompensated Care

TCRHCC receives PL 93-638 funds to provide health care services for its dedicated population. TCRHCC does not expect, nor does it accept, payment from Native Americans for the services provided. Therefore, TCRHCC does not provide uncompensated care in the traditional sense of the term; rather, services are provided free of charge to its dedicated population regardless of their ability or inability to pay. Costs are reimbursed primarily through the Office of Management and Budget (OMB) predetermined Medicaid and Medicare billing rates for a patient visit. This payment is taken into effect after any other third-party insurance that the patient may already have. Furthermore, if TCRHCC is unable to provide services necessary for its dedicated population, there are allocated purchased/referred care funds to provide these necessary services.

Recent Accounting Pronouncements

In February 2016, the FASB issued Accounting Standards Update (ASU) 2016-02, *Leases*, to make leasing activities more transparent and comparable. This new standard will require all leases with terms of more than 12 months be recognized by lessees as a right-of-use asset and a corresponding lease liability on the balance sheet. It will apply to both capital (or finance) leases and operating leases. In addition, ASU 2016-02 requires retrospective application to leases that exist at the beginning of the earliest comparative period presented. Management expects this new standard to have a significant effect on TCRHCC's balance sheet. For nonpublic companies, the standard is effective for fiscal years beginning after December 15, 2019 (i.e. TCRHCC's fiscal year ending September 30, 2021).

Additionally, the FASB issued ASU 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*, to make the information in the financial statements more meaningful. The new standard will no longer require not-for-profit entities to distinguish between resources with temporary and permanent restrictions on the face of the financial

statements, meaning only two classes will be presented, instead of three. The guidance will also change how not-for-profit entities report certain expenses and provide information about available resources and liquidity. This guidance is effective for fiscal years beginning after December 15, 2017 (i.e. TCRHCC's fiscal year ending September 30, 2019).

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, to create a single comprehensive framework for revenue recognition. The purpose of the new standard was to do away with industry specific revenue recognition guidance and better align with international standards. The new standard requires revenue to be recognized at various points within a transaction. TCRHCC will be required to make significant judgements regarding collectability and estimations for variable consideration, and will also have to change aspects of their financial statement presentation and expand disclosures on judgements used in determining transaction pricing. This guidance is effective for periods beginning after December 15, 2017 (i.e. TCRHCC's fiscal year ending September 30, 2019).

TCRHCC is currently evaluating the impact that the new guidance will have on its consolidated financial statements.

Reclassifications
Certain reclassifications have been made to the 2016 financial information to conform to the 2017 financial statement presentation. Such reclassifications had no effect on 2016 net assets or change in net assets.

2) Net Patient Service Revenue

Agreements with third-party payors provide for payments to TCRHCC at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors.

A summary of payment arrangements with major third-party payors follows:

Medicare—Services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge or per visit. Payment for inpatient services is based upon rates that vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Payment for outpatient services is based upon a per

visit rate negotiated between IHS and the U.S. Office of Management and Budget (OMB).

Medicaid—Services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per day (per diem) or per visit. Payment for inpatient and outpatient services is based upon a per diem or per visit rate negotiated between IHS and the OMB.

Periodic rate adjustments are made, sometimes resulting in retroactive settlements. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as more information is available to improve estimates or final settlements are determined. Based on information existing at September 30, 2017 and 2016, no material retroactive settlements were anticipated; therefore, no estimates were recorded at September 30, 2017 and 2016.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near-term. Estimates are continually monitored and reviewed, and as settlements are made or more information is available to improve estimates, differences are reflected in current operations.

Other Third-Party Payors—TCRHCC has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to TCRHCC under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

The following summary details the components of net patient service revenue for the years ended September 30:

	2017	2016
Gross revenue		
Inpatient	$ 37,235,711	$ 36,320,072
Outpatient	173,497,317	172,189,001
Professional fees	62,159,960	77,560,572
	272,892,988	286,069,645
Less third-party contractual adjustments and provision for uncollectible accounts	153,005,563	181,173,699
Net patient service revenue	$ 119,887,425	$ 104,895,946

3) Investments

Investments at fair value at September 30 are as follows:

	2017	2016
Money market funds (presented as cash equivalents and/or designated cash)	**$ 18,197,817**	$ 6,071,082
Restricted negotiable certificate of deposit	**$ -**	$ 4,000,000
U.S. government securities	**$ 14,888,194**	$ 20,153,122
Equity mutual funds	**3,794,503**	4,119,535
Municipal obligations	**317,802**	-
Fixed preferred stock - nonconvertible	**1,157,421**	-
Real estate and alternative investments	**545,834**	537,791
Corporate bond	**1,146,296**	1,358,461
	$ 21,850,050	$ 26,168,909

The fair value of TCRHCC's marketable securities that are measured on a recurring basis as of September 30 are as follows:

	2017			
	Level 1	Level 2	Level 3	Total
Money market funds (presented as cash equivalents)	$ 18,197,817	$ -	$ -	$ 18,197,817
U.S. government securities	$ 14,888,194	$ -	$ -	$ 14,888,194
Equity mutual funds	-	3,794,503	-	3,794,503
Municipal obligations	-	317,802	-	317,802
Fixed preferred stock - nonconvertible	1,157,421	-	-	1,157,421
Corporate bond	-	1,146,296	-	1,146,296
Real estate and alternative investments	-	545,834	-	545,834
	$ 16,045,615	$ 5,804,435	$ -	$ 21,850,050

	2016			
	Level 1	Level 2	Level 3	Total
Money market funds (presented as cash equivalents)	$ 6,071,082	$ -	$ -	$ 6,071,082
U.S. government securities	$ 20,153,122	$ -	$ -	$ 20,153,122
Equity mutual funds	-	4,119,535	-	4,119,535
Restricted negotiable certificate of deposit	4,000,000	-	-	4,000,000
Corporate bond	-	1,358,461	-	1,358,461
Real estate and alternative investments	-	537,791	-	537,791
	$ 24,153,122	$ 6,015,787	$ -	$ 30,168,909

4) Concentrations of Credit Risk

TCRHCC grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payor agreements. TCRHCC maintains an allowance for doubtful accounts based on management's assessment of collectability, current economic conditions, and prior experience. Because of the uncertainty regarding the ultimate collectability of patient accounts receivable, there is at least a reasonable possibility that recorded estimates of the allowance for doubtful accounts and contractual allowances will change by a material amount in the near-term.

The mix of gross accounts receivable from third-party payors was as follows at September 30:

	2017	2016
Medicare	**34%**	21%
Medicaid	**50%**	64%
Other third-party payors	**16%**	15%
	100%	100%

TCRHCC provides care for Native Americans under an agreement with the Department of Health and Human Services (DHHS). During 2017 and 2016, funding for services to patients covered by the agreement with DHHS represented 49% and 59%, respectively, of total net patient service revenue.

5) Functional Expenses

TCRHCC provides health care services primarily to residents within its geographic area. Expenses related to providing these services for the years ended September 30 are as follows:

	2017	2016
Health care services	**$ 155,185,117**	$ 147,444,209
Management and general	**14,462,853**	15,600,544
Total operating expenses	**$ 169,647,970**	$ 163,044,753

6) Long-Term Debt

TCRHCC's long-term debt consisted of the following at September 30:

	2017	2016
Bank of Arizona loan for $7.5 million to finance and refinance personal property and equipment at TCRHCC's hospital and campus. The Hospital has given a security interest in the equipment to secure payments. Forty-eight monthly payments of $169,449 at an interest rate of LIBOR + 2% [3.33% at September 30, 2017], maturing in September 2017.	$ -	$ 1,875,000
Bank of Arizona promissory note for $850,000 for mobile medical and dental coaches to provide health care services to patients located in remote portions of TCRHCC's service area. The note is secured by the two coaches. Sixty monthly payments of $15,586 at an interest rate of LIBOR +2% [3.33% at September 30, 2017], maturing in June 2018.	**127,503**	297,507
Bank of Arizona equipment loan for $2.5 million. The Hospital has given a security interest in the equipment to secure payments. Proceeds of the loan to be disbursed by March 2015, at which point advances on the line terminates. Beginning in March 2015, repayment will be over 36 months with payments of $33,692 at an interest rate of LIBOR + 2% [3.33% at September 30, 2017], maturing in March 2018.	**416,650**	1,249,990
Bank of Arizona converting line of credit loan for $4.0 million was refinanced commencing January 2014. Proceeds of the loan shall be disbursed in that period of time commencing on the January 2014 closing date of the loan until the maximum loan commitment has been advanced but in no event ending no later than July 2015, at which point lender's obligation to make any advance shall terminate. The Hospital will make monthly payments equal to the accrued interest on the Note until January 2019. Loan bears an interest rate of LIBOR + 1.5% [2.83% at September 30, 2017] and matures in January 2019.	**1,878,817**	3,212,161
Bank of Arizona converting line of credit loan for $4.0 million was refinanced commencing February 2016. Proceeds of the loan shall be disbursed in that period of time commencing on the February 2016 closing date of the loan until the maximum loan commitment has been advanced but in no event ending no later than February 2017, at which point lender's obligation to make any advance shall terminate. The Hospital will make monthly payments equal to the accrued interest on the Note until February 2017 when the payment will become monthly payments of principal and interest in amount to pay off the loan in 48 months. Loan bears an interest rate of LIBOR + 2.0% [3.33% at September 30, 2017] and matures in February 2021.	**1,696,067**	-
Western Alliance/Industrial Development Authority of Coconino County Revenue Bonds financing agreement with the Navajo-Hopi Health Foundation commencing August 1, 2017 to pay a portion of the costs of acquiring, constructing, and equipping an approximately 23,400 square foot full service medical clinic located in Flagstaff, Arizona. The Navajo-Hopi Health Foundation will pay monthly payments of $26,986, until the maturity of the bonds on February 8, 2029. The loan bears an interest rate of 3.32%.	**5,460,000**	-
Total debt	**9,579,037**	6,634,658
Less current portion	**2,331,473**	4,211,688
Long-term debt, less current portion	**$ 7,247,564**	$ 2,422,970

Debt Covenants

TCRHCC is subject to certain debt covenant requirements, specified in the Bank of Arizona $7.5M loan agreement, including maintaining a tangible net worth and minimum liquidity over $45,000,000 and $18,500,000, respectively. In addition TCRHCC must maintain a Fixed Charge Coverage Ratio of 1:25 to 1. As of September 30, 2017 and 2016, TCRHCC was in compliance with all financial covenants.

Required principal payments on long-term debt as of September 30, 2017, are as follows:

Years ended September 30,	
2018	$ 2,331,473
2019	1,124,428
2020	629,941
2021	356,198
2022	154,656
Thereafter	4,982,341
	$ 9,579,037

7) Retirement Plans

Government Plan

TCRHCC has a defined contribution retirement government plan. This plan covers substantially all direct hire employees. Employees may contribute a percentage of their salaries within allowed limits. TCRHCC matches the employee contribution up to 4% of compensation. TCRHCC may also make a discretionary contribution to the plan, that is determined by executive management and the Retirement Committee. TCRHCC's matching contributions associated with the plan were approximately $2,307,882 and $2,683,238 for 2017 and 2016, respectively.

Retained Federal Benefits (Defined Federal Benefit Plan)

TCRHCC funds 15 former federal employees for a special contribution to the Federal Employees Retirement System (FERS) cost sharing multiple employer defined benefit pension plans administered by the federal government. Pension expense is recorded for the amount TCRHCC is contractually required to contribute for the year. The plans provide for retirement and death benefits, which are established by federal statute. These amounts are reported on and accounted for by the U.S. Office of Personnel Management.

Funding Policy—Retained Federal Benefits

- FERS—This plan is a three-tiered plan consisting of Social Security, a basic FERS annuity, and the Thrift Savings Plan. Plan members are required to contribute 0.8% of compensation for the basic benefit. TCRHCC is required to contribute 11.2% of the employee's pay. To be vested, the federal employees must have at least five years of creditable civilian service. Eligibility is determined by the employee's age and number of years of creditable service.
- Thrift Savings Plan—FERS employees may also contribute up to 100% of their compensation to the Thrift Savings Plan, with a yearly maximum of $16,500 as a tax-deferred contribution. TCRHCC is required to contribute 1% of the employee's pay and matches a portion of the employee's contribution, up to 5% of compensation.

Contribution requirements are established by federal statute.

8) Commitments and Contingencies

Healthcare Regulatory Environment
The healthcare industry is subject to laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse of statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs, the imposition of significant fines and penalties, and significant repayments for patient services previously billed.

Management believes that TCRHCC is in compliance with applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to assure health insurance portability, guarantee security and privacy of health information, enforce standards for health information, and establish administrative simplification provisions. Under the Health Information Technology for Economic and Clinical Health Act (HITECH), several of the HIPAA security and privacy requirements have been expanded, including business associates being subject to civil and criminal penalties and enforcement proceedings for violations of HIPAA. Management believes that TCRHCC is in compliance with all applicable provisions of HIPAA and HITECH.

Litigation

TCRHCC is a party to claims and lawsuits arising in the ordinary course of business. As part of TCRHCC's Self-Governance Compact with DHHS, medical malpractice claims are covered under the Federal Tort Claims Act. As a result, claims made against TCRHCC would be defended by the United States Attorney General. Management believes, based upon consultation with legal counsel, that losses, if any, will not have a material adverse effect on the financial statements.

9) Related Party Transactions

On July 19, 2016, TCRHCC approved a resolution authorizing a transfer of $4,000,000 to the Foundation for the purposes of acquiring land and constructing facilities to continue, maintain and expand TCRHCC's Sacred Peaks Clinic located in Flagstaff, AZ and the services it provides. The Foundation will lease the medical office building to TCRHCC when construction is estimated to be completed in July 2019. As of September 30, 2016, $1,010,000 of the $4,000,000 had been transferred to the Foundation's escrow account. In 2017, the remaining $2,990,000 was transferred to the Foundation.

10) Subsequent Events

Subsequent events through March 20, 2018, the date the financial statements were available to be issued, were evaluated for recognition and disclosure in the September 30, 2017, financial statements.

Tuba City Regional Health Care Corporation and Subsidiary
Consolidating Statement of Financial Position
September 30, 2017

	TCRHCC	Foundation	Total
Assets			
Current assets			
Cash and cash equivalents	$ 26,873,449	$ 2,037,885	$ 28,911,334
Investments	21,850,050	-	21,850,050
Patient accounts receivable, net of allowance for doubtful accounts of $1,265,603	9,427,873	-	9,427,873
Grant receivable	217,453	-	217,453
Other receivables	1,261,148	3,130	1,264,278
Supplies	1,693,741	-	1,693,741
Prepaid expenses and other	742,143	25,766	767,909
Total current assets	62,065,857	2,066,781	64,132,638
Designated cash and cash equivalents	15,103,402	6,341,968	21,445,370
Property and equipment, at cost			
Buildings and land improvements	24,464,556	73,632	24,538,188
Land	-	902,292	902,292
Furniture and fixtures	491,023	-	491,023
Equipment	36,065,083	2,055	36,067,138
	61,020,662	977,979	61,998,641
Less accumulated depreciation	26,787,575	-	26,787,575
Total property and equipment, net	34,233,087	977,979	35,211,066
Construction in progress	11,158,506	199,273	11,357,779
Total assets	$ 122,560,852	$ 9,586,001	$ 132,146,853
Liabilities and Net Assets			
Current liabilities			
Accounts payable	$ 6,946,117	$ -	$ 6,946,117
Accrued liabilities	11,333,320	-	11,333,320
Purchased/referred care payable	2,616,090	-	2,616,090
Current portion of long-term debt	2,331,473	-	2,331,473
Total current liabilities	23,227,000	-	23,227,000
Deferred revenue	277,937	-	277,937
Long-term debt, less current portion	1,787,564	5,460,000	7,247,564
Total liabilities	25,292,501	5,460,000	30,752,501
Net assets			
Board designated net assets – capital activities	15,103,402	-	15,103,402
Undesignated net assets	82,164,949	4,126,001	86,290,950
Unrestricted net assets	97,268,351	4,126,001	101,394,352
Total liabilities and net assets	$ 122,560,852	$ 9,586,001	$ 132,146,853

Tuba City Regional Health Care Corporation and Subsidiary
Consolidating Statement of Financial Position
September 30, 2016

	TCRHCC	Foundation	Total
Assets			
Current assets			
Cash and cash equivalents	$ 10,826,206	$ 107,969	$ 10,934,175
Investments	26,168,909	-	26,168,909
Patient accounts receivable, net of allowance for doubtful accounts of $2,360,603 in 2016	9,426,072	-	9,426,072
Grant receivable	301,972	-	301,972
Other receivables	188,226	240	188,466
Supplies	1,588,926	-	1,588,926
Prepaid expenses and other	730,680	7,830	738,510
Total current assets	49,230,991	116,039	49,347,030
Designated cash and cash equivalents	19,080,574	-	19,080,574
Restricted cash and cash equivalents	2,990,000	1,010,000	4,000,000
Property and equipment, at cost			
Buildings and equipment	24,320,170	4,673	24,324,843
Furniture and fixtures	425,740	-	425,740
Equipment	29,695,362	-	29,695,362
	54,441,272	4,673	54,445,945
Less accumulated depreciation	21,861,216	-	21,861,216
Total property and equipment, net	32,580,056	4,673	32,584,729
Construction in progress	5,955,058	-	5,955,058
Total assets	$ 109,836,679	$ 1,130,712	$ 110,967,391
Liabilities and Net Assets			
Current liabilities			
Accounts payable	$ 3,713,191	$ 4,000	$ 3,717,191
Accrued liabilities	10,586,884	-	10,586,884
Purchased/referred care payable	2,246,673	-	2,246,673
Current portion of long-term debt	4,211,688	-	4,211,688
Total current liabilities	20,758,436	4,000	20,762,436
Deferred revenue	514,214	-	514,214
Long-term debt, less current portion	2,422,970	-	2,422,970
Total liabilities	23,695,620	4,000	23,699,620
Net assets			
Board designated net assets – capital activities	18,190,000	-	18,190,000
Undesignated net assets	67,951,059	1,126,712	69,077,771
Unrestricted net assets	86,141,059	1,126,712	87,267,771
Total liabilities and net assets	$ 109,836,679	$ 1,130,712	$ 110,967,391

Tuba City Regional Health Care Corporation and Subsidiary
Consolidating Statement of Activities
For the Year Ended September 30, 2017

	TCRHCC	Foundation	Total
Operating Revenue			
Net patient service revenue	$ 119,887,425	$ -	$ 119,887,425
Indian self-governance compact revenue	56,803,225	-	56,803,225
Grant revenue	2,699,084	-	2,699,084
Rental income	1,597,866	-	1,597,866
Other	2,397,042	166,347	2,563,389
Total operating revenue	183,384,642	166,347	183,550,989
Operating Expenses			
Salaries and wages	83,843,498	102,842	83,946,340
Supplies and other	25,232,343	145	25,232,488
Employee benefits	22,510,673	-	22,510,673
Purchased services and professional fees	11,002,429	-	11,002,429
General and administrative	9,062,236	56,571	9,118,807
General services	8,136,236	-	8,136,236
Depreciation	5,112,179	-	5,112,179
Purchased/referred care	4,588,818	-	4,588,818
Total operating expenses	169,488,412	159,558	169,647,970
Operating income	13,896,230	6,789	13,903,019
Nonoperating Income (Expense)			
Interest expense	(172,434)	-	(172,434)
Investment income	899,858	-	899,858
Other	(506,362)	2,500	(503,862)
Nonoperating income, net	221,062	2,500	223,562
Other changes in unrestricted net assets			
Transfers	(2,990,000)	2,990,000	-
Change in net assets/revenues over expenses	11,127,292	2,999,289	14,126,581
Net assets, beginning of year	86,141,059	1,126,712	87,267,771
Net assets, end of year	$ 97,268,351	$ 4,126,001	$ 101,394,352

Tuba City Regional Health Care Corporation and Subsidiary
Consolidating Statement of Activities
For the Year Ended September 30, 2016

	TCRHCC	Foundation	Total
Operating Revenue			
Net patient service revenue	$ 104,895,946	$ -	$ 104,895,946
Indian self-governance compact revenue	55,691,396	-	55,691,396
Grant revenue	3,810,189	-	3,810,189
Rental income	1,464,943	-	1,464,943
Other	602,878	198,656	801,534
Total operating revenue	166,465,352	198,656	166,664,008
Operating Expenses			
Salaries and wages	83,118,062	74,721	83,192,783
Supplies and other	20,694,022	78	20,694,100
Employee benefits	22,505,359	-	22,505,359
Purchased services and professional fees	9,255,828	-	9,255,828
General and administrative	8,919,521	80,951	9,000,472
General services	8,178,503	-	8,178,503
Purchased/referred care	5,397,435	-	5,397,435
Depreciation	4,820,273	-	4,820,273
Total operating expenses	162,889,003	155,750	163,044,753
Operating income	3,576,349	42,906	3,619,255
Nonoperating Income (Expense)			
Interest expense	(207,337)	-	(207,337)
Investment income	871,396	-	871,396
Other	22,606	-	22,606
Settlement income	80,808	-	80,808
Nonoperating income, net	767,473	-	767,473
Other changes in unrestricted net assets			
Transfers	(1,010,000)	1,010,000	-
Change in net assets/revenues over expenses	3,333,822	1,052,906	4,386,728
Net assets, beginning of year	82,807,237	73,806	82,881,043
Net assets, end of year	$ 86,141,059	$ 1,126,712	$ 87,267,771

Tuba City Regional Health Care Corporation
Schedule of Expenditures of Federal Awards
For the Year Ended September 30, 2017

Federal Grantor/Pass-Through Grantor/Program Title	Grant/Contract Period FYE	Federal CFDA Number	Pass-Through Grantor Number or Other Identifying Number	Expenditures
U.S. Department of Housing and Urban Development				
Kaibeto Creek Independent Living Facilities	9/30/2016	14.867	Block Grant 55IH0402810	$ 1,428
Total U.S. Department of Housing and Urban Development				**1,428**
U.S. Department of Justice				
Office of Victims of Crime				
American Indian and Alaska Native SANE-SART Program	9/30/2016	16.582	2011-VR-GX-K030	54,523
Total U.S. Department of Justice				**54,523**
U.S. Department of Health and Human Services				
Continuing Prospective Birth Cohort Study Involving Environmental Uranium Exposure in the Navajo Nation	6/30/2016	93.161	HHSI245201100234A	68,180
Tribal Self-Governance Program: IHS Compacts/Funding Agreements	9/30/2016	93.210	63G119104	56,803,225
Steven's Bill	10/1/2016	93.210	N/A	40,372
				56,843,597
Health Resources and Services Administration				
Consolidated Health Centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care, and School Based Health Centers)	5/31/2016	93.224	H80CS24200-01-00	678,743
HRSA Quality Improvement	05/31/16	93.224	H80CS24200-03.07	27,797
				706,540
Indian Health Services				
Special Diabetes Program for Indians-Diabetes Prevention and Treatment Projects	9/30/2016	93.237	HID1IHS0420-11-00	843,086
	9/29/2016	93.237	HID1IHS0473-09-00	318,540
		93.237	H1D4IHS0122-02-01	2,410
FYE 09/30/12 Carry Over	2014 C/O	93.237	H1D2IHS0032-09-01	100,191
				1,264,227
HRSA Community Health Counseling Center		93.526	C8DCS29758-01-05	19,855
				1,284,082
PPHF Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges	9/14/2016	93.750	CA-NAV-130007-01-00	15,000
Domestic Violence Prevention Initiative	09/26/16	93.933	BH15IHS0027-01-00	297,349
Meth & Suicide Prevention Initiative	09/29/16	93.933	BH16IHS0084-01-00	226,266
				523,615
Passed through the State of Arizona				
Emergency Fund (Bio Terrorism)	6/30/2016	93.889	AHHS14-056996 / HR954050	5,344
Total U.S. Department of Health and Human Services				**59,446,358**
Total expenditures of federal awards				**$ 59,502,309**

See accompanying notes to the schedule of expenditures of federal awards.

Tuba City Regional Health Care Corporation

Notes to Schedule of Expenditures of Federal Awards
September 30, 2017

1) Summary of Significant Accounting Policies

The accompanying schedule of expenditures of federal awards presents the activity of all federal award programs of Tuba City Regional Health Care Corporation (TCRHCC) and is presented on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), wherein certain types of expenditures are not allowable or are limited as to reimbursement.

2) Subrecipients

TCRHCC did not provide any federal awards to subrecipients during 2017.

3) Indirect Cost Rate

TCRHCC negotiates an indirect cost rate with the federal government. Accordingly, TCRHCC has elected not to use the ten percent de minimis indirect cost rate allowed under the Uniform Guidance.

Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
Tuba City Regional Health Care Corporation

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, the consolidated financial statements of Tuba City Regional Health Care Corporation and Subsidiary (TCRHCC), a nonprofit organization, which comprises the consolidated statement of financial position as of September 30, 2017, and the related consolidated statements of activities and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated March 20, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered TCRHCC's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of TCRHCC's internal control. Accordingly, we do not express an opinion on the effectiveness of TCRHCC's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did identify a deficiency in internal control, described in the accompanying schedule of findings and questioned costs as item 2017-001, that we consider to be a material weakness.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether TCRHCC's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

TCRHCC's Response to Findings

TCRHCC's responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. TCRHCC's responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of TCRHCC's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering TCRHCC's internal control and compliance. Accordingly, the communication is not suitable for any other purpose.

REDW LLC

Phoenix, Arizona
March 20, 2018

Independent Auditor's Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by the Uniform Guidance

Board of Directors
Tuba City Regional Health Care Corporation

Report on Compliance for Major Federal Program

We have audited Tuba City Regional Health Care Corporation's (TCRHCC) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have direct and material effect on TCRHCC's major federal program for the year ended September 30, 2017. TCRHCC's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for TCRHCC's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance 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 the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about TCRHCC's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of TCRHCC's compliance.

Opinion on Major Federal Program

In our opinion, TCRHCC complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended September 30, 2017.

Report on Internal Control over Compliance

Management of TCRHCC is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered TCRHCC's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of TCRHCC's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

REDW LLC

Phoenix, Arizona
March 20, 2018

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs
For the Year Ended September 30, 2017

Section I — Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified
Internal control over financial reporting:	
Material weaknesses identified?	Yes
Significant deficiencies reported?	No
Noncompliance material to financial statements noted?	No

Federal Awards

Type of auditor's report issued on compliance for major programs:	Unmodified
Internal control over major programs:	
Material weaknesses identified?	No
Significant deficiencies reported?	No
Any audit findings that are required to be reported in accordance with section 200.516(a) of the Uniform Guidance?	No

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2017

Section I — Summary of Auditor's Results — continued

Identification of major programs:

CFDA Number	Name of Federal Program
93.210	Tribal Self-Governance Program: I.H.S. Compacts/Funding Agreements

Dollar threshold used to distinguish between type A and type B programs:	$1,785,069
Auditee qualified as low-risk auditee?	No

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2017

Section II — Financial Statement Findings

2017-001 —Account Reconciliations (Material Weakness)

Criteria or Specific Requirement: All accounts in TCRHCC's trial balance should be reconciled on a regular basis and adjustments should be made, as needed, to accurately reflect TCRHCC's current financial position.

Condition: The internally generated trial balance and related financial statements as of September 30, 2017, and the trial balance provided for the audit, did not include many adjusting entries as an analysis had not been performed on many liability accounts. Specifically, the following adjustments were needed to agree to supporting documentation:

- An adjustment to increase trade accounts payable by $1,863,162.
- An adjustment to increase accrued payroll and benefits by $488,190.
- An adjustment to increase accrued government employee wages by $398,007.

Cause: Due to the new accounting software transition, the processes around account reconciliations and the analysis of accruals were not properly defined. Based on discussions with management, it appears the linkage between items received and purchase orders may not have been operating properly.

Effect: Without appropriate reporting capabilities and timely analysis of accounts, the balance sheet may not be accurate. Inaccurate financials may have affected Board decisions.

Auditor's Recommendation: Management should develop a timeline and designate responsibilities for the reconciliation and analysis of all balance sheet accounts.

Management's Response:

1000-2801 Account Payable

The system conversion that took effect in May 2017 had a significant impact on our internal processes, particularly with account reconciliations. Accounting will reconcile the Account Payable accounts by April 30, 2018. Thereafter, Accounting will continue with monthly reconciliation of the Accounts Payable account to ensure the Aged TB reconciles at month end. This will be added to the month-end closing schedule beginning May 2018.

Section II — Financial Statement Findings — continued

2017-001 —Account Reconciliations (Material Weakness) — continued

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Management's Response: — continued

1000-2806 Direct Hire-Wages Payable

The system manages PTO accruals and adjustments processed in the Payroll module, however a GL transaction is not created. Payroll manually accrues the liability with two journal entries created to record the PTO liability. A schedule for these journal entries will be added to the month-end closing schedule. Payroll will communicate with Human Resource on any adjustment and system changes. Upon final review by Payroll, a final adjusting entry will be made; this shall reconcile to the General Ledger at month end and Human Resource will be responsible for reconciling/validating that all PTO accruals are set up correctly per policy for all employees. In addition, weekly meetings with Payroll and Human Resource will continue as needed to discuss issues, updates and provide training.

1000-2807 IPA and CO-Wages Payable

Currently, a journal entry for nondirect hire employees (federal employees and commissioned officers) are posted each month per estimated costs provided from Navajo Area Indian Health Service office. Due to the lag in invoice receipt and recording an accrual, the balance in the Payable account does not reconcile. Each quarter, NAIHS and TCRHCC meet to reconcile accounts, payments, etc. and at fiscal year-end, any/all balance will be adjusted and posted to either wages and salaries and/or other receivable.

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2017

Section III — Federal Award Findings and Questioned Costs

None.

TUBA CITY REGIONAL HEALTH CARE CORPORATION

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Tuba City Regional Health Care Corporation

Summary Schedule of Prior Audit Findings
For the Year Ended September 30, 2017

Prior Audit Findings	Current Status
2016-001 Deferred Revenue and Grant Receivables	Resolved
2016-002 Purchased/Referred Care Liability Estimate	Resolved
2016-003 Accounts Receivable Analysis	Resolved
2016-004 Property and Equipment Physical Count	Resolved

TUBA CITY REGIONAL HEALTH CARE CORPORATION

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Tuba City Regional Health Care Corporation

Single Audit Corrective Action Plan
For the Year Ended September 30, 2017

Audit Finding	Corrective Action Plan	Person Responsible	Estimated Completion Date
2017-001 Account Reconciliations	In reference to PTO accruals for Direct Hire Wages Payable, Payroll will manually accrue PTO liability after each pay period with a final journal entry at the end of the month for any/all adjustments made by Human Resources upon thorough review. The final adjusting entry shall reconcile with the General Ledger at month end. Human Resources will be responsible for reconciling and validating all PTO accruals are set up correctly in the financial system per policy for all employees. Human Resources and Payroll will continue to meet weekly to continue discussion of issues, provide updates and training. Lastly, TCRHCC continues to work closely with Navajo Area Indian Health Service regarding non-Direct hire employees; the Federal employees and Commissioned Officers (IPA and CO). Currently, a journal entry for non-Direct hire (IPA and CO) employees are posted each month per estimated costs provided from Navajo Area Indian Health Service office. Due to the lag in invoice receipt and recording an accrual, the balance in the Payable account does not reconcile. Each quarter, NAIHS and TCRHCC meet to reconcile accounts, payments, etc. and at fiscal yearend, any/all balance will be adjusted and posted to either Wages and Salaries and/or Other Receivable.	Christine Keyonnie, CFO	March 30, 2018

TUBA CITY REGIONAL HEALTH CARE CORPORATION

Financial Statements,
Independent Auditor's Report, and
Single Audit Reporting Package

September 30, 2016 and 2015

REDW LLC
CPAs | Business & Financial Advisors

Tuba City Regional Health Care Corporation

Table of Contents

Independent Auditor's Report

Board of Directors
Tuba City Regional Health Care Corporation

Report on Financial Statements

We have audited the accompanying financial statements of Tuba City Regional Health Care Corporation (the "Hospital"), a nonprofit organization, which comprise the statements of financial position as of September 30, 2016 and 2015, and the related statements of activities and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of September 30, 2016 and 2015, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated May 5, 2017, on our consideration of the Hospital's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control over financial reporting and compliance.

REDW LLC

Phoenix, Arizona
May 5, 2017

Tuba City Regional Health Care Corporation
Statements of Financial Position
September 30,

	2016	2015
Assets		
Current assets		
Cash and cash equivalents	**$ 9,816,206**	$ 24,625,804
Investments	**26,168,909**	10,470,056
Patient accounts receivable, net of allowance for doubtful accounts of $2,360,603 in 2016 and $1,632,603 in 2015	**9,426,072**	10,252,627
Grant receivable	**490,198**	1,743,507
Supplies	**1,588,926**	2,062,950
Prepaid expenses and other	**730,680**	834,199
Total current assets	**48,220,991**	49,989,143
Designated cash and cash equivalents	**19,080,574**	19,451,393
Restricted cash and cash equivalents	**4,000,000**	4,000,000
Property and equipment, at cost		
Buildings and equipment	**24,320,170**	23,715,823
Furniture and fixtures	**425,740**	425,740
Equipment	**29,695,362**	27,314,057
	54,441,272	51,455,620
Less accumulated depreciation	**21,861,216**	17,040,942
Total property and equipment, net	**32,580,056**	34,414,678
Construction in progress	**5,955,058**	959,401
Total assets	**$ 109,836,679**	$ 108,814,615
Liabilities and Net Assets		
Current liabilities		
Accounts payable	**$ 3,713,191**	$ 6,259,843
Accrued liabilities	**10,586,884**	7,825,466
Purchased/referred care payable	**2,246,673**	1,045,830
Current portion of long-term debt	**4,211,688**	2,974,981
Total current liabilities	**20,758,436**	18,106,120
Deferred revenue	**514,214**	584,168
Long-term debt, less current portion	**2,422,970**	7,317,090
Total liabilities	**23,695,620**	26,007,378
Net assets		
Board designated net assets – capital activities	**19,200,000**	19,200,000
Undesignated net assets	**66,941,059**	63,607,237
Unrestricted net assets	**86,141,059**	82,807,237
Total liabilities and net assets	**$ 109,836,679**	$ 108,814,615

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

Tuba City Regional Health Care Corporation

Statements of Activities
For the Years Ended September 30,

	2016	2015
Operating Revenue		
Net patient service revenue	**$ 104,799,472**	$ 100,313,358
Indian self-governance compact revenue	**55,691,396**	57,905,689
Grant revenue	**2,800,189**	3,840,760
Rental income	**1,464,943**	1,405,139
Other	**613,022**	2,201,123
Total operating revenue	**165,369,022**	165,666,069
Operating Expenses		
Salaries and wages	**85,366,087**	81,494,174
Supplies and other	**31,444,989**	28,811,751
Employee benefits	**17,812,238**	15,413,650
Purchased services and professional fees	**9,240,374**	9,900,288
Purchased/referred care	**5,397,435**	4,157,030
General and administrative	**4,351,473**	3,731,649
General services	**4,347,198**	3,114,099
Depreciation	**4,820,273**	5,181,834
Total operating expenses	**162,780,067**	151,804,475
Operating income	**2,588,955**	13,861,594
Nonoperating Income (Expense)		
Interest expense	**(207,337)**	(225,855)
Investment income	**871,396**	106,162
Settlement income	**80,808**	242,293
Nonoperating income, net	**744,867**	122,600
Change in net assets/revenues over expenses	**3,333,822**	13,984,194
Net assets, beginning of year	**82,807,237**	68,823,043
Net assets, end of year	**$ 86,141,059**	$ 82,807,237

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

Tuba City Regional Health Care Corporation
Statements of Cash Flows
For the Years Ended September 30,

	2016	2015
Cash flows from operating activities		
Change in net assets	**$ 3,333,822**	$ 13,984,194
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Provision for doubtful accounts	**728,000**	(1,358,001)
Depreciation	**4,820,273**	5,181,834
Unrealized (gain) loss on investments	**(719,410)**	421,647
Net changes in operating assets and liabilities		
Patient accounts receivable	**98,555**	(2,407,234)
Grant receivable	**1,253,309**	319,442
Settlement receivable	**-**	(251,393)
Accounts payable and accrued expenses	**214,766**	3,121,859
Purchased/referred care payable	**1,200,843**	(12,879)
Deferred revenue	**(69,954)**	(2,146,484)
Other current assets and liabilities	**948,362**	(538,638)
Cash provided by operating activities	**11,808,566**	16,314,347
Cash flows from investing activities		
Transfers (to)/from investments	**(14,979,443)**	8,116,622
Purchase of property and equipment	**(7,981,308)**	(6,046,561)
Cash provided by (used for) investing activities	**(22,960,751)**	2,070,061
Cash flows from financing activities		
Proceeds from issuance of long-term debt	**-**	2,828,812
Payments on long-term debt	**(3,657,413)**	(2,461,174)
Cash provided by (used for) financing activities	**(3,657,413)**	367,638
Increase/(decrease) in cash and cash equivalents	**(14,809,598)**	18,752,046
Cash and cash equivalents, beginning of year	**24,625,804**	5,873,758
Cash and cash equivalents, end of year	**$ 9,816,206**	$ 24,625,804
Supplemental Information		
Cash paid for interest	**$ 207,337**	$ 225,855

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

Tuba City Regional Health Care Corporation
Notes to Financial Statements
September 30, 2016 and 2015

1) Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Tuba City Regional Health Care Corporation (the "Hospital" or TCRHCC) operates an acute care hospital and related clinics. It primarily earns revenues and receives funding by providing inpatient, outpatient, and emergency care services, environmental health, public health nursing, school health, dental health services, telemedicine services, and public education to residents in and around Tuba City, Arizona.

In August 2002, the Hospital entered into an agreement with the Secretary of the Department of Health and Human Services under the Indian Self-Determination and Education Assistance Act, Public Law 93-638. As a result of this agreement, the federal government has transferred responsibility of all the programs, functions, services and activities (PFSA) relating to health care services, including all related administrative functions, to the Hospital. Before the formation of TCRHCC in August 2002, the facility was operated by the United States Government Indian Health Service.

The Navajo-Hopi Health Foundation (the "Foundation") is a legally separate, tax-exempt organization under the Internal Revenue Code Section 501(c)(3) whose sole purpose is the support of TCRHCC by solicitation of gifts of financial resources and commitments of time from volunteers. Although the Hospital does not control the timing or amount of receipts from the Foundation, the majority of the Foundation's resources and related income are restricted by donors for the benefit of the Hospital. The resources and operations were determined not to be significant to the Hospital and, therefore, the Foundation is not consolidated with the Hospital in the accompanying financial statements.

Basis of Presentation

Financial statement presentation follows the requirements of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Section 958-205, *Not-for-Profit Entities—Presentation of Financial Statements*. Under this section, the Hospital is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. The Hospital had no temporarily or permanently restricted net assets at September 30, 2016 and 2015.

Use of Estimates

Financial statement preparation in conformity with accounting principles generally accepted in the United States of America 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 financial statement date and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates contained in the Hospital's financial statements

include the allowance for doubtful accounts, contractual allowances, purchased/referred care payable, and depreciation.

Cash and Cash Equivalents

For purposes of reporting cash flows, the Hospital considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents, which at times may exceed the federally insured limits. The Hospital has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on its cash balances. At September 30, 2016 and 2015, cash equivalents consisted primarily of money market accounts.

Designated and Restricted Cash and Cash Equivalents

Cash and cash equivalents classified as designated on the statements of financial position are to be used for future capital expansion projects as designated by the Board of Directors. The restricted cash and cash equivalents represents amounts held in a certificate of deposit (CD) to secure a bank loan.

Investments

The Hospital carries investments in marketable equity securities with readily determinable fair values and all investments in debt securities at their fair values in the statements of financial position in accordance with applicable generally accepted accounting principles. Realized and unrealized gains and losses are included in investment income in the accompanying statements of activities.

Fair Value Measurements

The Hospital follows FASB ASC Section 820, *Fair Value Measurements and Disclosures*, which applies to all assets and liabilities that are being measured and reported on a fair value basis. This section requires disclosures that establish a framework for measuring fair value in generally accepted accounting principles. FASB ASC Section 820 enables readers of the financial statements to assess the inputs used to develop those measurements by establishing a hierarchy for ranking the quality and reliability of the information used to determine fair values. Under FASB ASC Section 820, assets and liabilities carried at fair value are required to be classified in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets and liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are not corroborated by market data.

For the year ended September 30, 2016, the application of valuation techniques to similar assets and liabilities has been consistent with previous years. In determining the appropriate valuation levels, the Hospital performed a detailed analysis of the assets and liabilities that are subject to FASB ASC Section 820.

Fair Value of Financial Instruments

For financial statement purposes, receivables, accounts payable, purchased/referred care payable, and debt are considered financial instruments. The Hospital estimates that the fair value of these financial instruments at September 30, 2016 and 2015, does not differ materially from the aggregate carrying values of its financial instruments recorded in the accompanying statements of financial position.

Patient Accounts Receivable and Related Allowances

The Hospital reports patient accounts receivable for services rendered at net estimated realizable amounts from third-party payors, patients, and others. As a service to the patient, the Hospital bills third-party payors directly and bills the patient when the patient's liability, if any, is determined. Patient accounts receivable are due in full when billed. Accounts are considered delinquent and subsequently written off as bad debts based on individual credit evaluation and specific circumstances of the account.

Contractual allowances represent the amounts which reduce patient accounts receivable to amounts that are considered to be collectible from third-party payors based on existing contracts the Hospital has with these payors. The contractual allowance percentages are based upon historical collection information by payor class. Contractual allowances are deducted from gross patient accounts receivable in the statements of financial position.

Periodic rate adjustments are made, sometimes resulting in retroactive settlements. Retroactive settlements are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as more information is available to improve estimates or final settlements are determined. Based on information existing at September 30, 2016 and 2015, no material retroactive settlements were anticipated; therefore, no estimated settlements were accrued at September 30, 2016 or 2015.

The allowance for doubtful accounts is that amount which, in management's judgment, is considered adequate to reduce patient accounts receivable to an amount that is considered to be ultimately collectible. The net accounts receivable balance as of September 30, 2016 and 2015, represent actual subsequent cash collections and an estimated additional amount of cash to be received based on an analysis of historical collection trends.

Supplies

Supplies are stated at lower of cost (the first-in, first-out method), or market and consist primarily of medical supplies and medications.

Property and Equipment

Property and equipment are recorded at cost. Assets held under capital leases are recorded at the lower of the net present value of the minimum lease payments or the fair value of the leased asset at the inception of the lease. Additions, improvements, and other capital outlays that significantly extend the useful life of an asset and are greater than $5,000 are capitalized. Costs incurred for repair and maintenance are expensed as incurred.

Depreciation is computed using the straight-line method over the assets' estimated useful lives ranging from 3 to 20 years. Leasehold improvements are amortized over their useful lives not to exceed the term of the related lease.

Donations of property and equipment are reported at fair value as an increase in unrestricted net assets unless use of the assets is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service. No such restrictions existed in 2016 or 2015.

Under the terms of the Tribal Self-Governance Compact and Funding Agreement with the Department of Health and Human Services, TCRHCC has been authorized to use the federally owned real property comprising the facilities of the Hospital in order to carry out its requirements under the compact. The real property is held by the Navajo Area Indian Health Service and title of said property may be transferred to TCRHCC during the term of the compact. Since the Hospital facilities would be substantially depreciated and the fair rental value is not determinable, in-kind rent expense and the offsetting contribution income have not been recorded in the accompanying financial statements.

Accrued Liabilities

The accrued liabilities on the statements of financial position consist primarily of accruals for vendor invoices, and employee paid time off and health insurance.

Net Assets and Changes Therein

Net assets and income, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of the Hospital and changes therein are classified and reported as follows:

Unrestricted—Unrestricted net assets represent those resources that are not restricted by donors, or for which donor-imposed restrictions have expired.

Temporarily Restricted—Temporarily restricted net assets reflect donor-imposed restrictions that require the Hospital to use or expend the related assets as specified. The restrictions are satisfied either by the passage of time or by the satisfaction of donor-specified use.

The Hospital records contributions as temporarily restricted if they are received with donor stipulations that limit their use through either purpose or time restrictions. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is fulfilled, temporarily restricted net assets are reclassified to unrestricted net assets. Temporarily restricted contributions received and expended in the same accounting period are recorded in the unrestricted net asset category. Temporarily restricted revenues and reclassifications were not significant to the Hospital for the years ended September 30, 2016 and 2015, and are therefore not presented separately in the accompanying statements of activities.

Permanently Restricted—Permanently restricted net assets reflect donor-imposed restrictions which stipulate that the related resources be maintained in perpetuity, but which permit the Hospital to expend part or all of the income and capital appreciation derived from the donated assets for either specified or unspecified purposes. Permanently restricted revenues and reclassifications were not significant to the Hospital for the years ended September 30, 2016 and 2015, and are therefore not presented separately in the accompanying statements of activities.

Tax Status

The Hospital is exempt from state and federal income taxes on related income under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(3). The Hospital is classified as other than a private foundation. Accounting principles generally accepted in the United States of America require TCRHCC to evaluate and disclose uncertain tax positions. TCRHCC does not believe any such positions exist at September 30, 2016 and 2015 that would require accrual or disclosure in the financial statements. TCRHCC's policy, when applicable, is to classify interest and penalties, if any, as miscellaneous expense.

Indian Self-Determination Compact Revenue

Effective April 30, 2011, TCRHCC executed a compact with the Department of Health and Human Services, Indian Health Service (IHS) under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638. Title V compacting allows self-governance and enables TCRHCC to redesign programs, merge or reallocate funds.

Under Title V, TCRHCC receives annual lump-sum payments based on negotiations between IHS and TCRHCC, as provided in the Funding Agreement (FA), for services provided during the annual compact period. The cost of providing these services to IHS-eligible beneficiaries approximates the funding received under the FA over time.

Purchased/referred care are services provided to IHS-eligible beneficiaries by private sector health care providers, such as hospitals and physicians, under contract with TCRHCC. Purchased/referred care expense was approximately $11.4 million and $12.0 million in 2016 and 2015, respectively. TCRHCC reported purchased/referred care payable for estimated services provided by private sector health care providers but not yet paid by TCRHCC, of $2.2 million and $1.1 million in the accompanying statements of financial position as of September 30, 2016 and 2015, respectively. Because of the uncertainty regarding payments made to private sector health care providers, the amounts ultimately paid may materially differ from purchased/referred care payable recorded in the accompanying statements of financial position.

Uncompensated Care

TCRHCC receives PL 93-638 funds to provide health care services for its dedicated population. The Hospital does not expect, nor does it accept, payment from Native Americans for the services provided. Therefore, the Hospital does not provide uncompensated care in the traditional sense of the term; rather, services are provided free of charge to its dedicated population regardless of their ability or inability to pay. Costs are reimbursed primarily through the Office of Management and Budget (OMB) predetermined Medicaid and Medicare billing rates for a patient visit. This payment is taken into effect after any other third-party insurance that the patient may already have. Furthermore, if the Hospital is unable to provide services necessary for its dedicated population, there are allocated purchased/referred care funds to provide these necessary services.

Electronic Health Records Incentive Reimbursement

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). These provisions were designed to increase the use of electronic health records (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. Initial Medicaid incentive payments are available to hospitals that adopt, implement or upgrade certified EHR technology. TCRHCC accounts for EHR incentive payments in accordance with FASB ASC 450-30, *Gain Contingencies*. TCRHCC recognizes EHR incentive payments when all contingencies relating to the incentive payment have been satisfied with no subsequent payment adjustment. Medicaid EHR incentive payments are fully funded by the federal government and administered by the states; however, the states are not required to offer EHR incentive payments to hospitals.

TCRHCC did not recognize any incentive revenue during the year ended September 30, 2016. The Hospital received a hardship exemption for fiscal year 2016.

2) Net Patient Service Revenue

Agreements with third-party payors provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors.

A summary of payment arrangements with major third-party payors follows:

Medicare—Services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge or per visit. Payment for inpatient services is based upon rates that vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Payment for outpatient services is based upon a per visit rate negotiated between IHS and the U.S. Office of Management and Budget (OMB).

Medicaid—Services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per day (per diem) or per visit. Payment for inpatient and outpatient services is based upon a per diem or per visit rate negotiated between IHS and the OMB.

Periodic rate adjustments are made, sometimes resulting in retroactive settlements. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as more information is available to improve estimates or final settlements are determined. Based on information existing at September 30, 2016 and 2015, no material retroactive settlements were anticipated; therefore, no estimates were recorded at September 30, 2016 and 2015.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near-term. Estimates are continually monitored and reviewed, and as settlements are made or more information is available to improve estimates, differences are reflected in current operations.

Other Third-Party Payors—The Hospital has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

The following summary details the components of net patient service revenue for the years ended September 30:

	2016	2015
Gross revenue		
Inpatient	**$ 36,332,534**	$ 31,082,907
Outpatient	**172,189,001**	161,595,117
Professional fees	**77,560,572**	65,008,296
	286,082,107	257,686,320
Less third-party contractual adjustments and provision for uncollectible accounts	**181,282,635**	157,372,962
Net patient service revenue	**$ 104,799,472**	$ 100,313,358

3) Investments

Investments at fair value at September 30 are as follows:

	2016	2015
Money market funds (presented as cash equivalents and/or designated cash)	**$ 6,071,082**	$ 20,037,139
Restricted negotiable certificate of deposit	**$ 4,000,000**	$ 4,000,000
U.S. government securities	**$ 20,153,122**	$ 5,039,222
Equity mutual funds	**4,119,535**	3,428,381
Corporate bond	**1,358,461**	1,373,731
Municipal bond	**537,791**	628,722
	$ 26,168,909	$ 10,470,056

The fair value of the Hospital's marketable securities that are measured on a recurring basis as of September 30 are as follows:

	2016			
	Level 1	**Level 2**	**Level 3**	**Total**
Money market funds (presented as cash equivalents)	**$ 6,071,082**	**$ -**	**$ -**	**$ 6,071,082**
U.S. government securities	**$ 20,153,122**	**$ -**	**$ -**	**$ 20,153,122**
Equity mutual funds	**-**	**4,119,535**	**-**	**4,119,535**
Restricted negotiable certificate of deposit	**4,000,000**	**-**	**-**	**4,000,000**
Corporate bond	**-**	**1,358,461**	**-**	**1,358,461**
Real estate and alternative investments	**-**	**537,791**	**-**	**537,791**
	$ 24,153,122	**$ 6,015,787**	**$ -**	**$ 30,168,909**

	2015			
	Level 1	Level 2	Level 3	Total
Money market funds (presented as cash equivalents)	$ 20,037,139	$ -	$ -	$ 20,037,139
U.S. government securities	$ 5,039,222	$ -	$ -	$ 5,039,222
Equity mutual funds	-	3,428,381		3,428,381
Restricted negotiable certificate of deposit	4,000,000			4,000,000
Corporate bond	-	1,373,731	-	1,373,731
Real estate and alternative investments	-	628,722	-	628,722
	$ 9,039,222	$ 5,430,834	$ -	$ 14,470,056

4) Property and Equipment

The major classes of capital assets at September 30 and related activity for the year then ended is as follows:

	Year Ending September 30, 2016				
	Beginning Balance	Additions	Transfers	Retirements	Ending Balance
Capital assets not being depreciated					
Construction in progress	$ 959,401	$ 7,957,854	$ (2,962,197)	$ -	$ 5,955,058
Capital assets being depreciated					
Land improvements	383,320	-	11,431	-	394,751
Building	23,332,503	-	592,916	-	23,925,419
Equipment	9,755,016	-	502,031	-	10,257,047
Major moveable	12,540,324	23,455	1,776,116	-	14,339,895
Furniture	425,740	-	-	-	425,740
Computer software	5,018,717	-	79,703	-	5,098,420
Total depreciable assets	51,455,620	23,455	2,962,197	-	54,441,272
Less accumulated deprecation for:					
Land improvement	59,807	46,479	-	-	106,286
Buildings	4,511,574	1,130,045	-	-	5,641,619
Equipment	9,136,605	2,484,916	-	-	11,621,521
Major moveable	-	-	-	-	-
Furniture	247,964	32,943	-	-	280,907
Computer software	3,084,992	1,125,891	-	-	4,210,883
Total accumulated deprecation	17,040,942	4,820,274	-	-	21,861,216
Capital assets being depreciated, net	34,414,678	(4,796,819)	2,962,197	-	32,580,056
Capital assets, net	$ 35,374,079	$ 3,161,035	$ -	$ -	$ 38,535,114

	Year Ending September 30, 2015				
	Beginning Balance	Additions	Transfers	Retirements	Ending Balance
Capital assets not being depreciated					
Construction in progress	$ 4,259,015	$ 5,765,809	$ -	$ 9,065,423	$ 959,401
Capital assets being depreciated					
Land improvements	244,892	138,428	-	-	383,320
Building	18,093,407	5,239,096	-	-	23,332,503
Equipment	8,751,959	1,003,057	-	-	9,755,016
Major moveable	9,940,166	2,600,158	-	-	12,540,324
Furniture	425,740	-	-	-	425,740
Computer software	4,644,279	374,438	-	-	5,018,717
Total depreciable assets	42,100,443	9,355,177	-	-	51,455,620
Less accumulated deprecation for:					
Land improvement	31,540	28,267	-	-	59,807
Buildings	3,469,395	1,042,179	-	-	4,511,574
Equipment	6,659,335	2,477,270	-	-	9,136,605
Major moveable	-	-	-	-	-
Furniture	212,574	35,390	-	-	247,964
Computer software	1,477,262	1,607,730	-	-	3,084,992
Total accumulated deprecation	11,850,106	5,190,836	-	-	17,040,942
Capital assets being depreciated, net	30,250,337	4,164,341	-	-	34,414,678
Capital assets, net	$ 34,509,352	$ 9,930,150	$ -	$ 9,065,423	$ 35,374,079

5) Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payor agreements. The Hospital maintains an allowance for doubtful accounts based on management's assessment of collectability, current economic conditions, and prior experience. Because of the uncertainty regarding the ultimate collectability of patient accounts receivable, there is at least a reasonable possibility that recorded estimates of the allowance for doubtful accounts and contractual allowances will change by a material amount in the near-term.

The mix of gross accounts receivable from third-party payors was as follows at September 30:

	2016	2015
Medicare	**21%**	34%
Medicaid	**64%**	50%
Other third-party payors	**15%**	16%
	100%	100%

The Hospital provides care for Native Americans under an agreement with the Department of Health and Human Services (DHHS). During 2016 and 2015, funding for services to patients covered by the agreement with DHHS represented 56% and 61%, respectively, of total net patient service revenue.

6) Functional Expenses

The Hospital provides health care services primarily to residents within its geographic area. Expenses related to providing these services for the years ended September 30 are as follows:

	2016	2015
Health care services	**$ 148,210,886**	$ 138,733,962
Management and general	**14,569,181**	13,070,513
Total operating expenses	**$ 162,780,067**	$ 151,804,475

7) Long-Term Debt

TCRHCC's long-term debt consisted of the following at September 30:

	2016	2015
Bank of Arizona loan for $7.5 million to finance and refinance personal property and equipment at TCRHCC's hospital and campus. The Hospital has given a security interest in the equipment to secure payments. Forty-eight monthly payments of $169,449 at an interest rate of LIBOR + 2% [2.52% at September 30, 2016], maturing in September 2017.	**$ 1,875,000**	$ 3,750,000
Bank of Arizona promissory note for $850,000 for mobile medical and dental coaches to provide health care services to patients located in remote portions of TCRHCC's service area. The note is secured by the two coaches. Sixty monthly payments of $15,586 at an interest rate of LIBOR +2% [2.52% at September 30, 2016], maturing in June 2018.	**297,507**	458,741
Bank of Arizona equipment loan for $2.5 million. The Hospital has given a security interest in the equipment to secure payments. Proceeds of the loan to be disbursed by March 2015, at which point advances on the line terminates. Beginning in March 2015, repayment will be over 36 months with payments of $33,692 at an interest rate of LIBOR + 2% [2.52% at September 30, 2016], maturing in March 2018.	**1,249,990**	2,083,330
Bank of Arizona converting line of credit loan for $4.0 million. The Hospital has given a security interest in the form of a certificate of deposit to secure payments. Proceeds of the loan shall be disbursed in that period of time commencing on the January 2014 closing date of the loan until the maximum loan commitment has been advanced but in no event ending no later than July 2015, at which point lender's obligation to make any advance shall terminate. Until all funds are advanced, the Hospital pays a fee in an amount equal one quarter of one percent (.25%) of the outstanding balance to be advanced. Loan bears an interest rate of LIBOR + 1.5% [2.02% at September 30, 2016] and matures in January 2019.	**3,212,161**	4,000,000
Total debt	**6,634,658**	10,292,071
Less current portion	**4,211,688**	2,974,981
Long-term debt, less current portion	**$ 2,422,970**	$ 7,317,090

Debt Covenants

TCRHCC is subject to certain debt covenant requirements, specified in the Bank of Arizona $7.5M loan agreement, including maintaining a tangible net worth and minimum liquidity over $30,000,000 and $12,500,000, respectively. In addition the Hospital must maintain a Fixed Charge Coverage Ratio of 1:25 to 1. As of September 30, 2016 and 2015, TCRHCC was in compliance with all financial covenants.

Required principal payments on long-term debt as of September 30, 2016, are as follows:

Years ended September 30,	
2017	$ 4,211,688
2018	1,877,497
2019	545,473
	$ 6,634,658

8) Retirement Plans

Government Plan

The Hospital has a defined contribution retirement government plan. This plan covers substantially all direct hire employees. Employees may contribute a percentage of their salaries within allowed limits. The Hospital matches the employee contribution up to 4% of compensation. The Hospital may also make a discretionary contribution to the plan, that is determined annually by the Board of Directors. The Hospital's matching contributions associated with the plan were approximately $2,683,238 and $2,589,512 for 2016 and 2015, respectively.

Retained Federal Benefits (Defined Federal Benefit Plan)

The Hospital funds 15 former federal employees for a special contribution to the Federal Employees Retirement System (FERS) cost sharing multiple employer defined benefit pension plans administered by the federal government. Pension expense is recorded for the amount the Hospital is contractually required to contribute for the year. The plans provide for retirement and death benefits, which are established by federal statute. These amounts are reported on and accounted for by the U.S. Office of Personnel Management.

Funding Policy—Retained Federal Benefits

- FERS—This plan is a three-tiered plan consisting of Social Security, a basic FERS annuity, and the Thrift Savings Plan. Plan members are required to contribute 0.8% of compensation for the basic benefit. The Hospital is required to contribute 11.2% of the employee's pay. To be vested, the federal employees must have at least five years of creditable civilian service. Eligibility is determined by the employee's age and number of years of creditable service.

- Thrift Savings Plan—FERS employees may also contribute up to 100% of their compensation to the Thrift Savings Plan, with a yearly maximum of $16,500 as a tax-deferred contribution. The Hospital is required to contribute 1% of the employee's pay and matches a portion of the employee's contribution, up to 5% of compensation.

Contribution requirements are established by federal statute.

9) Commitments and Contingencies

Healthcare Regulatory Environment

The healthcare industry is subject to laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse of statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs, the imposition of significant fines and penalties, and significant repayments for patient services previously billed.

Management believes that the Hospital is in compliance with applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to assure health insurance portability, guarantee security and privacy of health information, enforce standards for health information, and establish administrative simplification provisions. Under the Health Information Technology for Economic and Clinical Health Act (HITECH), several of the HIPAA security and privacy requirements have been expanded, including business associates being subject to civil and criminal penalties and enforcement proceedings for violations of HIPAA. Management believes that the Hospital is in compliance with all applicable provisions of HIPAA and HITECH.

Litigation

The Hospital is a party to claims and lawsuits arising in the ordinary course of business. As part of the Hospital's Self-Governance Compact with DHHS, medical malpractice claims are covered under the Federal Tort Claims Act. As a result, claims made against the Hospital would be defended by the United States Attorney General. Management believes, based upon consultation with legal counsel, that losses, if any, will not have a material adverse effect on the financial statements.

In 2015, the Hospital discovered information which indicated that a subcontracted provider may have billed the Hospital (for IHS beneficiaries) and insurance companies for services which were not rendered. The Hospital engaged a forensic accounting and investigations firm to help determine the extent of the potential overbilling. On December 8, 2015, final settlement was reached for a total of $450,000. This settlement was paid on December 16, 2015, and no further liability is expected as the case is considered closed.

10) Sacred Peaks Clinic Expansion

On July 19, 2016, TCRHCC approved a resolution authorizing a transfer of $4,000,000 to the Foundation for the purposes of acquiring land and constructing facilities to continue, maintain and expand TCRHCC's Sacred Peaks Clinic located in Flagstaff, AZ and the services it provides. The Foundation will lease the medical office building to TCRHCC when construction is estimated to be completed in January 2019. As of September 30, 2016, the $4,000,000 had not been transferred to the Foundation and is reported on the Hospital's Statement of Financial Position as designated cash and cash equivalents until the Foundation is ready to receive the funds.

11) Subsequent Events

Subsequent events through May 5, 2017, the date the financial statements were available to be issued, were evaluated for recognition and disclosure in the September 30, 2016, financial statements.

Tuba City Regional Health Care Corporation
Schedule of Expenditures of Federal Awards
For the Year Ended September 30, 2016

Federal Grantor/Pass-Through Grantor/Program Title	Grant/Contract Period FYE	Federal CFDA Number	Pass-Through Grantor Number or Other Identifying Number	Expenditures
U.S. Department of Housing and Urban Development				
Kaibeto Creek Independent Living Facilities	9/30/2016	14.867	Block Grant 55IH0402810	$ 15,839
Total U.S. Department of Housing and Urban Development				**15,839**
U.S. Department of Justice				
Office of Victims of Crime				
American Indian and Alaska Native SANE-SART Program	9/30/2016	16.582	2011-VR-GX-K030	232,898
Total U.S. Department of Justice				**232,898**
U.S. Department of Health and Human Services				
Continuing Prospective Birth Cohort Study Involving Environmental Uranium Exposure in the Navajo Nation	6/30/2016	93.161	HHSI245201100234A	62,354
Tribal Self-Governance Program: IHS Compacts/Funding Agreements	9/30/2016	93.210	63G119104	55,691,396
Steven's Bill	10/1/2016	93.210	N/A	14,005
				55,705,401
Health Resources and Services Administration				
Consolidated Health Centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care, and School Based Health Centers)	5/31/2016	93.224	H80CS24200-01-00	1,002,649
HRSA Quality Improvement	05/31/16	93.224	H80CS24200-03.07	84,136
				1,086,785
Indian Health Services				
Special Diabetes Program for Indians-Diabetes Prevention and Treatment Projects	9/30/2016	93.237	HID1IHS0420-11-00	585,493
FYE 09/30/12 Carry Over	2014 C/O	93.237	HID1IHS0420-11-02	4,541
	9/29/2016	93.237	HID1IHS0473-09-00	227,621
FYE 12/31/15 Carry Over (Recurring Grant)	12/31/16	93.237	HID1IHS0420-11-00	36,914
FYE 12/31/15 Carry Over (Special Funding 1)	12/31/16	94.237	HID1IHS0420-11-00	2,741
FYE 09/30/12 Carry Over	2014 C/O	93.237	HID2IHS0032-09-01	1,000
				858,310
Injury Prevention Program for American Indians and Alaskan Natives – Cooperative Agreements	8/31/2015	93.284	D261IHS0104-03-00	1,422
PPHF Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges	9/14/2016	93.750	CA-NAV-130007-01-00	25,000
Domestic Violence Prevention Initiative	09/26/16	93.933	BH15IHS0027-01-00	72,739
Meth & Suicide Prevention Initiative	09/29/16	93.933	BH16IHS0084-01-00	208,982
				281,721
Passed through the State of Arizona				
Emergency Fund (Bio Terrorism)	6/30/2016	93.889	AHHS14-056996 / HR954050	3,938
Passed through the Navajo Nation				
Demonstration Projects for Indian Health - Methamphetamine and Suicide Prevention Initiative	8/31/2015	93.933	HHS124520060003C / 63G110104	145,403
Total U.S. Department of Health and Human Services				**58,170,334**
Total Expenditures of Federal Awards				**$ 58,419,071**

See accompanying notes to the schedule of expenditures of federal awards.

Tuba City Regional Health Care Corporation
Notes to Schedule of Expenditures of Federal Awards
September 30, 2016

1) Summary of Significant Accounting Policies

The accompanying schedule of expenditures of federal awards presents the activity of all federal award programs of Tuba City Regional Health Care Corporation (TCRHCC) and is presented on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), wherein certain types of expenditures are not allowable or are limited as to reimbursement.

2) Subrecipients

TCRHCC did not provide any federal awards to subrecipients during 2016.

3) Indirect Cost Rate

TCRHCC negotiates an indirect cost rate with the federal government. Accordingly, TCRHCC has elected not to use the ten percent de minimis indirect cost rate allowed under the Uniform Guidance.

Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
Tuba City Regional Health Care Corporation

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, the financial statements of Tuba City Regional Health Care Corporation (the "Hospital"), a nonprofit organization, which comprises the statement of financial position as of September 30, 2016, and the related statements of activities and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated May 5, 2017.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Hospital's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as described in the accompanying schedule of findings and questioned costs, we identified certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable

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possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. We consider the deficiencies described in the accompanying schedule of findings and questioned costs as items 2016-001 through 2016-003 to be material weaknesses.

A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiency described in the accompanying schedule of findings and questioned costs as item 2016-004 to be a significant deficiency.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The Hospital's Response to Findings

The Hospital's responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. The Hospital's responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospital's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control and compliance. Accordingly, the communication is not suitable for any other purpose.

REDW LLC

Phoenix, Arizona
May 5, 2017

Independent Auditor's Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by the Uniform Guidance

Board of Directors
Tuba City Regional Health Care Corporation

Report on Compliance for Each Major Federal Program

We have audited Tuba City Regional Health Care Corporation's (the "Hospital") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have direct and material effect on the Hospital's major federal program for the year ended September 30, 2016. The Hospital's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for the Hospital's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance 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 the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Hospital's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of the Hospital's compliance.

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Opinion on Each Major Federal Program

In our opinion, the Hospital complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended September 30, 2016.

Report on Internal Control over Compliance

Management of the Hospital is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Hospital's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

REDW LLC

Phoenix, Arizona
May 5, 2017

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs
For the Year Ended September 30, 2016

Section I — Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified
Internal control over financial reporting:	
Material weaknesses identified?	Yes
Significant deficiencies reported?	Yes
Noncompliance material to financial statements noted?	No

Federal Awards

Type of auditor's report issued on compliance for major programs:	Unmodified
Internal control over major programs:	
Material weaknesses identified?	No
Significant deficiencies reported?	No
Any audit findings that are required to be reported in accordance with section 200.516(a) of the Uniform Guidance?	No

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2016

Section I — Summary of Auditor's Results — continued

Identification of major programs:

CFDA Number	Name of Federal Program
93.210	Tribal Self-Governance Program: IHS Compacts/Funding Agreements

Dollar threshold used to distinguish between type A and type B programs:	$1,752,572
Auditee qualified as low-risk auditee?	No

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2016

Section II — Financial Statement Findings

2016-001 — Deferred Revenue and Grant Receivables (Material Weakness)

Criteria or Specific Requirement: Deferred revenues and grant receivables should be based on a roll-forward that maintains all cash draw downs and expenditures for a specific grant. This detail should be updated monthly as expenses are incurred and cash is received. The ending balance should be either a reflection of the following:

- A deferred revenue if the cash receipts drawn/received are greater than the expenses incurred; or,
- A grant receivable in the amount of expenses exceeding the drawdown but not greater than the award amount.

Condition: The current process for recording deferred revenues and grant receivables in the accounting software creates both a deferred revenue and receivable for grant funds.

Cause: The Hospital recorded deferred revenue and grant receivables based on their cash draw down and period of award rather than actual expenditures incurred. Grant award details are maintained on separate spreadsheets for each fund which track activity for the year. This information is not being properly updated to the trial balance on a regular basis to reflect either the ending deferred revenue or grant receivable balance.

Effect: Audit adjustments were required to adjust the ending deferred revenue and grant receivable balances as of September 30, 2016. In total these adjustments reduced grant receivables by $1.1 million and increased deferred revenue amounts by $2.3 million.

Auditor's Recommendation: Management should only record grant receivables when expenses related to the grant have been incurred, on only record deferred revenue when forward funded grants provide advances prior to the expenses being incurred. Each grant should only have either a grant receivable or deferred revenue balance, depending on the type of funding arrangement. Management should create a roll-forward to track the activity of all grants such that the ending balances can be tied to the trial balance as of fiscal year-end.

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2016

Section II — Financial Statement Findings — continued

2016-001 — Deferred Revenue and Grant Receivables (Material Weakness) — continued

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Management's Response: Finance will review and approve all grant journal entries monthly to attest that the accurate recognition of Receivable and/or Deferred Revenue is made. Finance will also reconcile the grant roll forward quarterly to ensure the ending balance agrees to the trial balance.

A significant contributor to reporting a grant roll forward stems from the lack of a software system to account for grants. Grants have many differing fiscal years from the corporation, different treatment of a fixed asset that is treated as an expense for the grant but as a fixed asset in the general ledger. As a result, grant activity has been tracked manually since our current system is unable to do so. A new software system, expected to go live in May 2017, includes an Analytical Accounting module that tracks grant activity. Instead of accounting for each grant individually in its own General Ledger account, all grant activity will be reported in one GL account which will also be the roll forward.

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2016

Section II — Financial Statement Findings — continued

2016-002 — Purchased/Referred Care Liability Estimate (Material Weakness) (Repeat of Prior Year Finding 2015-002)

Criteria or Specific Requirement: Estimates for Purchased/Referred Care (PRC) services should be evaluated on a quarterly basis to support the assessment of the liability balance.

Condition: An audit adjustment of approximately $1,023,000 was necessary to increase the PRC liability as of September 30, 2016.

Cause: Management has not developed a formal process for the evaluation of the PRC liability on a regular basis.

Effect: Financial statements provided to management and the board during the fiscal year may not have reflected accurate information.

Auditor's Recommendation: Improve the process for analyzing, reconciling and adjusting Purchased/Referred Care claims and the related liability. Adjustments should be made during the fiscal year so that internal financial statements reflect accurate amounts.

Management's Response: Review of current processes for claims management within Purchased Referred Care (PRC) was completed on April 12, 2017, by the Chief Executive Officer, Chief Financial Officer, Chief Quality Officer, and Sr. Financial Consultant. An additional review was completed on April 14, 2017, with PRC Supervisor and Chief Quality Officer. Process flow for claims management was reviewed for errors and was completed on April 18, 2017, by the PRC Supervisor and Chief Quality Officer. Once a claim is processed through the PLEXIS software program and paid in full, the claim is closed. The final cost for claims will be entered into PLEXIS to ensure accurate concurrent financial cost reports when the final claims payment detail is provided from the AZ Foundation. Beginning in April 2017, the PRC/Financial Team will be created to review/audit and monitor this progress monthly. This meeting will ensure review of monthly activity in PLEXIS and BC/BS of NM and accurate financial recognition of potential PRC liabilities in accordance with GAAP. These reviews will be held monthly until an effective process for managing Purchased Referred Care claims are accomplished. Thereafter, the reviews will be held quarterly.

By September 30, 2017, an effective internal control measure will be in place. An Accountant will be employed to assist with managing PRC claims. This internal control measure will separate claims processing duties from claims payment duties.

Section II — Financial Statement Findings — continued

2016-003 — Accounts Receivable Analysis (Material Weakness) (Repeat of Prior Year Finding 2015-001)

Criteria or Specific Requirement: Accounts receivable (AR) aging reports should be produced at least monthly to support the evaluation and collectability of accounts receivable balances. Each payor class should be evaluated based on past collection history and a reserve for uncollectible accounts should be established for both contractual allowances and bad debt. Periodic adjustments to these reserves should be approved by management in light of billing and collection performance.

Condition: Management has not developed a formal process to estimate the allowance for doubtful patient accounts receivable. Reserves were not analyzed and adjusted on a timely basis. During the year, management was reviewing cash collections and booking reserves based on these amounts. However, because the analysis was reliant on subsequent cash collections, the adjustments were not as timely as an established model.

Cause: Management has been refining the reports used from Stockell, Propharm and Dentrix to create a methodology. However, the methodology has not been formalized and approved by the board.

Effect: Prior to the audit, management completed an analysis to determine how much cash was collected and an estimation of additional cash collections based on previous history. This analysis yielded a year-end adjustment of approximately $437,000.

Auditor's Recommendation: Management should continue to work with the billing systems to better refine the methodology for estimating an allowance for doubtful accounts based on historical trends, and assess accounts receivable on a monthly basis. The estimation should include an analysis by payor class for contractual adjustments and by age for the allowance for doubtful accounts. Adjustments should be recorded on a monthly basis to ensure that the financial statements presented to the board are accurate. The board should approve the established methodology.

It is our understanding that implementation of the Hospital's new electronic health record (EHR) system has been delayed until FY 2018, thus hindering management's ability to obtain the information necessary to prepare comprehensive allowance estimates. In the interim, management should consider using alternative methods to produce timely allowance estimates, such as an incurred but not reported (IBNR) technique that incorporates average lag times for claims payments.

Tuba City Regional Health Care Corporation

Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2016

Section II — Financial Statement Findings — continued

2016-003 — Accounts Receivable Analysis (Material Weakness) (Repeat of Prior Year Finding 2015-001) — continued

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Management's Response: Currently, Finance is using the same subsequent cash receipt method that REDW performs to determine the collectible Accounts Receivable at September 30, 2016. This determines total A/R based on the previous four months of cash collections. To get a better current month A/R estimate, Finance staff is developing a "Cash to Net Revenue" lag methodology and an "Incurred But Not Reported" technique on cash payments by financial class. The four month subsequent cash receipts method will still be used to verify the accuracy of the two new methods.

A "Cliff method" of calculating Allowance for Doubtful Accounts together with high % reserves for 0-120 days will be implemented. Any account over 120 days will be 100% Reserved which will reserve the balance in full. Any collections on these claims after 120 days will be recorded as Recovery of Bad Debt income.

These corrective actions will be completed by June 30, 2017, and not necessary for FY 2018 with the implementation of E.H.R.

Section II — Financial Statement Findings — continued

2016-004 — Property and Equipment Physical Count (Significant Deficiency)

Criteria or Specific Requirement: A property and equipment physical count should be completed at the end of the year as outlined in the Purchasing and Property Management Policy.

Condition: According to the Hospital's Purchasing and Property Management Policy, an annual end-of-year physical inventory should be conducted for expendable equipment, capital equipment and property owned, possessed, and under control of the Hospital.

Cause: The Hospital has contradictory policies regarding the frequency of property and equipment physical counts. According to the Hospital's Purchasing and Property Management Policy, an annual end-of-year physical inventory should be conducted for expendable equipment, capital equipment and property owned, possessed, and under control of the Hospital. However, the Capital Asset Policy requires that a count be completed every five years. Based on discussions with Hospital employees, it appears because of these contradictory policies, there is confusion regarding how often physical counts are to be completed.

Effect: The Hospital has not completed a property and equipment count for the last five years, which appears to be out of compliance with both policies. Without a physical count done on a regular basis, there is greater potential for the property and equipment listing to be misstated.

Auditor's Recommendation: We recommend that periodic physical counts of property, especially removable equipment items, be taken and compared to the detailed fixed asset subsidiary ledger. Regular property and equipment inventory counts will do the following:

- Assist in planning for capital expenditures.
- Help determine accurate amounts and values of insurable assets.
- Help detect the loss of unauthorized use of valuable Hospital property.

Additionally, management should review these two policies to ensure the guidelines are consistent and ensure employees responsible for overseeing these counts are informed of the policy revisions and expectations.

Management's Response: By September 30, 2017, a physical inventory will be performed and fixed asset records will be updated to reflect changes. The new ERP system includes a fixed asset management module that tracks all fixed assets. Currently, all fixed asset records are managed manually.

Finance will also review and revise the Fixed Asset policies to ensure consistency and compliance which will be Board approved by September 30, 2017.

Tuba City Regional Health Care Corporation

Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2016

Section III — Federal Award Findings and Questioned Costs

None.

Tuba City Regional Health Care Corporation
Summary Schedule of Prior Audit Findings
For the Year Ended September 30, 2016

Prior Audit Findings	Current Status
2015-001 – Accounts Receivable Analysis	Unresolved – Refer to 2016-002
2015-002 – Purchased/Referred Care Reconciliation	Unresolved – Refer to 2016-004

Tuba City Regional Health Care Corporation
Single Audit Corrective Action Plan
For the Year Ended September 30, 2016

Audit Finding	Corrective Action Plan	Person Responsible	Estimated Completion Date
2016-001 Deferred Revenue and Grant Receivables	See management's response in the schedule of findings and questioned costs.	Christine Keyonnie, CFO	September 30, 2017
2016-002 Purchased/Referred Care Liability Estimate	See management's response in the schedule of findings and questioned costs.	Phyllencia Begay, Director of Accounting	September 30, 2017
2016-003 Accounts Receivable Analysis	See management's response in the schedule of findings and questioned costs.	Gerard Diviney, Interim CFO	June 30, 2017
2016-004 Property and Equipment Physical Count	See management's response in the schedule of findings and questioned costs.	Christine Keyonnie, CFO	September 30, 2017

TUBA CITY REGIONAL HEALTH CARE CORPORATION

Financial Statements,
Independent Auditor's Report, and
Single Audit Reporting Package

September 30, 2015 and 2014

REDW LLC
CPAs | Business & Financial Advisors

Tuba City Regional Health Care Corporation

Table of Contents

Independent Auditor's Report

Board of Directors
Tuba City Regional Health Care Corporation

Report on Financial Statements

We have audited the accompanying financial statements of Tuba City Regional Health Care Corporation (the "Hospital"), a nonprofit organization, which comprise the statements of financial position as of September 30, 2015 and 2014, and the related statements of activities and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of September 30, 2015 and 2014, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 24, 2016, on our consideration of the Hospital's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control over financial reporting and compliance.

REDW LLC

Phoenix, Arizona
March 24, 2016

Tuba City Regional Health Care Corporation
Statements of Financial Position
September 30,

	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 24,625,804	$ 5,873,758
Investments	10,470,056	19,008,325
Patient accounts receivable, net of allowance for doubtful accounts of $1,632,603 in 2015 and $2,990,604 in 2014	10,252,627	6,487,392
Settlement receivable	-	19,200,000
Grant receivable	1,743,507	2,062,949
Supplies	2,062,950	2,007,737
Other assets	-	197,220
Prepaid expenses and other	834,199	765,592
Total current assets	49,989,143	55,602,973
Designated cash and cash equivalents	19,451,393	-
Restricted cash and cash equivalents	4,000,000	4,000,000
Property and equipment, at cost		
Buildings and equipment	23,715,823	25,491,152
Furniture and fixtures	425,740	425,740
Equipment	27,314,057	16,152,011
	51,455,620	42,068,903
Less accumulated depreciation	17,040,942	11,818,566
Total property and equipment, net	34,414,678	30,250,337
Construction in progress	959,401	4,259,015
Total assets	$ 108,814,615	$ 94,112,325
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 6,259,843	$ 4,670,482
Accrued liabilities	7,771,060	6,238,562
Purchased/referred care payable	1,045,830	1,058,709
Other liabilities	54,406	666,444
Current portion of long-term debt	2,974,981	2,296,662
Total current liabilities	18,106,120	14,930,859
Deferred revenue	584,168	2,730,652
Long-term debt, less current portion	7,317,090	7,627,771
Total liabilities	26,007,378	25,289,282
Net assets		
Board designated net assets – capital activities	19,200,000	19,200,000
Undesignated net assets	63,607,237	49,623,043
Unrestricted net assets	82,807,237	68,823,043
Total liabilities and net assets	$ 108,814,615	$ 94,112,325

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

Tuba City Regional Health Care Corporation

Statements of Activities
For the Years Ended September 30,

	2015	2014
Operating Revenue		
Net patient service revenue	$ 100,313,358	$ 89,110,161
Indian self-governance compact revenue	57,905,689	58,916,182
Grant revenue	3,840,760	2,432,586
Rental income	1,405,139	1,658,831
Other	2,201,123	3,010,183
Total operating revenue	165,666,069	155,127,943
Operating Expenses		
Salaries and wages	81,494,174	74,954,800
Employee benefits	15,413,650	16,530,960
Purchased services and professional fees	9,900,288	9,801,647
Supplies and other	28,811,751	27,688,728
General services	3,114,099	2,727,189
General and administrative	3,731,649	4,193,326
Purchased/referred care	4,157,030	10,436,501
Depreciation	5,181,834	4,733,730
Total operating expenses	151,804,475	151,066,881
Operating income	13,861,594	4,061,062
Nonoperating Income (Expense)		
Interest expense	(225,855)	(174,421)
Investment income	106,162	661,522
Settlement from IHS	242,293	19,200,000
Nonoperating income, net	122,600	19,687,101
Change in net assets/revenues over expenses	13,984,194	23,748,163
Net assets, beginning of year	68,823,043	45,074,880
Net assets, end of year	$ 82,807,237	$ 68,823,043

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

Tuba City Regional Health Care Corporation

Statements of Cash Flows

For the Years Ended September 30,

	2015	2014
Cash flows from operating activities		
Change in net assets	**$ 13,984,194**	$ 23,748,163
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Provision for doubtful accounts	**(1,358,001)**	1,942,957
Depreciation	**5,181,834**	4,733,730
Unrealized (gain) loss on investments	**421,647**	(442,573)
Net changes in operating assets and liabilities		
Patient accounts receivable	**(2,407,234)**	742,590
Grant receivable	**319,442**	(767,388)
Settlement receivable	**(251,393)**	(19,200,000)
Accounts payable and accrued expenses	**3,121,859**	1,910,439
Purchased/referred care payable	**(12,879)**	(1,792,465)
Deferred revenue	**(2,146,484)**	2,325,828
Other current assets and liabilities	**(538,638)**	246,725
Cash provided by operating activities	**16,314,347**	13,448,006
Cash flows from investing activities		
Transfers (to)/from investments	**8,116,622**	(8,026,934)
Transfers (to)/from restricted cash and cash equivalents	**-**	(4,000,000)
Purchase of property and equipment	**(6,046,561)**	(7,101,845)
Cash provided by (used for) investing activities	**2,070,061**	(19,128,779)
Cash flows from financing activities		
Proceeds from issuance of long-term debt	**2,828,812**	3,671,188
Payments on long-term debt	**(2,461,174)**	(2,045,504)
Cash provided by financing activities	**367,638**	1,625,684
Increase/(decrease) in cash and cash equivalents	**18,752,046**	(4,055,089)
Cash and cash equivalents, beginning of year	**5,873,758**	9,928,847
Cash and cash equivalents, end of year	**$ 24,625,804**	$ 5,873,758
Supplemental Information		
Cash paid for interest	**$ 225,855**	$ 174,421

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

Tuba City Regional Health Care Corporation
Notes to Financial Statements
September 30, 2015 and 2014

1) Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Tuba City Regional Health Care Corporation (the "Hospital" or "TCRHCC") operates an acute care hospital and related clinics. It primarily earns revenues and receives funding by providing inpatient, outpatient, and emergency care services, environmental health, public health nursing, school health, dental health services, telemedicine services, and public education to residents in and around Tuba City, Arizona.

In August 2002, the Hospital entered into an agreement with the Secretary of the Department of Health and Human Services under the Indian Self-Determination and Education Assistance Act, Public Law 93-638. As a result of this agreement, the federal government has transferred responsibility of all the programs, functions, services and activities (PFSA) relating to health care services, including all related administrative functions, to the Hospital. Before the formation of TCRHCC in August 2002, the facility was operated by the United States Government Indian Health Service.

The Tuba City Health Foundation (the "Foundation") is a legally separate, tax-exempt organization under the Internal Revenue Code Section 501(c)(3) whose sole purpose is the support of TCRHCC by solicitation of gifts of financial resources and commitments of time from volunteers. Although the Hospital does not control the timing or amount of receipts from the Foundation, the majority of the Foundation's resources and related income are restricted by donors for the benefit of the Hospital. The resources and operations were determined not to be significant to the Hospital and, therefore, the Foundation is not consolidated with the Hospital in the accompanying financial statements.

Basis of Presentation

Financial statement presentation follows the requirements of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Section 958-205, *Not-for-Profit Entities—Presentation of Financial Statements*. Under this section, the Hospital is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. The Hospital had no temporarily or permanently restricted net assets at September 30, 2015 and 2014.

Use of Estimates

Financial statement preparation in conformity with accounting principles generally accepted in the United States of America 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 financial statement date and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from

those estimates. Significant estimates contained in the Hospital's financial statements include the allowance for doubtful accounts, contractual allowances, purchased/referred care payable, and depreciation.

Cash and Cash Equivalents

For purposes of reporting cash flows, the Hospital considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents, which at times may exceed the federally insured limits. The Hospital has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on its cash balances. At September 30, 2015 and 2014, cash equivalents consisted primarily of money market accounts.

Designated and Restricted Cash and Cash Equivalents

Cash and cash equivalents classified as designated on the statements of financial position are to be used for future capital expansion projects as designated by the Board of Directors. No specific plans have been made as of September 30, 2015. The restricted cash and cash equivalents represents amounts held in a certificate of deposit (CD) to secure a bank loan.

Investments

The Hospital carries investments in marketable equity securities with readily determinable fair values and all investments in debt securities at their fair values in the statements of financial position in accordance with applicable generally accepted accounting principles. Realized and unrealized gains and losses are included in investment income in the accompanying statements of activities.

Fair Value Measurements

The Hospital follows FASB ASC Section 820, *Fair Value Measurements and Disclosures*, which applies to all assets and liabilities that are being measured and reported on a fair value basis. This section requires disclosures that establish a framework for measuring fair value in generally accepted accounting principles. FASB ASC Section 820 enables readers of the financial statements to assess the inputs used to develop those measurements by establishing a hierarchy for ranking the quality and reliability of the information used to determine fair values. Under FASB ASC Section 820, assets and liabilities carried at fair value are required to be classified in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets and liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are not corroborated by market data.

Property and Equipment

Property and equipment are recorded at cost. Assets held under capital leases are recorded at the lower of the net present value of the minimum lease payments or the fair value of the leased asset at the inception of the lease. Additions, improvements, and other capital outlays that significantly extend the useful life of an asset and are greater than $5,000 are capitalized. Costs incurred for repair and maintenance are expensed as incurred.

Depreciation is computed using the straight-line method over the assets' estimated useful lives ranging from 3 to 20 years. Leasehold improvements are amortized over their useful lives not to exceed the term of the related lease.

Donations of property and equipment are reported at fair value as an increase in unrestricted net assets unless use of the assets is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service. No such restrictions existed in 2015 or 2014.

Under the terms of the Tribal Self-Governance Compact and Funding Agreement with the Department of Health and Human Services, TCRHCC has been authorized to use the federally owned real property comprising the facilities of the Hospital in order to carry out its requirements under the compact. The real property is held by the Navajo Area Indian Health Service and title of said property may be transferred to TCRHCC during the term of the compact. Since the Hospital facilities would be substantially depreciated and the fair rental value is not determinable, in-kind rent expense and the offsetting contribution income have not been recorded in the accompanying financial statements.

Accrued Liabilities

The accrued liabilities on the statements of financial position consist primarily of accruals for vendor invoices, and employee paid time off and health insurance.

Net Assets and Changes Therein

Net assets and income, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of the Hospital and changes therein are classified and reported as follows:

Unrestricted—Unrestricted net assets represent those resources that are not restricted by donors, or for which donor-imposed restrictions have expired.

Temporarily Restricted—Temporarily restricted net assets reflect donor-imposed restrictions that require the Hospital to use or expend the related assets as specified. The restrictions are satisfied either by the passage of time or by the satisfaction of donor-specified use.

The Hospital records contributions as temporarily restricted if they are received with donor stipulations that limit their use through either purpose or time restrictions. When donor restrictions expire, that is, when a time restriction ends or a purpose restriction is fulfilled, temporarily restricted net assets are reclassified to unrestricted net assets. Temporarily restricted contributions received and expended in the same accounting period are recorded in the unrestricted net asset category. Temporarily restricted revenues and reclassifications were not significant to the Hospital for the years ended September 30, 2015 and 2014, and are therefore not presented separately in the accompanying statements of activities.

Permanently Restricted—Permanently restricted net assets reflect donor-imposed restrictions which stipulate that the related resources be maintained in perpetuity, but which permit the Hospital to expend part or all of the income and capital appreciation derived from the donated assets for either specified or unspecified purposes. Permanently restricted revenues and reclassifications were not significant to the Hospital for the years ended September 30, 2015 and 2014, and are therefore not presented separately in the accompanying statements of activities.

Tax Status

The Hospital is exempt from state and federal income taxes on related income under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(3). The Hospital is classified as other than a private foundation. Accounting principles generally accepted in the United States of America require TCRHCC to evaluate and disclose uncertain tax positions. TCRHCC does not believe any such positions exist at September 30, 2015 and 2014, that would require accrual or disclosure in the financial statements. TCRHCC's policy, when applicable, is to classify interest and penalties, if any, as miscellaneous expense.

Indian Self-Determination Compact Revenue

Effective April 30, 2011, TCRHCC executed a compact with the Department of Health and Human Services, Indian Health Service (IHS) under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638. Title V compacting allows self-governance and enables TCRHCC to redesign programs, merge or reallocate funds.

Under Title V, TCRHCC receives annual lump-sum payments based on negotiations between IHS and TCRHCC, as provided in the Funding Agreement (FA), for services provided during the annual compact period. The cost of providing these services to IHS-eligible beneficiaries approximates the funding received under the FA over time.

Purchased/referred care are services provided to IHS-eligible beneficiaries by private sector health care providers, such as hospitals and physicians, under contract with TCRHCC. Purchased/referred care expense was approximately $4.2 million and $10.4

million in 2015 and 2014, respectively. TCRHCC reported purchased/referred care payable for estimated services provided by private sector health care providers but not yet paid by TCRHCC, of $1.0 million and $1.1 million in the accompanying statements of financial position as of September 30, 2015 and 2014, respectively. Because of the uncertainty regarding payments made to private sector health care providers, the amounts ultimately paid may materially differ from purchased/referred care payable recorded in the accompanying statements of financial position.

Uncompensated Care

TCRHCC receives PL 93-638 funds to provide health care services for its dedicated population. The Hospital does not expect, nor does it accept, payment from Native Americans for the services provided. Therefore, the Hospital does not provide uncompensated care in the traditional sense of the term; rather, services are provided free of charge to its dedicated population regardless of their ability or inability to pay. Costs are reimbursed primarily through the Office of Management and Budget (OMB) predetermined Medicaid and Medicare billing rates for a patient visit. This payment is taken into effect after any other third-party insurance that the patient may already have. Furthermore, if the Hospital is unable to provide services necessary for its dedicated population, there are allocated purchased/referred care funds to provide these necessary services.

Electronic Health Records Incentive Reimbursement

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). These provisions were designed to increase the use of electronic health records (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. Initial Medicaid incentive payments are available to hospitals that adopt, implement or upgrade certified EHR technology. TCRHCC accounts for EHR incentive payments in accordance with FASB ASC 450-30, *Gain Contingencies.* TCRHCC recognizes EHR incentive payments when all contingencies relating to the incentive payment have been satisfied with no subsequent payment adjustment. Medicaid EHR incentive payments are fully funded by the federal government and administered by the states; however, the states are not required to offer EHR incentive payments to hospitals.

TCRHCC did not recognize any incentive revenue during the year ended September 30, 2015. The Hospital received a hardship exemption for fiscal year 2015. TCRHCC recognized approximately $1,265,000 of incentive revenue in 2014 for implementation of certified EHR technology as an eligible hospital. The amounts recorded are subject to audit by the federal government or its designee. This revenue is presented as a component of other operating revenue on the statements of activities.

Reclassifications
Certain amounts in the 2014 financial statements have been reclassified to conform to the 2015 presentation. These reclassifications had no effect on net assets or the change in net assets or cash flows.

Subsequent Events
Subsequent events through March 24, 2016, the date which the financial statements were available to be issued, were evaluated for recognition and disclosure in the September 30, 2015, financial statements.

2) Net Patient Service Revenue

Agreements with third-party payors provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors.

A summary of payment arrangements with major third-party payors follows:

Medicare—Services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge or per visit. Payment for inpatient services is based upon rates that vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Payment for outpatient services is based upon a per visit rate negotiated between IHS and the U.S. Office of Management and Budget (OMB).

Medicaid—Services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per day (per diem) or per visit. Payment for inpatient and outpatient services is based upon a per diem or per visit rate negotiated between IHS and the OMB.

Periodic rate adjustments are made, sometimes resulting in retroactive settlements. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as more information is available to improve estimates or final settlements are determined. Based on information existing at September 30, 2015 and 2014, no material retroactive settlements were anticipated; therefore, no estimates were recorded at September 30, 2015 and 2014.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near-term. Estimates are continually monitored and reviewed, and as settlements are made or more information is available to improve estimates, differences are reflected in current operations.

Other Third-Party Payors—The Hospital has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

The following summary details the components of net patient service revenue for the years ended September 30:

	2015	2014
Gross revenue		
Inpatient	$ 31,082,907	$ 34,623,988
Outpatient	161,595,117	140,308,518
Professional fees	65,008,296	61,219,330
	257,686,320	236,151,836
Less third-party contractual adjustments and provision for uncollectible accounts	157,372,962	147,041,675
Net patient service revenue	$ 100,313,358	$ 89,110,161

3) Investments

Investments at fair value at September 30 are as follows:

	2015	2014
Money market funds (presented as cash equivalents)	$ 20,037,139	$ 3,044,897
Restricted negotiable certificate of deposit	$ 4,000,000	$ 4,000,000
U.S. Government securities	$ 1,663,834	$ 7,281,189
U.S. Government-sponsored debt securities	3,375,388	4,545,139
Equity mutual funds	3,428,381	4,529,901
Corporate bond	1,373,731	2,642,006
Municipal bond	628,722	10,090
	$ 10,470,056	$ 19,008,325

The fair value of the Hospital's marketable securities that are measured on a recurring basis as of September 30 are as follows:

	2015		
	Level 1	Level 2	Total
Money market funds (presented as cash equivalents)	$ 20,037,139	$ -	$ 20,037,139
U.S. Government securities	$ 1,663,834	$ -	$ 1,663,834
U.S. Government-sponsored debt securities	3,375,388	-	3,375,388
Equity mutual funds	-	3,428,381	3,428,381
Restricted negotiable certificate of deposit	-	4,000,000	4,000,000
Corporate bond	1,373,731	-	1,373,731
Real estate and alternative investments	628,722	-	628,722
	$ 7,041,675	$ 7,428,381	$ 14,470,056

	2014		
	Level 1	Level 2	Total
Money market funds (presented as cash equivalents)	$ 3,044,897	$ -	$ 3,044,897
U.S. Government securities	$ 7,281,189	$ -	$ 7,281,189
U.S. Government-sponsored debt securities	4,545,139	-	4,545,139
Equity mutual funds	-	4,529,901	4,529,901
Restricted negotiable certificate of deposit	-	4,000,000	4,000,000
Corporate bond	2,642,006	-	2,642,006
Municipal bond	10,090	-	10,090
	$ 14,478,424	$ 8,529,901	$ 23,008,325

4) Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payor agreements. The Hospital maintains an allowance for doubtful accounts based on management's assessment of collectability, current economic conditions, and prior experience. Because of the uncertainty regarding the ultimate collectability of patient accounts receivable, there is at least a reasonable possibility that recorded estimates of the allowance for doubtful accounts and contractual allowances will change by a material amount in the near-term.

The mix of gross accounts receivable from third-party payors was as follows at September 30:

	2015	2014
Medicare	34 %	31 %
Medicaid	50	28
Other third-party payors	16	41
	100 %	100 %

The Hospital provides care for Native Americans under an agreement with the Department of Health and Human Services (DHHS). During 2015 and 2014, funding for services to patients covered by the agreement with DHHS represented 35% and 38%, respectively, of total net patient service revenue.

5) Functional Expenses

The Hospital provides health care services primarily to residents within its geographic area. Expenses related to providing these services for the years ended September 30 are as follows:

	2015	2014
Health care services	**$ 138,733,962**	$ 131,703,324
Management and general	**13,070,513**	19,363,557
Total operating expenses	**$ 151,804,475**	$ 151,066,881

6) Retirement Plans

Government Plan

The Hospital has a defined contribution retirement government plan. This plan covers substantially all direct hire employees. Employees may contribute a percentage of their salaries within allowed limits. The Hospital matches the employee contribution up to 4% of compensation. The Hospital may also make a discretionary contribution to the plan, that is determined annually by the Board of Directors. The Hospital's matching contributions associated with the plan were approximately $1,414,000 and $2,124,000 for 2015 and 2014, respectively.

Retained Federal Benefits (Defined Federal Benefit Plan)

The Hospital funds 15 former federal employees for a special contribution to the Federal Employees Retirement System (FERS) cost sharing multiple employer defined benefit pension plans administered by the federal government. Pension expense is recorded for the amount the Hospital is contractually required to contribute for the year. The plans provide for retirement and death benefits, which are established by federal statute. These amounts are reported on and accounted for by the U.S. Office of Personnel Management.

Funding Policy—Retained Federal Benefits

- FERS—This plan is a three-tiered plan consisting of Social Security, a basic FERS annuity, and the Thrift Savings Plan. Plan members are required to contribute 0.8% of compensation for the basic benefit. The Hospital is required to contribute 11.2% of the employee's pay. To be vested, the federal employees must have at least five years of creditable civilian service. Eligibility is determined by the employee's age and number of years of creditable service.

- Thrift Savings Plan—FERS employees may also contribute up to 100% of their compensation to the Thrift Savings Plan, with a yearly maximum of $16,500 as a tax-deferred contribution. The Hospital is required to contribute 1% of the employee's pay and matches a portion of the employee's contribution, up to 5% of compensation.

Contribution requirements are established by federal statute.

7) Commitments and Contingencies

Healthcare Regulatory Environment

The healthcare industry is subject to laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse of statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs, the imposition of significant fines and penalties, and significant repayments for patient services previously billed.

Management believes that the Hospital is in compliance with applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to assure health insurance portability, guarantee security and privacy of health information, enforce standards for health information, and establish administrative simplification provisions. Under the Health Information Technology for Economic and Clinical Health Act (HITECH), several of the HIPAA security and privacy requirements have been expanded, including business associates being subject to civil and criminal penalties and enforcement proceedings for violations of HIPAA. Management believes that the Hospital is in compliance with all applicable provisions of HIPAA and HITECH.

Litigation

The Hospital is a party to claims and lawsuits arising in the ordinary course of business. As part of the Hospital's Self-Governance Compact with DHHS, medical malpractice claims are covered under the Federal Tort Claims Act. As a result, claims made against the Hospital would be defended by the United States Attorney General. Management believes, based upon consultation with legal counsel, that losses, if any, will not have a material adverse effect on the financial statements.

In 2015, the Hospital discovered information which indicated that a subcontracted provider may have billed the Hospital (for IHS beneficiaries) and insurance companies for services which were not rendered. The Hospital engaged a forensic accounting and investigations firm to help determine the extent of the potential overbilling. On December 8, 2015, final settlement was reached for a total of $450,000. This amount is included in accrued liabilities on the statement of financial position as of September 30, 2015.

8) Long-Term Debt

TCRHCC's long-term debt consisted of the following at September 30:

	2015	2014
Bank of Arizona loan for $7.5 million to finance and refinance personal property and equipment at TCRHCC's hospital and campus. The Hospital has given a security interest in the equipment to secure payments. Forty-eight monthly payments of $169,449 at an interest rate of LIBOR + 2% [2.19% at September 30, 2015], maturing in September 2017.	$ 3,750,000	$ 5,625,000
Bank of Arizona promissory note for $850,000 for mobile medical and dental coaches to provide health care services to patients located in remote portions of TCRHCC's service area. The note is secured by the two coaches. Sixty monthly payments of $15,586 at an interest rate of LIBOR +2% [2.19% at September 30, 2015], maturing in June 2018.	458,741	628,245
Bank of Arizona equipment loan for $2.5 million. The Hospital has given a security interest in the equipment to secure payments. Proceeds of the loan to be disbursed by March 2015, at which point advances on the line terminates. Beginning in March 2015, repayment will be over 36 months with payments of $33,692 at an interest rate of LIBOR + 2% [2.19% at September 30, 2015], maturing in March 2018.	2,083,330	1,173,508
Bank of Arizona converting line of credit loan for $4.0 million. The Hospital has given a security interest in the form of a certificate of deposit to secure payments. Proceeds of the loan shall be disbursed in that period of time commencing on the January 2014 closing date of the loan until the maximum loan commitment has been advanced but in no event ending no later than July 2015, at which point lender's obligation to make any advance shall terminate. Until all funds are advanced, the Hospital pays a fee in an amount equal one quarter of one percent (.25%) of the outstanding balance to be advanced. Loan bears an interest rate of LIBOR + 1.5% [1.69% at September 30, 2015] and matures in January 2019.	4,000,000	2,497,680
Total debt	10,292,071	9,924,433
Less current portion	2,974,981	2,296,662
Long-term debt, less current portion	$ 7,317,090	$ 7,627,771

Debt Covenants

TCRHCC is subject to certain debt covenant requirements, specified in the Bank of Arizona $7.5M loan agreement, including maintaining a tangible net worth and minimum liquidity over $30,000,000 and $12,500,000, respectively. In addition the Hospital must maintain a Fixed Charge Coverage Ratio of 1:25 to 1. As of September 30, 2015 and 2014, TCRHCC was in compliance with all financial covenants.

Required principal payments on long-term debt as of September 30, 2015, are as follows:

Years Ended September 30,	
2016	$ 2,974,981
2017	2,800,485
2018	516,605
2019	4,000,000
	$ 10,292,071

9) Indian Health Services Settlement

TCRHCC filed claims with the U.S. Department of Health and Human Services – Indian Health Services alleging miscalculation and underpayment of contract support costs for fiscal years 2006–2011 including actual cost plus penalties and fees under the Indian Self-Determination Act. A negotiated settlement was reached in the amount of $19.2 million. This amount was a combination of an $18,500,000 settlement plus estimated interest of $700,000. The $19,200,000 was recognized in the accompanying financial statements as a receivable and revenue as of and for the year ended September 30, 2014. In 2015, the Hospital received the full amount of $19,200,000 plus an additional $242,293 of funds from the interest earned which is presented as non-operating revenue in the statement of activities for the year ended September 30, 2015.

Schedule of Expenditures of Federal Awards

Tuba City Regional Health Care Corporation
Schedule of Expenditures of Federal Awards
For the Year Ended September 30, 2015

Federal Grantor/Pass-Through Grantor/Program Title	Grant/Contract Period FYE	Federal CFDA Number	Pass-Through Grantor Number or Other Identifying Number	Expenditures
U.S. Department of Housing and Urban Development				
Kaibeto Creek Independent Living Facilities	9/30/2015	14.867	Block Grant 55IH0402810	$ 8,989
Tuba City Long Term Care	9/30/2015	14.867	Block Grant 55IH0402810	45,002
Total U.S. Department of Housing and Urban Development				53,991
U.S. Department of Justice				
Office of Victims of Crime				
American Indian and Alaska Native SANE-SART Program	9/30/2015	16.582	2011-VR-GX K030	83,166
Total U.S. Department of Justice				83,166
U.S. Department of Health and Human Services				
Continuing Prospective Birth Cohort Study Involving Environmental Uranium Exposure in the Navajo Nation	6/30/2015	93.161	HHSI245201100234A	54,656
Health Resources and Services Administration				
Consolidated Health Centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care, and School Based Health Centers)	5/31/2015	93 224	H80CS24200-01-00	774,184
	6/30/2015	93.224	H80CS24200-02-01	46,496
				820,680
Indian Health Services				
Special Diabetes Program for Indians-Diabetes Prevention and Treatment Projects	9/30/2015	93.237	HID1IHS0420-11-00	939,150
FYE 09/30/12 Carry Over	2014 Carry Over	93.237	HID1IHS0420-11-02	90,807
	9/29/2015	93.237	HID1IHS0473-09-00	323,268
				1,353,225
Injury Prevention Program for American Indians and Alaskan Natives – Cooperative Agreements	8/31/2015	93 284	D261IHS0104-03-00	75,327
Tribal Self-Governance Program IHS Compacts/Funding Agreements	9/30/2015	93 210	63G119104	58,857,285
Steven's Bill	10/1/2015	93.210	N/A	39,204
				58,896,489
PPHF Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges	10/01/13 - 09/30/14	93 750	CA-NAV-130007-01-00	27,599
Demonstration Projects for Indian Health - Methamphetamine and Suicide Prevention Initiative	8/31/2015	93.933	HHS124520060003C / 63G110104	273,529
Passed through the State of Arizona				
Emergency Fund (Bio Terrorism)	07/01/13 - 06/30/14	93 889	AHHS14-056996 / HR954050	1,497
Total U.S. Department of Health and Human Services				61,503,002
Total Expenditures of Federal Awards				$ 61,640,159

See accompanying notes to the schedule of expenditures of federal awards.

Tuba City Regional Health Care Corporation

Notes to Schedule of Expenditures of Federal Awards
September 30, 2015

1) Summary of Significant Accounting Policies

The accompanying schedule of expenditures of federal awards presents the activity of all federal award programs of Tuba City Regional Health Care Corporation (TCRHCC) and is presented on the modified accrual basis of accounting. The information in the schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Therefore, some amounts presented in the schedule may differ from amounts presented in, or used in the preparation of, the basic financial statements.

2) Correction to Previously Reported Schedule of Expenditures of Federal Awards

The Hospital's fiscal year 2014 schedule of expenditures of federal awards (SEFA) did not include approximately $414,920 that had been reported as expenditures in draw-down requests to the U.S. Department of Health and Human Services submitted during the 2014 fiscal year for the I.H.S. Special Diabetes Program for Indians-Diabetes Prevention and Treatment program, Federal CFDA number 93.237. It was determined that the expenditures were related to the purchase and remodel of a mobile home.

3) Subrecipients

TCRHCC did not provide any federal awards to subrecipients during 2015.

Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
Tuba City Regional Health Care Corporation

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of Tuba City Regional Health Care Corporation (the "Hospital"), a nonprofit organization, which comprises the statement of financial position as of September 30, 2015, and the related statements of activities and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated March 24, 2016.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Hospital's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as described in the accompanying schedule of findings and questioned costs, we identified certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable

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possibility that a material misstatement of the Hospital's financial statements will not be prevented, or detected and corrected on a timely basis. We consider the deficiency described as item 2015-001 in the accompanying schedule of findings and questioned costs to be a material weakness.

A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiency described as item 2015-002 in the accompanying schedule of findings and questioned costs to be a significant deficiency.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Hospital's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The Hospital's Response to Findings

The Hospital's responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. The Hospital's responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Hospital's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Hospital's internal control and compliance. Accordingly, the communication is not suitable for any other purpose.

REDW LLC
Phoenix, Arizona
March 24, 2016

Independent Auditor's Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by OMB Circular A–133

Board of Directors
Tuba City Regional Health Care Corporation

Report on Compliance for Each Major Program

We have audited Tuba City Regional Health Care Corporation's (the "Hospital") compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of the Hospital's major federal programs for the year ended September 30, 2015. The Hospital's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the Hospital's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance 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 OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Hospital's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the Hospital's compliance.

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Opinion on Each Major Federal Program

In our opinion, the Hospital complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended September 30, 2015.

Report on Internal Control Over Compliance

Management of the Hospital is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Hospital's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Hospital's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

REDW LLC
Phoenix, Arizona
March 24, 2016

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs
For the Year Ended September 30, 2015

Section I — Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified
Internal control over financial reporting:	
Material weaknesses identified?	Yes
Significant deficiencies reported?	Yes
Noncompliance material to financial statements noted?	No

Federal Awards

Type of auditor's report issued on compliance for major programs:	Unmodified
Internal control over major programs:	
Material weaknesses identified?	No
Significant deficiencies reported?	No
Any audit findings that are required to be reported in accordance with section 510(a) of OMB Circular A-133?	No

Tuba City Regional Health Care Corporation

Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2015

Section I — Summary of Auditor's Results — continued

Identification of major programs:

CFDA Number	Name of Federal Program
93.210	Tribal Self-Governance Program: IHS Compacts/Funding Agreements

Dollar threshold used to distinguish between type A and type B programs:	$1,849,205
Auditee qualified as low-risk auditee?	No

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2015

Section II — Financial Statement Findings

2015-001 — Accounts Receivable Analysis

Criteria or Specific Requirement: Accounts receivable aging reports should be produced at least monthly to support the evaluation and collectability of accounts receivable balances. Each payor class should be evaluated based on past collection history and a reserve for uncollectible accounts should be established for both contractual allowances and bad debt. Periodic adjustments to these reserves should be approved by management in light of billing and collection performance.

Condition: Management has not developed a formal process to estimate the allowance for doubtful patient accounts receivable.

Cause: The integrity of reports produced from the Stockell billing system has limited management's reliance on the receivable data.

Effect: Audit adjustments were required to adjust the ending balances to the estimated net realizable value. The net accounts receivable balance was understated by $6,266,193.

Auditor's Recommendation: Management should continue to work with the billing systems to better refine the methodology for estimating an allowance for doubtful accounts based on historical trends, and assess accounts receivable on a monthly basis. The estimation should include an analysis by payor class for contractual adjustments and by age for the allowance for doubtful accounts. Adjustments should be recorded on a monthly basis to ensure that the financial statements presented to the board are accurate.

Management's Response: The Finance Division has included developing a methodology for all Deductions from Revenue (Contractual, I.H.S. and Bad Debt) in the Board approved Strategic Plan for FY 2016. The contracted B. E. Smith Interim CFO has extensive experience in developing, training and implementing these monthly calculations both using the Balance Sheet and Statement of Activities methods. This contractor has been assigned to complete this project before the FY 2016 year end. These methodologies will be developed for the current General Ledger and Billing vendors and revised when the new Enterprise Resource Planning system is installed.

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2015

Section II — Financial Statement Findings — continued

2015-002 — Purchased/Referred Care Reconciliation

Criteria or Specific Requirement: The liability for Purchased/Referred Care amounts owed to other providers should be reconciled and adjusted on a regular basis.

Condition: The Purchased/Referred Care liability was overstated by $1,662,879 at year-end, requiring an audit adjustment.

Cause: Purchased/Referred Care claims were not analyzed or compared to third-party information during the fiscal year.

Effect: Liabilities were overstated by $1,662,879 at year-end. Financial statements provided to management and the board during the fiscal year may not have reflected accurate information.

Auditor's Recommendation: Improve the process for analyzing, reconciling and adjusting Purchased/Referred Care claims and the related liability. Adjustments should be made during the fiscal year so that internal financial statements reflect accurate amounts.

Management's Response: An action plan has been developed and agreed upon by the Hospital, AZ Foundation and Plexis, the billing software company. This plan will coordinate all aspects of billing both regular and CHEF claims and provides an uncomplicated audit trail. This should be completed before FY 2016 year-end.

Tuba City Regional Health Care Corporation
Schedule of Findings and Questioned Costs — continued
For the Year Ended September 30, 2015

Section III — Federal Award Findings and Questioned Costs

None.

Tuba City Regional Health Care Corporation

Summary Schedule of Prior Audit Findings

For the Year Ended September 30, 2015

Prior Audit Findings	Current Status
No prior year findings.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES
NATIONAL EXTERNAL AUDIT REVIEW CENTER
1100 WALNUT STREET, SUITE 850
KANSAS CITY, MO 64106

MAY 18 2018

Report Number: A-09-18-33631

BOARD OF DIRECTORS
TUBA CITY REGIONAL
HEALTH CARE CORPORATION
167 NORTH MAIN STREET
P.O. BOX 600
TUBA CITY, ARIZONA 86045-0600

Dear Board Members:

We have completed our initial review of the audit report on the Corporation for the period October 1, 2016, through September 30, 2017. The report was accepted by the Federal Audit Clearinghouse on April 13, 2018, (identification number 217851). Based on our initial review, we believe the audit, performed by REDW LLC, Certified Public Accountants, met Federal audit requirements.

Please refer to Attachment A, where we have summarized the finding and recommendation and identified the Federal department responsible for resolution. Final determinations with respect to actions to be taken on the Department of Health and Human Services (HHS) recommendation will be made by the HHS resolution agency identified on Attachment A. You may receive separate communications from the resolution agencies requesting additional information to resolve the findings.

Any questions or correspondence related to the findings identified on Attachment A should be directed to the following HHS resolution official address. The above report number should be referenced in any correspondence relating to this report.

HHS RESOLUTION OFFICIAL

Division of Audit
Office of Finance and Accounting
Indian Health Service
Mail Stop: 10E54
5600 Fishers Lane
Rockville, MD 20857

In accordance with the principles of the Freedom of Information Act (Public Law No. 90-23), reports issued on the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent that information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5 Section 5.21 of the Department's Public Information Regulations.)

If you have any questions, please contact our office at (800) 732-0679.

Sincerely,

Patrick J. Cogley
Regional Inspector General for Audit Services

Enclosure

Recommendation Codes	*Page*	*Amount*	*Resolution Agency*	*Recommendations*
200922100	27, 32-33	N/A	HHS/IHS	2017-001. Account Reconciliations. This is a material weakness. We recommend procedures be developed and implemented to ensure accounting records are reconciled accurately and timely.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES
NATIONAL EXTERNAL AUDIT REVIEW CENTER
1100 WALNUT STREET, SUITE 850
KANSAS CITY, MO 64106

JUN 30 2017

Report Number: A-09-17-32078

BOARD OF DIRECTORS
TUBA CITY REGIONAL
HEALTH CARE CORPORATION
167 NORTH MAIN STREET
P.O. BOX 600
TUBA CITY, ARIZONA 86045-0600

Dear Board Members:

We have completed our initial review of the audit report on the Hospital for the period October 1, 2015, through September 30, 2016. The report was accepted by the Federal Audit Clearinghouse on May 26, 2017, (identification number 217851). Based on our initial review, we believe the audit, performed by REDW LLC, Certified Public Accountants, met Federal audit requirements.

Please refer to Attachment A, where we have summarized the findings and recommendations and identified the Federal department responsible for resolution. Final determinations with respect to actions to be taken on Department of Health and Human Services (HHS) recommendations will be made by the HHS resolution agency identified on Attachment A. You may receive separate communications from the resolution agencies requesting additional information to resolve the findings.

Any questions or correspondence related to the findings identified on Attachment A should be directed to the following HHS resolution official address. The above report number should be referenced in any correspondence relating to this report.

HHS RESOLUTION OFFICIAL

Division of Audit
Office of Finance and Accounting
Indian Health Service
Twinbrook Metro Plaza, Suite 360
12300 Twinbrook Parkway
Rockville, MD 20852

In accordance with the principles of the Freedom of Information Act (Public Law No. 90-23), reports issued on the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent that information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5 Section 5.21 of the Department's Public Information Regulations.)

If you have any questions, please contact our office at (800) 732-0679.

Sincerely,

Patrick J. Cogley
Regional Inspector General for Audit Services

Enclosure

Report Number
A-09-17-32078

Recommendation Codes	*Page*	*Amount*	*Resolution Agency*	*Recommendations*
205922100	24, 29-30	N/A	HHS/IHS	2016-001. Deferred Revenue and Grant Receivables. This is a material weakness. We recommend procedures be strengthened to ensure deferred revenue and grant receivables are accurately recorded and grant activity is properly tracked.
201901100	24, 31	N/A	HHS/IHS	2016-002, 2015-002. Purchased/Referred Care Liability Estimate. This is a material weakness and a repeat finding. We recommend procedures be strengthened to ensure purchased/referred care amounts are accurate and properly reconciled in a timely manner.
221901100	24, 32-33	N/A	HHS/IHS	2016-003, 2015-001. Accounts Receivable Analysis. This is a material weakness and a repeat finding. We recommend procedures be developed and implemented to ensure allowance for doubtful accounts estimates are accurate and recorded in a timely manner.
220202100	34	N/A	HHS/IHS	2016-004. Property and Equipment Physical Count. We recommend procedures be strengthened to ensure periodic physical inventories are performed in a timely manner and reconciled to the fixed asset records.

REVISED AND RESTATED BYLAWS OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION (2018)

TABLE OF CONTENTS

CERTIFICATION

The foregoing revised and restated Bylaws were presented and reviewed at a properly noticed meeting of the Board of the Tuba City Regional Health Care Corporation , a quorum being present, and were adopted by a vote of 7 in favor, 0 opposed, and 0 abstained, on the 8th day of February, 2018.

Motion: Dolly Lane Seconded: Kimberlee Williams

We, the undersigned, hereby certify that we are the presently elected President and Treasurer of the Tuba City Regional Health Care Corporation, a non-profit corporation, and that the foregoing Bylaws, including this page, are the Bylaws of this Corporation as adopted at the above stated meeting.

Christopher Curley, President _____

Kimberlee Williams, Treasurer Kimberlee Williams

REVISED AND RESTATED BYLAWS OF THE
TUBA CITY REGIONAL HEALTH CARE CORPORATION (February 8, 2018)

ARTICLE I
NAME, OFFICE, SEAL, PURPOSES

SECTION 1: NAME OF THE CORPORATION -- The name of the Corporation shall be the Tuba City Regional Health Care Corporation (TCRHCC or Corporation).

SECTION 2: OFFICE -- The principal office of the TCRHCC shall be located in Tuba City, Arizona. The TCRHCC may have such other offices, either within or outside the jurisdiction of the Navajo Nation, as the Board of Directors may designate or as the business of the TCRHCC may require from time to time.

SECTION 3: CORPORATE SEAL -- The corporate seal of the TCRHCC shall be inscribed with the name of the Corporation. No instruction executed by the Board of Directors of the TCRHCC need bear any seal unless required by law.

SECTION 4: PURPOSES -- TCRHCC is organized as a non-profit organization and may engage in any activity permitted under Section 501(c)(3) of the Internal Revenue Code. TCRHCC is dedicated and committed to the following purposes:

A. To provide for the safety and quality of care, treatment and services for all patients of TCRHCC. Care may be provided at the main hospital location, an off-site clinic, a school, a chapter house or IHS facility via telemedicine link, a patient's home, or a community event.
B. To exercise all legal powers that are in furtherance of the delivery of high quality health care services, pursuant to the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, and to carry out all activities specified in the Articles of Incorporation.
C. To seek funding from all available public and private sources to improve the health care services and delivery system for beneficiaries.

ARTICLE II
BOARD OF DIRECTORS

SECTION 1: GOVERNANCE -- Subject to the limitations of the Articles of Incorporation, the powers and authority of TCRHCC shall be exercised by and/or under the authority of a Board of Directors of the TCRHCC (Board). The members of TCRHCC shall be the Directors and TCRHCC shall not have regular members other than the Directors.

SECTION 2: RESPONSIBILITIES OF THE BOARD --
The business and affairs of TCRHCC shall be managed by the Board of Directors. Responsibilities include without limitation:

A. To develop and approve Board policies for the operation and direction of the Corporation.
B. To appoint a Chief Executive Officer to oversee the hospital and health care activities of the Corporation.

C. To delegate the day-to-day operation management of the TCRHCC hospital to the Chief Executive Officer and, as deemed appropriate, delegate the health care management to the organized medical staff and Senior Leadership.[1]
D. To review and, as appropriate, grant appointment and privileges to members of the medical staff.
E. Approve the hospital scope of services.
F. Provide adequate resources for the hospital consistent with the purpose and mission of TCRHCC to the extent allowable by the TCRHCC budget.
G. Annually, with input and assistance from the organized medical staff and Senior Leadership, evaluate the hospital's performance related to TCRHCC's mission, vision and goals and as set forth in the Joint Commission requirements.
H. Provide policies and procedures to resolve conflicts among staff of the hospital and among the Leadership Groups at the hospital.
I. Provide the organized medical staff the opportunity to be represented at Board of Directors' meetings, through attendance and voice, by one or more medical staff members selected by the organized medical staff and to consider advice and input to the Board of Directors from such medical staff members in order to assist the Board.
J. Approve the structure of the medical staff by the review and approval of the Medical Staff Bylaws and Rules and Regulations.
K. Provide orientation for new members to the Board and to the hospital.
L. With the assistance from the organized medical staff and Senior Leadership, annually review, modify as necessary and approve the mission, vision, goals and Bylaws of TCRHCC.
M. Approve the annual operating budget and long-term capital expenditures for all TCRHCC operations.
N. Review annual patient safety reports.
O. Sign an annual disclosure of Conflict of Interest Statement.
P. Review the Bylaws to ensure they are up to date and all necessary modifications are made.

SECTION 3: AUTHORITY OF BOARD -- Without limiting its general powers, the Board shall have the power to take all lawful actions necessary for and incidental to carrying out the purposes of the TCRHCC. These shall include, but are not limited to, the following powers:

A. To conduct, manage and control the affairs and business of the Corporation and to adopt rules, regulations and policies consistent with Federal, tribal and other laws as applicable and appropriate and with the requirements of the Joint Commission.
B. To buy, sell, lease, obtain by gift or bequest, or otherwise acquire and maintain or dispose of buildings, offices and other real and personal

[1] Senior Leadership consists of TCRHCC's Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Deputy Chief Medical Officer, Chief Nurse Officer, Chief Financial Officer, Senior Financial Advisor, Chief Quality Officer, Human Resources Director, Chief Information Officer, Chief Community Health Services Officer, Chief Support Services Officer, Chief Ancillary Officer, Director of Outpatient Services, Chief of Staff, Deputy Chief of Staff and Chief Compliance Officer (regardless of any "interim" or "acting" designation for such positions), to the extent such positions exist and are not vacant at the relevant time.

property necessary for carrying out the purposes of the TCRHCC, either within or outside the jurisdiction of the Navajo Nation.

C. To enter into and make contracts of every kind and nature with any person, firm, association, corporation, municipality, Indian tribe, state or local government; apply for and accept grants; incur debts; invest its funds, and raise or borrow funds and secure the payment of any money in any lawful manner.

D. To employ or engage attorneys or agents of the Corporation and to define their duties and compensation.

E. To obtain a certificate of authority to transact business outside of the boundaries of the Navajo Nation in any state as a foreign corporation, and to comply with applicable state law governing foreign corporations.

F. To access and confer with the Chief Executive Officer, TCRHCC's legal counsel and TCRHCC's auditor, and to inspect TCRHCC's books and records, other relevant data, and facilities during regular business hours and with notice to the President and Chief Executive Officer if reasonably necessary for the performance of the Board's duties.

AUTHORITY OF INDIVIDUAL BOARD MEMBERS:

A. Board members shall have no authority except when functioning as a member of the Board at an official meeting, or when appointed by the Board to carry out a specific delegation of authority. Except as set forth above, individual Board members have no authority to act for or on behalf of TCRHCC.

B. No individual member of the Board may attempt to exercise authority with respect to the operation of the Corporation or the hospital by virtue of his or her status as a member of the Board of Directors.

SECTION 4: DEFINITIONS --

A. Board: Board shall mean the Board of Directors of TCRHCC which may be referred to in these Bylaws as "Board" or "BOD."

B. Director: Director shall mean a duly qualified, appointed and currently serving member of the Board of Directors of TCRHCC. Directors may be referred to in these Bylaws as "members."

C. Non-profit Corporation: Non-profit corporation shall mean a corporation organized pursuant to the Navajo Nation Corporation Code, 5 N.N.C. §§ 3301 – 3332, no part of the income or profit of which is distributable to its members, directors or officers.

D. Agent: Agent shall mean a person, who is not an employee, authorized by TCRHCC to act on TCRHCC's behalf or who is entrusted with the business of TCRHCC.

E. Compensation: Compensation shall mean anything of value received as payment.

F. Emergent issues: Emergent issues shall mean such business of TCRHCC that arises unexpectedly and requires immediate action in order to protect lives, TCRHCC property or the interests of TCRHCC.

G. Consensus: Consensus shall mean a unanimous collective opinion, agreement or general accord.

H. Duly Called Meeting: Duly called meeting shall mean a meeting called in strict compliance with the procedures stated in these Bylaws.

I. Conflict of Interest: Conflict of interest shall mean any situation in which a Director's personal, economic interest or increase thereof may affect that Director's official decisions or action on behalf of the TCRHCC. A conflict of interest arises when the person takes action in his or her official capacity on matters in which (s)he, or a member of his or her immediate family has a personal, monetary or proprietary interest. Personal, monetary or proprietary interests include the interests of the immediate family members of the Director or anyone residing with the Director. Conflict of Interest may be defined further in the Board's Code of Conduct. If there is a perceived inconsistency between the definition of Conflict of Interest in these Bylaws and the definition in the Code of Conduct, the more restrictive definition shall apply.

J. Immediate Family: Immediate family shall mean a Director's spouse, father, stepfather, mother, stepmother, daughter, stepdaughter, son, stepson, sister, stepsister, half-sister, brother, stepbrother, half-brother, father-in-law, mother-in-law, daughter-in-law, son-in-law, grandfather, grandmother, grandchild, niece, nephew, and first cousin. This term shall also include all persons actually residing within the household or traditional homestead of the Director.

K. Nepotism: Nepotism is favoritism shown to immediate family especially in appointments to positions of employment. Anti-nepotism policies generally require that a person take no official action that will treat the official's immediate family differently than any other person in making employment decisions and often prohibit supervision of an immediate family member by immediate family. Nepotism may be defined further in the Board's Code of Conduct. If there is a perceived inconsistency between the definition of Nepotism in these Bylaws and the definition in the Code of Conduct, the more restrictive definition shall apply.

SECTION 5: NUMBER OF DIRECTORS -- The number of Directors constituting the Board shall be no more than ten (10). The Board shall strive to ensure that the Board consists of one (1) member representing each of the eight (8) Navajo Nation Chapters within the TCRHCC service area; one (1) member representing the Hopi Village of Moenkopi; and one (1) member representing the San Juan Southern Paiute Tribe. Vacancies in any position, or failure of the Board to have representatives from the localities described in the preceding sentence shall not, in itself, render null, void or ultra vires any action of the Board. An individual is considered to be eligible for representing one of the eight Navajo Nation Chapters or the Hopi Village of Moenkopi or the San Juan Southern Paiute Tribe only if

said individual is a voting member of the particular Navajo chapter, Hopi Village of Moenkopi or of the San Juan Southern Paiute Tribe. An individual seeking appointment to the Board of Directors must provide proof that he or she is a voting member of such chapter or community and an enrolled member of a federally recognized Indian tribe.

SECTION 6: QUALIFICATIONS -- Directors shall meet the following qualifications:

A. Every Director must be an enrolled member of a federally recognized Indian Tribe.

B. No current tribal, state, county or nationally elected or appointed official shall serve on the Board.

C. No Director applicant shall have a felony conviction within twenty years prior to the date of his or her application for appointment to the Board. No Director applicant shall have a misdemeanor conviction involving elements of fraud, concealment, misrepresentation, embezzlement or theft by deception within twenty years prior to the date of his or her application for appointment to the Board. Directors must successfully pass a reference and background check, fingerprint check, and drug screening, as more fully set forth in the Selection of the Board of Directors Policy, as required by P.L. 101-630. For purposes of this provision, "conviction" includes pleas of "guilty" or "no contest." An acting Director who is convicted of any crime described herein while serving as a Director shall notify the Board of said conviction and shall automatically be removed from the Board as of the date of the conviction, with no further action or notice required.

D. The Board shall strive to appoint Directors from different fields and backgrounds, including, but not limited to, health care delivery, law, financing, and education. The Board shall make appointments with a goal of diversity and to help ensure the overall success of the TCRHCC.

E. No more than one immediate family member (as defined in Article II, Section 4.J. and Article VI, Section 1.B. of these Bylaws) shall serve simultaneously as a Director.

F. No Director shall be eligible to apply for employment with the TCRHCC for a period of six (6) months following the relinquishment of his or her position as a Director.

G. Director applicants shall be more than 21 years of age as of the date of appointment.

H. Every Director shall have a commitment to the delivery of quality health care to the community and the fulfillment of the purpose of these Bylaws.

I. Every Director shall meet the requirements of the Selection of the Board of Directors' Policy.

J. Every Director shall comply with these Bylaws and the Board's Code of Conduct.

SECTION 7. VACANCIES -- Vacancies, caused by end of the term of office, or by death, illness, resignation or removal of a Director or failure of the Board to timely appoint a candidate for a vacant position, shall be filled in accordance with these Bylaws. Persons filling vacancies shall serve until the expiration date of the term of the Director they replace. The Board shall fill any vacant Director positions by a majority vote of the Board and in accordance with the Selection of the Board of

Directors' Policy. The Board will consider recommendations from the Navajo Nation Chapters within the TCRHCC service area, the Moenkopi Village government and the San Juan Southern Paiute Tribal Council; however, these recommendations shall not be binding on the Board in making its appointments.

SECTION 8: TERM OF OFFICE – For those Directors that were elected in 2011 or before, the term of the Director shall be for three (3) years and shall be staggered in such a manner in which to allow for the selection of not more than four (4) total Directors in each year. The Directors' term, whose term of office commenced in 2011 or before, shall commence on October 1st and shall expire on September 30th, three (3) years from the commencement date, regardless of the date in which a Director takes the Oath of Office. It is intended that whenever possible the Oath of Office shall be administered to all new Directors prior to the October 1st commencement of office. However, as for those Directors whose term shall start in 2012 forward, the term of office shall be for four (4) years and shall be staggered in such a manner in order to allow for the selection of not more than four (4) total Directors in each year. The term of office shall commence on October 1st and shall expire on September 30th, four (4) years from the commencement date, regardless of the date in which a Director takes the Oath of Office. In the event that no successor has been appointed at the expiration of a Director's term, the Director's term shall be extended with no further action or notice required and the Director shall serve until his or her successor has been appointed and has taken the oath of office. It is intended that whenever possible, the Oath of Office shall be administered to all new Directors prior to the October 1st commencement of office date.

SECTION 9: RESIGNATIONS -- Any Director may resign at any time by delivering a written resignation to the President of the Board. Such resignations shall be effective upon receipt of the letter by the Board President. If the resigning Director also serves as the President and is resigning from both the Board and his or her Office, the President may resign at any time by delivering a written resignation to the Board and shall be effective upon receipt of the letter by the Board. The Board is not required to approve, accept, or take other action in order for a written resignation to become effective upon receipt. If a Board member declines to deliver a written resignation, the Board member may resign by announcing such resignation on the record, to be included in the minutes of any Duly Called Meeting. The Board is not required to approve, accept, or take other action in order for the announced resignation to become effective upon the resigning Board member's announcement.

SECTION 10: REMOVAL -- A Director may be removed from office at any Duly Called Meeting by a vote of two-thirds of the total number of Directors then seated on the Board. The Director being considered for removal shall not vote and shall not be counted for purpose of determining how many Directors are then seated and how many votes constitute a two-thirds vote. A Director may be removed on the following grounds:

A. Neglect or violation of the standards of conduct and/or fiduciary duties, including the duties of care and loyalty, to the TCRHCC, including, but not limited to, those standards and duties described in the Bylaws, the Code of Conduct, or the Oath of Office; or

B. Missing three (3) consecutive Official Board Meetings without being excused in advance by the Presiding Officer for good cause.

SECTION 11: TRANSFER OF MEMBERSHIP -- Directorship in the Board is not transferable or assignable. Directorship may only be obtained in accordance with the provisions of these Bylaws.

SECTION 12: COMPENSATION – Directors shall not receive compensation for their services as Directors, except that, by resolution or by Board approved policy of the Board of Directors, Directors may receive a fee in addition to expenses for attendance at meetings or for carrying out the business of the TCRHCC, and may include costs of travel for attendance. The Board shall adopt a separate policy governing payment of the fee and travel costs.

ARTICLE III
MEETINGS OF THE BOARD

SECTION 1: OFFICIAL MEETINGS --

A. Monthly Meetings: Monthly Meetings of the Board shall be held at such times and places as determined by the Board in an action of record, a quorum being present, except that Monthly Meetings of the Board shall be held on the third Thursday of each month. Written notice shall be provided to each Director not less than twenty-four (24) hours prior to the date of the meeting. Written notice may be given in any form reasonably calculated to provide actual notice of the meeting to the Director. Receipt of actual notice by the Director or attendance at the meeting shall constitute a waiver of the technical requirements of notice pursuant to these Bylaws.

B. Credentialing Meetings: Credentialing Meetings of the Board may be called at the request of the President, or upon the written request of any two (2) other Directors, at any time, stating the purpose for which the meeting is called. Notice shall be given to all Directors of such Credentialing Meeting, fixing the time and place of the meeting and giving a statement of the purpose for which the meeting is called. Notice of such a Credentialing Meeting shall be given by telephone and by such written or electronic form as will provide each Director with the greatest opportunity for attendance.

Telephonic participation in Credentialing Meetings is not allowed and meeting stipends will not be paid to those attempting telephonic participation, unless there are other non-credentialing issues placed on the agenda. If there are other non-credentialing issues on the agenda, Directors can participate telephonically and receive a meeting payment.

If there are issues beyond credentialing considered at a Credentialing Meeting, then all may participate by telephone or in person. All participants in a Credentialing Meeting where there are matters in addition to credentialing considered, will receive a meeting payment at a special meeting rate of $150.00 or as it may be adjusted. If it is solely a meeting

for credentialing, there is no telephonic participation allowed or meeting payment to those not present and actually participating in person.

C. Quality Team Special Meeting: On a regular basis, but in no event not less than quarterly, the full Board shall meet as the Quality Team for the purpose of collaborating with hospital Administration/Medical Staff to maintain an active review of the provisions of health care at TCRHCC and to ensure that the Board is fulfilling its ongoing responsibility to effectively manage the quality and safety of health care at TCRHCC. To achieve this goal, the Board of Directors desires to meet for a review and discussion of quality care and performance on a regular, ongoing basis. The Board of Directors, acting as the Quality Team, shall, among other things, receive ongoing information and reports from the Administration/Medical Staff and shall review and monitor patient information, review and assess quality outcomes, monitor patient satisfaction surveys and reports, review patient complaints, review facilities management reports, and receive other information to assist in assessing and managing overall patient care and patient satisfaction. Additionally, the Board of Directors, as the Quality Team, shall receive and review ongoing TCRHCC safety management reports, all in accordance with the Board of Directors' statement of purpose and work for the Quality Team.

D. Annual Meetings: An Annual Meeting of the Board shall be held in November each year. At the Annual Meeting, the Board of Directors shall receive the Annual Report of TCRHCC, including an update on its activities, financial status, and review of the Annual Patient Safety report. At this meeting, the Directors shall also elect Officers and transact such other business as may come before the Board. Written notice of this meeting shall be given to all current Directors no later than ten (10) days prior to the meeting date. Written notice may be given in any form reasonably calculated to provide actual notice of the meeting to the Director. Receipt of actual notice by the Director or attendance at the meeting shall constitute a waiver of the technical requirements of notice pursuant to these Bylaws.

E. Special Meetings: Special Meetings of the Board may be held at such times and places as determined necessary by the Board President, or in the absence of the Board President, by the Board Vice President. The full Board may also elect to hold a Special Meeting by the majority vote at a monthly meeting of the Board. Written notice shall be provided to each Director of the Special Board Meeting not less than 24 hours prior to the date of the meeting. Notice may be given in any form reasonably calculated to provide actual notice of the meeting to the Directors. Receipt of actual notice by the Director or attendance at the Special Meeting shall constitute a waiver of the technical requirement of notice pursuant to these Bylaws.

F. Emergency Meetings: In the event of a true emergency, as determined by the President or the Executive Board through a majority vote, the Board may hold an emergency meeting and waive the 24 hour notice requirement to the members of the Board of Directors. In the event that the Board of Directors finds that an emergency exists and waives the 24 hour notice requirement, such notice as is practicable shall be provided to the Directors prior to the emergency Board meeting. Notice of the emergency

Board meeting shall be given in any form reasonably calculated to provide actual notice of the meeting to the Directors. Receipt of actual notice by the Director or attendance at the meeting shall constitute a waiver of the technical requirements of notice pursuant to these Bylaws.

SECTION 2: QUORUM -- A majority of the Directors then seated shall constitute a quorum for the transaction of business.

SECTION 3: EXECUTIVE SESSION -- The Board may meet in Executive Session during a part of any meeting by majority vote to consider matters of a sensitive or confidential nature including, but not limited to, personnel issues, legal issues, and sensitive negotiations. Executive Sessions are confidential. It is a violation of these Bylaws for any Board Member to disclose or discuss anything stated in or related to Executive Session with a person not present at such Executive Session and a Board Member may be removed for disclosing Executive Session material. The Board may not vote or take final action in Executive Session, except that the Board may direct its attorney and other representatives regarding the Board's position regarding legal matters, litigation, negotiations, settlements, and similar matters.

SECTION 4: NOTICE OF MEETINGS -- A Notice of each Board meeting shall be provided to each Director at the times stated in these Bylaws. Actual attendance of a Director at a meeting of the Board shall constitute a waiver of the technical requirements of notice pursuant to these Bylaws.

SECTION 5: CONDUCT OF MEETINGS -- All meetings of the Board shall be conducted in accordance with the general principles of the then current version of Robert's Rules of Order, except if those Rules are in conflict with these Bylaws, the Bylaws shall govern. The Board, by consensus and without express approval, may proceed informally rather than in strict accordance with Robert's Rules of Order. The failure of the Board to comply with Robert's Rules of Order shall not, in itself, render null, void or ultra vires any action of the Board.

SECTION 6: AGENDA -- The procedure for development of the Agenda for Board meetings shall be as follows:

A. Each Monthly Board Meeting Agenda shall include a provision for public comment on business related to the Corporation. This portion of the agenda shall not be used to receive comments from TCRHCC employees.

B. Any employee of the TCRHCC or community member wishing to add an item to the Monthly Board Meeting Agenda shall submit the item to the Chief Executive Officer.

C. The Chief Executive Officer shall determine which proposed Monthly Board Meeting Agenda items submitted by employees or community members shall be sent to the Executive Committee for its review. The Chief Executive Officer shall inform the Executive Committee of any items not submitted.

D. The Agenda for each Monthly Board Meeting shall be developed by the Executive Committee of the Board not less than ten (10) days prior to the Monthly Board Meeting. The Monthly Board Meeting Agenda shall be

subject to the final approval of the Board by vote at the beginning of each Monthly Meeting.

E. Any Board meeting Agenda may be amended by a majority of the Directors prior to its approval. Items may be deleted and the order of items to be considered may be changed; items may not be added without majority consent of all seated Directors.

F. Monthly Board Meeting Agendas need only include: roll call, approval of the agenda, review and approval of the minutes of previous meeting(s), President's Report, Chief Executive Officer's Report, any other reports by Board Committees or staff, and approved community/employee comments.

G. Draft Monthly Board Meeting Agendas will be available to the public via the TCRHCC website or upon request to the TCRHCC administration office, at least 24 hours in advance of the meeting or as soon thereafter as possible.

SECTION 7: MANNER OF ACTING AND VOTING -- All actions of the Board shall be of record, whether determined by formal resolution or by majority vote in a duly called meeting of the Board or by delegation of authority to the Executive Committee of the Board regarding emergent issues only. Where there is evident consensus of the Directors present at such meeting on a particular issue, the President may declare a decision by consensus unless a call is made for a vote on the record, on a point of order by one of the Directors.

SECTION 8: PUBLIC ATTENDANCE AT MEETINGS -- All meetings of the Board shall be open to the public, except during any Executive Session, and shall be held in facilities which should accommodate public attendance. Members of the public shall be given at least five (5) minutes per person to express their concerns about an issue on the agenda, and the Board may elect to take action, based on such public input, on any issues which the Board has already discussed or taken action on, by a two-thirds (2/3) majority vote to reconsider that issue. The Presiding Officer may end the public comments section of the meeting if public comments become, in the judgment of the Presiding Officer, repetitive or harassing or if such action is needed to allow time to complete the business of the Board.

SECTION 9: EXECUTIVE COMMITTEE -- As provided below in Article V, the Board may delegate authority to an Executive Committee comprised of the President, Vice President, and Secretary/Treasurer of the Board to make decisions on behalf of the Board on emergent issues requiring a decision of the TCRHCC between Board meetings. Such decision shall be reported to the Board at its next meeting, and shall be subject to review and/or reversal where feasible if, by a two-thirds majority vote of the Directors then seated, the Board does not agree with the decision made.

SECTION 10: MINUTES --

A. A record shall be kept of all actions of the Board. Minutes of Board actions must be approved by majority vote of the Board at a subsequent Official Meeting.

B. Minutes shall record: The date, time, place of meeting and adjournment; the attendance of Board and other participants; the agenda adopted; and

the motion and second of any actions, the content of the action, the tally of the votes taken or the declaration of a consensus by the Presiding Officer of the meeting.

C. Minutes shall not be taken of discussion in Executive Session.

D. Minutes need not reflect the discussion preceding any action nor the names of individuals contributing to the discussion of an action. Minutes shall not include proprietary information of the TCRHCC.

E. Draft minutes are to be disseminated to the Board seven (7) days before the next Monthly or Annual Board Meeting.

F. Once approved by the Board, the Board President will sign the Minutes in black ink. Minutes of all meetings shall be kept in chronological order and available for public inspection at the principal Administrative offices of TCRHCC.

ARTICLE IV
OFFICERS OF THE BOARD

SECTION 1: OFFICERS -- The Officers of the TCRHCC Board of Directors shall consist of a President, Vice President, and a Secretary/Treasurer.

SECTION 2: QUALIFICATIONS -- Any Director is eligible to serve as an Officer of the TCRHCC Board.

SECTION 3: SELECTION -- The Officers of the TCRHCC shall be selected by the Directors at the Board's Annual Meeting. Any Director may nominate himself or herself or be nominated by any other Director for any Officer position. If only one Director is nominated for an Officer position, that Director will be deemed selected for the position. If more than one Director is nominated for an Officer position, a vote by private written ballot shall be held. Nominated Directors may vote. The Director who receives the most votes of the Directors voting shall be deemed selected for the position.

SECTION 4: RESIGNATION --

A. The President may resign by submitting written notice of resignation to the Board and such resignation shall be effective on the date of the next meeting of the Board or on such later date specified in the notice.

B. The Vice President and Secretary/Treasurer may resign at any time by giving written notice to the President, and such resignation shall be effective on the date of the next monthly meeting of the Board or on such later date specified in the notice.

C. The Board is not required to approve, accept, or take other action in order for a written resignation to become effective. If an Officer declines to deliver a written resignation, the Officer may resign by announcing such resignation on the record, to be included in the minutes, of any Duly Called Meeting. The Board is not required to approve, accept, or take other action in order for the announced resignation to become effective upon the resigning Officer's announcement. Resignation of a Director from Office does not otherwise affect that Director's membership on the Board.

SECTION 5: REMOVAL -- Any Officer may be removed from Office, with or without cause, upon a vote of two-thirds of the total number of Directors then seated on the Board. The Officer being considered for removal shall not vote and shall not be counted for purpose of determining how many Directors are then seated and how many votes constitute a two-thirds vote. Removal of a Director from Office does not remove that Director from membership on the Board.

SECTION 6: VACANCIES -- A vacancy in any Office, because of death, resignation, removal, disqualification or for any other reason, may be filled by a majority vote of the Board at any meeting for the unexpired portion of that term.

SECTION 7: DUTIES AND RESPONSIBILITIES-- The duties and responsibilities of the Officers of the TCRHCC Board shall include, but not be limited to, the following:

A. PRESIDENT. The duties and responsibilities of the President shall be to:

1. Preside at all meetings of the Board and serve as an ex-officio member of all committees of the Board, other than the Executive Committee.
2. Exercise general supervision, on behalf of the Board, of the activities of the Chief Executive Officer.
3. Represent the Board in dealing with the governmental entities of the Navajo Nation, other Indian Nations, State and Federal governments and other outside entities, and shall speak for the Board in these settings as authorized by the Board and/or Executive Committee.
4. Serve as the signatory of the Board where Board authority is required, on such business instruments as may be needed to carry out the purpose of TCRHCC, including but not limited to, policies, minutes, funding, contracts, credential files, grants, and applications therefor; employment contracts; major procurement documents; promissory notes, bonds, debentures, deeds of trust, mortgages, pledges, and the like.
5. Carry out such other corporate powers and duties as the Board may delegate from time to time.
6. Delegate duties to other Officers or Directors as appropriate.

B. VICE PRESIDENT. Duties and responsibilities of the Vice President shall be to:

1. In the absence of the President or in the event of his or her inability or refusal to act in a situation where action is required for the protection of TCRHCC's interests, perform the duties of the President and, when acting, shall have all the powers and duties of, and shall be subject to all the restrictions upon, the President.
2. Assume such other powers and duties as may be assigned from time to time by the President or the Board.

C. SECRETARY/TREASURER. Duties and responsibilities of the Secretary/Treasurer shall be to:

1. Chair the Finance Committee.
2. Provide oversight and guidance by keeping complete and accurate records of financial operations.
3. With the assistance of the Chief Financial Officer, provide reports and recommendations to the Board regarding the financial status of the Corporation.
4. Perform such other powers and duties as may be assigned from time to time by the President or the Board.
5. Ensure that accurate minutes of meetings are taken, recorded and approved and that copies of final approved minutes or resolutions are maintained in the corporate records.
6. Attend to all correspondence and perform all duties incident to the office of Secretary/Treasurer.

ARTICLE V
COMMITTEES OF THE BOARD

SECTION 1: ESTABLISHMENT OF COMMITTEES -- The Board shall authorize the establishment of committees, including standing or special committees, appointments thereto, and the authorities and duties of such committees for such time periods as it deems necessary in order to conduct its business efficiently.

SECTION 2: AUTHORITY --

A. Committees of the Board shall only have the authority to make recommendations to the Board, unless otherwise specified herein or by the Board when a committee is created.
B. No committee of the Board shall have authority to amend the Articles of Incorporation or Bylaws of TCRHCC, to initiate a voluntary dissolution of the TCRHCC, or to overturn any action of the Board itself.
C. Delegation of authority to a committee and information, reports, or recommendations received from such committee shall not operate to relieve the Board itself or any individual Director of any responsibility imposed by law.

SECTION 3: APPOINTMENT TO COMMITTEES -- The Board shall, by a majority vote, appoint members of each committee. Membership on committees shall include only current Directors. However, TCRHCC staff may also be asked, as appropriate, to assist a Committee in an informal, non-voting capacity.

SECTION 4: VACANCIES -- The Board shall, by a majority vote, fill vacancies on the committees of the Board as soon as possible after the vacancy arises, subject to review and approval by a majority of the Board.

SECTION 5: QUORUM AND VOTING -- A Quorum is the simple majority of seated committee members. The action of a majority present at any meeting, a quorum being present, shall be the act of the committee.

SECTION 6: RULES -- Each committee may adopt rules for the conduct of its business so long as they are consistent with these Bylaws or Robert's Rules of Order. Unless

otherwise specified in these Bylaws, the members of each committee shall elect their own chairperson.

SECTION 7: STANDING COMMITTEES -- There shall be at a minimum the following standing committees, provided, however, that the Board may from time to time appoint and dissolve other standing committees as needed:

A. Executive Committee: The Executive Committee shall meet and act only on such emergent issues as is required to be conducted between Monthly Meetings of the Board. The Executive Committee shall also be authorized to carry out such additional duties as may be assigned or instructed by the Board. The Executive Committee shall be chaired by the Board President and comprised of all three (3) Board Officers.

B. Finance Committee: The Secretary/Treasurer of the Board shall serve as the Chair of the Finance Committee. The Finance Committee will be comprised of the Secretary/Treasurer and three (3) additional Directors, one (1) other Director who shall serve as an alternate and the Chief Financial Officer, ex officio. The alternate member shall vote only if a regular member is absent. The Finance Committee shall provide oversight of TCRHCC finances and shall make recommendations to the Board of Directors regarding the financial status of TCRHCC. The Finance Committee shall also oversee the audit process for TCRHCC.

C. Joint Conference Committee (Board Members): The Board shall, at its Annual Meeting, appoint three members who, if necessary, shall join together with three members selected by the Chief of Staff to form a Committee called the Joint Conference Committee. In addition to selecting three members to a possible Joint Conference Committee, the Board shall also select an alternative Board member to the Committee, who shall act in the absence of one of the Committee members. In the event a request for a Joint Conference Committee is called, pursuant to the Medical Staff Bylaws, these three Board members shall join together with three members selected by the Chief of Staff from the MEC for the creation of a six person Joint Conference Committee. This Joint Conference Committee shall review disagreements that may arise between the MEC and the Board about the Medical Staff Bylaws, Credentialing/Privileging, adverse action recommendations, policies, or other issues set forth in the Bylaws of the Medical Staff, Article XII. The Joint Conference Committee is not a standing committee, but the Board will appoint Board membership to this Committee in the event that this Committee is called for, in accordance with the Medical Staff Bylaws. In the event a Joint Conference Committee is called into being, the six Committee members will attempt to reach consensus on any disputes and shall submit their recommendations, within thirty (30) days following the appointment of the Committee, to the full Board.

SECTION 8: SPECIAL COMMITTEES -- The Board may establish such Special Committees as it deems necessary from time to time. In doing so, it shall specify the duties of each such committee, determine the time period for that committee's existence and performance of its duties, and approve appointments to that committee.

ARTICLE VI
CONFLICT OF INTEREST AND NEPOTISM

SECTION 1: DUTY OF DISCLOSURE -- When a conflict of interest arises for any Director in the course of TCRHCC business, that person or anyone who is aware of the conflict has an affirmative obligation to declare the conflict immediately for the record. Such conflicts may be declared at any point in a Board or Committee meeting, but should be disclosed as early as possible in the meeting.

A. All TCRHCC Directors shall complete a disclosure form that specifies any potential conflicts of interest.
B. On an annual basis each Director shall update a disclosure form to include any changes regarding the conflict of interest.
C. In recognizing the high ethical standards expected of any Director, a Director will not engage in any effort to achieve personal gain through appointment as a Director, other than the compensation or benefits provided by TCRHCC and the Director shall make all decisions solely on the basis of promoting the best interests of TCRHCC. Therefore, the Director shall avoid actual or potential conflicts of interest, as well as the appearance of a conflict of interest, and the Director shall promptly report to the President of the Board any situation in which the Director reasonably believes that he or she may be or may become involved in a conflict of interest or an appearance of conflict of interest, whether or not such situation is specifically described in these Bylaws. The President shall report such situations to the Board as a whole.

SECTION 2: ABSTENTION FROM FURTHER INVOLVEMENT -- Upon the discovery or determination of a conflict of interest or a likely potential conflict of interest or the appearance of a conflict of interest on the part of any Director, the individual involved shall abstain from any further involvement in, discussion of, or attempt to influence the decisions of the Board or Committee or other actions of the TCRHCC, whether directly or indirectly, with regard to the matter from which the conflict arises. Further, the Director shall leave the room where the Board is discussing the matter giving rise to the conflict of interest until such time as the discussion and action ends.

TCRHCC has not adopted an Anti-Nepotism policy. However, any Director who votes on the employment of an immediate family member despite having a conflict of interest or votes on any item that may result in personal gain will be considered in violation of these Bylaws and the Code of Ethics for Board members and may be subject to sanctions including without limitation removal from the Board.

SECTION 3: CHALLENGE -- Any person present, or any member of the Board may inquire whether a Director has a conflict of interest or a likely potential conflict of interest in the matter(s) under consideration. In the event that it is determined by the Board by majority vote that a Director appears to have a conflict of interest or a likely potential conflict of interest as defined in these Bylaws, the President shall request that the Director abstain from any participation in the matter(s) under consideration. In the event the President is the Director in question, the Vice-President shall request that the Director abstain.

SECTION 4: CONCEALMENT OR FAILURE TO ABSTAIN -- Willful concealment of a conflict of interest on the part of any Director or failure to abstain where a conflict exists shall be grounds for removal from the Board for cause.

SECTION 5: REQUEST FOR GUIDANCE -- In the event that a Director is in doubt regarding whether he or she has a conflict of interest or a potential conflict of interest in any matter up for discussion by the Board, that Director may request guidance from the general counsel to the TCRHCC who shall respond as promptly as possible under the circumstances. A Director shall be permitted to reasonably rely on any such legal advice in determining whether he or she has an actual or potential conflict of interest.

SECTION 6: CODE OF CONDUCT: The Board has adopted a Code of Conduct which includes provisions dealing with conflicts of interest. Nothing in these Bylaws shall limit the application of those provisions. If there is a perceived inconsistency between the provisions regarding Conflict of Interest in these Bylaws and the Code of Conduct, the more restrictive provisions shall apply.

ARTICLE VII
BOOKS AND RECORDS

SECTION 1: LOCATION -- There shall be maintained in the principal Administrative Offices of TCRHCC all financial books and records of accounts, all minutes of the Board, Executive and other committee meetings of the TCRHCC, and copies of all materials, corporate records, books, documents and contracts.

SECTION 2: AVAILABILITY -- The Board shall have access to books, records, minutes, documents, contracts and documents evidencing compliance issues. These documents shall be made available for inspection at any reasonable time during usual business hours by any Director or a duly-authorized representative thereof for a lawful purpose. The Board shall maintain the confidentiality of any confidential or proprietary information that it accesses. The Board does not have access to records and documents regarding personnel, patients' names and/or health records.

ARTICLE VIII
INDEMNIFICATION OF DIRECTORS AND OFFICERS

SECTION 1: INDEMNITY -- TCRHCC shall indemnify any Director and/or Officer against reasonable expenses actually and necessarily incurred by such person who was or is a party, or is threatened to be made a party to any threatened, pending or completed civil or administrative action, suit or proceeding, or as a result of an investigation by a federal, state or tribal government agency, by reason of the fact that such person is or was a Director and/or Officer of the TCRHCC provided that:

A. Such person acted in good faith and in a manner such person reasonably believed to be in, or not opposed to, the best interests of the TCRHCC; and

B. Such person did not act, fail to act willfully or with gross negligence or with fraudulent or criminal intent; and

C. Any legal fees paid (arrangements for representation and legal fees must be discussed with the Chief Executive Officer and general legal counsel to TCRHCC and evaluated for reasonableness before they are incurred) or any settlements made are reasonable;

D. The person seeking indemnification did not act beyond the scope of his or her office; and

E. The person seeking indemnification did not initiate, directly or indirectly, the action, suit or proceeding for which he or she is seeking indemnification.

The Chief Executive Officer, after first consulting with the general counsel of the TCRHCC, shall recommend to the Board whether any request for reimbursement should be approved; provided, indemnification of any Director shall solely be determined by the Board in accordance with these Bylaws. A request submitted by the then current Chief Executive Officer shall be reviewed and approved by the Board, after first consulting with the general counsel of the TCRHCC, and the Board's decision shall be final.

SECTION 2: INSURANCE -- By action of the Board, notwithstanding any interest of the Directors in the decision to purchase and maintain insurance, the TCRHCC shall purchase and maintain insurance, in such amounts as the Board deems appropriate, on behalf of any person who is or was a Director and/or Officer of the TCRHCC, or is or was serving at the request of the TCRHCC Board as a Director and/or Officer of another corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against such a person and incurred by such a person in any such capacity, or arising out of that person's status as such, whether or not the TCRHCC has the power or would be required to indemnify that person against such liability under the TCRHCC Articles of Incorporation or these Bylaws.

SECTION 3: NO THIRD PARTY RIGHTS -- Nothing in these Bylaws, express or implied, is intended or shall be deemed to create or confer upon any third party any rights or remedies, including without limitation the right to enforce the terms hereof, under or by reason of these Bylaws.

ARTICLE IX
DISSOLUTION OF THE CORPORATION

SECTION 1: DISSOLUTION -- Any voluntary decision to dissolve the TCRHCC must be made by a two-thirds (2/3) majority vote of the seated Board of TCRHCC.

SECTION 2: PROCEDURE -- TCRHCC shall immediately cause notice of the dissolution to be mailed to each known creditor of TCRHCC; shall proceed to collect its assets, convey and dispose of its properties as allowed by law; shall pay, satisfy and discharge its liabilities and obligations and do all other acts required to liquidate its business and affairs; and, after paying or adequately providing for the payment of all its obligations, shall distribute the remainder of its assets as allowed by applicable law.

ARTICLE X
AMENDMENTS TO THE BYLAWS

SECTION 1: AMENDMENT -- These Bylaws may be amended only by the affirmative vote of not less than two-thirds (2/3) of the seated Board.

SECTION 2: NOTICE -- All members of the Board shall be given twenty-one (21) days advance written notice of any proposed amendments to the Bylaws, in the manner provided herein for notice, and the notice shall include a complete copy of the proposed amendments. The requirement for twenty-one (21) days advance notice of any proposed amendments may be waived if all seated Directors agree to such waiver in writing. Bylaws may be amended at any Official Meeting, provided that proper notice is given.

TUBA CITY REGIONAL HEALTH CARE CORPORATION (TCRHCC)
TUBA CITY, ARIZONA

SUBJECT: BOARD OF DIRECTORS TRAVEL POLICY FOR BOARD AUTHORIZED TRAVEL

I. Purpose:

The purpose of this policy is to document and monitor travel activity of the Governing Board and to provide an effective and efficient travel policy for Board authorized travel.

II. Policy:

Service as a Director of the Tuba City Regional Health Care Corporation (TCRHCC) is a public trust and Directors have a duty to conserve the financial resources of TCRHCC in order for TCRHCC to fulfill its mission and goal of providing the highest quality medical services available to its patients and the TCRHCC service area. Therefore, Directors shall only undertake travel at TCRHCC expense when it is approved and when it is essential to the interests of TCRHCC. Director travels shall use the most economical means reasonably available for such travel. A Director traveling on official business is expected to exercise the same care in incurring expenses that a prudent person would exercise if traveling on personal business. Excess costs, circuitous routes, delays or luxury accommodations and services unnecessary or unjust in the performance of official business shall not be approved nor reimbursed under this travel policy. Directors will be responsible for excess costs and all additional expenses incurred for personal preferences or convenience that was not prior approved as set forth in this policy.

III. Procedures:

A. General:

1. Use of GSA/Corporate Vehicles:

a. Directors shall make use of safe, reliable and well-maintained GSA/Corporate Vehicles for official Board travel if said vehicles are reasonably available.

b. Prior to any use of the GSA/Corporate Vehicles, Directors must provide TCRHCC with a copy of a valid driver's license, a copy of their personal vehicle insurance policy and a three-year good driving record. This information must be updated annually by the Director and shall be kept on file with the CEO's Administrative Assistant.

c. Failure to provide the information set forth in (b) above shall render the Director ineligible to use a GSA/Corporate Vehicle for official Board travel.

d. Actual gasoline expenses for GSA/Corporate Vehicle shall be paid by use of a TCRHCC gasoline credit card.

e. When a TCRHCC credit card is used for gasoline expenses for the GSA/Corporate Vehicle, the Director shall keep copies of all gasoline receipts and shall provide these receipts to the CEO's Administrative Assistant for review and record keeping.

f. Use of the GSA/Corporate Vehicle shall only be for official Board travel to and from the meeting/conference/event.

2. Use of a Director's Personal Vehicle:

a. When a TCRHCC GSA/Corporate Vehicle is not available or when approved by the Board President, a Director may use his/her personal vehicle for official Board travel. In which case the driver of the vehicle shall receive mileage reimbursement based on the existing U.S. Government Published Federal Travel Regulations rate.

b. When a TCRHCC GSA/Corporate Vehicle is available and a Director, nonetheless, elects to use his/her personal vehicle for official Board travel, the Director so electing to use his/her personal vehicle shall receive only one-half the mileage reimbursement based on the existing U.S. Government Published Federal Travel Regulations Rate. If more than one Director travels in a personal vehicle under these circumstances, only the driver shall receive the limited mileage reimbursement established herein.

c. If more than one Director is traveling to the same location for TCRHCC business, the Director shall carpool in order to save travel costs for TCRHCC. Only the driver of the vehicle will be reimbursed for the mileage.

d. If it is less expensive to travel by air than the cost of mileage plus associated travel costs for use of a personal vehicle, then the driver will be reimbursed only for the lesser of the cost of the mileage or the cost of the air fare.

e. Travel must be by the most expeditious means of transportation practicable considering energy conservation, the cost of per diem,

the actual transportation costs, the total distance traveled, number of points visited, and number of travelers traveling together.

f. The route of travel will be the most direct route based on uninterrupted travel. Any additional costs associated with deviations from the most direct route shall be borne by the Director.

g. Mileage reimbursement shall be paid based on actual mileage taken from an odometer reading to and from the meeting using the most direct route. However, such reimbursement shall not exceed the reimbursement that would be paid for map mileage plus ten (10%) percent of map mileage using the most direct route.

h. Normally it is expected that the Director will be traveling to and from his/her Chapter residence. However, in the event that the Director is traveling from a location (either to and from) **that is not** the Director's Chapter residence then the Director will be reimbursed only for the lesser of the mileage reimbursement rate to and from the Director's Chapter residence or the mileage reimbursement to and from the actual location where the Director commenced travel to the business event. In other words, if the Director is a resident of the Cameron Chapter but is traveling to a business meeting in Phoenix from his/her summer residence in Utah, the mileage reimbursement rate will be to and from his/her Cameron residence. On the other hand, if the Director is traveling to a meeting in Phoenix from his/her temporary residence in Glendale, the mileage reimbursement will be from Glendale. In no event shall mileage reimbursement be paid for greater than the round trip mileage reimbursement from the Director's Chapter residence.

3. Air Fare:

a. If it is determined by the President of the Board of Directors that it would be less expensive to travel by air than the cost of mileage plus associated travel costs or use of a personal vehicle/GSA/Corporate Vehicle then the Board President shall authorize that the Director may travel on official business using a commercial air carrier and said Director shall use coach class airline accommodations.

b. Director must submit a travel itinerary and airline costs quote to the President of the Board of Directors and receive prior approval from the President of the Board of Directors prior to purchasing airline tickets.

c. If after travel arrangements are made and an airline ticket is issued, the Director chooses to make changes to these travel arrangements and/or ticket, the Director will be responsible for all costs incurred due to ticket changes and penalties and fare differences.

d. If after travel arrangements are made and a ticket is issued, the Director cancels a trip or chooses not to use the airline ticket, the ticket must be immediately returned to the Board of Directors Administrative Assistant. The Director is now responsible for reimbursing TCRHCC the cost of the ticket with ten (10) days of the Director's cancellation of the ticket.

4. Lodging:

a. Normally, lodging arrangements shall be made through TCRHCC. The Director must choose a hotel that is economical and reasonably located to the destination. Where it is possible, the Director will stay at the hotel where a conference or meeting is taking place and the cost of such lodging at the conference/meeting hotel will be paid directly by TCRHCC. If lodging at the conference/meeting hotel is not available then the Director must choose a hotel that does not exceed the maximum lodging rate for the area, per the federal register. The Director is responsible for paying the difference that exceeds the federal maximum.

b. In extra-ordinary circumstances, and only after the prior approval of the Board President for good cause shown, the Board President (or in his/her absence the Vice President) may authorize TCRHCC reimbursement for lodging that exceeds the maximum lodging rate for that area per the federal register. No reimbursement shall be made for alternative lodging if not approved in advance by the President of the Board.

c. Lodging is authorized if a conference/meeting event is expected to go after 4:00 o'clock p.m. or the meeting/conference is expected to go beyond one day or be multiple days.

d. In the case of an emergency such as inclement weather, road closures, etc. the Board President, or in the absence of the Board President, the Vice President of the Board, may authorize emergency lodging for a Director on official TCRHCC business. In which case, the Director shall use the hotel where the conference/meeting/event is taking place or will select lodging that does not exceed the maximum lodging rate for that area, per the

federal register. In such a case, the Director will be reimbursed for the actual, reasonable lodging expenses incurred.

5. Per Diem or Actual Expenses:

- General:

a. A per diem allowance, or actual expenses may be allowed when the Director is performing authorized official travel away from his/her Chapter residence[1] and only if he/she is in travel status for and on behalf of TCRHCC for more than twelve (12) hours.

b. Normally, the Director will be entitled to per diem unless he/she has received the President of the Board of Director's approval to receive actual expenses.

- Per Diem:

a. What is Per Diem?

Per diem is the allowance which shall cover lodging (excluding taxes), meals and incidental expenses. The General Services Administration (GSA) establishes per diem rates for destinations within the Continental United States. It is the intent of TCRHCC to utilize the GSA per diem rates as set forth in the GSA per diem website.

b. Per diem allowance shall not exceed the maximum per diem rates established by the Administrator of General Services and listed in the Meals and Incidental Expense rate (M & IE).

c. The per diem allowance for M & IE will be paid as follows:

(1) When travel is more than twelve (12) but less that twenty-four (24) hours – seventy-five (75%) percent of M & IE rate.

(2) First and last travel days – seventy-five (75%) percent of M & IE rate.

(3) Full days – one hundred (100%) percent of M & IE rate.

d. The M & IE rate shall be adjusted for a meal(s) furnished to Director at a nominal or at no cost to the Director or TCRHCC or

[1] "Chapter residence" means the residence which is recognized by the Chapter the Board member represents as the Board member's official residence.

as included in the registration, by deducting the appropriate amount shown in the M & IE chart.

e. When a Director is requesting the per diem method for payment of meals, the Director is not required to provide meal receipts.

f. When the Director is paid a per diem, the Director shall not be entitled to any incidental expenses.

- Actual Expenses:

a. In lieu of a per diem allowance and when approved by the President of the Board of Directors, the Director may receive reimbursement based upon actual expenses. No reimbursement shall be paid for any actual expenses that are not supported by a receipt which must be submitted within ten (10) days after the end of travel. If actual expenses are reimbursed, then per diem reimbursement will not be paid.

b. The actual expense reimbursement entitlement starts on the day that the Director departs from his/her Chapter residence (or such other authorized point) and ends on the day the Director returns to his/her Chapter residence (or other authorized point). An authorized point may be a temporary residence from which the Director commenced travel and to which the Director is returning after travel. If the Director is traveling to or from a place that is not his/her Chapter residence then the Director must receive prior approval for said travel to and from such an authorized point from the Board President. The actual expense reimbursement for meals shall be limited to M & IE rate and may include such additional incidental expenses such as taxi cab fares, rental cars, meal tips, parking, and other travel related expenses not otherwise reimbursed upon the submission of receipts by the Director.

c. The maximum amount that may be reimbursed under actual expenses is limited to three times (rounded to the next higher dollar) of the applicable maximum per diem rate set forth in the GSA per diem rate charts.

d. Personal expenses, not directly related to the cost of official travel for and on behalf of TCRHCC which may include, but are not limited to, the cost of movies, personal telephone calls, laundry, etc. shall be the sole and personal expense of the Director and shall not be reimbursed by TCRHCC. Only in the case of an emergency or unforeseen circumstance, the President of the Board of Directors, for good cause shown, may allow re imbursement for

some or all personal expense submitted by the Director. The request and approval of such personal expenses must be documented on a TCRHCC Board of Directors waiver request/approval form (Attachment A) and maintained on file within the administrative offices.

6. Cancellation and Pre-payment for Travel:

   a. If the Director cancels Board related travel for any reason, the Director must notify TCRHCC administration of such cancellation at least twenty-four (24) hours in advance of the start time of the travel.

   b. Director shall be responsible to reimburse TCRHCC for any travel costs paid for by TCRHCC in advance if he/she cancels the trip after the date when a refund can be obtained, and/or if the Director fails to notify TCRHCC administration that he/she will not be making a trip (or fails to notify the lodging directly in time to receive a reimbursement). Reimbursement is due and payable to TCRHCC no later than ten (10) days after the date in which travel was to commence.

   c. Costs for airline tickets for cancelled trips is as set forth in Paragraph 3 (c) and (d) above.

   d. If the Director does not reimburse TCRHCC as required, then funds will be withheld from any payments due to the Director until the amount due is repaid in full. The Director will be provided with a written statement of amounts withheld and the reasons said amounts are being withheld.

   e. Failure to give any of the advance notifications required by this section may be excused for good cause and solely at the discretion of the Board President. If the Board President fails to give any of the advance notifications required by this section, it may be excused for good cause shown by the Executive Committee. The request and approval must be documented on Attachment A and the form must be maintained on file within the administration department.

B. Attendance at Special Events:

1. Mileage, expense reimbursement and meeting fees for special events may be paid in accordance with the policy if the attendance at such special event was done with the approval of the President of the Board of Directors.

2. When the special event is in the home Chapter of the Director, expense reimbursement and meeting fees may be paid as set forth in this section, but mileage will not be reimbursed for travel to and from the Director's Chapter residence and the event.

3. Unless authorized by the Board President, no Director shall receive mileage reimbursement for attending a meeting, conference or special event in the Director's Home Chapter.

C. Meeting Fees:

1. Directors shall receive meeting fees in the amounts set forth below:

a. Board of Directors Meetings:

(1) Monthly and Annual Board Meetings:

$300.00 per day (or part of day).

(2) Special Board Meetings: (called by President of Board of Directors)

$200.00 per meeting.

(3) Credentialing Meetings:

$125.00 per meeting.

(4) Quality Team Meetings:

$150.00 per meeting.

b. Board Committee Meetings:

(1) Executive Committee Meetings:

$125.00 per meeting.

(2) Finance Committee Meetings:

$125.00 per meeting.

(3) All authorized Board Committee Meetings:

$125.00 per meeting.

c. A Board member may attend more than one authorized meeting on the same day, but shall not receive more than a total of $750.00 in meeting fees in any one day, regardless of the number of meetings attended.

d. Other Meetings:

Directors who are authorized by TCRHCC to attend other meetings, training sessions, special events and conferences will receive meeting fees at a rate of $150.00 per day. This includes, but is not limited to, meetings such as:

(1) Navajo Area Indian Health Board (NAIHB) Meetings;

(2) Indian Health Service (IHS) Committee Meetings;

(3) Western Agency Meeting;

(4) Bodaway/Gap Health Center Steering Committee;

(5) Special Events except Chapter Meetings and Planning Meetings;

(6) Regional PL 93-638 Consortium Meetings; and

(7) Chapter Quarterly Updates.

e. Contract Negotiations with IHS:

Directors will receive $300.00 per day for attendance at IHS P.L. 93-638 contract negotiations, Navajo Nation Health, Education and Human Services Committee (HEHSC) meetings, Navajo Nation Council meetings, Navajo Nation Naa'bik'iyati' Committee meetings, and other meetings with other applicable oversight and governmental entities.

f. Fees for travel time:

Directors will receive a fee in the amount of $50.00 per day for any days in which four (4) hours or more are spent traveling to and/or from meetings, conferences, or training sessions. Travel time is for the direct route and not including stops or detours from the direct route. Documentation of travel time traveling may be ascertained using the travel time estimation found in commonly used electronic maps for travel to and from the Chapter residence (or, if applicable, alternative residence whichever travel time is less) to the event/meeting.

2. Meeting fees shall be paid as follows:

a. Fees for attendance at Board of Directors meetings shall be paid by Wednesday of the following week.

b. Fees for attendance at other meetings, contract negotiations, and conferences shall be paid in advance.

c. Directors must attend the full meeting, conference or training each day in order to receive meeting fees.

d. Directors who attend less than the full meeting shall not receive the meeting fee and shall reimburse the TCRHCC for any fee amount paid in advance. Repayment may be waived by the President upon a showing of good cause by the Director. If the President of the Board attends less than the full meeting, he shall not receive the meeting fee and shall reimburse the TCRHCC for any fee amount paid in advance. The President of the Board may request that repayment be waived for good cause. Such a request may be waived by the Executive Committee. All requests for waiver, to include the good cause reasons, shall be documented on Attachment A. Upon completion, this form will be forwarded to, and maintained by Administration.

If a Director has been paid for a meeting in which the Director did not attend or which was not authorized by this policy or by the President of the Board, the Director shall be so notified in writing and must reimburse TCRHCC within ten (10) days of receiving the fee or the fee shall be taken out of his/her next meeting attendance fee payment.

IV. **Miscellaneous**

A. No Self Authorization – The President is authorized by this policy to approve certain actions, deviations or other conduct. When the President seeks such authorization for said actions, deviations or conduct, the President must obtain such authorization from the Vice President or the next ranking available officer or a Director if no other such officers are available. No officer or Director should authorize their own such actions, deviations or conduct and shall ensure that such authorization is obtained from the highest ranking officer available or in their absence, another Director.

B. Preapproval of Travel – The administration shall continue to compile a list of all known travel for the next month, attach said list as a consent agenda item to the monthly Executive Committee meeting and provide copies to committee members prior to the meeting, along with the minutes to be approved. The list of such travel shall then be provided to the board as a report. Any travel on the list may be identified by any Director at the monthly meeting, for discussion and separate approval requiring the majority of the Board Members attending that meeting.

C. The administration shall keep a current accounting of all payments to Board Members made under this policy. Each Director may, upon reasonable request to administration, review the accounting relating to that Director.

D. The administration shall annually, on or before February of each year or as otherwise directed by the CEO or board, conduct a survey of other 638 health care entities and other health care entities in the geographical area and such other information as may be relevant, regarding compensation paid by health care entities to their Directors and provide the results of such survey to the Board of Directors to ensure the reasonableness of these policies.

V. **Distribution**:

A. Administrative Office Files; and

B. TCRHCC general legal counsel.

CERTIFICATION

The foregoing revised and restated Board of Directors Travel Policy for Board Authorized Travel was presented and reviewed at a properly noticed meeting of the Board of the Tuba City Regional Health Care Corporation, a quorum being present, and were adopted by a vote of 7 in favor, 0 opposed, and 0 abstained, on the 29th day of October, 2015.

Motion: Tincer Nez, Sr. Seconded: Kimberlee Williams

We, the undersigned, hereby certify that we are the presently elected President and Treasurer of the Tuba City Regional Health Care Corporation, a non-profit corporation, and that the foregoing Board of Directors Travel Policy for Board Authorized Travel, including this page, is the Board of Directors Travel Policy for Board Authorized Travel of this Corporation as adopted at the above stated meeting.

TUBA CITY REGIONAL HEALTH CARE CORPORATION
167 North Main Street, PO Box 600
Tuba City, AZ 86045-0600
(928) 283-2501

CODE OF CONDUCT
OF THE BOARD OF DIRECTORS
TUBA CITY REGIONAL HEALTH CARE CORPORATION

(Revised February, 2018)

I. Purpose

The Board of Directors of the Tuba City Regional Health Care Corporation (TCRHCC) recognizes that employment by or association with the TCRHCC, including appointment to the Board of Directors or other non-compensated positions, is a public trust that requires certain obligations related to treatment of individuals and to the promotion and integrity of the TCRHCC's interests and mission. Every Director of the TCRHCC is expected to read, understand, comply with and uphold this Code of Conduct.

II. Definitions

A. "Board Member" or "Director" means a member of the Board of Directors of the TCRHCC.

B. "Business" means any corporation, limited liability company, partnership, sole proprietorship, trust or foundation, or other individual or organization carrying on a business, whether or not operated for profit.

C. "Contractor" means any person or entity to whom the TCRHCC makes payments for goods, services or facilities provided by the person or entity (sometimes referred to as vendors) or any person or entity that makes payments to the TCRHCC for goods, services or facilities furnished by the TCRHCC (sometimes referred to as third-party payors).

D. "Compensation" includes money, any other thing of value and any benefit of any nature, including but not limited to any fee, compensation, gift, or payment of expense.

E. "Conflict of interest" means any situation or transaction in which a Director has a direct or indirect interest such that he or she may realize a personal benefit from the situation or transaction or which causes the Director to act in a way that is not in the best interest of the TCRHCC.

F. "Director" means an individual who is a Director of the TCRHCC.

G. "Financial interest" shall mean a substantial interest held by a Director or by an immediate family member or member of the household of the Director which is:

1. An ownership interest in a business. A substantial interest shall mean being the actual or beneficial owner of five percent (5%) or more of the stock or controlling interest of the business.

2. A creditor interest in a bankrupt business.

3. An employment or prospective employment for which negotiations have begun.

4. An ownership interest in real or personal property. A substantial interest shall mean being the owner of five percent (5%) or more of the property.

5. A loan or any debtor interest.

6. A position as a member of the governing board or the management, a limited or general partner, an employee, or an agent of a business.

7. A position as a scientific advisor or consultant for a business.

8. Any other direct or indirect dealings with a business from which the Director or his immediate family member is materially benefited. "Materially benefited" means the receipt, directly or indirectly, in cash or other property (exclusive of dividends and interest) in excess of $1,000 total in any calendar year.

H. "Immediate Family Member" means a Director's spouse, father, stepfather, mother, stepmother, daughter, stepdaughter, son, stepson, sister, stepsister, half-sister, brother, stepbrother, half-brother, father-in-law, mother-in-law, daughter-in-law, son-in-law, grandfather, grandmother, grandchild, niece, nephew, and first cousin. This term shall also include all persons actually residing within the household or traditional homestead of the Director.

I. "Official action" shall mean any vote, decision, recommendation, approval, disapproval, or other action, including inaction, which involves the use of discretionary authority.

III. Scope of Compliance

This Code of Conduct sets forth the general ethical principles of the TCRHCC with which every Director is expected to comply. It is the responsibility of all Directors to familiarize themselves with this Code of Conduct, documents and requirements referenced in this Code of Conduct, the Bylaws of TCRHCC, and the laws and regulations relevant to their assigned duties and responsibilities (collectively "Member Requirements") and to conduct themselves in accordance with the Member Requirements. All Directors are expected to observe high standards of business and personal ethics while performing their assigned duties. The TCRHCC will implement the programs necessary to further such awareness and to monitor and promote compliance with Member Requirements, but ultimately it is up to each Director to be familiar with them. Legal interpretation of laws and regulations should be directed to the General Counsel for the TCRHCC.

IV. Individual Commitment

The position of a Director is a public trust. As a general principle in support of the public trust each Director:

A. Shall abide by the Member Requirements.

B. Shall demonstrate a commitment to providing high-quality services to TCRHCC patients, striving to improve his or her ability to perform his or her duties and treating others in a respectful manner.

C. Shall support equal employment and other employee development programs. The TCRHCC prohibits discrimination on the basis of race, gender, color, age, religion, national origin, veteran status, marital status, sexual orientation, or individual disabilities, but also promotes Navajo and Indian preference in compliance with applicable federal and Navajo Nation laws. Employment related decisions shall reflect this firm commitment.

D. Shall strive to create a workplace and treatment environment free of all forms of harassment, including without limitation sexual harassment as that term is defined and used in the TCRHCC policy regarding Sexual Harassment, or favoritism. Harassment is prohibited in all TCRHCC facilities and programs.

E. Shall strive through words and actions to create a professional atmosphere in the work environment and shall observe professional standards and judgment.

V. Individual Responsibility

A. It is the responsibility of all Directors to comply with the Member Requirements and the policies and programs of the TCRHCC to the extent such policies and programs are not inconsistent with the Board's authority and each Board member's duties and responsibilities as a Board member.

B. It is also the personal responsibility of each Director to bring violations or suspected violations of the Member Requirements or the underlying policies of which they are aware to the attention of the CEO.

C. TCRHCC prohibits retaliation or retribution against Directors for making any such report in good faith.

D. Failure to comply with the Member Requirements or the underlying policies, including but not limited to the failure to report such violations or suspected violations by others, of applicable law or TCRHCC policies to the President of the Board will subject Directors to appropriate disciplinary action.

VI. Commitment to Community

All Directors shall actively strive to be good citizens of the community in which services are provided and where business is conducted. Directors serve as role models in the community. Moreover, TCRHCC's reputation is reflected by the actions of its Directors. Therefore, Directors are expected to meet high standards of ethics, integrity, and conduct even while outside of official Board activities and away from TCRHCC's facilities and events.

VII. Quality of Care

A. Each Director shall:

1. Keep the needs of patients at the forefront of all decision making and promote delivery of high-quality health services to patients in a responsible, reliable and cost-effective manner.

2. Support equal, ethical and respectful treatment of all patients, employees, and other persons associated with the TCRHCC and at all times demonstrate a personal commitment to honesty, fair and consistent management, to providing a safe and healthy environment, and to respecting the dignity due to everyone.

3. Comply with all Member Requirements, applicable laws, regulations, policies and standards including tribal and federal legislation regarding patients' rights.

4. Uphold high standards of professional practice in all TCRHCC facilities and programs and ensure that only properly qualified individuals may practice in TCRHCC facilities and programs.

5. Uphold the requirements of the Medical Staff Bylaws, TCRHCC policies, accreditation standards, and all applicable laws and regulations regarding accurate documentation and maintenance of medical records.

6. Maintain patient confidentiality and ensure that confidential patient information will not be released without a properly executed consent form.

VIII. Business Ethics and Conflicts of Interest

A. Being a Director is a position of public trust that requires certain obligations related to treatment of other individuals and promotion of the TCRHCC's interests. Any effort to achieve personal gain through appointment as a Director, other than the compensation or benefits provided by the TCRHCC, is a violation of the public trust. All decisions of Directors are to be made solely on the basis of promoting the best interests of the TCRHCC.

B. Each Director is expected to abide by the following general principles:

1. Serve the public, and treat all persons employed by or associated with the TCRHCC with respect, concern, courtesy, and responsiveness.

2. Support equal treatment of all patients, employees and other persons associated with the TCRHCC, or obtaining or providing services to the TCRHCC, without regard to race, gender, color, age, religion, national origin, veterans status, marital status, sexual orientation, or individual disabilities, and compliance with the Navajo Preference in Employment Act.

3. Avoid actual or potential conflicts of interest, and the appearance of a conflict of interest, except as allowed by this policy or other policies of the Board of

Directors. Promptly report to the President of the Board any situation in which a Director reasonably feels that he may be or may become involved in a conflict of interest, whether or not such situation is specifically described in this policy. If the President is involved in such a situation, he or she shall report it to the Board as a whole.

4. Recognize that personal gains from employment or service to the TCRHCC are limited to respect, recognition, and such meeting attendance fees as are authorized by the TCRHCC Bylaws.

5. Demonstrate the highest standards of personal integrity in all actions related to or affecting the business of the TCRHCC.

6. Not use his relationship with the TCRHCC to bestow any benefit on anyone related to the person by family, business, or social relationship.

7. Not disclose or use or allow others to use confidential information obtained from his relationship with the TCRHCC for private gain or private purposes.

8. Not accept any fee, compensation, gift, payment of expense, or any other thing of monetary value except as authorized by policies of the TCRHCC, including this Code of Conduct.

9. Not use TCRHCC time, property, equipment, supplies, or support services for private gain, or private purposes, except such limited use as authorized by policies of the TCRHCC.

C. Business transactions with vendors, contractors and other third parties shall be transacted free from provision, or acceptance of, or offers to provide or solicitation of, gifts and favors or other improper inducements in exchange for influence or assistance in a transaction. This Code shall be construed broadly to avoid even the appearance of improper activity. If there is any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, a Director should contact the President of the Board or the General Counsel for the TCRHCC. If the Director in question is the President, he or she should confer with the Board as a whole or the General Counsel.

1. Gifts from Patients or Immediate Family Members. Directors are prohibited from soliciting tips, personal gratuities or gifts from patients and immediate family members of patients and from accepting monetary tips or gratuities. Directors may accept (but not solicit) non-monetary gifts of a nominal value, up to a cumulative total of $50 per Director per calendar year, from patients and immediate family members of patients. If a patient or another individual wishes to present a monetary gift, he or she shall be referred to the Chief Executive Officer.

2. Gifts Influencing Decision-making. Directors shall not solicit or accept gifts, favors, services, entertainment, or other things of value that would influence their decisions or actions of the TCRHCC or which give the appearance of influencing their decision or actions. Similarly, it is prohibited for Directors to

offer or give money, services or other items of value with the hope or expectation of influencing the judgment or decision making process of any purchaser, supplier, customer, government official or other person. Any such conduct must be reported immediately to the Chief Executive Officer and the President of the Board. If the President is involved in such matter, the report must be made to the Board as a whole.

3. Gifts From Existing Vendors. Directors may accept (but not solicit) gifts from vendors that have a nominal value up to a cumulative total of $50 per Director per calendar year. The TCRHCC expects its Directors to exercise good judgment and discretion in accepting gifts. The Director should consult with the President of the Board or General Counsel where appropriate. Directors shall not solicit or accept excessive gifts, meals, expensive entertainment, or other offers of goods or services that have more than a nominal value, nor may they solicit gifts or favors from vendors, suppliers, contractors, or other persons.

4. Vendor-sponsored Entertainment. A Director may accept (but not solicit) meals or refreshments of nominal value at the vendor's invitation and expense.

5. Workshops, Seminars and Training Sessions. Attendance at local, vendor-sponsored workshops, seminars and training sessions is permitted. Attendance at out of town seminars, workshops and training sessions at vendor expense is permitted only with the approval of the Board of Directors.

6. Contracting. Directors may not utilize "insider" information for any business activity conducted by or on behalf of the TCRHCC. All business relations with contractors must be conducted at arms' length both in fact and in appearance and in compliance with the TCRHCC's policies and procedures. Directors must disclose any personal relationships and business activities with contractor personnel, which potentially would be construed by an impartial observer as influencing the Director's performance or duties. Directors have a responsibility to obtain clarification on questionable issues that may arise.

D. To promote the TCRHCC's commitment to the highest standards of business ethics and integrity, Directors will accurately and honestly represent the TCRHCC and will not engage in any activity or scheme intended to defraud anyone of money, property or honest services. Ethical business standards include:

1. Honest Communication. The TCRHCC requires openness and honesty from all Directors in the performance of their responsibilities and in communication with others, including the TCRHCC's employees, attorneys, auditors, managers, and other investigative personnel. Notwithstanding the foregoing, Directors must not disclose confidential or privileged information. Directors are encouraged to confer with TCRHCC's General Counsel if there is any doubt as to whether certain information is confidential or privileged.

2. Misuse of Proprietary Information. Directors shall not misuse confidential or proprietary information belonging to another person or entity nor use any publication, document, computer program, information, or product in violation

of a third party's interest in such product. Directors shall not copy for their own or others' use documents or computer programs in violation of applicable copyright laws or licensing agreements. Directors shall not use confidential business information obtained from competitors, including customers lists, price lists, contracts, or other information in violation of a non-competition agreement, prior employment agreements, or in any other manner that would provide an unfair competitive advantage to the TCRHCC or to the individual.

3. Fraud. Directors shall refrain from conduct that may constitute fraud.

E. All Directors will strive to preserve and protect the TCRHCC's assets by making prudent and effective use of the TCRHCC's resources and accurately reporting its financial condition.

1. Internal Control. The TCRHCC has established control standards and procedures to ensure that assets are protected and properly used and that financial records and reports are accurate and reliable. All Directors share the responsibility for maintaining and complying with required internal controls.

2. Financial Reporting. All financial reports, accounting records, research reports, expense accounts, time sheets, and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting by a Director is a violation of this Code.

3. Travel and Entertainment. Travel and entertainment expenses should be consistent with each Director's responsibilities and the TCRHCC's needs and resources, and must be incurred in compliance with the TCRHCC's travel policies. Directors are expected to exercise reasonable judgment in the use of the TCRHCC's assets and to spend the TCRHCC's assets as carefully as they would spend their own.

4. Personal Use of TCRHCC Assets. All Directors shall refrain from converting assets of the TCRHCC to personal use. All business of the TCRHCC shall be conducted in the manner designed to further the TCRHCC's interest rather than the personal interest of an individual. All Directors are prohibited from the unauthorized use on or off premises, or taking of the TCRHCC's equipment, supplies, materials, or services. Unauthorized use includes without limitation uses unrelated to official TCRHCC business.

IX. APPLICATION OF GENERAL PRINCIPLES/PROHIBITED CONDUCT

A. Compensation:

1. No Director shall solicit or accept any pay, commission, money or gift:

a. Under circumstances in which the acceptance may result in the actual, potential, or appearance of any of the following:

i. An undertaking to give preferential treatment to any person; or

ii. Any loss of complete independence or impartiality; or

iii. The making of a decision outside of official channels; or

iv. Which the person knows or may suspect is primarily for the purpose of rewarding him/her for official action taken.

2. The following items may be accepted so long as none of the circumstances listed in Section IX.A.1. of this Code exist. However, no Director shall solicit any of the items listed in subparagraphs (a) and (b) below.

a. An occasional non-monetary gift of nominal value up to $50, so long as such gift is consistent with the requirements set forth in Section VIII.C of this Code.

b. A non-monetary award publicly presented by the TCRHCC or by another nonprofit organization in recognition of public service.

c. Payment of or reimbursement for actual and necessary travel expenditures for attendance at a convention, training or other meeting at which the person is scheduled to participate.

d. Reimbursement for or acceptance of an opportunity to participate in a social function or meeting not directly relevant to the position held by the Director.

e. Payment for speeches, appearances or articles received as honoraria or royalties authorized by policies of the TCRHCC.

f. Payment of salary from outside employment authorized by policies of the TCRHCC.

3. Items of nominal, perishable, or nonpermanent value, including but not limited to meals, lodging, travel expenses, or tickets to sporting, recreational, educational, or cultural events may be accepted (but not solicited) by a Director if (a) acceptance of the item(s) is in regards to the promotion of the legitimate business objectives of the TCRHCC, (b) the item(s) is not offered or accepted under any of the circumstances listed in Section IX.A.1. of this policy, (c) acceptance of the item(s) will not result in an actual conflict of interest or the appearance of conflict of interest or impropriety; and (d) acceptance is consistent with the requirements set forth in Section VIII.C of this Code. Directors have a responsibility to keep in mind that the TCRHCC is a public entity, and should at all times use discretion in their conduct to avoid public criticism of their actions, and thus of the TCRHCC.

4. With regard to items covered by Section IX.A.3., it shall be the TCRHCC's policy that each Director shall pay his own expenses for such items and obtain

reimbursement from the TCRHCC in accordance with policies of the TCRHCC, if attendance at such functions is to promote the legitimate business objectives of the TCRHCC.

a. If in any month a Director receives items totaling in excess of two hundred dollars ($200), which can reasonably be interpreted as having been received because of his position with the TCRHCC, he shall report such items in writing to the President of the Board, including the date of receipt of each item, the nature of the item, its actual or estimated value, the identity of the donor, and the purpose for the gift. If the Director in question is the President, he or she shall report to the Board as a whole.

b. If the Director pays for tickets or other items using TCRHCC funds in excess of two hundred dollars ($200) per month, a written report of such expenses shall be provided to the President of the Board, except that meals, lodging and travel expenses that are processed in accordance with TCRHCC policies for the reimbursement of such expenses do not need to be separately reported. If the Director in question is the President, he or she shall report to the Board as a whole.

B. Personal Benefit or Preferential Treatment:

1. No Director shall:

a. Engage in a substantial financial transaction for his private business purposes with a person whom he oversees, regulates or supervises as part of his duties for the TCRHCC.

b. Conduct non-TCRHCC related business with any vendor, supplier or contractor of the TCRHCC, or any of their officers or employees.

c. Accept a fee or other compensation for assistance in obtaining any contract, claim, license, or other economic benefit from the TCRHCC.

d. Perform an official TCRHCC action that affects the economic benefit of a business or other duty in which he either has a substantial financial interest or is engaged as counsel, consultant, representative, or agent.

e. Compete with the TCRHCC, directly or indirectly, in the purchase, sale or ownership of property or property rights or interests, or business investment opportunities.

f. Obtain or hold interest in any business or undertaking which he has reason to believe may be directly or indirectly economically affected by official action taken by the TCRHCC. This subparagraph will apply only to Directors whose official actions or influence may be able to affect the official action to be taken.

g. Use his relationship with the TCRHCC to bestow any preferential benefit on anyone related to the Director by family, business, or social relationship.

h. Solicit, negotiate for or promise to accept employment from any individual, business or other entity when the Director is aware that such individual, business or entity has pending transactions or business with the TCRHCC or in connection with which the Director may exercise discretionary power or decision making authority.

2. No Director shall seek to use his position to obtain employment with the TCRHCC and, if a Board Member accepts a position with the TCRHCC, he shall resign from the Board of Directors.

C. Contracts with Interested Persons:

1. Except for employment contracts and contracts described in Section IX.C.2., the TCRHCC shall not enter into a contract with any interested Board Member, member of the Executive Staff, or physician unless the contract is awarded after having been released for competitive bidding.

2. Subject to compliance with the Navajo Business Opportunity Act, as applicable, if a contract is in a field where, in the judgment of the TCRHCC Board competitive bidding is inappropriate, then as a substitute, a disinterested Board Member or member of the Executive Staff of the TCRHCC shall be appointed to investigate to determine whether the contract is the best available to the TCRHCC.

a. The investigation shall include gathering information about potential competitors of the interested person, the products and/or services offered by such competitors, and the prices charged by such competitors, or generally charged in the marketplace.

b. Support for his findings, including a list of the competitors contacted, shall be entered in the records and available for review by the Board Members or members of the Executive Staff who will make the decision before their action is taken.

c. Any contract with a Board Member, physician, or a member of the Executive Staff shall be approved only if the provisions of this Section IX. C. are met, and an explicit finding is made and documented that the contract is in the best interest of the TCRHCC and that the terms of the contract are reasonable and fair to the TCRHCC.

X. DISCLOSURE OF CONFLICTS OF INTEREST; ABSTAINING FROM ACTION

A. Any Director who becomes aware of an actual or potential conflict of interest or the appearance of a conflict of interest and who has occasion to participate in a

recommendation or decision which may involve such conflict of interest, shall make full disclosure of the conflict or potential conflict or appearance of conflict.

1. This disclosure shall be noted in the minutes of the meeting, a memorandum of disclosure, a letter to the person's supervisor, or in some other appropriate written record.

B. Each Director shall, at the time of his appointment and annually thereafter, disclose in writing any transaction that in their (that person's) best judgment constitutes an actual or potential conflict of interest.

1. Such disclosure shall be made on forms provided by the President of the Board, who shall be responsible for obtaining a response in regards to the conflict of interest statement annually, prior to the Annual meeting, from each member of the Board of Directors.

2. The President of the Board will report to the Board of Directors the results of the initial questionnaire and each annual conflict of interest survey for full discussion and disposition.

3. Individual conflicts will be resolved promptly during the year as soon as they are reported.

4. Failure to disclose or to resolve conflicts may be grounds for disciplinary action.

C. Any Board Member who has an actual or potential conflict or appearance of conflict of interest in any matter brought up for decision shall not vote on such matter.

1. Any Board Member or member of the Executive Staff shall not use or attempt to use his personal influence to influence the vote.

2. The interested Board Member shall be counted for purposes of determining a quorum for the meeting. However, the interested Board Member shall not be counted for purposes of determining how many votes of the Board constitute a majority for purposes of voting.

3. The minutes of the meeting shall reflect that a disclosure was made, the existence or non-existence of a quorum and that the interested Board Member refrained from influencing the vote or voting.

4. The provisions of this Section X.C. shall apply to every Director who has any personal, business or other interest pending before the body, or under consideration by the TCRHCC.

D. To the extent permitted by law, the concerned Director shall leave the room when transactions in which he has an actual or potential conflict or appearance of conflict of interest are discussed. This may allow non-interested Board Members or Executive

Staff Members to be less inhibited in making sure that the interests of the TCRHCC are protected.

XI. CONFIDENTIAL AND PRIVILEGED INFORMATION

A. A confidential relationship is one that is founded on openness and trust, and prohibits disclosure of sensitive information. The extent to which the confidential information will be used, will be determined by the expectations of the parties and the purpose of their relationship. In some cases, the laws regarding patient information impose a specific duty of confidentiality.

B. Each Director to whom this policy applies has an obligation at all times to preserve the confidential nature of sensitive information learned in the course of his association with the TCRHCC. In determining which information is confidential, legal requirements, all policy and procedures, the nature of the information, and common sense should be considered. The Director should at all times act carefully, in good faith, in a manner which promotes the best interests of the TCRHCC and its clients, and in a way that recognizes and promotes ethical considerations and the duty of loyalty that each person owes to the TCRHCC. In case of doubt, the Director should act to preserve the confidence of the information at issue and confer with TCRHCC's General Counsel before disclosing the information.

C. Specific principles applicable to treatment of confidential/privileged information, which are not inclusive of all possible situations, are as follows:

1. Information regarding patients shall be treated with the highest regard for confidentiality. Discussions regarding patients, including their medical condition, personal situation or any other private or sensitive matters, should only occur when necessary to promote the care and well-being of the patient, or as specifically required by law (e.g., a court order to testify in a particular case). Each Director shall refrain from discussing such matters whether to other persons covered by this policy, to family members, to friends, or to any other persons.

2. Each Director shall respect sensitive, personal information learned about employees and other Directors, and shall refrain from discussing information with others except as necessary to promote the legitimate business of the TCRHCC. This may include information such as performance issues, salary, and personal information or data.

3. Confidential information regarding the business of the TCRHCC should be maintained and not disclosed to others except as necessary to promote the business of the TCRHCC, as may be determined by the consensus of the Board. No Director shall realize any personal gain as a result of disclosing or using confidential information learned about the TCRHCC.

4. Matters discussed in executive session of the Board of Directors, or any other board, committee or group performing the business of the TCRHCC, shall be

treated as confidential information and shall not be disclosed except as may be required by law.

5. Attorney-client communications and other confidential and privileged legal matters and communications shall not be disclosed without the prior written advice of TCRHCC's General Counsel.

6. This duty of non-disclosure and the obligation not to benefit from confidential information learned during the course of a Director's employment or other association with the TCRHCC shall continue indefinitely after the Director's appointment with the TCRHCC ends.

7. Even confidential and privileged matters may be disclosed if required by a lawfully issued subpoena or other legal mandate. If the Board or Director learns of or receives a request or order for disclosure of such matters pursuant to legal authority, the Board or Director shall confer with and receive written advisement from TCRHCC's General Counsel before disclosing the matter.

XII. FAVORITISM

A. No Director shall participate in any decision affecting direct benefits such as employment, transfer, promotion, separation, salary, benefits, or leaves of absence of any immediate family member. If such a relationship exists, the relationship shall be disclosed to the Board and the Director shall recuse himself from any such decision.

B. This policy shall not be interpreted to prevent the hiring of persons, including the Chief Executive Officer, who have a pre-existing relationship with a Director but only to prevent an actual or potential conflict of interest or the appearance of a conflict of interest. If the person(s) to be hired has been determined for other reasons to be the most qualified person(s) available for the job, every effort should be made to permit such employment while avoiding an actual or potential conflict of interest, or the appearance of a conflict of interest.

C. All efforts should be made to avoid even the appearance of favoritism or nepotism.

XIII. SANCTIONS BY THE BOARD

A. If there has been a complaint about an alleged breach of the Member Requirements, the Board (or its duly appointed delegate) will investigate the complaint to determine whether or not a breach of the Member Requirements has occurred and, if so, the appropriate sanctions to be applied in the circumstances.

B. When the Board (or its delegate) is considering whether there has been a breach of the Member Requirements or the sanctions that are appropriate, the Board (or its delegate) will notify the Director whose conduct is in question and give him or her a right to be heard by the Board (or its delegate). However, the Board (and its delegate) is not obliged to allow legal representation before it. If a breach has been alleged, the Board (or its delegate) will:

1. give consideration to the serious consequences of a finding that there has been a breach of the Member Requirements; and

2. make a finding that a breach has occurred on the basis of a preponderance of the evidence or find that a breach has not occurred.

C. The Board should consider the seriousness of the breach and may then impose such sanctions as it considers are warranted by the seriousness.

D. The sanctions, which may be imposed, include, but are not limited to, the following:

1. removal of the breaching Director from membership of the Board of Directors and termination of payment of fees payable in repsect of the services involved;

2. suspension of the breaching Director from Board meetings and activities for a specified period of time or number of meetings and activities;

3. suspension of the breaching Director from membership of any Committee or Committees of which he or she is a member and termination of payment of fees to that Director in respect of services on the Committee or Committees for the period of suspension;

4. removal of the breaching Director from such Committee or Committees of which he or she is a member as the Board considers appropriate and termination of payment of fees payable in respect of the services involved;

5. verbal or written censures, admonishments, warnings, and directives;

6. attendance at mandatory training;

7. court action in respect of alleged breaches of any of the general law or statutory duties owed by the Director.

XIV. DIRECTOR ACKNOWLEDGMENT

I hereby certify and acknowledge that I have been provided with a copy of the Code of Conduct of the Board of the Tuba City Regional Health Care Corporation (Code) and have read the Code and been given an opportunity to ask questions about its content.

Date:_____ _____

Director's Name

APPLICATION FOR AMENDMENT
TO
ARTICLES OF INCORPORATION
OF
TUBA CITY REGIONAL HEALTH CARE CORPORATION

Pursuant to the provisions of Chapter 19, Section 3329 of the Navajo Nation Corporation Code, the undersigned Corporation adopts the amendments to its Articles of Incorporation as set forth herein.

I. The name of the Corporation is Tuba City Regional Health Care Corporation.

II. The text of the amendments is set forth in the attached Exhibit A.

III. The amendments were adopted on the 8th day of February, 2018.

IV. The amendments were duly adopted by the unanimous vote of the Board of the Directors of the Corporation.

DATED as of this 14th day of February, 2018.

Tuba City Regional Health Care Corporation

By: Christopher Curley
Its: Board President

Exhibit A
Text of Amendments to Articles of Incorporation of Tuba City Regional Health Care Corporation

A. Article III of the Articles of Incorporation is hereby deleted and replaced in its entirety as follows:

ARTICLE III

The corporation is organized exclusively for charitable, religious, educational and scientific purposes including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code. Such purposes may include, without limitation, the following:

A. To own and operate, directly or through subsidiary corporations, joint ventures, associations, partnerships or otherwise, any tribally operated, restricted and improved health care delivery system for the Navajo Nation and other eligible beneficiaries, for the management of health services formerly operated and managed by the Navajo Area Indian Health Services, Tuba City Service Unit, securing other resources to improve health services.

B. The corporation may engage in any activity under section 501 (c) (3) of the Internal Revenue Code.

C. The corporation may enter into and form partnerships, joint ventures, associations, and other health care arrangements.

D. To integrate and merge direct medical service and preventative health activities, and resources of the Navajo Area Indian Health Service, Tuba City Service Unit, and certain programs, functions, services or activities of the Navajo Nation Division of Health.

E. To conduct activities in all phases of health care delivery system either within or outside the jurisdiction of the Navajo Nation.

F. To elevate the health status and quality of life of Navajo and other American Indians through the provision of high quality, cost effective, responsive and culturally appropriate health care services that are prevention oriented and respect the teachings and gifts of both western medicine and traditional native healing.

G. To provide an integrated and responsive high quality health care delivery system for the Navajo people and other beneficiaries, including outpatient and emergency medical services, environmental health, public health nursing, dental, and school health services, and to provide liability an malpractice insurance provisions.

H. To maintain all books, records, files, patient data, and other documents related to the health system in accordance with all applicable laws and regulations of United States and Navajo Nation regarding the protection of privacy and assurance in confidentiality.

No part of the net earnings of the corporation shall inure to the benefit of, or be distributable to its members, trustees, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes of this Article. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or (b) by a corporation, contributions to which are deductible under section 170(c)(2) of the Internal Revenue Code, or the corresponding section of any future federal tax code.

B. Article VI.B of the Articles of Incorporation is hereby deleted and replaced in its entirety as follows:

> B. Board of Directors: The number of Directors constituting the Board shall be no more than ten (10). Directors shall be appointed in the manner set forth in the corporation's Bylaws.

C. Article VII of the Articles of Incorporation is hereby deleted and replaced in its entirety as follows:

ARTICLE VII

The corporation shall indemnify any Director and/or Officer against reasonable expenses actually and necessarily incurred by such person who was or is a party, or is threatened to be made a party to any threatened, pending or completed civil or administrative action, suit or proceeding, or as a result of an investigation by a federal, state or tribal government agency, by reason of the fact that such person is or was a Director and/or Officer of The corporation provided that:

A. Such person acted in good faith and in a manner such person reasonably believed to be in, or not opposed to, the best interests of the corporation; and
B. Such person did not act, fail to act willfully or with gross negligence or with fraudulent or criminal intent; and
C. Any legal fees paid (arrangements for representation and legal fees must be discussed with the Chief Executive Officer and general legal counsel to the corporation and evaluated for reasonableness before they are incurred) or any settlements made are reasonable;
D. The person seeking indemnification did not act beyond the scope of his or her office; and

E. The person seeking indemnification did not initiate, directly or indirectly, the action, suit or proceeding for which he or she is seeking indemnification.

Procedures for seeking indemnification and related matters shall be as set forth in the corporation's Bylaws.

D. Article VIII of the Articles of Incorporation is hereby deleted and replaced in its entirety as follows:

ARTICLE VIII

Upon the dissolution of the corporation, assets shall be distributed for one or more exempt purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or shall be distributed to the federal government or to a state or local government (including the Navajo Nation) for public purposes.

Tuba City Regional Health Care Corporation

Tuba City, AZ

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

April 7, 2017

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #9508
Print/Reprint Date: 04/11/2017

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Tuba City Regional Health Care Corporation

Tuba City, AZ

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

February 27, 2016

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #9508
Print/Reprint Date: 05/26/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Tuba City Regional Health Care Corporation

Tuba City, AZ

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Laboratory Accreditation Program

December 16, 2016

Accreditation is customarily valid for up to 24 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #9508
Print/Reprint Date: 02/17/2017

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

TUBA CITY REGIONAL HEALTH CARE CORPORATION

167 North Main Street, P.O. Box 600
Tuba City, Arizona 86045-0600

List of Licensing, Certifying and Oversight Authorities

Hospital-wide (Financial and Clinical):
- Navajo Nation Council Health, Education and Human Services Committee
- Centers for Medicare & Medicaid Services
- US Department of Health and Human Services
- Office of Self Governance I.H.S.
- Arizona Department of Health Services (SPHS)
- American Institute of Certified Public Accountants (AICPA)
- Healthcare Financial Management Association (HFMA)
- The Joint Commission
- Accreditation Association for Ambulatory Health Care, Inc.,
- American Payroll Association (Finance)

Anesthesiology:
- Academy of Anesthesiology
- American Society of Anesthesiologists

Audiology:
- American Academy of Audiology

Case Management:
- Arizona Advance Directives
- Life Care Planning

Dental:
- American Academy of General Dentistry
- American Academy of Pediatric Dentistry
- American College of Dentists

Diabetes Education:
- American Association of Diabetes Education & Clinical Nutrition

Dietetics:
- The Dietetics Academy

Ears, Nose, Throat:
- American Academy of Otolaryngology

Emergency Room/Trauma:
- Arizona Trauma Center
- ACS Trauma
- American Academy of Emergency Medicine
- American College of Emergency Physicians
- Emergency Nurses Association

Family Medicine:

American Academy of Family Physicians
American Board of Family Medicine
American College of Osteopathic Family Physicians

Internal Medicine:

American College of Physicians – Internal Medicine
American Board of Internal Medicine

Intensive Care Unit:

American Association of Critical-Care Nurses

Infection Prevention:

Association for Professionals in Infection Control
Centers for Disease Control
Morbidity and Mortality Weekly Report (MMWR)

Infusion Therapy:

National Academy of Infusion Therapy

Laboratory:

ADHS: Division of Public Health Services: Bureau of State Laboratory Services
Clinical Laboratory Improvement Amendments (CLIA)
College of American Pathologists

Medical Records:

American Health Information Management Association (AHIMA)

Nursing:

American Nurses Association

Obstetrics and Gynecology:

American Congress of Obstetricians and Gynecologists
American Collect of Obstetricians and Gynecologists

Occupational Therapy:

American Occupational Therapy Association

Operating Room:

Association of Peri-Operative Registered Nurses

Ophthalmology:

American Academy of Ophthalmology

Pediatrics:

American Academy of Pediatrics
American College of Pediatrics
Society of Pediatric Nurses

Performance Improvement:

Agency for Healthcare Research and Quality (AHRQ)
Arizona Association for Healthcare Quality
Continuous Quality Improvement and Managed Care
Institute for Healthcare Improvement

The Joint Commission Center for Transforming Healthcare
Quality & Satisfaction Improvement
Safety Leaders

Pharmacy:

American Association of Colleges of Pharmacy
American College of Clinical Pharmacy
American Society of Health-System Pharmacists (ASHP)
Drug Enforcement Agency

Podiatry:

American Association of Colleges of Podiatric Medicine
American Podiatric Medical Association

Physical Therapy:

American Physical Therapy Association

Radiology:

American College of Radiology
Diagnostic Medical Physicists
American College of Nuclear Medicine
Food and Drug Administration
Mammography Quality Standards Act and Program

Respiratory Therapy:

American Association for Respiratory Care

Safety – Environment of Care:

American Society for Healthcare Engineering
National Fire Protection Association
Environmental Protection Act
Occupational Safety and Health Administration

Speech Therapy:

American Speech-Language-Hearing Association

Surgery:

American College of Surgeons
American College of Eye Surgeons
American College of Orthopaedic Surgeons
American Association of Oral and Maxillofacial Surgeons
American Society of General Surgeons

No. 17-3004

Arizona Department of Health Services

Level III
Trauma Center Designation
to
Tuba City Regional Health Care Corporation

December 10, 2017 to December 10, 2018

Cara M. Christ, MD, MS, ADHS Director

Bentley J. Bobrow, MD., Medical Director
Bureau of EMS and Trauma System

Terry Mullins, Bureau Chief
Bureau of EMS and Trauma System

ARIZONA DEPARTMENT
OF HEALTH SERVICES

PREPAREDNESS

January 29, 2018

Lynette Bonar
Chief Executive Officer
Tuba City Regional Health Care Corporation
PO Box 600
Tuba City, Arizona 86045

Dear Ms. Bonar:

Congratulations on your institution's designation as a Level III Trauma Center!

The Arizona Department of Health Services ("Department"), Bureau of Emergency Medical Services and Trauma System has approved your application for designation as a Level III trauma center effective December 10, 2017 through December 10, 2018. Please find enclosed the Level III Trauma Center Certificate for Tuba City Regional Health Care Corporation. The certificate is:

- The property of the Department;
- Non-Transferable to another party;
- Valid only at the location indicated on the certificate; and
- Valid for the term indicated on the certificate

The trauma center designation Level of your health care institution, specified on the certificate, cannot be changed without the prior written approval of the Department. Any change in location, name, or ownership of the health care institution requires you to submit a written notice of the change to the Department at least 30 days before the date of change. The Department will issue an amended certificate, reflecting the change within 30 days after receiving your notice of change. The amended certificate will retain the expiration date of the current designation.

Pursuant to A.A.C. R9-25-1308(B), at least 90 days before a trauma center ceases to offer trauma services, the owner must send to the Department a written notice of intention to cease to offer trauma center services and the desire to relinquish designation.

Thank you for your dedication to the citizens and visitors of your community and participation in the Arizona trauma system.

Sincerely,

Kimberly Boehm, NRP
Trauma Center Compliance Coordinator
Bureau of Emergency Medical Services and Trauma System

c: Ralph Zane Kelly, DO, Trauma Medical Director
Shannon Johnson, RN, Trauma Manager

THE AMERICAN ACADEMY OF PEDIATRICS
ARIZONA CHAPTER

The Arizona Chapter of the American Academy of Pediatrics
Pediatric Prepared Emergency Care Program

is pleased to verify

Tuba City Regional Health Care Corporation

has earned certification as a

Prepared Care Facility

November 2017—November 2020

John Pope, MD, MPH, FAAP — Board President
Arizona Chapter of the American Academy of Pediatrics

Anne Stafford, MA Executive Director
Arizona Chapter of the American Academy of Pediatrics

PediatricPrepared Emergency Care
meeting the emergency needs for Arizona's children

THE AMERICAN ACADEMY OF
PEDIATRICS
ARIZONA CHAPTER

2600 N. Central Ave., Suite 1860
Phoenix, AZ 85004
602.532.0137 office
602.532.0139 fax
www.AzAAP.org
TAX ID 86-0917603

January 2, 2018

Delores Succo, RN
Supervisory Clinical Nurse
Emergency Department
Tuba City Regional Health Care Corporation

Dear Ms. Succo:

On behalf of the staff, members, and board of directors of the Arizona Chapter of the American Academy of Pediatrics, we are writing to thank you for your continued participation in the voluntary certification program of Pediatric-Prepared Emergency Care.

It is our great honor to inform you that Tuba City Regional Health Care Corporation has met the criteria for recertification as a **Prepared Care Emergency Department**. This recertification represents your dedication to optimal care for Arizona's infants, children, and teens. We congratulate you on your rigorous work to maintain this prestigious designation.

We look forward to your active participation in the membership activities, shared learning, and attention to issues that will continue to make a significant difference in the quality of pediatric emergency care throughout our state.

We ask that you report any material changes to your services that would affect your facility's ability to maintain the Essential Criteria for a Prepared Care Emergency Department to the program staff in a timely manner.

Congratulations again and thank you for your ongoing participation.

Sincerely,

Anne Stafford

Anne Stafford
Executive Director
Arizona Chapter of the American Academy of Pediatrics

Enc.

2017 Annual Report

Tuba City Regional Health Care Corporation

2017 Annual Report

Tuba City
Regional Health Care Corporation

167 N Main Street • P.O. Box 600 • Tuba City, AZ 86045 • TCHEALTH.ORG


Tuba City Regional Health Care Corporation
LEVEL III TRAUMA CENTER


LeChee Health
Tuba City

About
Tuba City Regional Health Care Corporation

The Tuba City Regional Health Care Corporation (TCRHCC) is a 73-bed, acute and outpatient regional health system organized as a private nonprofit healthcare organization operating under the Indian Self-Determination Act P.L. 93-638 since September 30, 2002. TCRHCC serves a large geographic area, primarily encompassing over 6,000 square miles on the western Navajo Nation and adjacent Hopi and other communities.

Tuba City is the largest community by zip code on the Navajo Nation. Tuba City's Hospital is the primary campus, or hub, for TCRHCC's integrated health system. The hospital and satellite clinics in Flagstaff, Dinnebeto, and Cameron provide primary care services to over 33,000 Navajo, Hopi and San Juan Southern Paiutes.

TCRHCC also serves as a regional referral medical center for over 75,000 residents across the Navajo Nation and adjacent communities.

In FY 2016, the TCRHCC health system had 681,908 total patient visits. Building on the legacy of the Navajo Area Indian Health Service, previously as Tuba City Indian Medical Center (TCIMC), the formal incorporation process under P.L. 93-638 for Tuba City Regional Health Care Corporation (TCRHCC) began on January 19, 2001 followed by approval by the Navajo Nation Council as a Title I 638 contractor in 2002. In June 2005, the Navajo Nation Council approved the organization for the purpose of managing and operating contracts with the Indian Health Service for a 15-year period through September 30, 2020.

Today, TCRHCC is in its 15th year of 638 funding and operation, and it continues to grow as a regional, community-based health care system. In July, 2010, TCRHCC was approved as a Title V Compactor under the IHS Office of Tribal Self-Governance by the 21st Navajo Nation Council.

TCRHCC provides hundreds of clinical and patient care support services spanning the medical spectrum. It provides a full range of primary and specialty care preventive health and wellness services. All areas of service incorporate cultural sensitivity and the Navajo philosophy of the four sacred directions.

The condition of TCRHCC is fiscally and operationally sound. The top priority of the Board of Directors, Executive Leadership, Medical Staff and support staff is the quality of patient care. Patients, families and communities can be assured that TCRHCC adheres to the highest standards of patient care as evidenced by its accreditation by the national accrediting body - The Joint Commission. All areas of the facility meet or exceed national health care standards. All medical service providers are fully credential to practice medicine. TCRHCC has an experience and stable medical staff. Many of the physicians, nurses and allied professional staff have been at TCRHCC for decades.

An audit is conducted each year by an independent accounting firm to assure that TCRHCC is reporting financial information at high level of standards and practices. Fiscal Year 2016 ended with a positive operating margin and reserves. The Clinical and Finance Department team continuously reviews the practices of the corporation in order to capture every dollar that is due to TCRHCC from third-party sources for the improved health care of the community we serve. Every dollar is put back into our healthcare Mission.

TCRHCC is fully compliant with the Navajo Preference in Employment Act (NPEA). Ninety-five percent of all new hires for non-technical positions are Navajo, and the remaining five percent meet a category under the order for Navajo Preference (spouse of Navajo or other Native American). Every effort is being made to encourage, train, mentor and attract Navajo and Native American individuals to health professions for the future, including leadership, technical and professional positions.

TCRHCC has set the goal of being the Employer of Choice in the Tuba City region to attract, retain and promote talented and qualified Navajos and Native Americans residing on the reservation, in Flagstaff, and other accessible areas.

"Sustaining and Improving Our Healthcare Delivery System"

Our Mission is to provide *"safe, accessible, quality, and culturally sensitive" health care.*

Tuba City Regional Health Care Corporation (TCRHCC) is similar to many healthcare delivery systems off Native Land. We have long surpassed being compared to an Indian Health System, or "I.H.S.". Our Mission is to provide "safe, accessible, quality, and culturally sensitive" health care.

Safety (Safe)

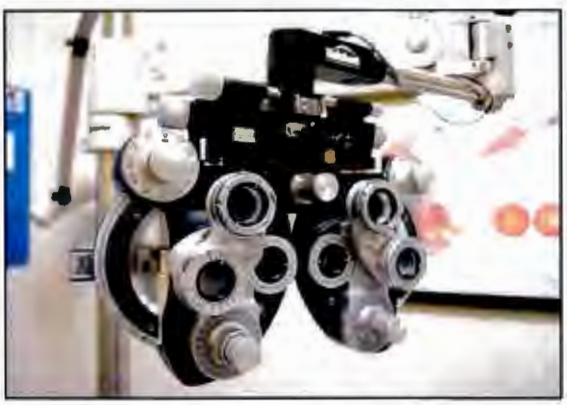
This past year has been a major transformative time. The entire staff has seen and experienced that "safety" needs to be called out and held at the highest priority. Events have occurred that communication and a culture of safety needs to be acknowledged to be at the forefront of our Mission.

Our entire staff has been focused on accountable, safe handoffs of patient care, staff will not tolerate abusive or bullying behavior by any staff, and administrative processes will stand behind those who make these complaints of abusive/bullying staff.

The TCRHCC Board of Directors has approved a tremendous commitment to a safe culture, by investing in our Electronic Health Record (E.H.R.) systems. Our E.H.R. will improve the transmission of health care data, hand off of patient care; wait times, administration of medications, data patients can take with them to other providers, and transmission back and forth to external health care providers for improved coordination of care.

Accessible

Our health care delivery system this past year has improved health care to our beneficiaries in Flagstaff, LeChee, and the surrounding community.



Sacred Peaks Health Center-West
Mental Health and Eye Care Services

Mental Health and Eye Care services have now become available in Flagstaff. LeChee has staffed an Internal Medicine provider, and Pediatric provider.

The Mobile Health Vans have provided outpatient services at convenient places for our community

members, to include areas of frequent visits by our community members; at the local grocery store and the local public events, i.e., Fleas Markets, Just Move It. Our telemedicine services have been increasing in volumes. This service has nowhere to go but up, and we continue to push our Tribal leaders to address the challenge of broadband service in our areas.

Our Board of Directors continues to support improvements of access. Community members want convenience. Decisions to seek health care are not always easy for community members to make or access. Strategic Goals to make access easier will improve the health of many, because it takes away challenges or barriers that are part of the decision to seek health services.

Quality

Quality is a very personal perspective. Quality can be defined as; positive health outcomes, tolerable wait times, a positive customer experience, the kindness of all staff within a patient encounter, adequate timely pain relief or an understandable helpful experience of medical treatment and relieving a patient's fear or anxiety of the unknown.

The above is not an all-inclusive overview of how our organization can continually improve our patient experience, but how our services can continuously strive to sustainable and more authentic now and in the future. TCRHCC has performance measures set by the Federal Government that we do our best to improve or attain. But what really matters is the individual experience that is expressed by our community members.

Training for our staff this past year has focused on "why" we do what we do. Helping our patients with a "why" moment helps them in many ways. Service Recovery has been elevated. The Service Recovery acronym Hear Empathize Apologize Resolve helps staff to work through the process of improving the experience for our patients care and will hopefully just become second nature to our every experience approach to improving our care and our quality outcomes.

Culturally Sensitive

Our community and history is rich with culture. Our tribes have endured, yet survived total assimilation to a non-native way of life. Our current generations are desperately trying to hang on to a life that is respectful of all surroundings while surviving in a modern nontraditional daily way of life.

It is the Vision of the first Governing Board for our organization to deliver a culturally sensitive experience to all community members seeking care, "to respect, to heal and console", honor traditions through the continuum of life.

Tuba City Regional Health Care Corporation
On-site Interpreter Services

No matter, the advances in technology, transforming health care delivery models, or increased Federal regulations, we must uphold the core traditions of our community through our Mission and our Vision.

Transformation and Adaptation

Healthcare delivery today is in continuous transformation, transformation in many ways; delivery, reimbursement, data analytics, improvement, efficiency, and governance.

Our organization has met barriers head on, and with much discussion, deliberation and strategy. We have partnered and maneuvered within our organization and with external partners. This attitude has helped the organization achieve many of our FY17 Priorities this past Fiscal Year.

More than ever we must make our voices heard to combat mandates from our Federal oversight authorities. These mandates are not always in the best interest of Native Americans as well as falling very short of our treaty rights. Our tribal oversight committee, Health Education Human Services Committee, continues to face many battles on all human service fronts. Their responsibility is great in that the needs of the communities they oversee must overcome many barriers and challenges at the human basic need level.

FY2017 System Priorities

Our health system's FY2018 budget and strategy priorities incorporate four converging forces:

- Title V self-governance stewardship;
- Innovation
- Development, and
- Continued partnerships with health system providers, local tribal health providers, and entrepreneurial partners that believe in our successful system.

The FY2018 Capital and Operating Budget

1. Sustainable Revenues

The U.S. Department of Health & Human Services via I.H.S. approved the following hospital inpatient and outpatient rates for the 12-month period ending 12/31/2017:

Inpatient Hospital AHCCCS
Per diem rate: $2933 (+9.05% over CY16 $2655)

Outpatient OMB AHCCCS
Per visit: $391 (+9.411% over CY16 $368)

Outpatient OMB Medicare
Per visit rate: $350 (+9.25% over CY16 $324)

Inpatient Medicare Ancillary Pt B
Per diem: $679 (+9.38% over CY16 $637)

We always hope to have OMB increases in every Fiscal year.

Continuing Resolution (CR) – We have seen a CR again in FY2018, this fiscal year's operating margin is conservatively budgeted for a **+2.9%** positive margin. We will also continue to monitor several other variables in FY2018, including:

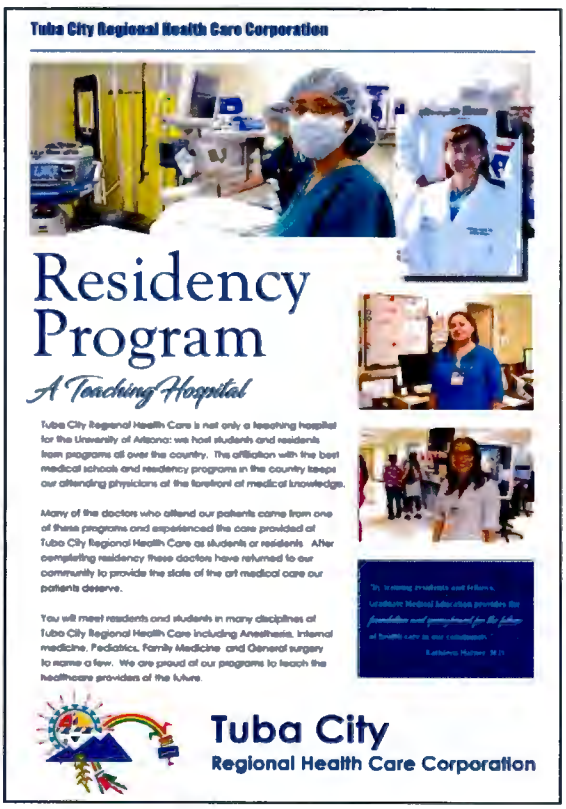
- Grants
- Maintaining Federal Medical Assistance Payment (FMAP)
- Navajo Hopi Health Foundation

2. Regional Health System Partnerships

We continue to combine the best of Tribal Healthcare Delivery models and sound business model as we seek to develop augmented partnerships with other providers and health systems.

Professional provider/nursing shortages are always of concern. We plan to continue to be aggressive in our recruitment and retention strategies that will include:

1. Recruitment through student/residency programs
2. Develop integrated specialty services
3. Maintain focus on more efficiencies within our clinical services
4. Developing our own succession and educational plans



Partnerships are created in order to maintain improve coordination of care, but the main reason for partnerships are to improve the quality of care being delivered to our community members. This need becomes increasingly the case, especially given anticipated changes in delivery and reimbursement now coming with health care reform, e.g. patient centered medical home models and integration of behavioral health.

3. 638 Title V Self Governance

As a whole, TCRHCC must continue to educate and communicate the importance of 638 Self Governance at all levels. Our strength as a 638 Indian Self Determination Health facility has only been strengthened with the addition of the San Carlos Healthcare Corporations and interest from Fort Defiance Indian Health. This need for successful education will only elevate the successes of Self Governance.

The TCRHCC Board and Administration are attempting to "reach out" to the Navajo Nation Council's HEHS Committee as well as the NN Division of Health (NNDOH) to provide collaboration via the 638 Association. Our American Indians for Self Determination in Health (AISDH) are becoming a stronger group. We have developed a well thought our Strategic Plan that encompasses the need to work at all levels of oversight and authority.

On Sept. 30, 2017, TCRHCC celebrated 15-Years of Self-Determination in Healthcare Celebration

Working in unison with other Title 1 and Title V organizations, we will continue to advocate and demonstrate the value of community involvement. A consistent program to educate our governing board is key to an open minded and improved vision of healthcare delivery on Navajo.

4. Human Capital

The TCRHCC Organizational structure is our most valuable asset Of our total 1077+ staff 94.7% are Direct Hire, 1.7% is Civil Service Employees, and 3.5% are Commissioned Corp Staff. This comprises our dedicated, complex healthcare workforce.

Our Journey to Excellence Customer Service Program will continue to be augmented by the following teams:

- Champions for Change
- Dream Team
- Recruitment & Retention
- Team Extreme
- Leadership Academy

Tuba City Regional Health Care Customer Service Committee

Values Statement

(Developed by: Bee Positive Champions for Change, Team Extreme, Dream Team)

"We take pride and honor the dignity in all individuals. We promise to uphold an environment dedicated to quality and a vision of excellence for today and tomorrow"

5. Strategic Capital Improvement Plan

The focus for FY2018 is continued provision of accessible primary and specialty care and improved strategies to deliver optimal customer service. The addition of improved leadership training programs demonstrates the value that our staff brings to our delivery of care.

The financial risk our organization and industry exists in and the presence of a Continuing Resolution cannot be ignored. This reality also causes us to assure we elevate the importance of fiscal responsibility and accountability to adhering to our goal to have transparent benchmarks.

In FY2018 we'll focus on the GO LIVE of our new E.H.R. and managing project development processes to assure improved efficiency. Our Strategic Plan focuses on Finance, Information Systems, and Quality and continued Advocacy as we move into the future of health care today and tomorrow. Technology upgrades this coming year will need to be a step into the world of data analytics that help bring more efficiency to our organization.

Our team (Board of Directors, Senior Leaders, Managers/Supervisors, & Staff) have the capability to be proactive and persistent to adapt and overcome the challenges that we face on a day to day basis. Our staff maintains a proactive stance and our Leaders provide a Vision in a continued environment of change.

6. Strategic Pillars

Each of our strategic pillars will be presented with the progress of our FY2017 year in review, as well as our Strategic Plan for FY2018. The Strategic Plan is our map to maintain the fundamentals goals with objectives and metrics that are needed for success. Our overall strategy is a living document, which will be updated and reported throughout our Fiscal Year.

In Conclusion:

Our strongest attribute we possess at our organization is the strong sense of commitment to quality and cultural sensitivity through our staff to our patients. Our position as a health delivery entity has no other purpose but to successfully meet the health care and wellness needs of those we serve. TCRHCC must address everyday how we move forward to keep our organization sustainable and successful. Addressing health disparities and implementing prevention and education to our varying generational groups is a strategy that will help us focus on specific adaptive health delivery models as well as the use of data and evidence based models of care.

The FY2018 budget and strategy is a work in progress, and our challenge is to continue to transform our healthcare delivery systems that will improve health for all populations of patients we serve. Without the passionate, hard work of all providers, staff, administration and the Board of Directors, this would be an impossible task.

Ahe'hee'

Lynette Bonar

Chief Executive Officer


Protect Our FUTURE
Stop Meth Abuse
National Drug
Abuse Hotline
800-662-HELP (4357)
Navajo Nation Dept. of
Behavioral Health Services
Tuba City: 928-283-3346

Senior Leadership Council

Board of Directors

Christopher Curley, President
Tonalea Chapter

Dr. Alan Numkena, Vice-President
Moenkopi Village

Kimberlee Williams, Treasurer
Kaibeto Chapter

Tincer Nez, Sr., Member
Coalmine Canyon Chapter

Dolly Lane, Member
Bodaway/Gap Chapter

Laura Gon, Member
Cameron Chapter

Herman Tso, Member
LeChee Chapter

Justice M. Beard, Member
To'Nanees'Dizi Chapter

Millie Brockie, Member
Coppermine Chapter

Senior Leadership Council

Lynette Bonar
Chief Executive Officer

Joette Walters
Chief Operating Officer

William Dey
Chief Quality Officer

Christine Keyonnie
Chief Financial Officer

Gerard Diviney
Interim Senior Financial Advisor

Dr. Holly Van Dyk
Interim Chief Medical Officer

Dr. Steve Holve
Deputy Chief Medical Officer

Dr. Sara Jager
Chief of Staff

Dr. Katherine Glaser
Deputy Chief of Staff

Alvina Rosales
Chief Nursing Officer

Shawn Davis
Chief Information Officer

Dollie Smallcanyon
Chief Community Health Services Officer

Julius Young II
Chief Support Services Officer

Sharr Yazzie
Human Resources Director

TCRHCC Achievements

AWARDS THAT *Measure Our Care*

Over the past few years, Tuba City Regional Health Care Corproation has received recognitions that support our unwavering commitment to being the best community healthcare system on the Navajo Nation. Below is a list of some of the recognitions from 2016 that help us measure the quality of care we provide our patients every day.

☐ The Joint Commission Accreditations

For Hospital Accreditation Program
For Home Care Accreditation Program
For Laboratory Accreditation Program

☐ '3 Star' Overall Rating from Centers for Medicaid and Medicare Services

Tuba City Regional Health Care is the only hospital on the Navajo Nation to hold a three-star rating from Centers for Medicaid and Medicare Services.

☐ Designated as a Level III Trauma Center by the American College of Surgeons

Tuba City Regional Health Care is the first and only hospital on the Navajo Nation – and one of just eight total organizations – in Arizona designated as a Level III Trauma Centers.

☐ Baby Friendly Hospital Certified

Tuba City is one of five designated facilities in the State of Arizona as of August 22, 2017.

☐ The Arizona Perinatal Trust Accreditations

Tuba City Regional Health Care Obstetrics Unit and Nursery is one of 41 Perinatal Care Centers in Arizona, and the only Level II Perinatal Care north of Flagstaff and on the Navajo Nation.

TCRHCC Infographics - Numbers

BY THE NUMBERS

TCHEALTH.ORG Tuba City Regional Health Care Corporation

1200+ employees

Entered into a Tribal Self-Governance Health Care System in 2002

73 beds

681,908 outpatient utilization in 2016

42,000 emergency visits in 2016 to our Level III Trauma Center

12,020 inpatient days in 2016

Providing Health Care Services to Meet the Demand of an Ever Growing Native American Population

50+ specialty clinics

4 satellite clinics

Cameron Dental
LeChee Health Facility
Sacred Peaks Health Center
Sacred Peaks Health Center-WEST

3 mobile clinics

Mobile Medical & Dental Unit
TeleHealth Unit

1 traditional native and western medicine program

Office of Native & Spiritual Medicine promotes partnership between traditional Native & Western medicine

Operating Revenue and Expenditures

FY 2016 Net Operating Surplus To Use for Vital New Facility/Service Improvements: $13,861,594

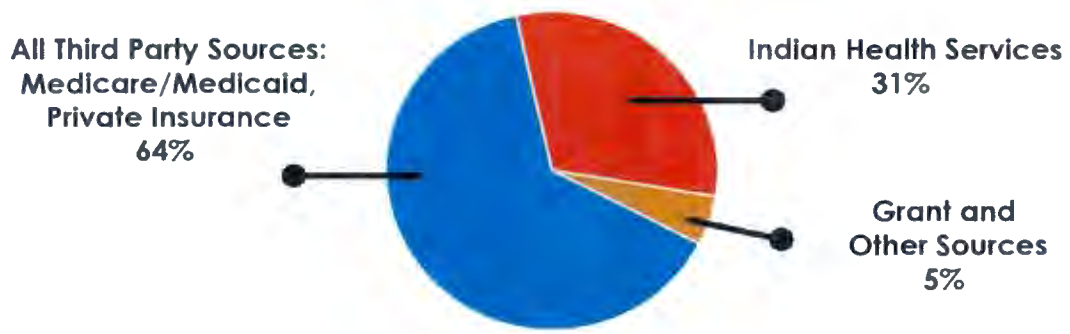
Last fiscal year TCRHCC saw a total of $165,369,022 in net revenue and $162,780,067 in expenses. In FY 2016, total patient visits was 681,908. Due to continued growth and higher level of patient services, $7.9 million was invested in the purchase of capital property and equipment.

TCRHCC is committed to serving its entire population in all geographical areas. Fiscal year 2016 was a year of further extension and commitment serving these communities as completely as possible, and delivering medical services as efficiently as possible.

TCRHCC projects all need at the present for new capital improvements, expanded services and technology.

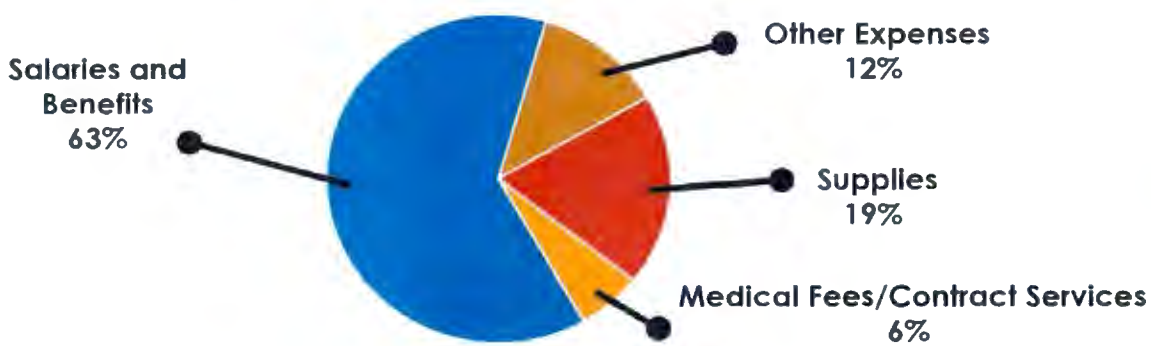
FY 2016 Revenue

Where the money comes from...



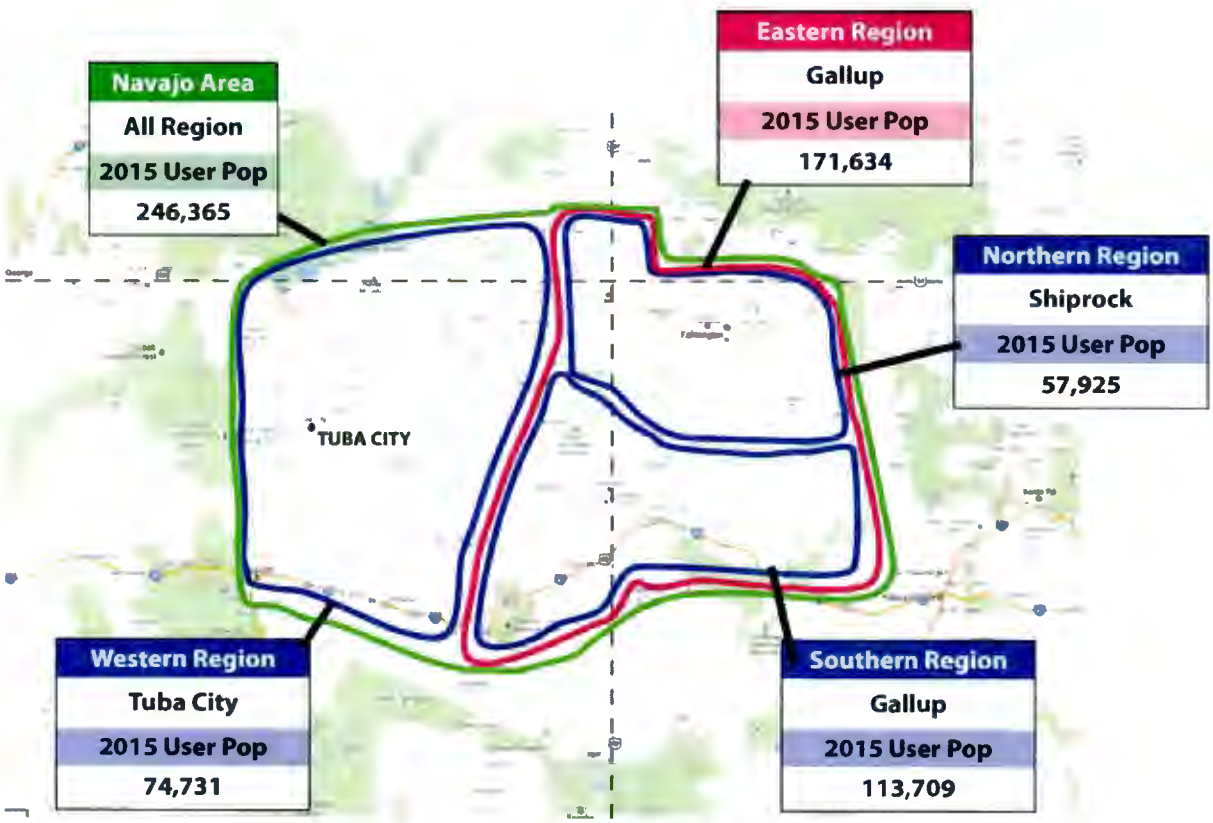
FY 2016 Expenditures

Where the money goes...



User Population
Navajo Area Indian Health Services (IHS)

Tuba City Service Unit, Gallup Service Unit, Navajo Area, Shiprock Service Unit



Inpatient & Outpatient Workload
FY 2002 - FY 2016

AHCCCS/OMB Billable Patients Visits (BPV)

INPATIENT	FY 2002	FY 2012	FY 2015	FY 2016
Hospital Discharges	**3,458**	**2,951**	**2,098**	**2,267**
Swing-Bed	–	*95*	*50*	*69*
ACU	–	*2,856*	*2,048*	*2,198*
Inpatient Days	**14,153**	**11,880**	**10,124**	**9,457**
Average Daily Census	**38.0**	**32.5**	**25.0**	**25.0**
Newborns	**512**	**454**	**456**	**412**
Newborn Days	**946**	**870**	**866**	**820**
Total Inpatient Days	**15,099**	**12,750**	**12,020**	**12,020**
Discharges	**3,970**	**3,405**	**2,554**	**2,679**
ALOS	**3.8**	**3.7**	**4.6**	**4.3**

OUTPATIENT	FY 2002	FY 2012	FY 2015	FY 2016
Total Outpatient Visits	**145,035**	**720,708**	**690,575**	**681,908**
Observations	–	*519*	*750*	*702*
Outpatient	–	*720,189*	*689,825*	*681,206*

GRAND TOTAL UTILIZATION	FY 2002	FY 2012	FY 2015	FY 2016
Grand Total Inpatient Days & Outpatient Visits	**160,134**	**733,458**	**693,129**	**684,587**

NOTE: BPV (Billable Patient Visits) = Reimbursable Patient Visits Counted per AHCCCS/OMB

Patient Care Utilization Data FY 2002-2016

The TCRHCC Inpatient and Outpatient Summary Report displays patient visits by the Navajo Area Indian Health Service (NAIHS). Trends in patient care workload from 2002 to 2016 are readily apparent. This growth helps the hospital's ability to grow and to provide new health services because it helps set reimbursement and funding levels each year. This data includes patient visits, as well.

The average rate of total utilization growth has been 10% annually in the period of 2002 through 2016. The majority of growth occurred on the outpatient side, while some also came from inpatient activity, as shown in the tables.

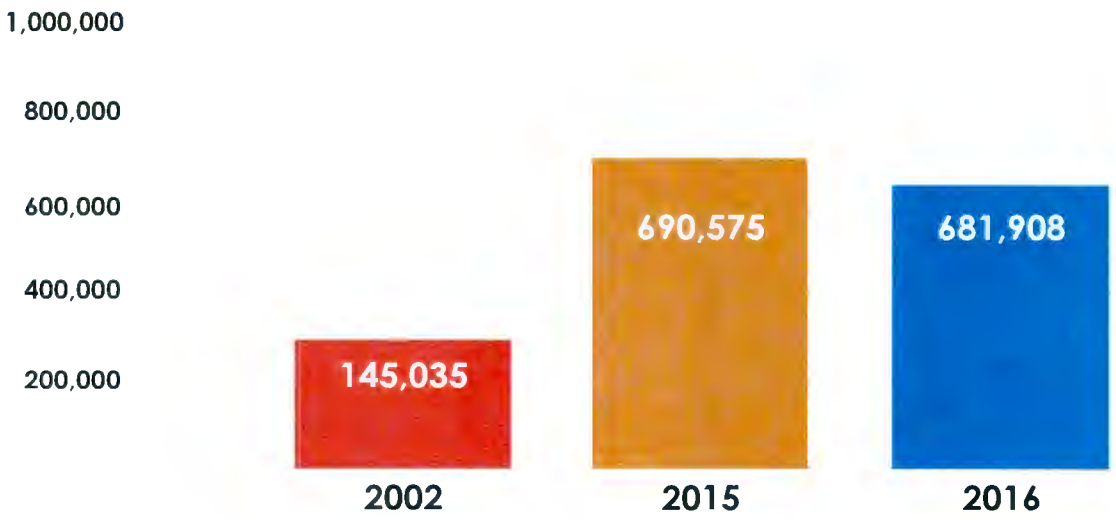
In FY 2016, total combined hospital inpatient and outpatient visits was a total of 684,587 visits. This represents a +328% increase in total patient visits during the twelve year period, growing from 160,134 visits in 2002.

The outpatient visit declined by 1 % in 2016 versus 2015 which was favorably impacted by expansion projects such as the LeChee Health Facility, Sacred Peaks Health Center, the Outpatient Primary Care Center, and providing access to healthcare by the Mobile Health Units and other new services changes in hospital utilization.

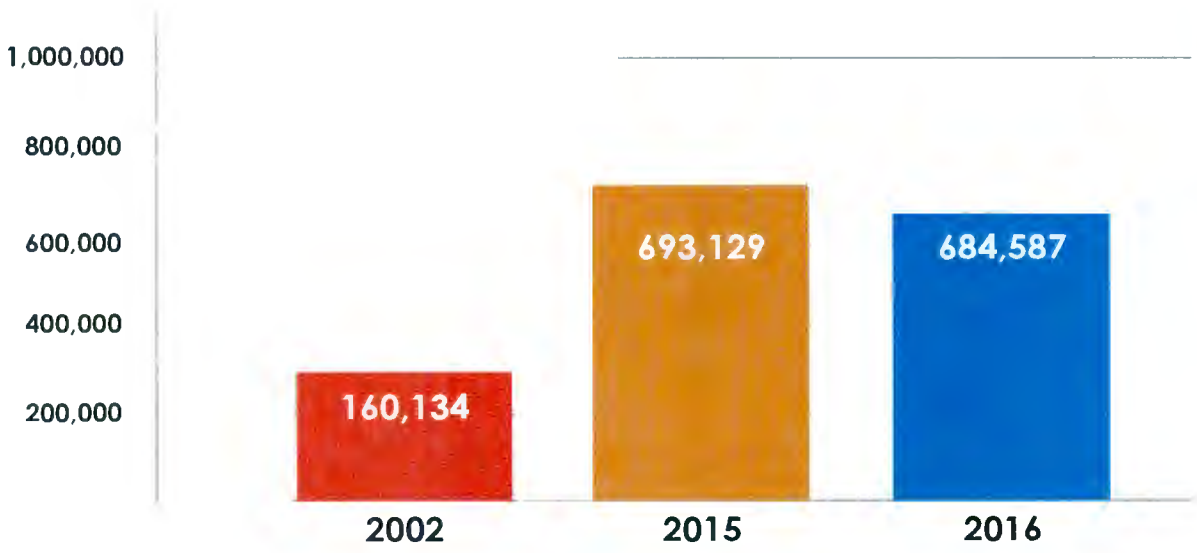
The need for additional housing for clinical staff continues to have a major bearing upon our ability to continue to grow with additional patient services, including inpatient, outpatient and emergency room services and other specialty services needed at TCRHCC as a regional medical center.

Patient Care Utilization Data FY 2002-2016

Total Outpatient Visits



Total Inpatient and Outpatient Visits



Strategic Plan
FY 2012 - FY 2017

Mission

Our Mission is to provide safe, accessible, quality and culturally sensitive healthcare.

Vision

Our Vision is embracing healthy living to heal, to respect, to console.

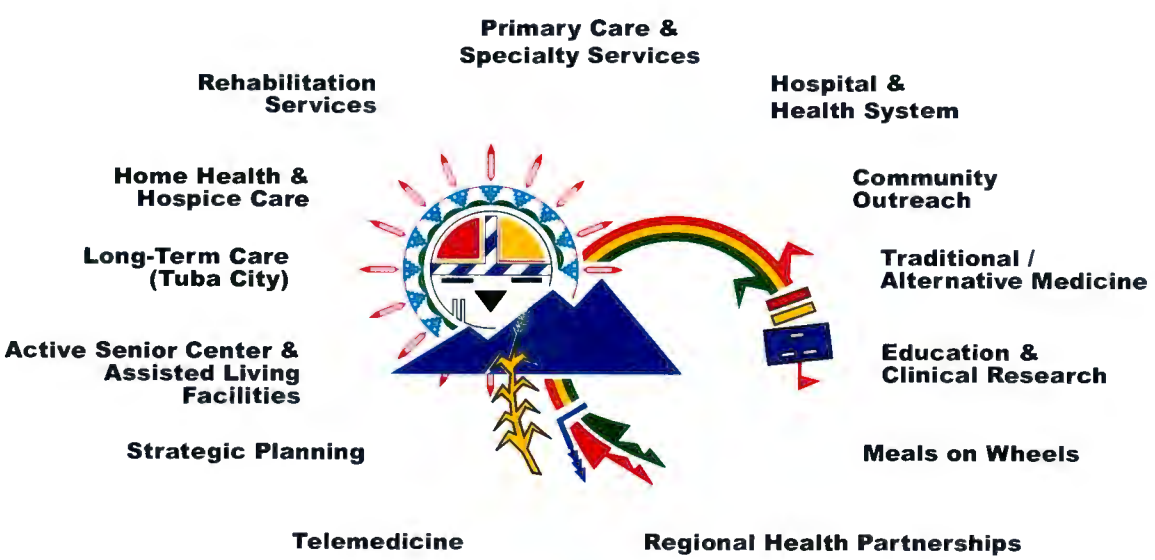
Promise

We take pride, and honor the dignity in all individuals. We promise to uphold a safe environment dedicated to quality and a vision of excellence for today and tomorrow.

Four Strategic Pillars:

- Financial Management
- IS/Data Management
- Quality Improvement
- Services Enhancement/Development

Integrated Regional Health System



TCRHCC Regional Health System

An Integrated Health System with a Regional Medical Center Hub and Network of Mobile / Fixed Satellite Health Services

Tuba City Regional Health Care

- Tuba City, AZ

Sacred Peaks Health Center

- Flagstaff, AZ

LeChee Health Facility

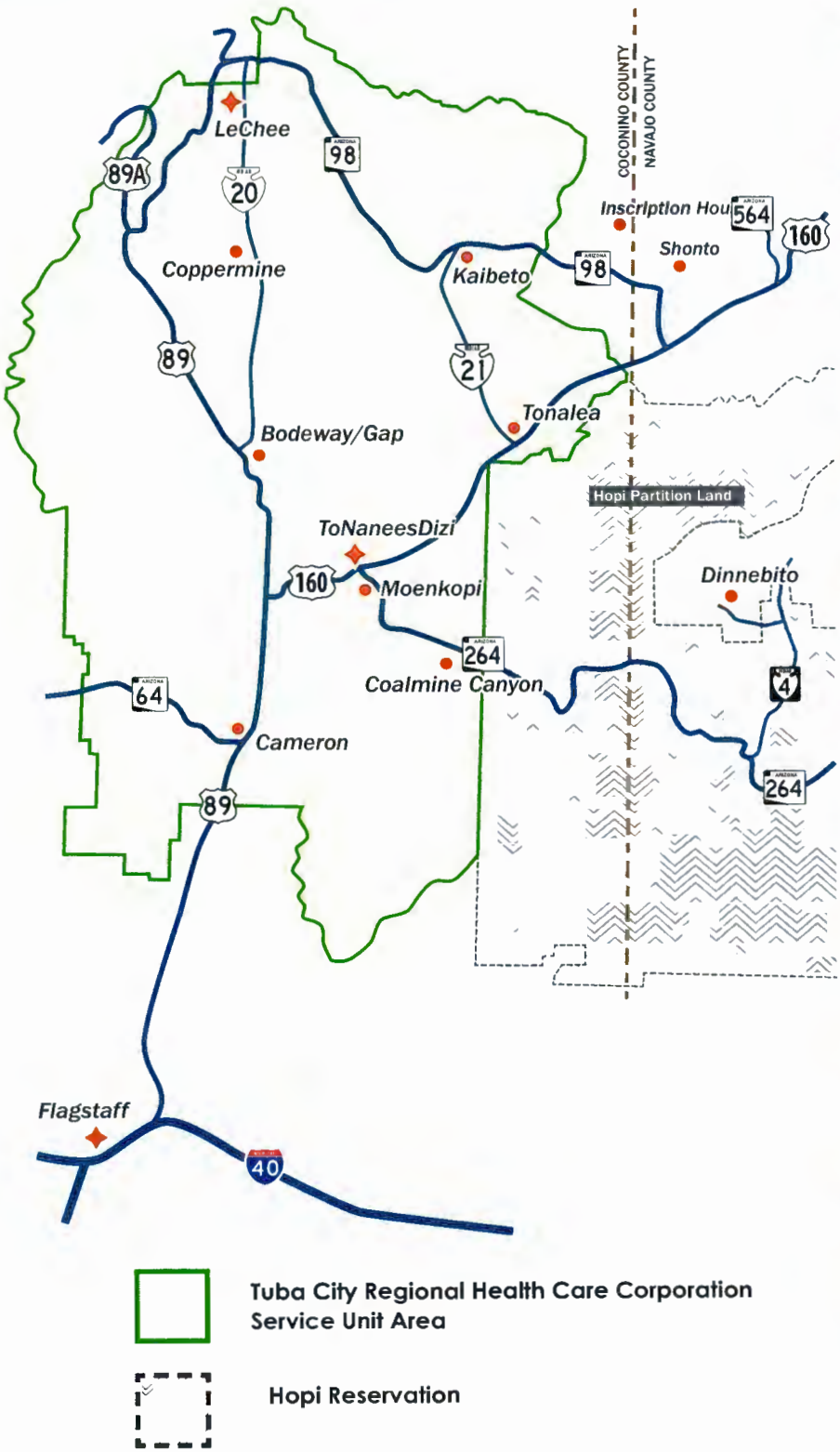
- Lechee, AZ

Mobile Health Unit Location Visit Sites

- Bodaway/Gap
- Cameron
- Coalmine
- Coppermine
- Dinnebito
- Kaibeto
- LeChee
- Moenkopi
- Tonalea
- Tuba City

Kaibeto Creek Independent Living Center

- Kaibeto, AZ



TCRHCC Capital Priorities FY 2016–2018

1. **Campus Expansion**
    a. Expanded Primary Care (Rehabilitation)
    b. SPHC Expansion
    c. Bodaway/Gap Health Center Recruitment
2. **Long Term Care (Complete Construction Design 10/15)**
3. **Electronic Health Record**
    a. Implementation
4. **Integrated Delivery System Master Plan (SLC f/u)**
5. **IT Fiber (Frontier)**
6. **Correctional Facility Health Care Funding (Multi Tribal Model)**
7. **Sustainable Reimbursement and Business Intelligence Model**
    a. HR Information System
    b. Enterprise Resource System
8. **Succession Planning for Future**
    a. Nursing Training Programs
9. **Community Health Center Development**
    a. Mobile Health Site Expansion
10. **Grant Program Expansion**
11. **Enhance Population Health Infrastructure**
    a. Care Coordination
    b. Population Health IT
    c. In Network Utilization
12. **Partnership: 638, Local, PCMH, Local Tertiary Providers**

TCRHCC Operational Priorities FY 2016–2018

1. ICD 10
2. Health Resource Information System
3. E.H.R. Implementation Plan
4. Improved Performance Improvement
5. Customer Service Program & Employee Engagement
6. The Joint Commission Accreditation
7. Grow Telemedicine
8. Health Promotions expansion
9. Call Center Development
10. New Specialty Clinics
11. Optimize OR Strategies, Surgical Assistant Trng Program
12. Comprehensive Plan Recruiting Strategy
13. Clinical Education Plan

TCRHCC Emergency Department

The Only Level III Trauma Center North of Phoenix

Our registered emergency department (ED) visits (Adult and Pediatrics combined) continue to grow and reached 42,000 patients for the year 2016, compared to 38,063 patient visit last year, a 10% increase from 2015. The trend reflects a significant continuing growth in volumes of patients coming to the ED for care.

TCRHCC Emergency Department saw 6,858 pediatric patients alone in 2016–compared to 6,458 pediatric patients, a 6% increase from the total volume seen in 2015.

Our volume has been consistently increasing over the year. From 2015 to 2016, our admission rate has increased from 3.4% to 3.8%.

Level 3 Capabilities

Since 2015, TCRHCC Emergency Department is the only Native American Hospital, in the lower 48 states, designated as a Level III Trauma Center by the American College of Surgeons.

TCRHCC Emeregency Department is also one of only eight hospitals in Arizona, and the only Level III Trauma Center north of Phoenix, designated by the Arizona Department of Health Services, Bureau of Emergency Medical Services & Trauma System. TCRHCC is distinguished from other healthcare centers on Navajo for meeting the highest standards of care.

A Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.

Elements of Level III Trauma Centers Include:

- 24-hour immediate coverage by residency trained emergency medicine physicians and the prompt availability of general/ trauma surgeons and anesthesiologists, and orthopeadics surgeon
- Incorporates a comprehensive quality assessment program
- Availability of advanced imaging techniques
- Intensive Care Unit (ICU) facilities and capabilities
- All attending physicans are board eligible or board certified
- Coordination of patients' post-hospital care

As a Level III Trauma Center, TCRHCC recognizes the significant resources in infrastructure, staff and training that Emergency Department must have to provide quality and safe care.

The Emergency Medicine team is available 24 hours a day, seven days a week. This means we have the staff and resources available to save more lives by performing emergency care within the critical time-frame.

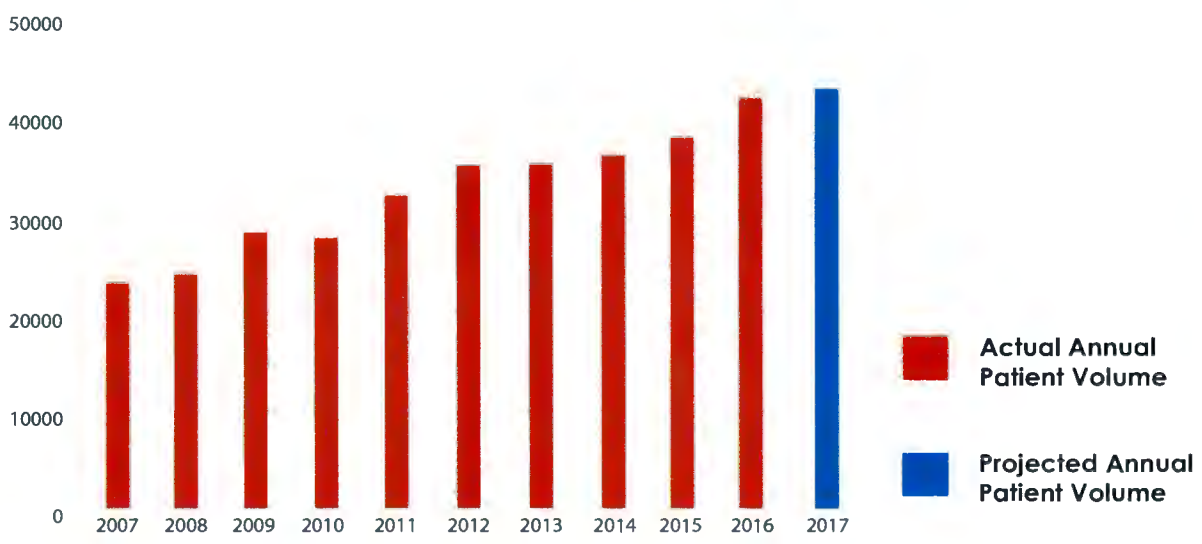
Emergency patients at TCRHCC Hospital also benefit from the latest in imaging technology, including a 128-slice CT scanner and 3.0T MRI. This state-of-the-art imaging equipment produces the most detailed imagery, making it possible for physicians to quickly diagnose and treat.

The hospital's intensive care unit (ICU) has a dedicated clinical team to accommodate the most crtical ill patients. The staff provides critical care 24 hours a day, seven days a week, and coordinates post-hospital care for all patients.

Emergency Department Highlight

- Since 2015, TCRHCC Emergency Department is the only Native American Hospital designated as a Level III Trauma Center by the American College of Surgeons.
- TCRHCC Emergency Department Sexual Assault Nurse Examiners (SANE) are Nurses who have advanced training in giving medical assessment/treatment and evidence collection for victims of sexual assault.
- TCRHCC Emergency Department is a Stroke Center Designation, granted by Mayo Clinic, aimed to improve stroke patients' health outcomes by coordinating the efforts of emergency response systems, ambulance services and hospitals.
- TCRHCC Emergency Department is a Pediatric Prepared Emergency Care center, certified by the The Arizona Chapter of the American Academy of Pediatrics (AzAAP). This level of certification provides services for pediatric care as part of a general Emergency Department.

Emergency Department Annual Patient Volume



TCRHCC Department of Clinical Education

A Center for Health Professions Lifelong Learning

Tuba City Regional Health Care in the community Tuba City, Arizona, is the largest hospital on the Navajo Nation. Located just an hour outside of Flagstaff, the hospital has more than 70 acute-care beds and 130 nurses that provide inpatient and outpatient care services. However attracting and retaining qualified nursing staff has proven difficult, leaving TCRHCC with a shortage of nurses. Improving access to health care for the communities they serve, the Clinical Education Department, at Tuba City Regional Health Care Corporation (TCRHCC), has responded to meet these needs for their current and future nurses.

Mildred Garcia, DNP, RN, Clinical Education Director, talked about a program that helps transition new nurses from the academic to the hospital environment, called the New Graduate Nurse Training Program. It provides a unique opportunity for new graduate nurses to gain clinical experience.

The New Graduate Nurse Training Program was initiated by MSN level nurses who are Clinical Educators and preceptors. The term preceptor means to tutor, guide, and evaluate. Experienced registered nurses are trained on how to precept the new graduate registered nurse by providing the skills and tools on how to precept. This type of training contributes to job satisfaction and increases long-term retention. In addition, our Preceptor Training empowers the preceptor with skills that will result in a mutual positive experience," said Garcia.

"We also believe that in order to fulfill our Mission and Vision at TCRHCC, tools must be given for those in the front lines to have the best chances to succeed."

"The New Graduate Nurse Training Program is designed with the new nurse graduate in mind," said Garcia. "Training based on preceptor and mentor relationships ensures that all nurses are prepared to transition from the classroom to the hospital with continued support from a community of professionals."

The New Graduate Nurse Training Program allows for these nurses to gain hands-on- clinical and specialty experience working alongside exceptional nurses at TCRHCC.

"Our program is 12-weeks long. The first 6-weeks of this program are spent with the Clinical Education team. During these first six weeks the nurses are provided training in the Simulation Lab that includes ACLS, PALS, ECG Class, physical assessment, documentation as well as IV Skills

and others. This includes rotations in various departments that contribute to experiencing the interdisciplinary relationships among all the units that are needed to provide optimal patient care. Once the nurse successfully completes the first 6 weeks each nurse is paired up with an amazing preceptor in their designated area work."

The Preceptor to New Graduate Nurse Training Program have been well received by the healthcare team and it has proven to be an important addition to the Clinical Education program at Tuba City Regional Health Care.

The mission of the TCRHCC Clinical Education Department works toward advancing best practices in healthcare education and improve patient safety through the development of effective didactic and simulation-based instruction and robust assessment that are Evidence Based. Furthermore, it has become a model of how a well-planned and implemented simulation-based curriculum can be integrated into training for nurses

Recruitment and retention of new nurses is a continuing and significant problem for rural healthcare organizations. Turnover of registered nurses in the first year of hire can be significant in terms of cost and employee morale, and can have potential effects on patient safety and quality of care.

"Our training programs have increased in demand and size forcing a cap of only 6-8 nurses per program however the program is growing and it is making a difference"

29 New Graduates

29 of TCRHCC new or recent graduate registered nurses have graduated the Preceptor Training Program since 2015

7 Scholarship Recipients

7 nurses were TCRHCC Scholarship Recipients. The recipents returned to TCRHCC and have now completed the TCRHCC Preceptor Training Program.

25 Employed at TCRHCC

25 nurses currently at TCRHCC have graduated the Preceptor Training Program since 2015

86% Retention of the New Grads

86% of nurses who completed the Preceptor Training Program are still working at TCRHCC

As the healthcare landscape becomes more demanding and calls for evolving training needs, the New Graduate Nurse and Preceptor Training Program offers TCRHCC current nursing team the experience, knowledge, and expertise needed to train future nurses and ensure they are prepared to meet the challenges associated with providing care in Tuba City Service Unit's rural communities.

"The future plans is developing an ancillary program with DINE College and grow from there," added Garcia.

TCRHCC Dr. Hu Nominated for the Native Public Health Innovation Award

April 2017, Dr. Diana Hu, a board certified pediatrician at Tuba City Regional Health Care Corporation (TCRHCC), was nominated for the Native Public Health Innovation Award for eliminating the long-standing health disparity in the diagnosis and treatment of Severe Combined Immunodeficiency (SCID) in Native American children. Her clinical work 25 years ago established the epidemiology and genetics of this illness. Her efforts culminated in the development of a newborn screening program for SCID on the Navajo Nation in 2012, and because of her lobbying efforts the state of Arizona will adopt newborn screening for SCID this year. Her work has taken an illness that previously was universally fatal and made it a treatable condition.

When Dr. Hu arrived in Tuba City in 1985 a handful of patients on the Navajo Nation had been identified with SCID. SCID is a heritable immunodeficiency disease in which the body fails to make the white blood cells needed to fight infection. Without a functioning immune system SCID patients die within the first few months of life. Prior to 1985 every Navajo patient diagnosed with SCID had died in infancy.

Dr. Hu's first public health work for SCID was to define the scope of the problem. Her epidemiologic work showed that the rate of SCID in Navajo children was markedly elevated: 1 in 2,000 Navajo births, much higher than the 1/60,000 rate in the general US population. Further work showed that this increased risk of SCID also occurred in other Athabascan tribes including the White Mountain and San Carlos Apache in Arizona, the Jicarilla and Mescalero Apache in New Mexico, and the Na Dene in Canada and Alaska.

With increased awareness came increased diagnosis. But because the diagnosis was often not made until infants manifested an infection, life saving bone marrow treatment was delayed. In the first 10 years of her career only 30% of Navajo infants survived. Earlier diagnosis would be the key to better survival.

An affordable newborn screen for SCID called the T-cell receptor excision (TREC) test became available in 2010. The test was adopted by only a few states: Arizona was not one of them. Realizing the value of this test for Native American children Dr. Hu arranged for a pilot study of TREC testing on the Navajo Nation from 2012 through 2014. Results published in 2015 showed this test was highly successful. Out of 7,900 Navajo infants screened four were identified with SCID by two weeks of age. All four successfully underwent bone marrow transplantation.

But success on the Navajo Nation did not translate across the state of Arizona. Many Native American births in Arizona occur off reservation in hospitals that do not perform TREC testing. Dr. Hu cared for several Navajo patients whose diagnosis was delayed for lack of newborn screening. The obvious goal was to get the state of Arizona to adopt TREC newborn screening for SCID.

Easier said then done. Since 2012 Dr. Hu has participated in education and lobbying with the Arizona Department of Health Services, Arizona Medicaid, the Arizona Chapter of the American Academy of Pediatrics, The March of Dimes, and the Inter tribal Council of Arizona. Efforts to add TREC testing to the Arizona newborn screening test failed in 2014, 2015 and 2016. But Dr. Hu's persistence has paid off. This year a bill to add TREC testing to newborn screening was endorsed by the Arizona governor, has passed both houses of the Arizona legislature, and is awaiting final budget reconciliation to become law.

Dr. Hu has taken an illness once thought rare and defined its unique epidemiology in Native American children. She has now brought public health prevention to the newborn period with the adoption of the TREC test. . An illness previously 100% fatal for Native American children is now 100% treatable.

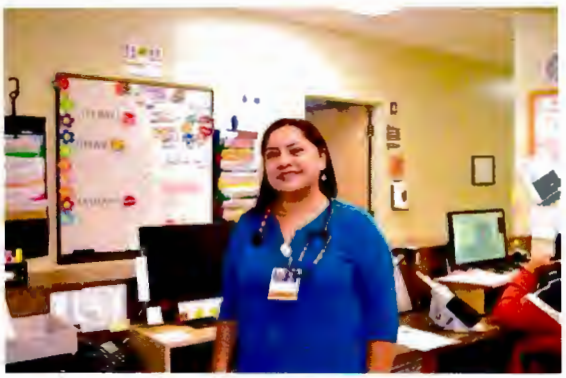
TCRHCC Dr. Calderon Receives Distinguished Alumni Award

Sophina Manheimer Calderon, M.D., Family Physician of Tuba City Regional Health Care Corporation (TCRHCC), was the recipient of the 2017 School of Medicine and Dentistry Alumni Humanitarian Award from the University of Rochester School of Medicine & Dentistry.

Established in 2009, the award is presented annually to recognize alumni who have made outstanding contributions in their professional and civic lives. The Awards Committee, comprised of the university's Alumni Council, commended Dr. Calderon for her life-long commitment to her home on the Navajo Nation near Tuba City, Arizona, and improving the delivery of care to patients. As a physician and educator, she has dedicated herself to improving access and making medical care better for patients at home.

"I am honored to have been recognized by the medical school that has provided me with such a strong foundation. The University of Rochester School of Medicine & Dentistry's biopsychosocial model of education was well-aligned with the Diné philosophy in which I was raised," said Dr. Calderon. "I am grateful for the opportunities I received while attending the University of Rochester School of Medicine & Dentistry, and I am proud to bring back those skills to my people who stand to benefit the most."

Under her leadership at Tuba City Regional Health Care, Dr. Calderon has distinguished herself as a medical educator, an academic physician with a focus on quality of care and patient-centered health and prevention, and a leader in a large health care system that is a model for integrated medical care for the Navajo, Hopi, and San Juan Southern Paiute Tribes.



"TCRHCC is fortunate to have one of our own community member's come back as a professional physician and provide medical service to our Native people, and we are very honored that she has been awarded such a prestigious honor for her selfless service to alieving suffering within special populations such as ours" stated Lynette Bonar, CEO, TCRHCC.

Dr. Calderon works as a family physician providing care in multiple clinical settings, including the Family Medicine Clinic, Same Day Clinic, Pediatric and High School Adolescent Clinics, Emergency Department and the Mobile Medical Clinic traveling to various outlying rural communities in the Tuba City Service Unit. She also provides inpatient obstetrical care and OB continuity of care from pregnancy diagnosis to delivery.

Dr. Calderon also serves as the HIV officer for TCRHCC to coordinate HIV care and provide education for other providers and patients in the community. She also serves as co-chair of the medical staff credentialing committee to ensure that TCRHCC employs high-quality medical providers.

Dr. Calderon is a fluent speaker of Spanish and, since returning to the Navajo Nation, has been committed to relearning the Navajo language. She has taken several semesters of Navajo language courses through Dine College in Tuba City.

TCRHCC Volunteer Program

Dedicated to Health Care Education

Tuba City Regional Health Care enthusiastically supports student interest in healthcare careers by encouraging them to see for themselves what healthcare has to offer as they consider their futures.

This summer, our Volunteer Program helped 45 students find work experience at Tuba City Regional Health Care. The students were hired through the Tuba City Workforce Development or To'NaneesDizi Chapter House. Our summer program offers students workers the opportunity to give their time while gaining valuable experience within a hospital setting. Students gain great satisfaction from constructive service and develop a sense of civic responsibility while performing day to day non-medical functions in their assigned area. Student volunteer opportunities are limited and based upon department availability.

WORKforce DEVELOPMENT INITIATIVE

The hospital's Foundation operates one of the only hospital gift shops on the Navajo Nation, and the Foundation House manned exclusively by our student volunteers. More than 10 volunteers help process and sell items to support our programs.

We have a number of department areas in which our students and community members can volunteer including: Waiting area desk, Information Technology (IT), Navajo Hopi Health Foundation, Human Resources, Finance, Health Promotion & Disease Prevention Program, Facilties and Maintenance, Gift Shop, Patient Financial Services, and more areas to serve based on interests.

NAVAJO · HOPI
HEALTH FOUNDATION

Mission

Develop resource partners to meet our increased medical demands.

Vision

- Support efforts of Tuba City Regional Health Care Corporation (TCRHCC) and bring the cultural "Beauty Way" to every aspect of our patients' care.
- Delivering integrative medicine to an underserved population.
- Provide an academic setting for the education of future generations.
- Make healthcare more accessible to the underserved.

Website

www.NavajoHopiHealth.ORG

Find us on Twitter

@NHHFoundationTC

About

The Navajo Hopi Health Foundation is a non-profit 509(a)(3) charitable organization established in October 2012, dedicated to raising funds for Tuba City Regional Health Care Corporation (TCRHCC), the designated healthcare provides to 75,000 Navajos, Hopis, and San Juan Southern Paiutes within a 6,000 plus square mile referral service area (larger than Connecticut and Rhode Island combined).

The Foundation's goal is to secure financial resources for continued development of improving the healthcare center and purchasing medical equipment needed in the area by providing support to Tuba City Regional Health Care Corporation and the region it serves.

Navajo Hopi Health Foundation

Impact of Giving

The Navajo Hopi Health Foundation is pleased to highlight the impact philanthropy has had on the lives of our patients and families. Together, we're transforming health care and meeting the needs of patients now and in the future. Your generosity heals.

As we reflect on 2016 and all the great things happening throughout our hospital and health centers every day, we are very thankful to be a part of such a generous and compassionate community.

The Foundation started in 2013, entirely staffed with volunteers. NHHF is a non-profit, 501(c)(3), Foundation that supports Tuba City Regional Health Care Corporation and their visionary projects.

NAVAJO · HOPI
HEALTH FOUNDATION

CURRENT GIVING CAMPAIGNS

Navajo Hopi Health Foundation currently seeks generous support of the following:

Celebrating the Spirit of Caring and Giving

Since 2002, as a Tribal Self-Governance Healthcare, Tuba City Regional Health Care has served eight chapter communities in the Western Navajo Nation by providing quality medical care to those who live, work and pass through in the area.

Gifts of all sizes have the power to save lives. Whatever the size or form of your contribution, you will ensure that Tuba City Regional Health Care continues providing excellent, innovative health care for our communities.

TCRHCC Cancer Center

The Cancer Center campaign was created to raise awareness about the importance of cancer center on the Navajo Nation. The Foundation is designed to build a cancer center, provide access to a range of coordinated services for cancer patients to deliver exceptional, compassionate care under one roof.

NHHF - The Canyon House

The Foundation Canyon House had its grand opening on October 15, 2016. The Canyon House was named in honor of Leona Canyon.

The Canyon House – The Thrift Shop

In remembering one of the Foundation's most committed volunteers, Leona Canyon, who tragically succumbed to cancer in March 2016, We called the house " NHHF The Canyon House."

The Canyon House, a restored house will provide so much for the community, a quaint little thrift shop, a yogurt shop and native arts and crafts.

Legendary Native actor Gary Farmer was invited as guest of honor and gave his endorsement to the Foundation's mission in establishing an oncology center on the Navajo Reservation. We appreciate you, Gary Farmer.

Leona's passing sheds light on how common cancer is on the reservation and that a majority of the people cannot seek treatment due to financial restraint and the distance to an adequate facility. By fate, she's managed to fuel the beginning of the first oncology center on the reservation.

HOW YOU CAN HELP

Philanthropic gifts from individuals, corporations, foundations, and organizations have a profound impact on Tuba City Regional Health Care's ability to carry out its mission of caring and providing accessible health care for patients.

Since its inception in 2013, the Hospital has received more than $000 from community friends, local businesses and the Hospital family.

The gifts received each year help ensure that Tuba City Regional Health Care will continue to provide modern facilities and technologically advanced treatments for our patients. Gifts to endowment help to ensure future financial well-being.

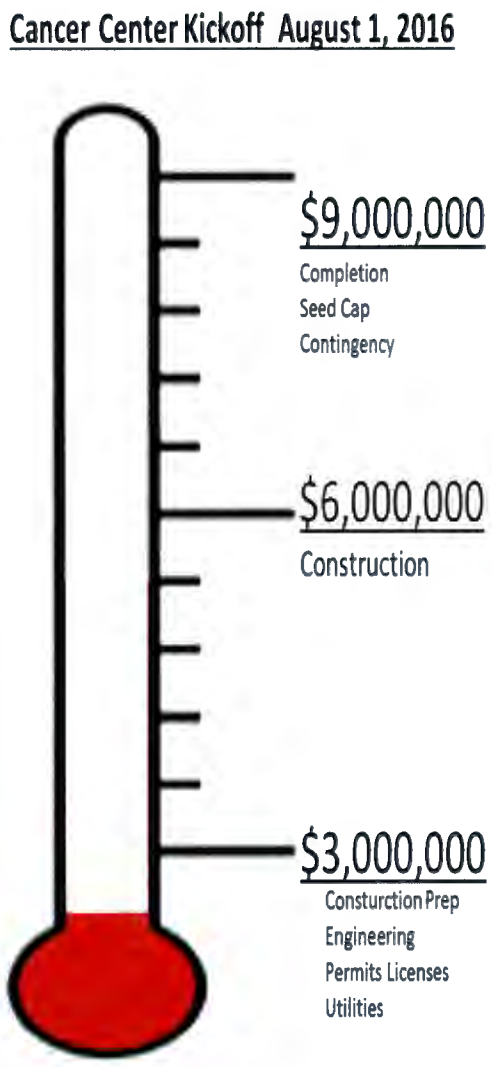
Through the Navajo Hopi Health Foundation, innovative expansions in healthcare are possible.

Please visit our website and see more of our accomplishments and what lies ahead

In 2016, recognition includes:

- Opened beautiful Comfort Care Rooms
- Restored Original Art in the hospital and continue to maintain art
- Provide furniture throughout the hospital
- Remodeled the cafeteria
- Provided a computerized SIM Lab for on going medical staff training
- Started a Strive for Five Program for TCRHCC employee Payroll Deductions
- Support and participate in all pillars of customer service programs
- Built a Hogan for traditional medicine in the Healing Garden
- Legacy Brick Program , provide a lasting memory on the hospital wall
- Solicited over $500,000 in Native American art work for the walls of our buildings.
- Sponsored outreach community events, little league, volley ball, soccer rodeos, parades, Diabetes awareness, On the Move runs,
- Developed NHHF Social Media that reaches over 28,000 peopl
- Provided OB department with Furniture and remodel
- Provided instruments for Dental Department
- Provided Flat Screen TVs in waiting rooms, and patient care rooms
- Developed Outstanding Summer Youth Program accept 50 students, focus, careers in healthcare
- Restoration of abandoned 1937 House on Main St. The Foundation Thrift Shop
- Provided a beautiful Chapel in the hospital

TCRHCC Cancer Center Funding Meter




Love Them
Protect Them
NO
Smallpox!
NO Polio!
KNOW PUBLIC
HEALTH!
Vaccinated?
Get A
Booster!
Bee
Wise
Immunize!

Tuba City
Regional Health
Care Corporation

2016 Annual Report

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Tuba City
Regional Health Care Corporation

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Tuba City Regional Health Care Corporation
ARIZONA STATE DESIGNATED & AMERICAN COLLEGE OF SURGEONS VERIFIED
LEVEL III TRAUMA CENTER


LeChee Health
Facility

About
Tuba City Regional Health Care Corporation

The Tuba City Regional Health Care Corporation (TCRHCC) is a 73-bed, acute and outpatient regional health system organized as a private nonprofit healthcare organization operating under the Indian Self-Determination Act P.L. 93-638 since September 30, 2002. TCRHCC serves a large geographic area, primarily encompassing over 6,000 square miles on the western Navajo Nation and adjacent Hopi and other communities.

Tuba City is the largest community by zip code on the Navajo Nation. Tuba City's Hospital is the primary campus, or hub, for TCRHCC's integrated health system. The hospital and satellite clinics in Flagstaff, Dinnebeto, and Cameron provide primary care services to over 33,000 Navajo, Hopi and San Juan Southern Paiutes.

TCRHCC also serves as a regional referral medical center for over 75,000 residents across the Navajo Nation and adjacent communities.

In FY 2015, the TCRHCC health system had 693,129 total patient visits. Building on the legacy of the Navajo Area Indian Health Service, previously as Tuba City Indian Medical Center (TCIMC), the formal incorporation process under P.L. 93-638 for Tuba City Regional Health Care Corporation (TCRHCC) began on January 19, 2001 followed by approval by the Navajo Nation Council as a Title I 638 contractor in 2002. In June 2005, the Navajo Nation Council approved the organization for the purpose of managing and operating contracts with the Indian Health Service for a 15-year period through September 30, 2020.

Today, TCRHCC is in its 14th year of 638 funding and operation, and it continues to grow as a regional, community-based health care system. In July, 2010, TCRHCC was approved as a Title V Compactor under the IHS Office of Tribal Self-Governance by the 21st Navajo Nation Council.

TCRHCC provides hundreds of clinical and patient care support services spanning the medical spectrum. It provides a full range of primary and specialty care preventive health and wellness services. All areas of service incorporate cultural sensitivity and the Navajo philosophy of the four sacred directions.

The condition of TCRHCC is fiscally and operationally sound. The top priority of the Board of Directors, Executive Leadership, Medical Staff and support staff is the quality of patient care. Patients, families and communities can be assured that TCRHCC adheres to the highest standards of patient care as evidenced by its accreditation by the national accrediting body - The Joint Commission. All areas of the facility meet or exceed national health care standards. All medical service providers are fully credential to practice medicine. TCRHCC has an experience and stable medical staff. Many of the physicians, nurses and allied professional staff have been at TCRHCC for decades.

An audit is conducted each year by an independent accounting firm to assure that TCRHCC is reporting financial information at high level of standards and practices. Fiscal Year 2015 ended with a positive operating margin and reserves. The Clinical and Finance Department team continuously reviews the practices of the corporation in order to capture every dollar that is due to TCRHCC from third-party sources for the improved health care of the community we serve. Every dollar is put back into our healthcare Mission.

TCRHCC is fully compliant with the Navajo Preference in Employment Act (NPEA). Ninety-five percent of all new hires for non-technical positions are Navajo, and the remaining five percent meet a category under the order for Navajo Preference (spouse of Navajo or other Native American). Every effort is being made to encourage, train, mentor and attract Navajo and Native American individuals to health professions for the future, including leadership, technical and professional positions.

TCRHCC has set the goal of being the Employer of Choice in the Tuba City region to attract, retain and promote talented and qualified Navajos and Native Americans residing on the reservation, in Flagstaff, and other accessible areas.

"Establishing the Health Care Delivery Foundation for Transforming Generations"

FY 2017 STRATEGIC EFFICIENCIES FOR INNOVATION AND EXPANSION

Tuba City Regional Health Care Corporation (TCRHCC) has transformed from an Indian Health Service Facility to an all-encompassing integrated health system.

Healthcare delivery today is in continuous transformation, transformation in many ways; delivery, reimbursement, controversy, improvement, efficiency, and governance.

The system that "we" have transformed is not even in a stable state, for us, or anyone else. TCRHCC staff is in many stages of change. Even though we live on a bundled rate, "OMB" Office of Management Budget, or "AIR" All Inclusive Rate, all the regulations that are passed affect how we must make changes to our software systems, data collection with the end results to improve better outcomes.

We must advocate changing the archaic ways of the Indian Health Service (I.H.S.) payment systems so we can bring all levels of care to our communities. I.H.S. was set up for only primary care (family, internal, obstetrics and pediatric care). Our communities need much more than this, they need a full continuum of services because we serve the entire continuum of life.

After much assessment and identifying that we have an acute care hospital, but an outpatient care service that is set up with a non-evolving outpatient care delivery system. An outpatient system that did not change with the varied support models that are more cost efficient and adaptable to a "standardized" care system.

Our Health System receives inpatient revenue reimbursements at approximately 18%, and the majority of systems supporting reimbursements are derived from outpatient services of 82%.

This past FY we have had a renewed overview of our outpatient delivery care model and the time has come to remodel our processes to be sustainable and stand up to deliver the best quality care that is patient centered. So we will build a patient delivery model that becomes a modified patient centered medical home that can assure we make use of patient information that keeps

patients safe through any level of care they have to access. A system that standardizes processes will help to attain high reliability and safe delivery of care.

The Federal Government is still and will not waiver from the Triple Aim- cost effective, accessible and best outcomes initiatives. In order to verify this is the care being given, organizations will need to report data outcomes that prove that delivery models that are standard improve patient safety and reduce costs.

Our Quality Division will discuss MIPS and MACRA, as related to our Electronic Health Record (E.H.R.) and as we now are reporting our Value Based Models and how our future data driven E.H.R. systems will function. Not only will these systems provide evidenced base data but they will improve communication among all health delivery systems that our patients encounter. Once system outcomes meet quality standards per Center for Medicare and Medicaid Services (CMS) criteria, the future benefits will be set at ~ 4-5% incentive payment rates. CMS is discovering more cons to this system so the implementation of this new Alternative Payment Model may be delayed in 2017, which will actually provide more time for smaller health systems across the nation to be ready for the nationwide changes. TCRHCC will be finished building, training and implementing our E.H.R. and will be ready for these changes at the end of FY17.

TCRHCC has motivated staff to build our systems to meet these upcoming Advanced Payment Model changes. But we must take the role in leadership to assure our voice is heard to get the most payment for specialty services we want to provide to our communities.

Our organization must meet barriers head on, partner and maneuver through problem solving with open minded thinking to realize and attain transformative ideas. An attitude of transformation has found a home in our organization. This attitude has helped the organization achieve many of our priorities this past Fiscal Year.

More than ever we must make our voices heard to combat mandates from our National Healthcare oversight authorities. These mandates are not always in the best interest of Native Americans; and fall short of our treaty rights. Our tribal oversight committee, Health, Education and Human Services Committee, continues to face many battles on all human service fronts. Their responsibility is great in that the needs of the communities they oversee are at the basic human need level. Our organization does not make light of the education we must provide to assure that our communities are not left out of important decisions that happen at Tribal capital. Our position as a health delivery entity has no other purpose but to successfully meet the health care and wellness needs of those we serve. TCRHCC must address everyday how we move forward to keep our organization sustainable and successful. Addressing health disparities and implementing prevention to the various population groups is a strategy that will help us focus on specific adaptive health delivery models as well as the use of data and evidence based models of care.

Population Health

From the perspective of the values of Population Health alone, we must also proactively involve both the Greater Community we serve and our Board of Directors as regional health system stewards and ambassadors to their respective communities.

Partnerships to improve Population health only create synergies to improve patient health. If we combine a medical intervention with a public health intervention you only get better outcomes. Most diseases that have been acute have now become chronic. Our communities need to be offered services that improve the quality of their lives. The Navajo Nation will always have disparities, but it is up to TCRHCC to implement delivery models that promote better outcomes. Our partner will be the Navajo Nation Department of Health; it is up to us to be the proactive catalyst to improve the lives of our patients.

Besides the Affordable Care Act, Indian Health Care Improvement Act, Quality based initiatives and pay for performance, and not to mention local governance issues, the attached "2017-2019 TCRHCC Priorities" list contains a summary of the ever-changing issues and opportunities facing us as strategic priorities and trends. These will be addressed at the FY17 Operating & Capital Budget and Strategic meeting and will help us focus our overall strategic vision. This list also comprises a summary of practical challenges in developing health system leaders within our organization as we prepare to take TCRHCC's regional health system forward into the future.

We are an integrated community-based Regional Health System serving more than100,000 patients, and we expect this number will continue to grow more than ten percent through FY2017 as our specialty services and communities grow.

Going forward, we must work harder than ever to attract and retain the families and patients we care for. We must attract and retain sufficient primary care providers as well as maintain and expand the space needed to improve our health disparities. Our space needs remain at breaking points, so we must bring to fruition ideas and strategies for FY2017 such as the expansion of Sacred Peaks and LeChee Health Promotion and Prevention services, as well as specialty services that should be offered in our local communities.

FY2016 Operating Outcomes

For the 10th consecutive fiscal year of TCRHCC operations out of the past ten, we again expect to end the fiscal year with a positive margin (in the black). Despite many challenges and barriers, and continued underfunding our "community based" and "integrated regional delivery system" continues to be effective. We have continued to take advantage of strong Board stewardship and all that Title V self-governance has to offer, coupled with the principles of private entrepreneurship.

FY2017 System Priorities

Our health system's FY2017 budget and strategy priorities incorporate four converging forces:

1st: Title V self-governance stewardship;

2nd: Innovative use of the health marketplace enrollment programs in the ACA/AZ Health insurance exchanges, and outside the box ideas to maximize the use of our Purchased Referred Care funding;

3rd: Development of an integrated Regional Medical System grounded in the communities we serve via primary care and specialty providers, and

4th: Continued partnerships with health system providers, local tribal health providers, and entrepreneurial partners that believe in our successful system.

The FY2017 capital and operating budgets and strategy include several longstanding as well as new changes:

1. Sustainable Revenues and Utilization Growth -- Back to Basics & New Opportunities

The U.S. Department of Health & Human Services via I.H.S. approved the following hospital inpatient and outpatient rates for the 12-month period ending 12/31/2016:

Inpatient Hospital AHCCCS
Per diem rate: $2655 (+7.98% over CY15 $2443) (excludes Doctor/FNP/PA services);

Outpatient OMB AHCCCS
Per visit: $ 368 (+4.89% over CY15 $350);

Outpatient OMB MC
Per visit rate: $ 324 (+5.24% over CY15 $307);

Inpatient MC Ancillary Part B
Per diem: $ 637 (+18.99% over CY15 $516)

We always hope to have OMB increases in every Fiscal year.

Continuing Resolution (CR) -- Knowing we will likely see a CR again in FY2017, this fiscal year's operating margin is conservatively budgeted for a **+2.8%** positive margin. We will also continue to monitor several other variables in FY2017, including:

- CMS RAC Accountability – We need to continue to significantly provide educational to our providers and support staff, and monitor patient record audits and request, from RAC, AHCCCS and private payers to enact greater accountability in patient care reimbursement. CMS's RAC programs seek to recoup greater CMS payments for inadequate documentation, medical necessity, coding deficits and other variables.

- Grants -- An annual update on grants activities will be presented, including the status of our current projects and applications. Grant funding is a funding source that we need to continue to explore and apply for.
- Federal Medical Assistance Payment (FMAP) This regulation
- Navajo Hopi Health Foundation – Our Foundation launch will provide an additional means of some financial and related support to TCRHCC mission priorities going forward.

2. Regional Health System Partnerships

We continue to combine the best of Tribal and I.H.S. health care and the private integrated business model as we seek to develop augmented partnerships with other providers and health systems. While we are working closer than ever before between TCRHCC and Flagstaff Medical Center, we hope that our recent Pathology partnership will flourish into more and continue to be a sound partnership.

Professional provider/nursing shortages are always of concern. We plan to continue to be aggressive in our recruitment and retention strategies that will include:

1. Recruitment partnerships
2. The development of new integrated specialty services
3. Maintain focus on doing well with the clinical services we have now
4. Developing our own succession and educational plans/partnerships

Partnerships are created in order to maintain a sustainable population base, but the main reason for partnerships is to improve the quality of care being delivered to our communities. This need becomes increasingly the case, especially given anticipated changes in delivery and reimbursement now coming with health care reform, e.g. expanded primary care models that will include behavioral health.

3. Integrated Clinical Care Center Network

As an integrated Regional Medical Center system (RMC), we need to continue to strategize in planning more advanced care systems in trauma, diabetes, cardiovascular, mental/behavioral, oncology, gastroenterology and other services suitable to our location and RMC capacity.

TCRHCC will need to consistently and aggressively plan our network partnership agreements, as well as develop and maintain reliable infrastructure networks. Our Annual Budgets and Strategy Agenda will be focusing on best practices and models that will be applied to our health care delivery system. Models that include sustainability are nursing training programs, as well as clinical support staff.

4. 638 Title V Self Governance and Community Assessment Needs

As a whole, TCRHCC must continue to educate and communicate the importance of 638 Self Governance at all levels. Our strength as a 638 Indian Self Determination Health facility has only been strengthened with the addition the Ramah, Alamo and Canoncito Navajo satellite communities. This need for successful education will only elevate the successes of Self Governance. The TCRHCC Board and Administration are attempting to "reach out" to the Navajo Nation Council's HEHS Committee as well as the NN Division of Health (NNDOH) to provide collaboration via the 638 Association. Our American Indians for Indian Self Determination in Health are becoming a stronger group. We have developed a well thought our Strategic Plan that encompasses the need to work at all levels of government; local to Federal level.

Working in unison with other Title 1 and Title V organizations, we will continue to advocate and demonstrate the value of community involvement, e.g. the Western Navajo Agency Council reports by TCRHCC Board representatives throughout the year. A consistent program to educate our governing board is key to an open minded and improved vision of healthcare delivery on Navajo.

5. Human Capital

The revised TCRHCC Organization Chart is included in our report. We believe that our most valuable asset is our "human capital," and is key to economic growth of the communities we serve. But not only economic growth, but sustainable growth that supports the Native population.

Of our total 1,221+ staff, 94% are Corporate Staff, 2% are Civil Service Employees, and 4% are Commissioned Corp Staff. This comprises our dedicated, complex healthcare workforce. The summary by the Human Resource Department leadership also depicts the number of Navajos who have grown into higher Management Staff positions, which is by design through our system wide Mentorship Program.

Our Journey to Excellence Customer Service Program will continue to be augmented by the following teams:

- Champions for Change
- Dream Team
- Bee Positive
- Recruitment & Retention
- Team Extreme
- Steering Team

We intend to be both an employer of choice and a patient destination of choice. Every employee needs to let every patient know how they are appreciated as they place their confidence in the TCRHCC providers.

6. Strategic Capital Improvement Plan

The focus for FY2017 is continued provision of accessible primary and specialty care as well as adapting to the major changes in healthcare technology. Elevating primary care and delivering cost effective models of specialized care are imperative to the sustainability of TCRHCC.

We need to be always ready to adapt to a Continuing Resolution and to provide needed services to complete a full continuum of care for

our population health. We need to continue to urge our tribal and congressional leaders to Mandate I.H.S. funding. Native health care should not be "Discretionary Funding".

In FY2017 we'll focus on the implementation of our new E.H.R. and our Enterprise Resource Planning programs, and close out our Joint Commission Accreditation Survey, as well as be ready for our Lab Accreditation in the first Quarter of FY17. Our Strategic Plan focuses on many of these areas as we move into the future of health care today and tomorrow.

Our team (Board of Directors, Senior Leaders, Managers/Supervisors, & Staff) have the capability to be proactive and persistent to adapt and overcome the challenges that we face on a day to day basis. Maintaining a proactive stance and Leaders that provide Vision is of high importance.

7. Strategic Pillars

Each of our strategic pillars will be presented with the progress of our FY2016 year in review, as well as our Strategic Vision for FY2017. The Strategic Vision is our map to maintain the fundamentals goals with objectives and metrics that are needed for success. Our overall strategy is a living document, which will be updated and reported through our Fiscal Year.

One system wide strategic priority is improving our working environment for our employees, and providing quality care in a fashion that will be conducive of a sustainable organizational model. Recruitment and retention will undoubtedly be a major priority throughout FY2017.

In Conclusion:

Our strongest attributes we possess at our organization is the strong sense of instilling cultural sensitivity with our staff to our patients. When our patients have to be transferred out of our organization it is not usually a pleasant experience, so allowing our services to expand for the needs of a cultural experience is of high priority.

Other transformations we are addressing are addressing our elders, and bringing and keeping this reality at the forefront of our Tribal leaders. We also have growing segment of millennial caregivers that we have the responsibility to build a foundational workforce that will carry forward knowledge for our future generations.

The FY2017 budget and strategy is a work in progress, and our challenge is to continue to transform our healthcare delivery systems that will improve health for all populations of patients we serve. Our deepest appreciation goes to all our staff who relentlessly worked on all our presentations. Without the passionate, hard work of all providers, support staff, administration and the Board of Directors, this would be an impossible task.

Ahe'hee'

Lynette Bonar

Chief Executive Officer


Y REGIONAL HEALTH CARE
TUBA CITY

Board of Directors

Christopher Curley, President
Tonalea Chapter

Tincer Nez, Vice-President
Coalmine Canyon Chapter

Kimberlee Williams, Treasurer
Kaibeto Chapter

Dr. Alan Numkena, Member
Moenkopi Village

Dolly Lane, Member
Bodaway/Gap Chapter

Laura Gon, Member
Cameron Chapter

Herman Tso, Member
LeChee Chapter

Justice M. Beard, Member
To'Nanees'Dizi Chapter

Millie Brockie, Member
Coppermine Chapter

Senior Leadership Council

Lynette Bonar
Chief Executive Officer

William Dey
Chief Quality Officer

Christine Keyonnie
Chief Financial Officer

Gerard Diviney
Interim Chief Financial Officer/Senior Advisor

Dr. James Kyle
Chief Medical Officer

Dr. Holly Van Dyk
Deputy Chief Medical Officer

Dr. Sara Jager
Chief of Staff

Dr. Joachim Chino
Deputy Chief of Staff

Alvina Rosales
Chief Nursing Officer

Joette Walters
Deputy Chief Nursing Officer

Shawn Davis
Chief Information Officer

Dollie Smallcanyon
Chief Community Health Services Officer

Julius Young II
Chief Support Services Officer

George Hunter
Interim Chief Human Resource Officer

Lorraine Begay
Deputy Chief Human Resource Officer

Operating Revenue and Expenditures

FY 2015 Net Operating Surplus To Use for Vital New Facility/Service Improvements: $13,861,594

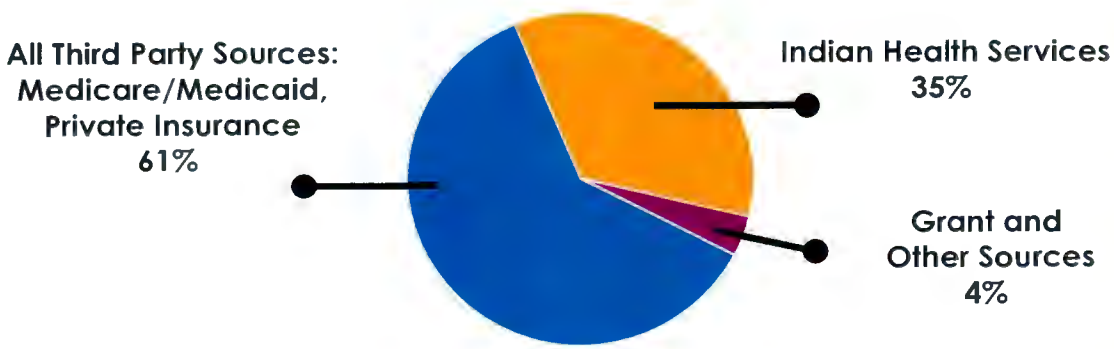
Last fiscal year TCRHCC saw a total of $165,666,069 in net revenue and $151,804,475 in expenses. In FY 2015, total patient visits was 693,129. Due to continued growth and higher level of patient services, $6.0 million was invested in the purchase of capital property and equipment.

TCRHCC is committed to serving its entire population in all geographical areas. Fiscal year 2015 was a year of further extension and commitment serving these communities as completely as possible, and delivering medical services as efficiently as possible.

TCRHCC projects all need at the present for new capital improvements, expanded services and technology.

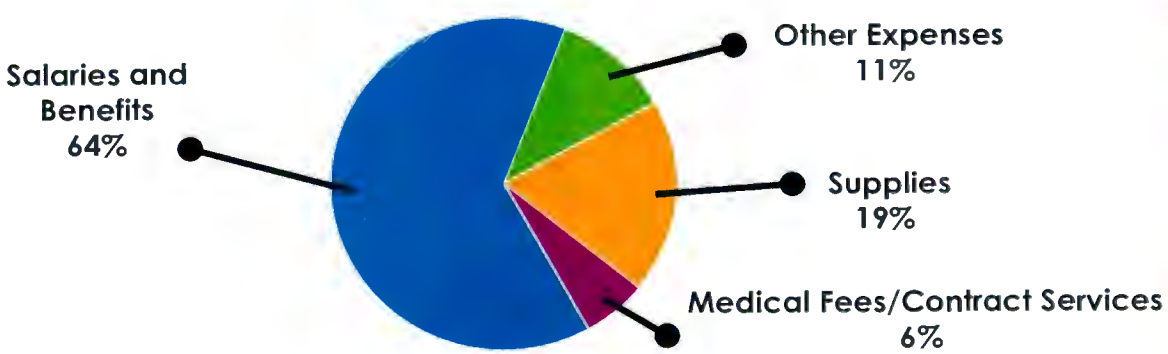
FY 2015 Revenue

Where the money comes from...



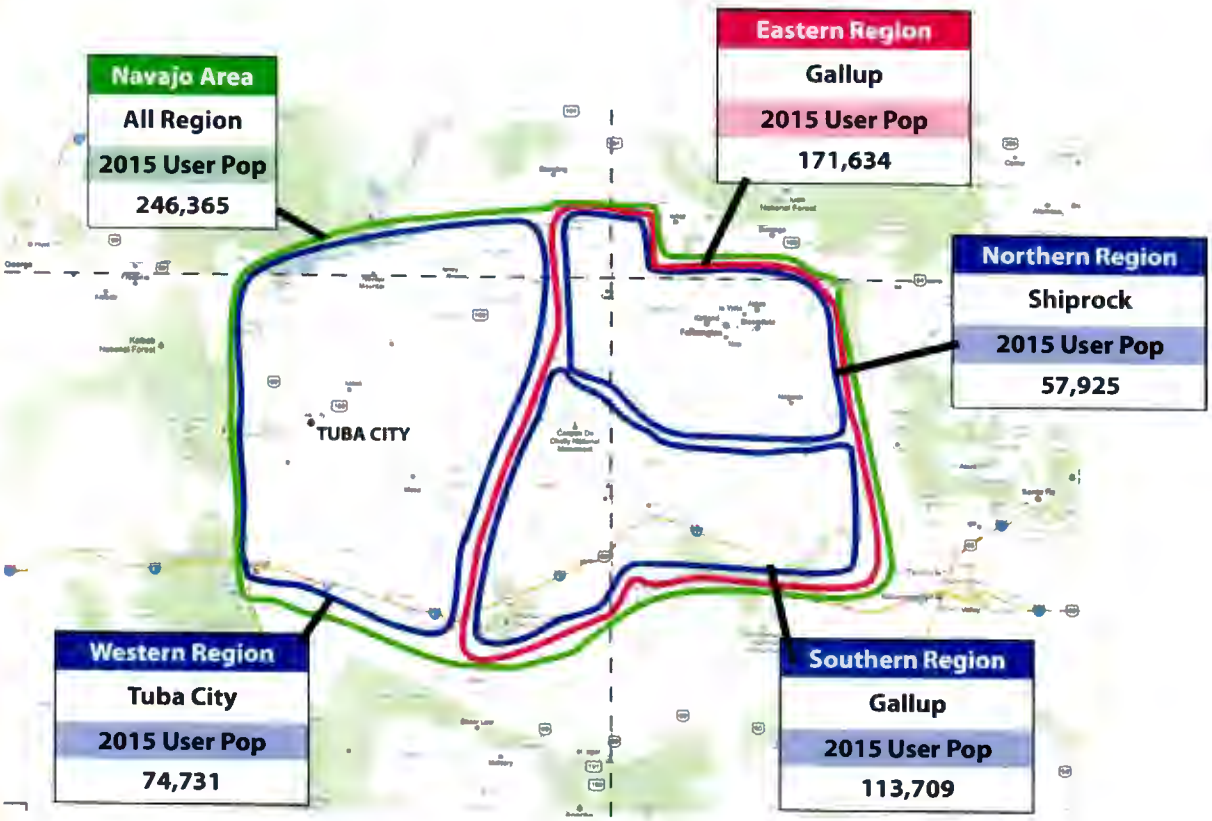
FY 2015 Expenditures

Where the money goes...



User Population
Navajo Area Indian Health Services (IHS)

Tuba City Service Unit, Gallup Service Unit, Navajo Area, Shiprock Service Unit



Inpatient & Outpatient Workload
FY 2002 - FY 2015

AHCCCS/OMB Billable Patients Visits (BPV)

INPATIENT	FY 2002	FY 2012	FY 2014	FY 2015
Hospital Discharges	**3,458**	**2,951**	**2,340**	**2,098**
Swing-Bed	–	*95*	*54*	*50*
ACU	–	*2,856*	*2,286*	*2,048*
Inpatient Days	**14,153**	**11,880**	**11,159**	**10,124**
Average Daily Census	**38.0**	**32.5**	**29.0**	**25**
Newborns	**512**	**454**	**429**	**456**
Newborn Days	**946**	**870**	**869**	**866**
Total Inpatient Days	**15,099**	**12,750**	**12,863**	**12,020**
Discharges	**3,970**	**3,405**	**2,769**	**2,554**
ALOS	**3.8**	**3.7**	**4.5**	**4.6**

OUTPATIENT	FY 2002	FY 2012	FY 2014	FY 2015
Total Outpatient Visits	**145,035**	**720,708**	**730,592**	**690,575**
Observations	–	*519*	*613*	*750*
Outpatient	–	*720,189*	*729,979*	*689,825*

GRAND TOTAL UTILIZATION	FY 2002	FY 2012	FY 2014	FY 2015
Grand Total Inpatient Days & Outpatient Visits	**160,134**	**733,458**	**733,361**	**693,129**

NOTE: BPV (Billable Patient Visits) = Reimbursable Patient Visits Counted per AHCCCS/OMB

Patient Care Utilization Data FY 2002-2015

The TCRHCC Inpatient and Outpatient Summary Report displays patient visits by the Navajo Area Indian Health Service (NAIHS). Trends in patient care workload from 2002 to 2015 are readily apparent. This growth helps the hospital's ability to grow and to provide new health services because it helps set reimbursement and funding levels each year. This data includes patient visits, as well.

The average rate of total utilization growth has been 24% annually in the period of 2002 through 2015. The majority of growth occurred on the outpatient side, while some also came from inpatient activity, as shown in the tables.

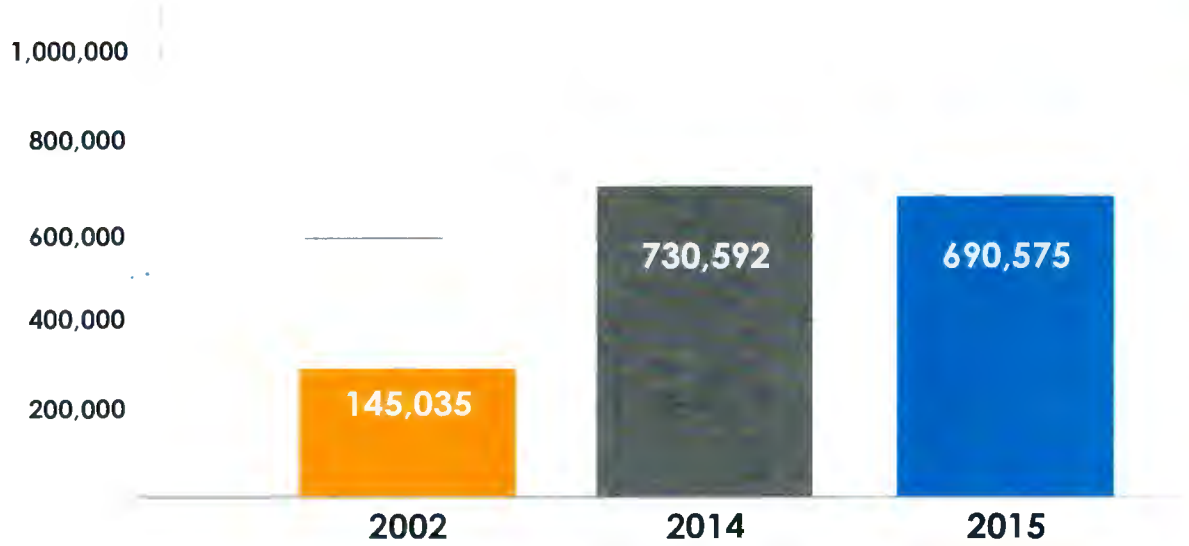
In FY 2015, total combined hospital inpatient and outpatient visits was a total of 693,129 visits. This represents a +333% increase in total patient visits during the twelve year period, growing from 160,134 visits in 2002.

The outpatient visit declined of -5 % in 2015 versus 2014 which was favorably impacted by expansion projects such as the LeChee Health Facility, Sacred Peaks Health Center, the Outpatient Primary Care Center, and providing access to healthcare by the Mobile Health Units and other new services changes in hospital utilization.

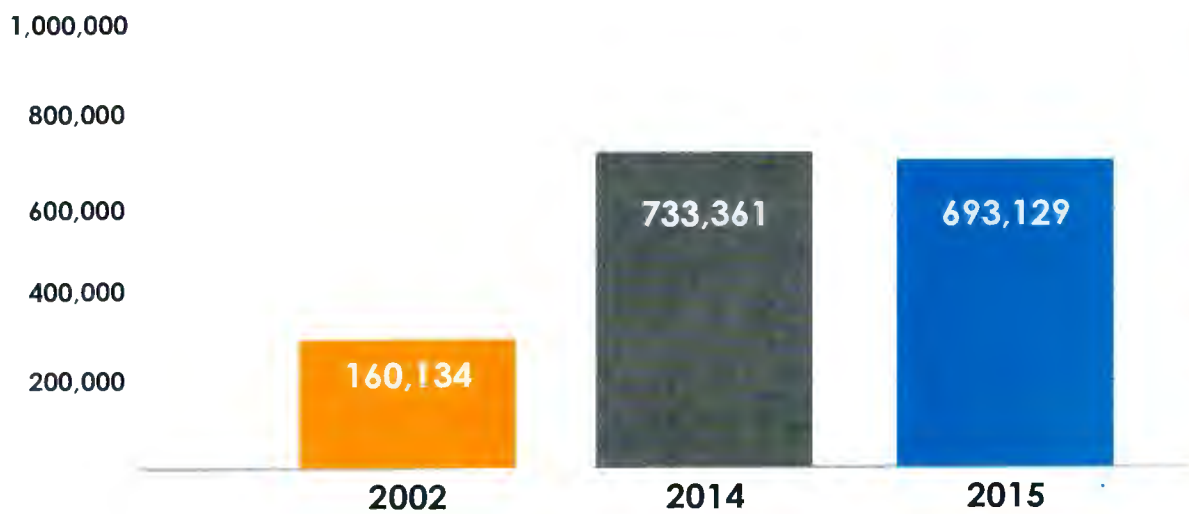
The need for additional housing for clinical staff continues to have a major bearing upon our ability to continue to grow with additional patient services, including inpatient, outpatient and emergency room services and other specialty services needed at TCRHCC as a regional medical center.

Patient Care Utilization Data
FY 2002-2015

Total Outpatient Visits



Total Inpatient and Outpatient Visits



Strategic Plan
FY 2012 - FY 2017

Mission

Our Mission is to provide accessible, quality and culturally sensitive healthcare.

Vision

Our Vision is embracing healthy living to heal, to respect, to console.

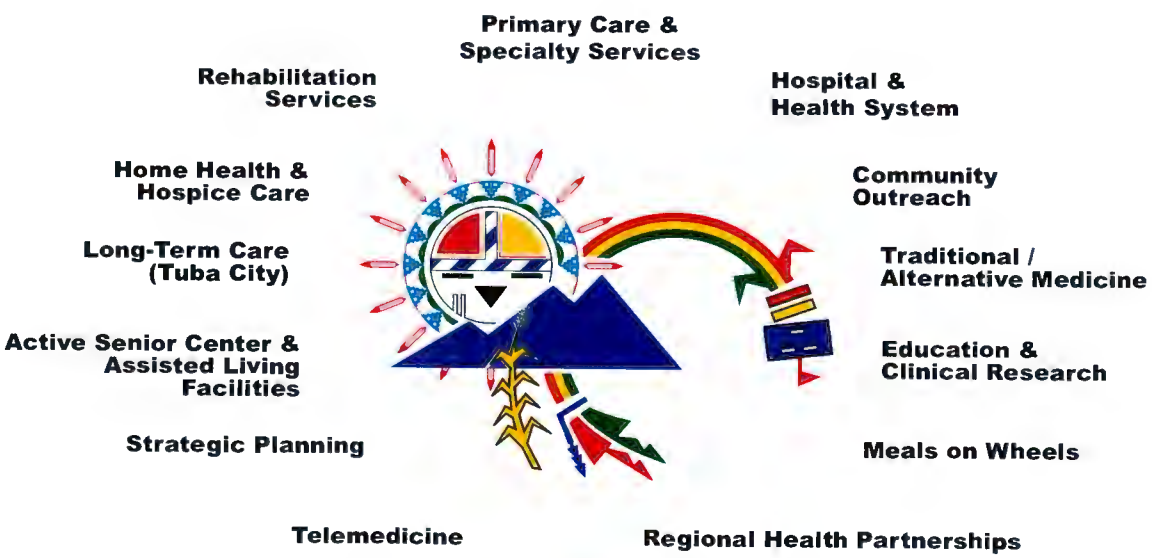
Promise

We take pride and honor the dignity in all individuals. We promise to uphold an environment dedicated to quality and a vision of excellence for today and tomorrow.

Four Strategic Pillars:

- Financial Management
- IS/Data Management
- Quality Improvement
- Services Enhancement/Development

Integrated Regional Health System



TCRHCC Regional Health System

An Integrated Health System with a Regional Medical Center Hub and Network of Mobile / Fixed Satellite Health Services

Tuba City Regional Health Care

- Tuba City, AZ

Sacred Peaks Health Center

- Flagstaff, AZ

LeChee Health Facility

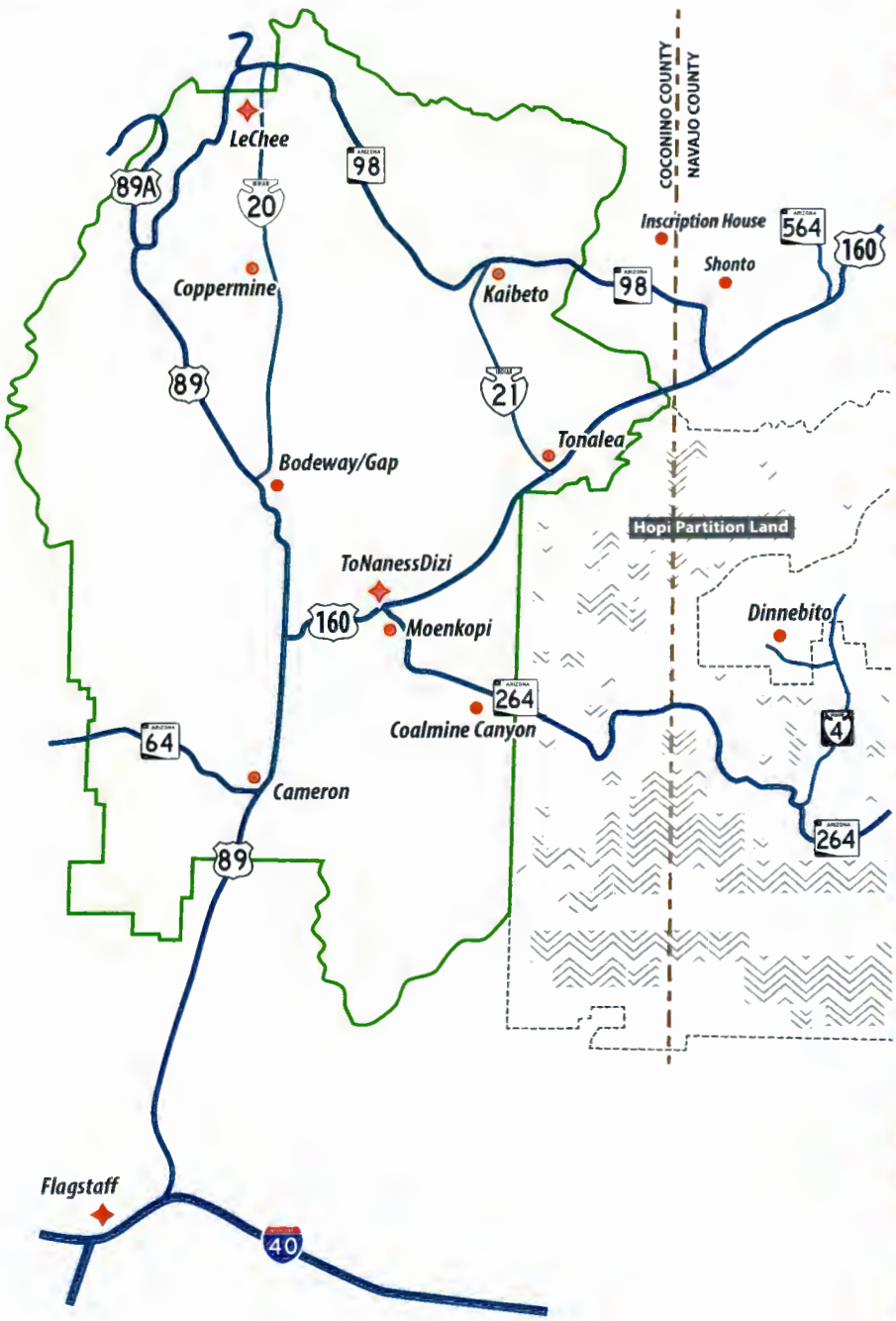
- Lechee, AZ

Mobile Health Unit

- Kaibeto
- Dinnebito
- Coppermine
- Bodaway/Gap
- Tonalea
- Moenkopi
- Cameron
- Coalmine

Kaibeto Creek Independent Living Center

- Kaibeto, AZ



TCRHCC Capital Priorities FY 2016–2018

1. **Campus Expansion**
    a. Expanded Primary Care (Rehabilitation)
    b. SPHC Expansion
    c. Bodaway/Gap Health Center Recruitment
2. **Long Term Care (Complete Construction Design 10/15)**
3. **Electronic Health Record**
    a. Implementation
4. **Integrated Delivery System Master Plan (SLC f/u)**
5. **IT Fiber (Frontier)**
6. **Correctional Facility Health Care Funding (Multi Tribal Model)**
7. **Sustainable Reimbursement and Business Intelligence Model**
    a. HR Information System
    b. Enterprise Resource System
8. **Succession Planning for Future**
    a. Nursing Training Programs
9. **Community Health Center Development**
    a. Mobile Health Site Expansion
10. **Grant Program Expansion**
11. **Enhance Population Health Infrastructure**
    a. Care Coordination
    b. Population Health IT
    c. In Network Utilization
12. **Partnership: 638, Local, PCMH, Local Tertiary Providers**

TCRHCC Operational Priorities FY 2016–2018

1. ICD 10
2. Health Resource Information System
3. E.H.R. Implementation Plan
4. Improved Performance Improvement
5. Customer Service Program & Employee Engagement
6. Joint Commission Accreditation
7. Grow Telemedicine
8. Health Promotions expansion
9. Call Center Development
10. New Specialty Clinics
11. Optimize OR Strategies, Surgical Assistant Trng Program
12. Comprehensive Plan Recruiting Strategy
13. Clinical Education Plan

TCRHCC's Sacred Peaks Health Center – Flagstaff

Continued growth in primary and specialty care

Sacred Peaks Health Center (SPHC) in Flagstaff is part of Tuba City Regional Health Care Corporation's (TCRHCC) integrated healthcare system -- a community-based ambulatory outpatient clinic providing non-urgent primary and preventive healthcare to Native American beneficiaries. It continues to grow to meet demand in the number of patient visits and the spectrum of available services, with an increasing list of specialty clinics and services.

Along with a patient population from the greater Flagstaff area, SPHC serves Native American beneficiaries from the western Navajo Reservation, and others traveling from outlying geographic locations including beneficiaries of the Navajo, Hopi, Havasupai, Apache, Yavapai, Hualapai and San Juan Southern Piute tribes. Patients also come by referral from the Winslow, Chinle, Kayenta, Sage Memorial Hospital, Hopi and Phoenix service unit areas.

Pediatricians and Family Medicine physicians provide wellness check-ups, immunizations, screenings, and vision care in addition to caring for ill patients.

Patient visits in Fiscal Year (FY) 2016 rose to a new high of 17,176 visits, served by a full time staff of 48 and part time staff of three.

Specialty Clinics

The increasing number of patients is in part due to the growing list of specialty clinics offered at SPHC. The Orthopedics Clinic is the only one of its kind available in Native American healthcare in Northern Arizona. Also offered are Dermatology Clinic, Neurology Clinic, Rheumatology Clinic, OB/GYN Clinic, Optometry, Physical Therapy, Occupational Therapy and a recently-initiated Prenatal Clinic. The Surgery Clinic screens patients and prepares them for surgery at other healthcare locations, then provides post-operative care, saving some patients time and money due to SPHC's location. Mental Health Services are available including Psychiatry.

An in-house Laboratory Department at SPHC speeds the diagnosis of illnesses and helps healthcare providers choose the proper course of treatment.

The SPHC Pharmacy Department Provides Efficient, Local Service

The Pharmacy Department at Sacred Peaks filled 91,848 prescriptions in FY 2016. Again, due to SPHC's location in Flagstaff, it is a popular location for obtaining prescription medication and refills with excellent patient education counseling and shorter waiting times. The SPHC Pharmacy accepts prescription medication orders from any medical provider in the area, so Flagstaff area patients have the convenience of picking up their medications without having to drive greater distances.

In mid-2014 the SPHC Pharmacy Department started a Meds In Hands program for Native American beneficiary patients who are being discharged from a stay in Flagstaff Medical Center. The goal is to increase patient education about the medications they will be taking, and how and when to take them. This is an attempt to decrease the number of patients having to return to the hospital if they don't take

their medications properly. When language is a barrier, translators assist pharmacists in explaining proper use of medications. There were more than 2,400 deliveries by SPHC Pharmacists to Flagstaff Medical Center patients in FY 16, delivering a total of nearly 10,000 prescription medications. The number of readmissions to the hospital due to improper administration of medications has dropped considerably.

Iina Wellness Program Changes Lives

The 12-week Iina Wellness Rehabilitation Program is a collaboration of the Physical Therapy and Nutrition Departments for patients who have been diagnosed with diabetes, prediabetes, or are at increased risk due to obesity. Patients are referred to the program by their primary care provider. The program begins with initial evaluations by a nutritionist and a physical therapist who collaborate on an individualized plan for wellness. A patient's weight, waist measurement, percent body fat, lipids, and an A1C test measuring glucose (sugar) in the blood, are all considered. Patients learn about a more healthy diet and improved cooking methods. The exercise or physical therapy portion of the program uses standardized outcome measures in order to evaluate the patient's success at the 6-week and 12-week marks. Program goals for participants include having a seven percent weight loss and an HgbA1C level improvement to normal if prediabetic, or less than 7.0% if diabetic. The patient's lipid panel is also monitored – cholesterol, HDL, LDL and triglycerides.

For patients who are dedicated and who stick with the program, profound and lasting improved health outcomes can be realized.

Doris Brodie, age 78, from Flagstaff entered the Iina Wellness program more than two years ago when she was diagnosed with prediabetes. Aside from a continued exercise regimen, Brodie said that she learned how to make healthy food choices.

"Now I know what I'm supposed to eat and what's important. I know what I'm not supposed to have," said Brodie. "I now watch the food that I eat and I learned that I love green, leafy vegetables such as spinach and kale. Aside from eating better foods I know I have to get my exercise!"

Brodie exercises at Sacred Peaks at least two days per week and gets out to walk two miles per day, most days. "I really feel good after walking," added Brodie. "It awakens everything about me. I now use the stairs in buildings where I used to rely on the elevator. I don't get out of breath. I attribute my good health to this program."

Thirty-six-year-old Sarah Jaramillo of Flagstaff was diagnosed with prediabetes at age 31. "When I was told I had prediabetes it really scared me. Anger and frustration ran through my mind. My family history included diabetes, but I never thought it would happen to me."

Jaramillo got her start on an entirely-changed lifestyle through the Iina Wellness Program. She weighed 160 pounds with blood sugar at 207 and an A1C level of 5.8. She, too, learned

how to change her diet entirely, and with that, the diet of her entire immediate family including her husband and four children. She started an exercise regimen at SPHC, working out for about an hour, three days per week. Today she has a local gym membership and works out vigorously for an hour, six days per week.

"My life has done a complete 180. I now weigh 136 pounds and I'm so much happier and I have more energy," remarked Jaramillo. She has guided the healthy behavior of her entire family. "Seeing how my family now participates with me on hikes, runs and healthy food choices makes me proud! And I'm in the best shape of my life." Jaramillo and her two daughters participate in 5K, 10K and half-marathon running events.

"My family members have been my biggest supporters. My numbers are back to normal and I can't begin to tell you how good that feels. It took a lot of hard work and dedication, but it was all worth it. I'm more active than ever, and I've gotten pretty strong both mentally and physically," added Jaramillo.

Sacred Peaks Health Center Staff Spotlight:
Navajo Reservation Natives Working to Improve the Community's Healthcare

Physical Therapist
Aaron Jones

Physical Therapist Aaron Jones graduated grew up in Gray Mountain, Arizona, and graduated from Tuba City High School in 1996. He then went to Northern Arizona University (NAU) in Flagstaff to earn a bachelors degree in Exercise Science with a minor in chemistry, then went on to earn a Doctor of Physical Therapy degree in 2007, and now works as a physical therapist at SPHC. Aaron lives with his wife and three boys in Flagstaff. He began his working career with TCRHCC in Tuba City and states that he is pleased to work for a growing organization that provides needed services to the Flagstaff community.

Medical Assistant
Raelynn Brown

Medical Assistant Raelynn Brown has been working at SPHC for the past four years. She is a graduate of Ganado High School in 2000, and moved to Redlands, California to continue her education to become a Medical Assistant. Raelynn said that always had plans to move back to the Navajo Reservation to help her own people and communities. She especially enjoys her work in the Pediatrics Department where she uses her skills to enhance the healthcare of children. Raelynn, her husband, and their four children now reside in Flagstaff.

Medical Assistant
Titania Lewis

Medical Assistant Titania Lewis grew up in Tuba City, raised primarily by her grandparents in the traditional way. Her first language was Navajo, and it has proved to be very valuable in her career as she is a Navajo Health Care Interpreter – providing invaluable assistance to Navajo-speaking patients. Titania graduated from Tuba City High School in 1999. She continued her education at the College of Eastern Utah, in Blanding, Utah, then graduated from College America in 2004 with an AA degree in Medical Specialties. She's been a nationally certified Medical Assistant for the past 11 years. She hopes to return to school to earn a degree in Nursing. Titania, too, always wanted to come back home and serve her community and her people. She and her husband live in Flagstaff with their five children. Titania says that she is very grateful for her knowledge in the medical field, traditional Navajo life and modern life.

LeChee Health Clinic Serves the Needs of Native American Beneficiaries in the Page and Rural Northwest Navajo Nation Areas

The LeChee Health Facility, a part of Tuba City Regional Health Care Corporation (TCRHCC), is three miles south of Page next to the LeChee Chapter House, first opening in July 2015, serving Native Americans in the surrounding area with non-urgent, primary healthcare services. Area beneficiaries now have nearby, locally-directed services.

Since July 2016, the LeChee Health Facility treated 464 patients. The Clinic provides high quality care in a new location that provides easier access to primary care for individuals and families.

LeChee Health Facility provides non-emergency primary care in LeChee and the surrounding area. If more specialized care is needed, the provider makes a referral to a specialist provider in the TCRHCC Health System in Tuba City. When appropriate, the Clinic will assist individuals by referring them to available local social service resources.

Key areas of medical service and treatment at LeChee Health Facility include:

- Primary/preventive care
- Well Woman exams
- Well Child checks
- Annual physicals
- Immunizations for children and adults
- Basic lab services
- EKGs (heart)
- Pharmacy

Patricia Kent, RN, is LeChee Health Director. She is working to provide what the community needs by listening to patients, attending chapter meetings to hear suggestions and concerns, and by strengthening community relationships. Kent is an RN with 15 years of experience in medical/surgical and primary care nursing.

"We're creating a little family here," said Kent. "Everyone is cross-trained and steps in wherever needed, especially as it relates to patient care. We're home-growing our own nurses and staff members from this area, thereby strengthening community relationships."

Leading a staff of 22 employees at present, Kent also visits area families at home on weekends, listening to their needs and concerns. "I have to listen to the patients and provide what the community needs," added Kent.

"In the future we are planning to add Physical Therapy as it is in demand by our patients. This will save patients from having to travel great distances to Tuba City and Flagstaff, and other distant clinics," said Kent.

On a typical Monday at the clinic, the busiest day of the week, the LeChee Health Clinic sees 20 to 30 patients; TCRHCC's Mobile Unit helps out with the patient load on Mondays seeing about 10 additional patients. Even on a busy day the staff strives to keep waiting times to a minimum, serving walk-in patients.

"Dr. Helen Bidawid has been an amazing addition to our facility and patient care," said Kent. "A patient satisfaction survey is planned for autumn once she has been on board for a while."

A full-service Pharmacy Department has been operating at LeChee for the past three years. Always growing in services and in volume, there are four full time pharmacists on duty at LeChee to handle a growing demand.

Pharmacist Clint McCormick has been at LeChee Health Center since its Pharmacy Department opened in November of 2012. "A hallmark of our service here is very short waiting times for in-person prescriptions orders and refills," said McClintock. "Pharmacists also administer adult vaccinations seven days a week. Demand for our services is always growing."

In one recent week over 3,300 prescriptions were filled at LeChee's Pharmacy. 2,400 of these were mail order prescriptions. The Pharmacy Department at LeChee handles all mail order prescription refills for TCRHCC. Three refills are available by mail order making it much more convenient for refilling prescriptions for those living in distant locations. After three refills patients must return to visit a doctor for a new prescription. The LeChee Pharmacy also fills prescriptions for patients who prefer to go to outside healthcare providers, such as private practice providers in Page.

The pharmacists provide individual and confidential counseling on patient medications.

"This is the best staff I've ever worked with. They go above and beyond! We're known for our quick refill times," remarked McClintock.

LeChee Pharmacy hours are 8:00 a.m. to 7:00 p.m., Monday through Friday, and 9:00 a.m. to 5:00 p.m. on Saturday and Sunday.

In April of this year, the LeChee Health Clinic was accredited to stringent national healthcare standards by the Joint Commission during its visit to all TCRHCC facilities including Tuba City and the Sacred Peaks Health Center in Flagstaff as well.

"Our staff did a superb job of preparing for the Joint Commission accreditation visit, seeing that every last detail of our operation was ready for inspection and up to national standards," remarked Kent.

2015 Tuba City Regional Health Care Hospital Highlights

Tuba City Regional Health Care Corporation (TCRHCC) operates a state-of- the-art, 73-bed hospital that provides comprehensive medical services to Navajo, Hopi and San Juan Southern Paiutes Tribes. TCRHCC is the only Level III Trauma Center on the Navajo Nation, received a 3-Star Recognition from the National Hospital Compare Report, which compares hospitals on quality healthcare measures and outcomes.

The American College of Surgeons (ACS) designated Tuba City Regional Health Care Corporation as a **Level III Trauma Center** enabling the hospital to see and take care of more critically injured patients. ACS has only verified one other Native American Level III trauma center. That one is located in Anchorage, Alaska.

TCRHCC has earned The **Joint Commission's Gold Seal of Approval®** for accreditation by demonstrating compliance with The Joint Commission's national standards for Hospital Accreditation Program, Laboratory Accreditation Program and Home Care Accreditation Program. The accreditation award recognizes TCRHCC's dedication to continuous compliance with The Joint Commission's state-of-the-art standards.

We **continue steadily expanding services and clinic space** at TCRHCC.

- **Sacred Peaks Health Center** continues to grow in providing greater access to TCRHCC's high quality health services and customer experience in Flagstaff, AZ.

- **LeChee Health Facility** opened 1-year ago. The LeChee Health Facility provides non-urgent primary care to the residents of LeChee and surrounding communities such as Coppermine, Gap/Bodaway, Kaibeto, and Page.

TCRHCC **Transitional Care Program** focuses on providing quality, cost-effective chronic care to patients who have more than one chronic health issue and are frequently admitted to the hospital for acute care. This strategic initiative reduces admissions and overall health care costs.

As our communities in the Tuba City Service unit continues to grow, demand for health services at TCRHCC increases, as well. TCRHCC is improving access by creating more clinical space and making our Medical Services Master Plan and Facility Master Plan come to life.

Mission

Our Mission is to provide accessible, quality and culturally sensitive healthcare.

Vision

Our Vision is embracing healthy living to heal, to respect, to console.

TCRHCC's Physical Rehabilitation Center

The Most Comprehensive Team in Physical Rehabilitation

Early spring, the Tuba City Regional Health Care Corporation (TCRHCC) celebrated the grand opening of the Physical Rehabilitation Center on April 26. The hospital's outpatient and inpatient physical rehabilitation center delivers state-of-the-art therapy for patients who have been disabled by illness or injury, offering an exceptional level of care locally.

"The center provides a great need in the region for patients facing a physical impairment caused by an illness or injury. Our goal is to help patients lead quality, productive lives after they are discharged ," said Lynnette Gilmore, Director of Physical Rehabilitation Department.

The Physical Rehabilitation Center at Tuba City Regional Health Care is a 4,800 square foot facility. The center houses a dedicated spacious outpatient therapeutic area and gym.

The Physical Rehabilitation Department also provides services at Sacred Peaks Health Center in Flagstaff, AZ. Services offered include physical therapy and occuptional therapy .

With state-of-the-art therapy for patients and an

experienced team of staff, TCRHCC Physical Rehabilitation services are targeted to patients who are able to tolerate an intensive therapy program.

"With the opening of the Physical Rehabilitation Center, Tuba City Regional Health Care has made a major investment in this specialized service for residents of Western Navajo and beyond," said Gilmore.

TCRHCC Physical Rehabilitation Department Services

Our staff consists of physical therapists, occupational therapists, speech language pathologists, and critical support staff – all

dedicated to providing a comprehensive scope of rehabilitative services to the patients we serve.

Physical Therapy

Our physical therapy staff represents such a wide range of combined skills that virtually any service recognized as within the scope of physical therapy can be provided by one or more of our staff. Physical therapists are 'hands on' therapists, and many interventions involve the therapists physically helping the patient learn new movement patterns and safer ways of accomplishing personal goals. Examples of services available include but are not limited to: Orthopedic care for arm/leg/neck/back pain and other injuries, neurological rehabilitation, wound care, clinical electrophysiologic examination, balance training, gait training, ergonomics education, pediatric services, and sensory integration.

Occupational Therapy

Occupational therapy is about safe functional movement – in and out of bed, in the home, and in the community. An occupational therapist is also trained to provide a number of other 'hands on' services, which include but are not limited to: orthopedic care for hand/wrist/elbow/shoulder injuries, functional mobility training, custom splinting, ergonomics assessments, pediatric care, and sensory integration.

Speech Language Pathology

A speech language pathologist is someone who helps children or adult patients who have problems with: speaking (dysarthria, apraxia of speech, fluency, articulation), with language (receptive aphasia, receptive aphasia, delayed language), with swallowing (feels like foods get stuck, coughs during eating, etc.), with voice problems (hypophonia, monophonia, etc.) and/ or with thinking skills (memory changes, difficulty planning, or problem solving). The Speech Pathologist, for example, evaluates and treats children who mispronounce lots of speech sounds so it is difficult to understand them, or children with cleft palate or hearing loss. The Speech Pathologist also evaluates and treats adults or children with head injury after an accident or brain surgery or a stroke.

Special Clinics

The therapists and support staff work together to conduct and/or assist with a clinic focused on a specific area of care which pertains to PT, OT, or Speech. Accordingly, the therapists treat those in need with a full evaluation, a follow-up, or a screen; whichever is more appropriate for the clinic and the patient. The clinics occur monthly, yearly, or seasonal. Below are the clinics that you as a patient can participate in if needed, or you as a physician can refer your patient to:

- **Prosthetic and Orthotic Clinic** – monthly, held at the Physical Rehabilitation Trailers
- **Functional Clinic** – monthly, held at the Physical Rehabilitation Trailers
- **Geriatric Clinic** – monthly, held at the OPCC building at Family Medicine
- **Wound Care** – year-round, held at the Physical Rehabilitation Trailers
- **High School Clinic** – held at the Tuba City High School, twice a week during regular school session

Navajo Hopi Health Foundation
2015 Youth Volunteer Program

NAVAJO · HOPI
HEALTH FOUNDATION

NAVAJO · HOPI HEALTH FOUNDATION

Mission

Develop resource partners to meet our increased medical demands.

Vision

- Support efforts of Tuba City Regional Health Care Corporation (TCRHCC) and bring the cultural "Beauty Way" to every aspect of our patients' care.
- Delivering integrative medicine to an underserved population.
- Provide an academic setting for the education of future generations.
- Make healthcare more accessible to the underserved.

Website

www.NavajoHopiHealth.ORG

Find us on Twitter

@NHHFoundationTC

About

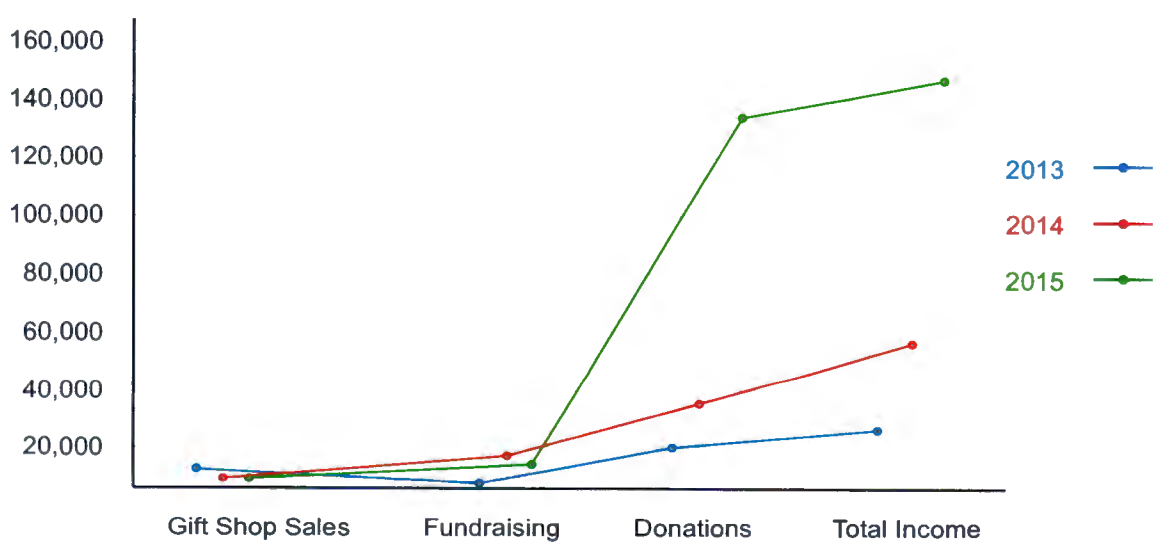
The Navajo Hopi Health Foundation is a non-profit 509(a)(3) charitable organization established in October 2012, dedicated to raising funds for Tuba City Regional Health Care Corporation (TCRHCC), the designated healthcare provides to 75,000 Navajos, Hopis, and San Juan Southern Paiutes within a 6,000 plus square mile referral service area (larger than Connecticut and Rhode Island combined).

The Foundation's goal is to secure financial resources for continued development of improving the healthcare center and purchasing medical equipment needed in the area by providing support to Tuba City Regional Health Care Corporation and the region it serves.

Navajo Hopi Health Foundation 2015 Highlights

- Entirely operated with volunteers
- Opened a Gift Shop
- Opened Comfort Care Rooms
- Restored Original Art in the Hospital
- Replaced new chairs in waiting areas
- Started a "Strive for 5" Program, an employee Payroll Deduction of the amount they choose
- Support and participate in all pillars of customer service programs
- Provided financial support to build a hogan in the Healing Garden for the patients of TCRHCC
- Decorated the Cafeteria
- Legacy Brick Program
- Solicited over $300,000 for the Outpatient Primary Care Center (OPCC), and other areas of the hospital
- Sponsored outreach community events
- Developed Social Media
- Provided OB Department with Furniture
- Provided $70,000 in equipment for Nursing Education Program
- Provided instruments for Dental Department
- Provided Flat Screen TVs in waiting rooms, and Patient Care Rooms
- Developed Summer Youth Program
- Restoration of the Foundation House, a Historical Building located on Main Street

Navajo Hopi Health Foundation 2015 Funding Support



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TUBA CITY REGIONAL HEALTH CARE

Tuba City
Regional Health
Care Corporation

2015
Annual Report

Tuba City
Regional Health
Care Corporation

2015 Annual Report

"Our Mission is to provide accessible, quality, and culturally sensitive healthcare."

"Our Vision is embracing healthy living to heal, to respect, to console."

We take pride and honor the dignity in all individuals. We promise to uphold an environment dedicated to quality and a vision of excellence for today and tomorrow.

Tuba City
Regional Health Care Corporation

167 North Main Street • P.O. Box 600 • Tuba City, Arizona 86045 • tchealth.org

About
Tuba City Regional Health Care Corporation

The Tuba City Regional Health Care Corporation (TCRHCC) is a 73-bed, acute and outpatient regional health system organized as a private nonprofit healthcare organization operating under the Indian Self-Determination Act P.L. 93-638 since September 30, 2002. TCRHCC serves a large geographic area, primarily encompassing over 6,000 square miles on the western Navajo Nation and adjacent Hopi and other communities.

Tuba City is the largest community by zip code on the Navajo Nation. Tuba City's Hospital is the primary campus, or hub, for TCRHCC's integrated health system. The hospital and satellite clinics in Flagstaff, Dinnebeto, and Cameron provide primary care services to over 33,000 Navajo, Hopi and San Juan Southern Paiutes.

TCRHCC also serves as a regional referral medical center for over 75,000 residents across the Navajo Nation and adjacent communities.

In FY 2014, the TCRHCC health system had 733,361 total patient visits. Building on the legacy of the Navajo Area Indian Health Service, previously as Tuba City Indian Medical Center (TCIMC), the formal incorporation process under P.L. 93-638 for Tuba City Regional Health Care Corporation (TCRHCC) began on January 19, 2001 followed by approval by the Navajo Nation Council as a Title I 638 contractor in 2002. In June 2005, the Navajo Nation Council approved the organization for the purpose of managing and operating contracts with the Indian Health Service for a 15-year period through September 30, 2020.

Today, TCRHCC is in its thirteenth year of 638 funding and operation, and it continues to grow as a regional, community-based health care system. In July, 2010, TCRHCC was approved as a Title V Compactor under the IHS Office of Tribal Self-Governance by the 21st Navajo Nation Council.

TCRHCC provides hundreds of clinical and patient care support services spanning the medical spectrum. It provides a full range of primary and specialty care preventive health and wellness services. All areas of service incorporate cultural sensitivity and the Navajo philosophy of the four sacred directions.

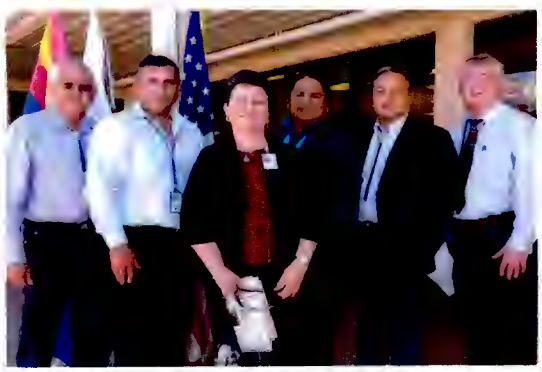
The condition of TCRHCC is fiscally and operationally sound. The top priority of the Board of Directors, Executive Leadership, Medical Staff and support staff is the quality of patient care. Patients, families and communities can be assured that TCRHCC adheres to the highest standards of patient care as evidenced by its accreditation by the national accrediting body - The Joint Commission. All areas of the facility meet or exceed national health care standards. All medical service providers are fully credential to practice medicine. TCRHCC has an experience and stable medical staff. Many of the physicians, nurses and allied professional staff have been at TCRHCC for decades.

An audit is conducted each year by an independent accounting firm to assure that TCRHCC is reporting financial information at high level of standards and practices. Fiscal Year 2014 ended with a positive operating margin and reserves. The Clinical and Finance Department team continuously reviews the practices of the corporation in order to capture every dollar that is due to TCRHCC from third-party sources for the improved health care of the community we serve. Every dollar is put back into our healthcare Mission.

TCRHCC is fully compliant with the Navajo Preference in Employment Act (NPEA). Ninety-five percent of all new hires for non-technical positions are Navajo, and the remaining five percent meet a category under the order for Navajo Preference (spouse of Navajo or other Native American). Every effort is being made to encourage, train, mentor and attract Navajo and Native American individuals to health professions for the future, including leadership, technical and professional positions.

TCRHCC has set the goal of being the Employer of Choice in the Tuba City region to attract, retain and promote talented and qualified Navajos and Native Americans residing on the reservation, in Flagstaff, and other accessible areas.


"FUTURE IN FOCUS"
All good things come to those who wait, but only what's left over from those who hustled."



Population Health: An Improved Path

FY 2016 Strategic Efficiencies for Innovation and Expansion

Tuba City Regional Health Care Corporation (TCRHCC) has transformed from an Indian Health Service Facility to an all-encompassing integrated health system. We have adapted to a transforming health care environment and continue to provide quality health service and new models of care delivery to meet the needs of our Communities within the Western Navajo Agency. We continue to meet challenges and are learning to adapt to opportunities for change. Our organization must meet barriers head on and maneuver through problem solving open minded thinking to realize and attain transformative ideas. An attitude of transformation has found a home in our organization. This attitude has helped the organization achieve many of our priorities this past Fiscal Year.

More than ever we must make our voices heard to combat mandates from our National Healthcare oversight authorities. These mandates are not always in the best interest of Native Americans as well as falling very short of our treaty rights. Our tribal oversight committee, Health Education Human Services Committee, continues to face many battles on all human service fronts. Their responsibility is great in that the needs of the communities they oversee are at the human basic need level. Our organization does not make light of the education we must provide to assure that our communities are not left out of important decisions that happen in our Tribal capital. Our position as a health delivery entity has no other purpose but to successfully meet the health care and wellness needs of those we serve. TCRHCC must address everyday how we move forward to keep our organization sustainable and successful. Addressing health disparities and implementing prevention to the various population groups is a strategy that will help us focus on specific health delivery models as well as the use of data and evidence based models of care.

This FY2015 strategic vision for the capital and operating budgets and strategic plan was a continuation of several themes that TCRHCC leadership addressed at last year's annual Board budget meeting in Flagstaff, and several themes discussed that are even more pertinent today, including:

POPULATION HEALTH

We must empower our front-line care givers, as they are the new foundation of population health. The creation of comprehensive care coordination systems is vital to our future sustainability.

From the perspective of the values of Population Health alone, we must also proactively involve both the Greater Community we serve and our Board of Directors as regional health system stewards and ambassadors to their respective communities.

Partnerships to improve Population health, only create synergies to improve patient health. If we combine a medical intervention with a public health intervention you only get better outcomes. Most diseases that have been acute have now become chronic. Our communities need to be offered services that improves the quality of their lives. The Navajo Nation will always have disparities, but it is up to TCRHCC to implement delivery models that promote better outcomes. Our partner will be the Navajo Department of Health, it is up to us to be the proactive catalyst to improve the lives of our patients.

Besides the Affordable Care Act, Indian Health Care Improvement Act, Quality based initiatives and pay for performance, and not to mention local governance issues, the attached "2016-2018 TCRHCC Priorities" list contains a summary of the ever-changing issues and opportunities facing us as strategic priorities and trends. These will be addressed at the FY16 Operating & Capital Budget and Strategic meeting and will help us focus our overall strategic vision. This list also comprises a summary of practical challenges in developing health system leaders within our organization as we prepare to take TCRHCC's regional health system forward into the future. We will explore each of these to flesh out our strategic vision.

We are an integrated community-based Regional Health System serving more than 100,000 patients, and we expect this number will continue to grow +10% through FY2016 due to greater beneficiary eligibility via expanded ACA and AHCCCS which started 1/1/2014. As changes continue in AHCCCS and employer-based health insurances, competition in Northern Arizona and across the Navajo Nation will increase for us. We must work all ACA alternatives to improve our care options so we care reach a modicum of similar choices that are available to every other population groups in the U.S.

Going forward, we must work harder than ever to attract and retain the families and patients we care for. We must attract and retain sufficient primary care providers as well as maintain the space capacity needed to serve these growing health care demands. Our space needs are already at the breaking point, so we must bring new ideas and strategies to the table for FY2016 such as innovative ideas to expand Sacred Peaks and LeChee Health Clinics, as well as the new Rehabilitation Modular 5,000 sq. ft. building to be situated on the east side of our campus.

FY2015 Operating Outcomes

For the 9th consecutive fiscal year of TCRHCC operations out of the past nine, we again expect to end the fiscal year with a positive margin (in the black). Despite many challenges, the continued "community based" and "integrated regional delivery system" strategic blueprint continues to be effective, e.g., the submitted grant via the Community Health Center. We have continued to take advantage of strong Board stewardship and all that Title V self-governance has to offer, coupled with the principles of private entrepreneurship.

Our successes and challenges were reflected in both the Orientation and Work session with the new HEHSC appointees. Updated information will be presented to the HEHSC/NN Council at the beginning of FY2016 and in the proposed FY2016 strategic plan.

Our success continues to emanate from good Board high-level stewardship, a quality Clinical and Support Staff, consistent management by Senior Leadership, and the support by our Greater Navajo, Hopi and San Juan Southern Paiute Communities which we serve.

FY2016 System Priorities

Our health system's FY2016 budget and strategy priorities now incorporate four converging forces:

1st–Title V self-governance stewardship;

2nd–Innovative use of the health marketplace enrollment programs in the ACA/AZ Health insurance exchanges;

3rd–Development of an integrated Regional Medical System grounded in the communities we serve via primary care and specialty providers, and

4th–Development of new and under developed partnerships that will create alliances with health system providers, local tribal health providers, and payers who believe in our Mission and the value in teaming up with our established successful system.

The FY2016 capital and operating budgets and strategy include several longstanding as well as new change waves as we chart a new course forward:

1. Sustainable Revenues and Utilization Growth -- Back to Basics & New Opportunities

The U.S. Department of Health & Human Services via I.H.S. approved the following hospital inpatient and outpatient rates for the 12-month period ending 12/31/2015:

Inpatient Hospital AHCCCS per diem rate: (excludes Doctor/FNP/PA svcs) (+1.23% over CY14 $2413);	**$2443**
Outpatient OMB AHCCCS per visit: (+2.3% over CY14 $342);	**$350**
Outpatient OMB MC per visit rate: (+3.25% over CY14 $297);	**$307**
Inpatient MC Ancillary Part B per diem: (+2.7% over CY14 $502)	**$516**

We always hope to have OMB increases in every Fiscal year.

Utilization variations – As those of you were at the I.H.S. Consultation in Sacramento, TCRHCC expressed our displeasure with the OMB rates in:

- Trauma
- Specialty Services- MRI
- Observation Stays
- ER

We are in discussion with our Legal Team- Hobbs Straus re: the OMB payment we receive for these services. Mr. Milhollin works closely with Carl Harper at I.H.S.

Continuing Resolution (CR) -- Knowing we will likely see a CR again in FY2016, this fiscal year's operating margin is conservatively budgeted for a **+2.5%** positive margin, the same as the FY15 margin. We will also continue to monitor several other variables in FY2016, including:

- CMS RAC Accountability – We need to continue to significantly provide educational to our providers and support staff, and monitor patient record audits and request, from RAC, AHCCCS and private payers to enact greater accountability in patient care reimbursement. CMS's RAC programs seek to recoup greater CMS payments for inadequate documentation, medical necessity, coding deficits and other variables.
- Medical Homes & Care Coordination -- Opportunities include such new changes as potential health alliances, Medical Homes that will focus more on quality outcomes and per-member monthly payments (PMPM) than on purely traditional patient volumes. We need to also focus on the value of Care Coordination for all Patient Population groups.
- Grants -- An annual update on grants activities will be presented, including the status of our current projects and applications. Grant funding is a funding source that we need to continue to explore and apply for.

- CSC Lawsuit –We are hopeful that we will have a settlement offer before FY2016's startup for the $2-4 million Contract Support Costs Shortfall Claim filed by the TCRHCC Board in federal district court in FY2014. The intent of this action is the full coverage of TCRHCC's past Administrative and Operating overhead expenses for FY2012-FY2013, but a final compromise settlement from the U.S. Treasury Judgment Fund could be lower.

- Medicare-Like Reimbursement (MLR) for Purchased Referred Care (PRC) Patients – There is legislation to be proposed in both houses of Congress that would require 100% maximum Medicare-like reimbursement for all Medicare beneficiaries referred out by TCRHCC providers. While unlikely to be enacted by 10/1/2015, if and when it is enacted, this would lower TCRHCC's PRC expense by a minimum of $3-4.0 million per year in FY2016 for beneficiary out-referred care because in recent years FMC and physician specialists have refused to contractually accept anything but 100% payment for their charges. We are monitoring this closely.

- Navajo Hopi Health Foundation – Our Foundation launch will provide an additional means of some financial and related support to TCRHCC mission priorities going forward.

2. Regional Health System Partnerships

We continue to combine the best of Tribal and I.H.S. health care and the private integrated business model as we seek to develop augmented partnerships with other providers and health systems. While we are working closer than ever before between TCRHCC's Sacred Peaks Health Center and Flagstaff Medical Center, we have a long ways to go before it becomes a true partnership—much of this confusion comes from the major Medicaid reimbursement regulations that differentiate FMC's "fee for service" from TCRHCC's "federal pass-through OMB" rate that requires no state match and other regulatory differences.

There are always concerns regarding the shortage of providers and physicians. We plan to continue to be aggressive in our recruitment and retention strategies that will include:

1. Recruitment of more Family Practitioners and Internal Medicine physicians
2. The development of new integrated specialty services
3. Maintain focus on doing well with the clinical services we have now

These steps will all reduce the amount of patient referrals out, reduce PRC payouts to other tertiary facilities and improve in system quality of care as essential foundations of our regional health system—building on the quality services we provide today.

Competitive border town health providers and large tertiary providers from Flagstaff, Phoenix, etc. are pressuring our service area more than ever. These are signs of the competitive changes in health care delivery both in our region and nationally now that the ACA and the IHCIA were upheld followed by related unfolding national health reforms and opportunities.

Partnerships are created in order to maintain a sustainable population base, but the main reason for partnerships is to improve the quality of care being delivered to our communities. This need becomes increasingly the case, especially given anticipated changes in delivery and reimbursement now coming with health care reform, e.g. expanded primary care models that will include behavioral health.

Change will continue to accelerate in FY2016, and we plan to stay on the competitive edge in developing

optimal primary and subspecialty medical services to benefit the people of our Greater Community and ensure our long-term sustainability.

3. Integrated Clinical Care Center Network

As an integrated Regional Medical Center system (RMC), we need to continue to strategize in planning more advanced care systems in trauma, diabetes, cardiovascular, mental/behavioral, orthopedics, rheumatology, nephrology and other services suitable to our location and RMC capacity.

TCRHCC will need to consistently and aggressively plan our network partnership agreements, as well as develop and maintain reliable infrastructure networks. Our Annual Budgets and Strategy Agenda will be focusing on best practices and models that will be applied to our health care delivery system. Models that include sustainability are nursing training programs, as well as clinical support staff.

We need to continue to pursue Arizona partners include the Maricopa Integrated Health Systems, which is a proven statewide model of care for burns, CHCs, and mental health. Unfortunately this System reaped an untoward effect of the ACA, in that it lost much its support from Disproportionate Share dollars that went away with the Medicaid expansion.

TCRHCC will continue to expand the Community Health Center (CHC) mobile primary care clinics which service nearly all our chapter communities especially for the elderly, young children and others in needs. CHC's have long been a part of our Nation's health resources and are a strong voice in the US government structure. TCRHCC staff has risen to a model dental health program under the oversight of Dr. Kate O'Connor-Moran. Our medical mobile service has also created an unprecedented following under our quality services via our Mid-Level Provider, Terris Thompson, Nurse Practitioner.

4. 638 Title V Self Governance and Community Assessment Needs

As a whole, TCRHCC must continue to educate and communicate the importance of 638 Self Governance at all levels. Our strength as a 638 Indian Self Determination Health facility has only been strengthened with the addition the Ramah, Alamo and Canoncito Navajo satellite communities. This need for successful education will only elevate the successes of Self Governance.

The TCRHCC Board and Administration are attempting to "reach out" to the Navajo Nation Council's HEHS Committee as well as the NN Department of Health (NDOH) to provide collaboration via the 6 members of the 638 Association. Our American Indians for Indian Self Determination in Health are becoming a stronger group. We have developed a well thought our Strategic Plan that encompasses the need to work at all levels of government; local to Federal level.

The Service Area wide Community Needs Assessment is complete for the year 2014-2015. This will assist in the success of all programs of TCRHCC. Transparency and communication will continue to elevate TCRHCC as a trusted entity in the community as well as quality "community first" trusted organization.

Working in unison with other Title I and Title V organizations, we will continue to advocate and demonstrate the value of community involvement, e.g. the Western Navajo Agency Council reports by TCRHCC Board representatives throughout the year. A consistent program to educate our governing board is key to an open minded and improved vision of healthcare delivery on Navajo.

5. Human Capital

We believe that our most valuable asset is our "human capital," and is key to economic growth of the communities we serve. But not only economic growth, but sustainable growth that supports the Native population.

Of our total 1,088+ staff, 91% are Corporate Staff, 3.8% are Civil Service Employees, and 4.8% are Commissioned Corp Staff. This comprises our dedicated, complex healthcare workforce. The summary by the Human Resource Department leadership also depicts the number of Navajos who have grown into higher Management Staff positions, which is by design through our system wide Mentorship Program.

Our Customer Service Program will continue to be augmented by the following teams:

- Champions for Change
- Dream Team
- Bee Positive
- Recruitment & Retention
- Team Extreme
- Steering Team

We intend to be both an employer of choice and a patient destination of choice. Every employee needs to let every patient know how they are appreciated as they place their confidence in the TCRHCC providers.

6. Strategic Capital Improvement Plan

The focus for FY2016 is continued provision of accessible primary and specialty care as well as adapting to the major changes in healthcare trends, including changes in reimbursement models. Elevating primary care and delivering cost effective models of specialized care are imperative to the sustainability of TCRHCC.

We need to be always ready to adapt to a Continuing Resolution and to provide needed services to complete a full continuum of care for our population health. We need to continue to urge our tribal and congressional leaders to Mandate I.H.S. funding. Native health care should not be "Discretionary Funding".

In FY2015 we gave special focus to addressing employee satisfaction via a new Customer Service Program and the Clinical recommendation from the Information Technology Leadership Group for the selection of our newly selected Electronic Medical Record. In FY2016 we'll focus on the implementation of our new E.H.R. and the newly mandated International Classification Diagnosis 10 system, and preparing for our scheduled Joint Commission Accreditation Survey. Our Strategic Plan focuses on many of these areas as we move into the future of health care today and tomorrow.

Our team (Board of Directors, Senior Leaders, Managers/Supervisors, & Staff) have the capability to be proactive and persistent to adapt and overcome the challenges that we face on a day to day basis. Maintaining a proactive stance and Leaders that provide Vision is of high importance.

7. Strategic Pillars

Each of our strategic pillars will be presented with the progress of our FY2015 year in review, as well as our Strategic Vision for FY2016. The Strategic Vision is our map to maintain the fundamentals goals with objectives and metrics that are needed for success. Our overall strategy is a living document, which will be updated and reported through our Fiscal Year.

One system wide strategic priority is improving our working environment for our employees, and providing quality care in a fashion that will be conducive of a sustainable organizational model. Recruitment and retention will undoubtedly be a major priority throughout FY2016.

Conclusion:

The FY2016 budget and strategy is a work in progress, and our challenge is to continue to transform our healthcare delivery systems that will improve health for all populations of patients we serve. Our deepest appreciation goes to all our staff who relentlessly worked on all our presentations. Without the passionate, hard work of all providers, support staff, administration and the Board of Directors, this would be an impossible task.

Ahe'hee',

Lynette Bonar

Lynette Bonar, CEO

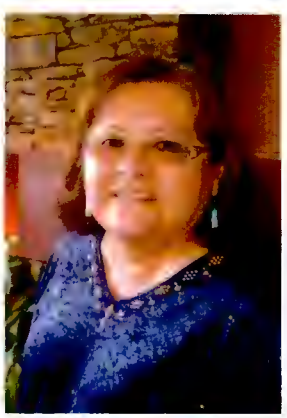
Board of Directors

Christopher Curley
President
Tonalea Chapter

Tincer Nez, Sr.
Vice-President
Coalmine Canyon Chapter

Dolly Lane
Treasurer
Bodaway/Gap Chapter

Dr. Alan Numkena
Vice-President
Moenkopi Village



Esther Tsinigine
Member
Coppermine Chapter

Merle Beard
Member
Tuba City Chapter

Laura Gon
Member
Cameron Chapter

Kimberlee Williams
Member
Kaibeto Chapter

Herman Tso
Member
LeChee Chapter

Leadership Council

(L to R): Joette Walters, RN, BSN, Deputy Chief Nurse Officer; **William Dey, RN, BS, MHA,** Chief Quality Officer; **Lynette Bonar, RN, MBA, BSN,** Chief Executive Officer; **Shawn Davis, BS, MIS,** Information Technology Director; **Katie Magee, MD,** Outpatient Medical Director; **Tim Newland, MHA, RN, CHSP;** Chief of Support Services; **Dollie Smallcanyon, MSN, RN,** Chief Community Health Services Officer/Director Diabetes Treatment & Prevention Services; **Kathleen Harner, MD,** Chief of Staff; **Alvina Rosales, RN, MBS,** Chief Nursing Officer; **Tanya "T.J." Riggs, MA,** Chief Human Resources Officer; **Christine Keyonnie, MSA,** Deputy Chief Financial Officer; **Gerard Diviney CPA, MA,** Interim Chief Financial Officer; **Holly Van Dyk, MD,** Deputy Chief Medical Officer.

Operating Revenue and Expenditures

FY 2014 Net Operating Surplus To Use for Vital New Facility/Service Improvements: $362,547

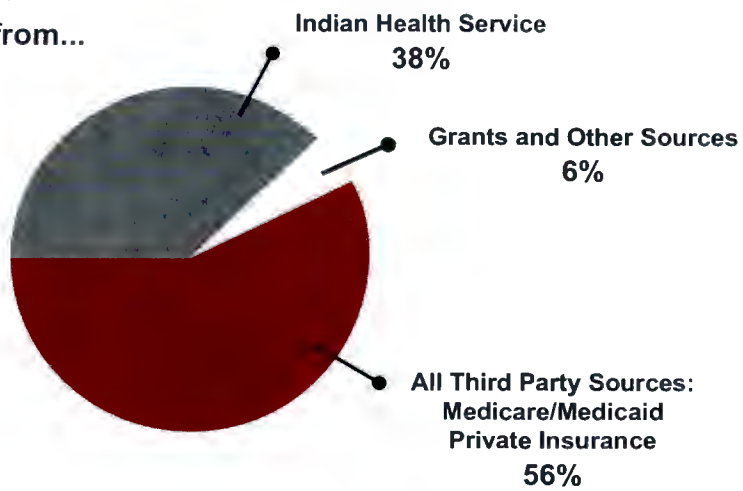
Last fiscal year TCRHCC saw a total of $143,859,238 in net revenue and $143,496,691 in expenses. FY 2014 was a period of continued growth to 745,496 total visits for a 1.6% increase over FY13's 733,458 volume/workload visits. Driving the growth and higher level of patient services, $4.0 million was invested in the purchase of capital property and equipment during FY 2014 compared to $5.9 million in 2013. This means that more than our net operating surplus was invested back into the facility and modern medical technology.

TCRHCC is committed to serving its entire population in all geographical areas. Fiscal year 2014 was a year of further extension and commitment serving these communities as completely as possible, and delivering medical services as efficiently as possible.

TCRHCC projects all need at the present for new capital improvements, expanded services and technology.

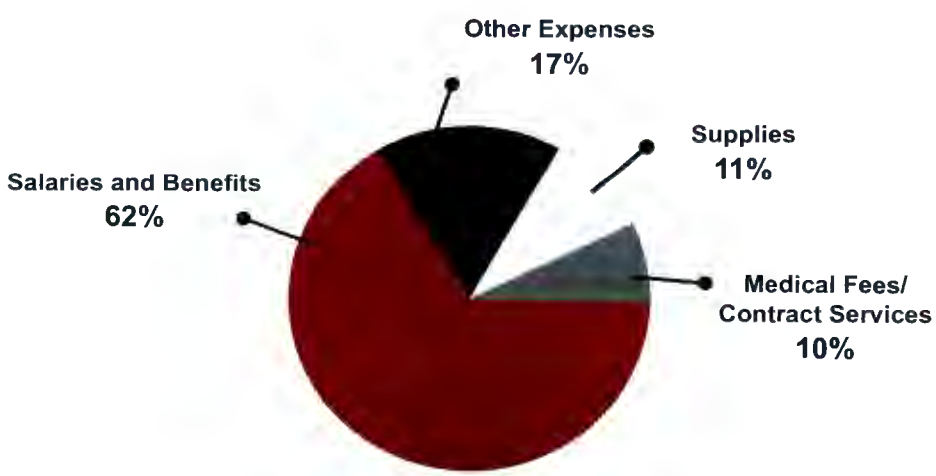
TCRHCC Revenue FY 2014

Where the money comes from...



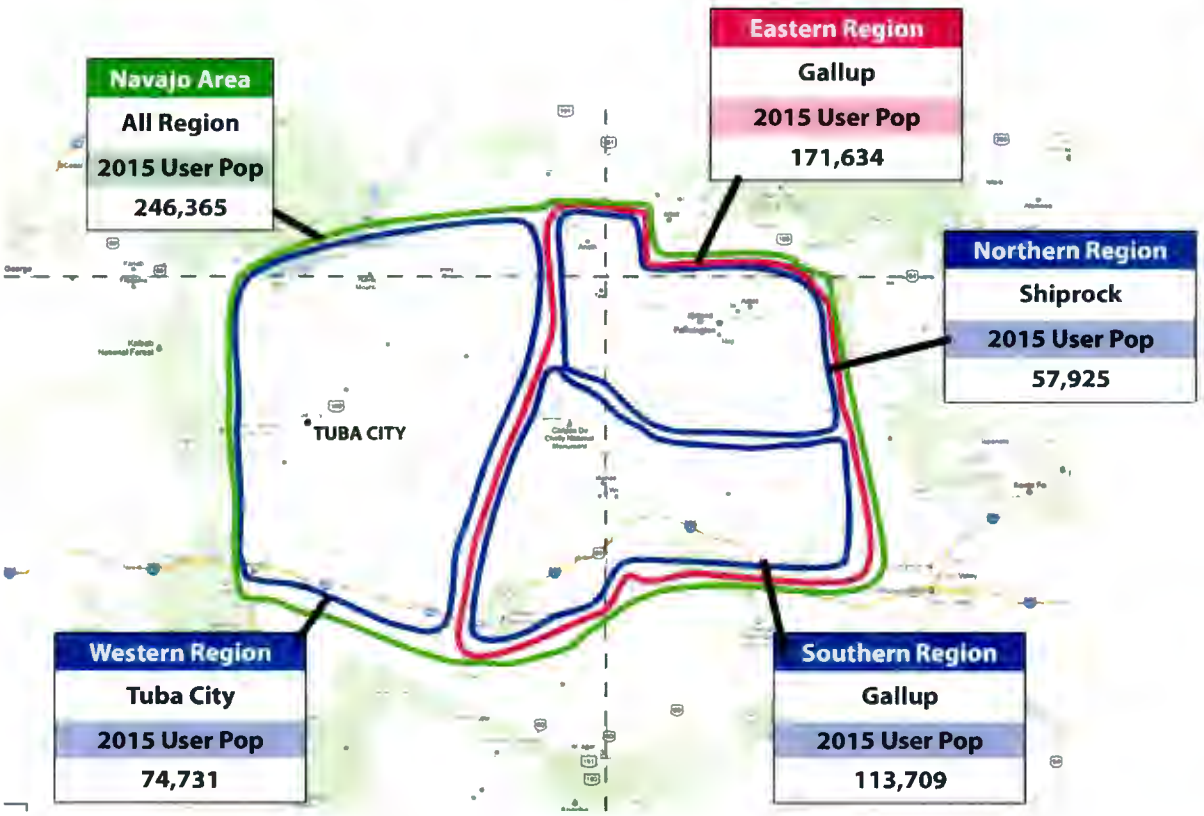
TCRHCC Expenditures FY 2014

Where the money goes...



User Population
Navajo Area Indian Health Services (IHS)

Tuba City Service Unit, Gallup Service Unit, Navajo Area, Shiprock Service Unit



Patient Care Utilization Data FY 2002-2014

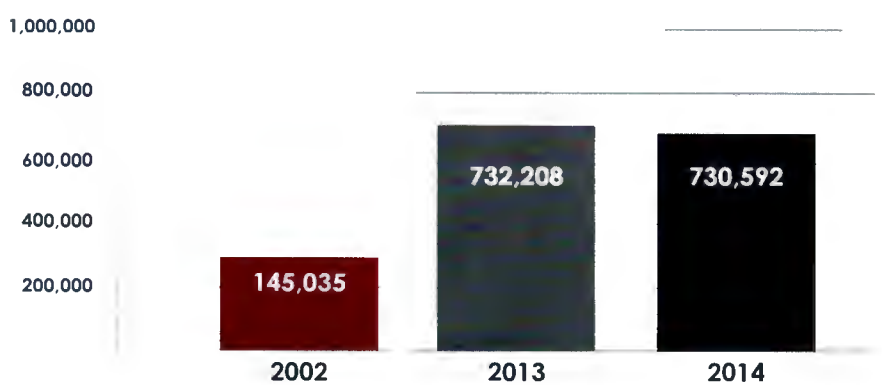
The TCRHCC Inpatient and Outpatient Summary Report displays patient visits by the Navajo Area Indian Health Service (NAIHS). Trends in patient care workload from 2002 to 2014 are readily apparent. This growth helps the hospital's ability to grow and to provide new health services because it helps set reimbursement and funding levels each year. This data includes patient visits, as well.

The average rate of total utilization growth has been 30% annually in the period of 2002 through 2014. The majority of growth occurred on the outpatient side, while some also came from inpatient activity, as shown in the tables.

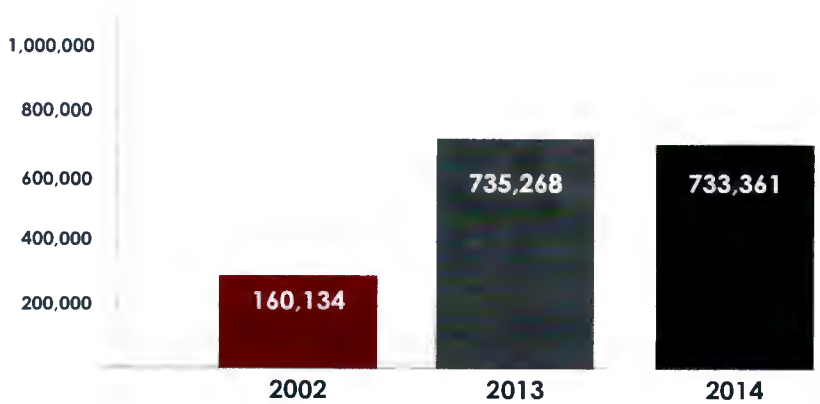
In FY 2014, total combined hospital inpatient and outpatient visits grew to a total of 733,361 visits. This represents a +358% increase in total patient visits during the twelve year period, growing from 160,134 visits in 2002.

The outpatient visit declined of -0.2 % in 2014 versus 2013 which was favorably impacted by expansion projects such as the Sacred Peaks Health Center, the Outpatient Primary Care Center, and providing access to healthcare by the Mobile Health Units and other new services changes in hospital utilization. Sacred Peaks Health Center and Cameron Dental also continued to grow. The need for additional housing for clinical staff continues to have a major bearing upon our ability to continue to grow with additional patient services, including inpatient, outpatient and emergency room services and other specialty services needed at TCRHCC as a regional medical center.

Total Outpatient Visits



Total Inpatient and Outpatient Visits



TCRHCC Inpatient & Outpatient Workload
AHCCCS/OMB Billable Patients Visits (BPV)
FY 2002 - FY 2014

INPATIENT	FY 2002	FY 2012	FY 2013	FY 2014
Hospital Discharges	**3,458**	**2,951**	**2,620**	**2,340**
Swing-Bed	–	*95*	*90*	*54*
ACU	–	*2,856*	*2,530*	*2,286*
Inpatient Days	**14,153**	**11,880**	**11,595**	**11,159**
Average Daily Census	**38.0**	**32.5**	**32.0**	**29.0**
Newborns	**512**	**454**	**440**	**429**
Newborn Days	**946**	**870**	**926**	**869**
Total Inpatient Days	**15,099**	**12,750**	**12,521**	**12,863**
Discharges	**3,970**	**3,405**	**3,060**	**2,769**
ALOS	**3.8**	**3.7**	**4.1**	**4.5**

OUTPATIENT	FY 2002	FY 2012	FY 2013	FY 2014
Total Outpatient Visits	**145,035**	**720,708**	**732,208**	**730,592**
Observations	–	*519*	*666*	*613*
Outpatient	–	*720,189*	*731,542*	*729,979*

GRAND TOTAL UTILIZATION	FY 2002	FY 2012	FY 2013	FY 2014
Inpatient Days & Outpatient Visits	**160,134**	**733,458**	**735,268**	**733,361**
Total Patients	**27,115**	**33,701**	–	–

NOTE: BPV (Billable Patient Visits) = Reimbursable Patient Visits Counted per AHCCCS/OMB

Rev. 07/29/15

Strategic Plan
FY 2012 - FY 2017

Mission

Our Mission is to provide accessible, quality and culturally sensitive healthcare.

Vision

Our Vision is embracing healthy living to heal, to respect, to console.

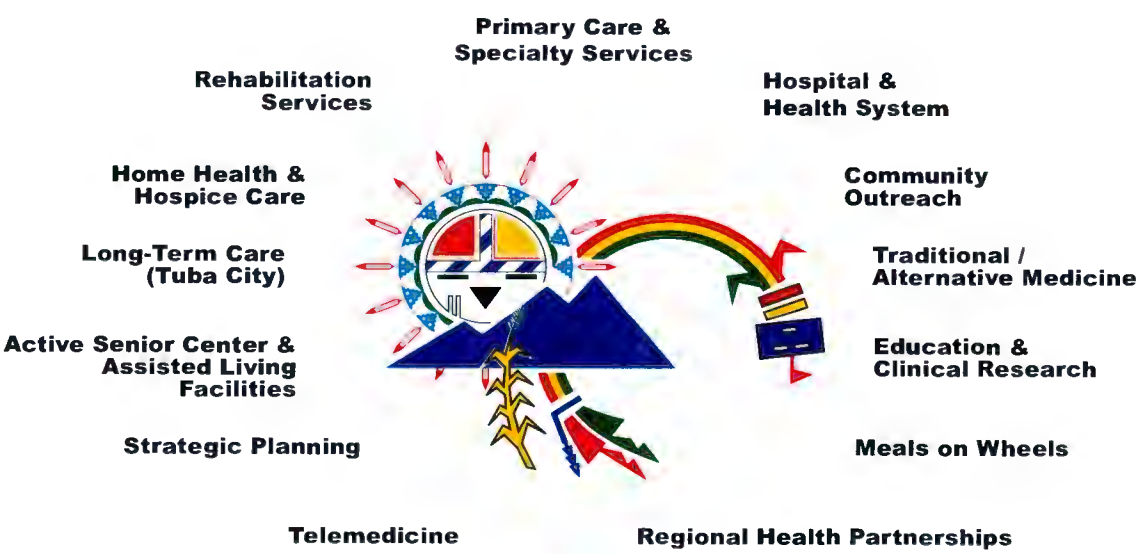
Values Statement:

We take pride and honor the dignity in all individuals. We promise to uphold an environment dedicated to quality and a vision of excellence for today and tomorrow.

Four Strategic Pillars:

- Financial Management
- IS/Data Management
- Quality Improvement
- Services Enhancement/Development

Integrated Regional Health System



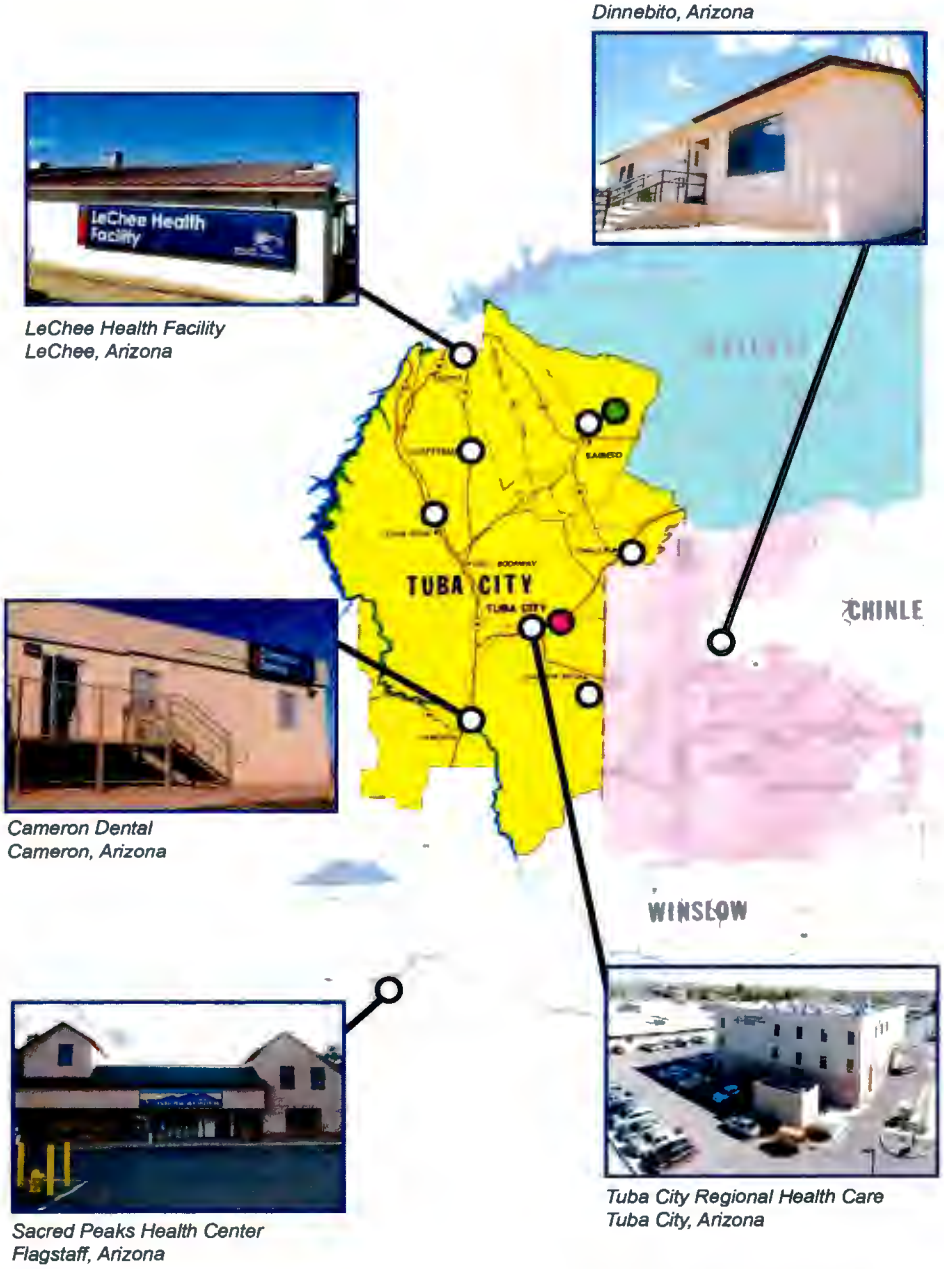
TCRHCC Regional Health System

An Integrated Health System with a Regional Medical Center Hub and Network of Mobile / Fixed Satellite Health Services

- Lechee
- Kaibeto
- Coppermine
- Bodaway Gap
- Tonalea
- Moenkopi
- Cameron
- Flagstaff
- Coalmine

Long Term Care (LTC)

Independent Long Care (ILC)



Dinnebito Clinic
Dinnebito, Arizona

LeChee Health Facility
LeChee, Arizona

Cameron Dental
Cameron, Arizona

Tuba City Regional Health Care
Tuba City, Arizona

Sacred Peaks Health Center
Flagstaff, Arizona

TCRHCC Capital Priorities FY 2016–2018

1. Campus Expansion
    a. Expanded Primary Care (Rehabilitation)
    b. SPHC Expansion
    c. Bodaway/Gap Health Center Recruitment
2. Long Term Care (Complete Construction Design 10/15)
3. Electronic Health Record
    a. Implementation
4. Integrated Delivery System Master Plan (SLC f/u)
5. IT Fiber (Frontier)
6. Correctional Facility Health Care Funding (Multi Tribal Model)
7. Sustainable Reimbursement and Business Intelligence Model
    a. HR Information System
    b. Enterprise Resource System
8. Succession Planning for Future
    a. Nursing Training Programs
9. Community Health Center Development
    a. Mobile Health Site Expansion
10. Grant Program Expansion
11. Enhance Population Health Infrastructure
    a. Care Coordination
    b. Population Health IT
    c. In Network Utilization
12. Partnership: 638, Local, PCMH, Local Tertiary Providers

TCRHCC Operational Priorities FY 2016–2018

1. ICD 10
2. Health Resource Information System
3. E.H.R. Implementation Plan
4. Improved Performance Improvement
5. Customer Service Program & Employee Engagement
6. Joint Commission Accreditation
7. Grow Telemedicine
8. Health Promotions expansion
9. Call Center Development
10. New Specialty Clinics
11. Optimize OR Strategies, Surgical Assistant Trng Program
12. Comprehensive Plan Recruiting Strategy
13. Clinical Education Plan

A Timeline: TCRHCC Historical Milestone FY 2009-2015

July 16, 2009
Sacred Peaks Health Center Lease Agreement Signing

October 22, 2009
TCRHCC celebrates the opening of the MRI (Medical Resonance Imaging)

December 1, 2009
TCRHCC celebrates Ground Breaking Ceremony of the NEW Outpatient Primary Care Center

March 9, 2012
Storz Donates Medical Equipment to TCRHCC OB/GYN Department

May 7, 2011
Grand Opening of the Outpatient Primary Care Center

June 29, 2012
TCRHCC signs 5-Year Funding Agreement with the Indian Health Service Office of Self-Governance

August 2012
TCRHCC begins the LeChee Health Facility Pharmacy Construction Project

September 29, 2012
TCRHCC celebrates 10-Years of Tribal Self-Governance

October 17, 2013

January 7, 2014
TCRHCC and Veteran Affairs of Northern Arizona Health System sign an agreement

TCRHCC celebrates with a Ribbon Cutting of the NEW Health Promotion & Diabetes Prevention Center

August 2013
TCRHCC construction project of the NEW Health Promotion & Diabetes Prevention Center

September 23, 2014
TCRHCC and Northern AZ VA Health Care System celebrate with a Grand Opening of the NEW VA-PTOC

June 17, 2014
TCRHCC celebrates with a Ground Breaking Ceremony for the NEW Kaibeto Creek Independent Living Center

March 10, 2010
TCRHCC celebrates the Grand Opening of the NEW Sacred Peaks Health Center

July 21, 2010
TCRHCC Approved Title V by the 21st Navajo Nation Council

November 10, 2010
'638' Compacting with the Indian Health Service Office of Self-Governance

April 27, 2011
Navajo Hopi Health Foundations was founded to raise funds for TCRHCC projects.

NAVAJO · HOPI
HEALTH FOUNDATION

November 2, 2012
TCRHCC celebrates with a Blessing Ceremony of the NEW LeChee Health Facility Pharmacy

October 18, 2012
TCRHCC celebrates with a Blessing Ceremony of the NEW Helipad

March 2013
TCRHCC receives the ARRA Grand Funding from the Indian Health Service

June 2013
TCRHCC unveils the NEW Dental and Medical Mobile Unit to the community

July 10, 2013
TCRHCC receives the ASET Grand Award

January 29, 2015
TCRHCC celebrates with a Ribbon Cutting of the NEW Pasture Canyon Apartment ComplexCenter

February 20, 2014
TCRHCC celebrates with a Ground Breaking Ceremony for the NEW Pasture Canyon Apartment Complex

TCRHCC is a Top Performer on The Joint Commission Key Quality Measure

When a health care organization seeks accreditation, it demonstrates commitment to giving safe, high quality health care and to continually working to improve that care.

Tuba City Regional Health Care Corporation
THE JOINT COMMISSION ACCREDITATIONS

The Joint Commission
Gold Seal of Approval®
Hospital Accreditation Program

The Joint Commission
Gold Seal of Approval®
Laboratory Accreditation Program

The Joint Commission
Gold Seal of Approval®
Home Care Accreditation Program

Tuba City Regional Health Care Corporation (TCRHCC) has earned The Joint Commission's Gold Seal of Approval® for accreditation by demonstrating compliance with The Joint Commission national standards for Hospital Accreditation Program, Laboratory Accreditation Program and Home Care Accreditation Program. The accreditation award recognizes TCRHCC's dedication to continuous compliance with The Joint Commission's state-of-the-art standards.

To ensure the highest quality healthcare at TCRHCC, we maintain accreditation with The Joint Commission. That means we meet or exceed the strict standards The Joint Commission has set for our performance, in everything from emergency response to infection management protocols.

The American College of Surgeons Designates TCRHCC as a Level III Trauma Center

Tuba City and western Navajo Nation residents now have access to advanced trauma care in their community.

In March 2015, the Tuba City Regional Health Care Corporation (TCRHCC) was designated by the American College of Surgeons (ACS) as a level III trauma center.

TCRHCC is the first hospital in the lower 48 states in Indian Country to be designated as an advanced Level III Trauma Center.

Dr. Ralph Zane Kelley, a trauma surgeon and also the chief of surgery and trauma at TCRHCC, said the hospital was designated by the state of Arizona as a level IV trauma center. The designation by ACS is a national ranking.

TCRHCC has a comprehensive team of surgeons, specialists, nurses and staff members who receive specialized training in trauma care.

In the state of Arizona there were only 11 verified Level III ACS trauma centers. Tuba City is now number 12 on that list. By comparison, Flagstaff Medical Center is a Level I.

The designation process ensures that proper procedures, staffing and processes are in place to best care for the most serious injuries, from ATV accidents, assault, gunshot and knife stab wounds to automobile accidents. As part of this designation, trauma surgeons, as well as other physician specialists, are required to be available 24 hours a day.

Shannon Johnson, RN director of trauma program services, and Kelley worked the last few years for the current Level III designation with an initial visit by ACS in 2013 and the final visit coming a year and a half later.

ACS specifically looks at the trauma patients an emergency department cares for - whether they are cared for or operated on at the hospital or whether they are shipped somewhere else. The organizataion also requires the facility to collect data for evaluation on an ongoing basis concerning trauma cases to improve outcomes and quality standards.

"It definitely increases the quality and competency of care that trauma patients receive here," Kelley said. "Tuba City is probably the only place on the rez that has ER residency trained board certified ER physicians. Also we have general surgeons who are advanced trauma trained."

Johnson added, the hospital has trauma nurse core curriculum certified nurses and emergency pediatric certified nurses as well.

"We're accredited by a national organization and we do care for a high level of patients and definitely care for and have a higher acuity of care than the majority of other reservation facilities," Kelly said. "Tuba is constantly adding new services and new specialties to keep patients on the reservation rather than having to ship them to Flagstaff or Phoenix where it is an inconvenience for themselves but also their families."

The Pasture Canyon Apartment Complex
A Solution to TCRHCC Recruitment

In February 2014, Tuba City Regional Health Care Corporation (TCRHCC) broke ground to build a 36-unit apartment complex, located off of East Drive, north of the Tuba City High School campus. The apartments would provide housing for hospital employees that are critical to the hospital's operation.

Recruitment and Retention for quality healthcare staff has been difficult in recent years; and the lack of housing in the community has been a hard hurdle to overcome for employees.

"To address the staffing challenge, TCRHCC began planning for a solution to our housing needs," said Lynette Bonar, TCRHCC CEO.

Housing is desperately needed to retain and recruit employees at TCRHCC. Some employees commute from Flagstaff, Page, Kayenta or reside at one of the local hotels to make it to work.

A year later, in January 2015, TCRHCC's 36-unit apartment complex was complete. The Hospital's employees voted to name the complex, the Pasture Canyon Apartment Complex.

High expectations surrounded the first apartment complex construction project as a Self-Determined Health Care System under TItle I. The new apartment complex now draws future nurses, dentists, pharmacists and physicians to Tuba City; stabilizing an evolving healthcare system; and stimulating new developments to grow as a Self-Governance Healthcare System.

"We really look at this as a retention tool," said Bonar. "The buildings are a statement about what we can accomplish for our employees as a Tribal Self-Determined Healthcare System."

Tincer Nez, Sr., TCRHCC Board Member expressed, "I am glad this completed project will keep staff closer to their jobs and employees will have more time with their families by being able to live closer to work."

"The completion of Pasture Canyon Apartments is a fine example of the progress we are making as a Self-Governed Healthcare System to address our greatest housing needs for our employees," said Bonar. "If we can provide housing, the committement to our organization is going to be there."

HIGHLIGHTS + ACHIEVEMENTS

- The Pasture Canyon Apartment Complex is a 36-unit complex for TCRHCC employees.
- The Pasture Canyon Apartment Complex was completed within 12-months.
- Over 90 percent of the workers hired for the construction project were Native Americans from the local area.
- The Pasture Canyon Apartment Complex was soley funded through TCRHCC.

Sacred Peaks Health Center's Meds in Hand Program Provide Continued Care and Healing

The convenience of having a local pharmacy that's open seven days a week, on a major highway in East Flagstaff, makes life easier for those who depend on services from the Pharmacy Department at Tuba City Regional Health Care Corporation's (TCRHCC) Sacred Peaks Health Center (SPHC) in Flagstaff.

TCRHCC beneficiaries and other Native Americans in the Flagstaff area enjoy the fast, professional service from the Pharmacy Department at SPHC.

For many, it means not having to drive the long distance to Tuba City to obtain much needed medications.

SPHC opened in March 2010 to serve the health care needs of Native Americans who otherwise were driving to Tuba City or Winslow for healthcare. The Pharmacy Department's services have continually grown in scope and in number since the clinic's opening.

The Pharmacy Department staff at SPHC includes five pharmacists, four pharmacy technicians, a pharmacy assistant, and two pharmacy billers. The staff is truly dedicated to friendly service and providing for the care and needs of its customers.

Meds in Hand Program

Beginning in May 2015, the SPHC Pharmacy Department initiated a service called the Meds in Hands Program. The program helps Native American patients who are about to be discharged from being in the hospital at Flagstaff Medical Center receive bedside delivery of the medications they will need for their continued care and healing when they go home.

The number of patients being readmitted to the hospital was high, as patients often didn't pick up their prescriptions or did not receive adequate instructions and counseling.

The program allows SPHC pharmacists deliver prescriptions to patients and provide counseling, answering any questions patients may have.

Since the Meds in Hands Program began there have already been over 1,100 prescriptions delivered – an average of four prescriptions per patient and about four patients per day. Patients could use Flagstaff Pharmacy at FMC, but there are no co-pays at the Pharmacy at SPHC.

Comments about the Pharmacy Department on patient satisfaction surveys are overwhelmingly positive – "Thanks for providing care in Flagstaff So appreciative!" -- "The best pharmacy team! Love our pharmacy!" -- "Very supportive, friendly, and concerned. Answered my questions." -- "Your service is so awesome!"

SPHC Pharmacy Devoted to Making a Difference

The Pharmacy is very efficient as far as waiting time compared to other pharmacies for Native Americans, and feedback from elderly patients is especially good due to the care and counseling on medications by the Pharmacy Department staff.

The SPHC Pharmacy has developed good relationships with many Flagstaff area health care providers, including those at the publicly-supported North Country Healthcare Clinic, and the Native Americans for Community Action Family Health Center (NACA). Patients who see healthcare providers at these additional clinics can easily have their prescription orders sent to TCRHCC's Sacred Peaks for fast and easy pick-up.

In 2011, 42,062 prescriptions were filled at SPHC. That number grew to 59,468 in 2012. A remarkable double-digit percentage growth has continued each year. Assistant Director of Pharmacy, LT Patrick Tully says that more than 86,000 prescriptions are projected to be filled in 2015.

The most up-to-date robotic equipment is used in the Pharmacy to assist in filling prescriptions. The 150 most-often-prescribed medications are loaded into the robotic unit, and prescription bottles are filled with speed and accuracy, freeing up the pharmacists' time for customer service. Pharmacists always check and verify the automated equipment before medications are released to customer.

Pharmacists at SPHC also give immunizations, mostly vaccines such as flu, pneumonia and tetanus. They are given on a walk-in basis or by referral, generally Monday through Friday. A health care provider is always available on site in case of an adverse reaction.

Sacred Peaks Health Center serves the TCRHCC beneficiaries living in the Flagstaff area, along with patients from across Arizona and Native Americans who may be traveling through the area. Regular Pharmacy hours are 8:00 a.m. to 7:00 p.m., Monday through Friday, and 9:00 a.m. to 5:00 p.m. on Saturdays and Sundays. The direct phone number for the Pharmacy Department is (928) 863-7331.

HIGHLIGHTS + ACHIEVEMENTS

- Sacred Peaks Health Center (SPHC), a part of Tuba City Regional Health Care Corporation (TCRHCC), opened March 2010.
- SPHC offers Family Medicine, Internal Medicine, basic Laboratory, basic Radiology, Physical Therapy, Pharmacy services, and other specialty services such as Nuerology, Dermatology, Mental, Nutrition, and more.

LeChee Health Facility Is Open To Serve
Fulfilling the Promise of Healthier Communities

Tuba City Regional Health Care Corporation (TCRHCC), a provider of high quality, accessible health care services, has opened the doors to its new health center in LeChee, AZ, the LeChee Health Facility.

Located 3-miles South of Coppermine Road, the 15,000-square foot facility houses 6 exam rooms and will potentially grow to provide over 10,000 patient visits annually. The new center serves as a powerful catalyst for improving the health and well-being of residents of LeChee and surrounding communities including Coppermine, Kaibeto, and Page offering high-quality health care for hundreds of residents who lacked access to affordable care.

"As a leader in community-based health initiatives, we are at the forefront of delivering patient-focused care and improving health outcomes. TCRHCC has been in the communities where we are needed most," said Lynette Bonar, CEO of TCRHCC. "The population in Greater LeChee is growing and it's imperative that we help fill this gap by providing high quality health care."

LeChee Health Center is TCRHCC's 3rd health center and the second outside of Tuba City. The new center, like TCRHCC's other locations, will be a portal to care and a higher quality of life for community residents.

At the new health center, a highly trained team of medical health professionals provide comprehensive primary care, including prenatal care, pediatrics, women's health, adult and senior medical care, as well as chronic disease management and pharmacy services. LeChee Health Facility also plans to add other speciality services such as dermatology, tele-medicine, health education and other services in the near future. Established TCRHCC patients will also have access to the Pharmacy located within the facility.

Critical to the success of making this health center a reality was the partnership and vision of TCRHCC and LeChee's community leaders. This spirit of collaboration is rooted in a common commitment to innovative leadership, health care responsibility and improved services.

"TCRHCC's commitment to LeChee is part of its overall commitment to provide accessible and quality medical health care that offer primary care and pharmacy services to our patients," said Bonar.

The community has responded positively in support of the health center.

Irene Nez Whitekiller, Chapter President of LeChee Chapter, is honored that the local leaders and community had the opportunity to play such a crucial role extending health services to their community.

"LeChee is pleased to support the new Clinic opening which will support the healthcare needs in our community," said Whitekiller.

"We are looking forward to being able to bring more opportunities for high quality and integrated care to patients in this community," Holly Van Dyk, M.D. and clinical director of LeChee Health Facility. "At LeChee Health Facility, patients will receive coordinated care and pharmacy services under one roof, without having to travel from office to office. This is a model of care that has been much appreciated by our patients and we are excited to be able to offer it in LeChee."

The LeChee Health Facility-Pharmacy is equipped with state-of-art tools they need to be providers of enhanced services and to engage with patients daily.

LeChee Health Facility-Pharmacy is also a distribution site for Mail-Order Prescription. Trained pharmacists prepare medication, up from 40,000 to 150,000 between 2002 and 2014. The Pharmacy services allow LeChee Health Facility to reach out to even more people, who are approaching pharmacists to ask questions not only about their prescriptions, but also about health-related issues.

To help keep their patients healthy, the pharmacy at LeChee Health Facility accepts NEW prescription written by your doctor outside of the TCRHCC healthcare system. Simply take your paper prescription to LeChee Health Facility-Pharmacy and a pharmacist will dispense your medication.

In recognizing the important role pharmacists play in improving health outcomes, Ron Chapman, pharmacy director of LeChee Heatlh Facility, said, "Healthcare is constantly changing and pharmacists are no longer simply dispensing medication. Our pharmacists are also providing important healthcare services through innovative programs and services across our practice settings."

LeChee Health Facility

Clinic Hours

Monday–Friday
8:00 AM to 5:00 PM

Schedule An Appointment
Call 928-698-4900

Pharmacy Hours

Monday–Friday
7:00 AM to 7:00 PM

Saturday–Sunday
8:00 AM to 5:00 PM

Pharmacy Phone Number
928-698-4911

Pharmacy Refill Line
928-698-4912

LeChee is closed on Federal holidays.

TCRHCC Community Health Center Mobile Health Receives Innovation Award

Roselyn Riggs, Mobile Health Program Manager received an award for her demonstration of endless enthusiasm, and continued success of the Tuba City Regional Health Care Corporation (TCRHCC) Community Health Center (CHC) Mobile Health Program.

The Arizona Alliance for Community Health Center's (AACHC) Innovation Award is presented to one program out of 19 organizations in Arizona that delivery primary healthcare at 135 delivery sites.

Ms. Riggs, was nominated for her efforts in coordinating the expansion of two service additional site initiatives within the TCRHCC service area

"Ms. Riggs has been able to assure the TCRHCC CHC Mobile Health Program is sustainable, as well as effective," said Lynette Bonar, CEO.

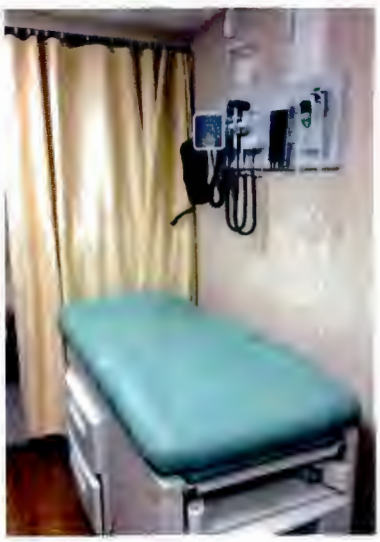
Members of AACHC recognized Riggs for coordinating services to provide non-emergent primary care to the community of Bittersprings after the road closure of Highway 89, from Bitterspring to Page, Arizona in 2013, and it continues today. They also applauded her initiative to provide a Uranium Clinic at selected Chapter Houses in the TCRHCC Service Area for patients affected by uranium mining.

TCRHCC Mobile Health Program was a vital component for the expansion of the two service initiatives. The mobile van provides patients the proper care they need through monitoring and treating illnesses, so care is not delayed.

Riggs received the award at the 2015 AACHC Annual Conference meeting on February 4, 2015 in Phoenix, AZ, before AACHC members; local, state, regional, and federal agencies; policy and advocacy organizations and foundations supporting access to healthcare.

"Ms. Riggs epitomizes the very highest levels of excellence and success to our organization," said Bonar. "We appreciate her commitment and dedication to our patients and communities."

The Mobile Health Program makes scheduled visits to the Chapter Houses 1-2 times a month within the Tuba City Service Area. The schedules can be found on the hospital website, at the Community Health Center building located on the eastside of the TCRHCC campus, or at your local Chapter House.

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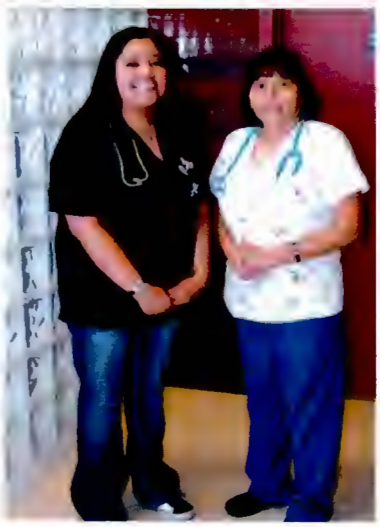

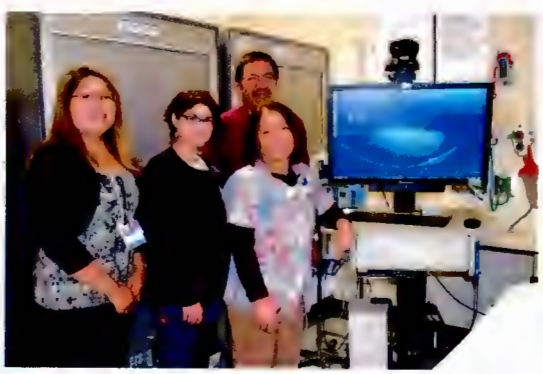

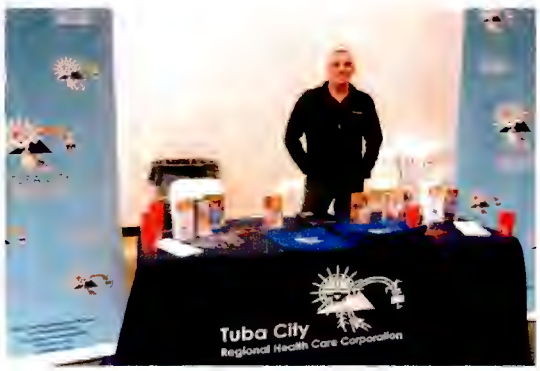
Tuba City
Regional Health Care Corporation


Telehealth

Tuba City Regional Health Care Corporation

167 N Main Street
P.O. Box 600
Tuba City, Arizona 86045

tchealth.org

NAVAJO NATION HEALTH COMPACT
between
AUTHORIZED NAVAJO NATION TRIBAL ORGANIZATIONS
and the
UNITED STATES OF AMERICA

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NAVAJO NATION HEALTH COMPACT
between
AUTHORIZED NAVAJO NATION TRIBAL ORGANIZATIONS
and the
UNITED STATES OF AMERICA

This Compact of Self-Governance ("Compact") is made and entered into by and between the Secretary of the Department of Health and Human Services of the United States of America ("Secretary"), represented by the Director of the Indian Health Service ("Director"), and each of the following: the Tuba City Regional Health Care Corporation ("TCRHCC"), the Winslow Indian Health Care Center, Inc. ("WIHCC") and the Utah Navajo Health System, Inc. ("UNHS") (hereinafter collectively referred to as "Co-Signers"), as authorized by the Navajo Nation Council, Resolution No. CJY-33-10. This Compact is entered into with each of the Co-Signers pursuant to Title V of the Indian Self-Determination and Education Assistance Act, as amended, ("the Act", "ISDEAA", "P.L. 93-638" or "Title V"), which authorizes the Secretary to enter into compacts and funding agreements with Indian tribes and tribal organizations. The Secretary has delegated this authority to the Director.

RECITALS,

WHEREAS, the Navajo Nation has exercised its inherent rights of self-governance since time immemorial; and

WHEREAS, the Navajo Nation is an Indian tribe, as defined in 25 U.S.C. § 450b(e) and 458aaa(b); and

WHEREAS, after substantial consideration and careful study, the Navajo Nation has sanctioned the Co-Signers, as tribal organizations, as defined in 25 U.S.C. § 450b(l) and authorized in 25 U.S.C. § 458aaa(b), for the purpose of providing health care services to members of the Navajo Nation and other eligible American Indians and to enter into this Compact with the Indian Health Service and for other purposes; and

WHEREAS, Congress has made findings that federal health services to maintain and improve the health of Indian people are consonant with and required by the federal government's historical and unique legal relationship with, and resulting responsibility to, Indian people, and to provide the resources, processes and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States, 25 U.S.C. §1601; and

WHEREAS, Congress has declared it the policy of the United States, in fulfillment of its special responsibilities and legal obligations to Indian people, to ensure the highest possible health status and to provide all resources necessary to effect that policy, to raise

the health status of Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives, 25 U.S.C. § 1602; and

WHEREAS, for purposes of this Compact, the "Co-Signer" or "Co-Signers" shall mean the tribal organizations authorized by Navajo Nation Council resolution and 25 U.S.C. § 458aaa(b) to enter and participate in the Compact; and

WHEREAS, under authority from the Navajo Nation, the Co-Signers have provided health services for years under self-determination contracts with the Indian Health Service and have been recognized by the Indian Health Service as "tribally operated service units or areas"; and

WHEREAS, Co-Signers have long been authorized to serve certain other Indian Tribes on or near the Navajo Reservation; these Co-Signers may, if properly authorized by resolution of the affected Indian Tribe(s), continue to provide such services, and include related funding, under this Compact and associated Funding Agreements; and

WHEREAS, Congress, in Title V, has authorized the Secretary to negotiate and enter a Compact and Funding Agreement ("Funding Agreement" or "Funding Agreements") with each Indian tribe or, pursuant to 25 U.S.C. § 458aaa(b), tribal organization, that has satisfied the qualification requirements set out in 25 U.S.C. § 458aaa-2(c), in a manner consistent with the federal government's trust responsibility, treaty obligations, and the government-to-government relationship between Indian tribes and the United States; and

WHEREAS, each Funding Agreement, attached hereto as Exhibit B, C and D respectively shall authorize the Co-Signers to plan, conduct, consolidate, administer, receive full tribal shares of funding, including tribal shares of discretionary competitive grants (excluding Congressionally earmarked competitive grants), redesign programs, and reallocate funds for all programs, services, functions and activities (or portions thereof) (hereinafter "PSFA", as provided in 25 U.S.C. § 458aaa-4(b) and 25 U.S.C. § 458aaa-5(e)); and

WHEREAS, each Funding Agreement shall set forth terms that generally identify the PSFAs, or portions thereof, to be performed and administered, and the general budget category assigned; the funds to be provided, including those funds to be provided on a recurring basis; the time and method of transfer of the funds; the responsibilities of the Secretary; and any other provision with respect to which the respective Co-Signer and the Secretary agree as provided in 25 U.S.C. § 458aaa – 4(d); and

WHEREAS, each Funding Agreement shall specify the authority of the respective Co-Signer to redesign or consolidate PSFAs (or portions thereof) and to reallocate funds as provided in 25 U.S.C. § 458aaa - 5(e); and

WHEREAS, to the extent funding is provided to a Co-Signer pursuant to a Funding Agreement, such Co-Signer shall be responsible for administration of PSFAs pursuant to this Compact and the associated Funding Agreement, as provided in 25 U.S.C. § 458aaa - 4; and

WHEREAS, nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the funding for any PSFA or project serving any other Indian Tribe or program under Title V or any other applicable federal law, pursuant to 25 U.S.C. § 458aaa – 14; and

WHEREAS, in Title V, Congress has directed that the Funding Agreements which the Secretary negotiates with Co-Signers shall contain certain provisions and, at the option of the Co-Signers, apply to certain PSFAs of the Indian Health Service, including construction, as provided in 25 U.S.C. §§ 458aaa – 4, 458aaa – 6(a)(2)(A), 458aaa – 8; and

WHEREAS, Congress has directed that, at the request of a Co-Signer and under the terms of a Funding Agreement, the Secretary shall provide funding to the Co-Signer to implement the Funding Agreement as provided in 25 U.S.C. § 458aaa – 7; and

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the implementation of this Compact and associated Funding Agreements as provided in 25 U.S.C. § 458aaa – 11(a)(2); and

WHEREAS, Congress has directed that the Secretary shall interpret federal laws and regulations in a manner that will facilitate the inclusion of PSFAs, or portions thereof, and funds associated therewith in Compacts and Funding Agreements, and the achievement of tribal health goals and objectives, as provided in 25 U.S.C. § 458aaa – 11(a)(1) and (3); and

WHEREAS, it is the intent of the parties that this Compact will be entered into, executed by and carried out by each of the sanctioned tribal organizations, further referred to herein as "Co-Signers" and that each authorized tribal organization that is a Co-Signer to this Compact executes this Compact as a separate and independent Co-Signer and is separately and independently bound by its terms and shall have separate and independent rights under the Compact; and

WHEREAS, it is the intent of the parties that each Co-Signer's Funding Agreement entered into under this Compact will be entered into and carried out by that Co-Signer, and that each Co-Signer will carry out its respective PSFAs as set out in its Funding Agreement, and shall be bound by the terms of its individual Funding Agreement and shall have separate and independent rights under its Funding Agreement; and

WHEREAS, the parties acknowledge and agree that by sanctioning certain tribal organizations to enter into and carry out PSFAs under this Compact and Funding Agreements, no aspects of the Navajo Nation's sovereignty are relinquished, and the Co-Signers only have the authority granted to them by Navajo Nation Council Resolution or other law; and

WHEREAS, the parties have reviewed and determined that all of the provisions of this Compact are authorized by Title V or other provisions of federal law and the parties have executed this Compact in reliance on this representation; and

NOW THEREFORE, the Secretary and the Co-Signers do hereby agree to enter into, undertake, and be bound by this Compact in accordance with the foregoing principles.

ARTICLE I – AUTHORITY AND PURPOSE

Section 1 – Authority. This Compact is authorized by ISDEAA, Title V, as amended, 25 U.S.C. § 458aaa *et seq.*, and is hereby entered into by the Secretary, represented by the Director, and the Co-Signers, as identified herein and any additions as may be subsequently approved by the Navajo Nation and the Secretary and identified in Exhibit A. The Director, by signing this Compact, commits the Secretary to the extent and within the scope of the Secretary's delegation of authority to the Director to enter into Compacts and Funding Agreements pursuant to Title V or as otherwise authorized.

Section 2 – Purpose. This Compact shall be liberally construed to achieve its purposes and any ambiguity shall be resolved in favor of the Co-Signers to achieve the purposes of the Compact, as follows:

(a) This Compact implements the federal policy of self-governance, as authorized by Title V, with the Navajo Nation and the Co-Signers. This Compact authorizes the sanctioned Co-Signers to plan, conduct, consolidate, re-design and administer PSFAs of the Indian Health Service under the terms of the Compact, as authorized by Title V, to reallocate funds in a manner that the applicable Co-Signer deems to be in the best interest of the health and welfare of the Indian community or communities being served by such Co-Signer, only if the redesign or consolidation does not have the effect of denying eligibility for service to population groups otherwise eligible to be served under applicable federal law.

(b) This Compact is to enable the United States to maintain and improve its unique and continuing relationship with and responsibility to the Navajo Nation and the Co-Signers, to permit an orderly transition from federal domination of programs and services to meaningful tribal control of federal health programs, and to provide for a measurable parallel reduction in the federal bureaucracy as PSFAs (or portion thereof) are assumed under this Compact and the associated Funding Agreements, as provided for in 42 C.F.R. § 137.2 (b)(2)(vi)-(vii).

(c) This Compact and associated Funding Agreements shall transfer to the Co-Signers, acting individually, the responsibility for the PSFAs of the Indian Health Service included in the Compact and the Co-Signers' respective Funding Agreements, and grant them full authority, in accordance with the ISDEAA, the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. 1601 *et seq.*, and other applicable federal law, to carry out their programs and services according to the needs and priorities of the Navajo Nation. In fulfilling its responsibilities under the Compact and consistent with the April 29, 1994, Memorandum from the President of the United States of America for the Heads

of Executive Departments and Agencies, Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments, the September 23, 2004, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, the November 5, 2009, Memorandum from the President of the United States of America for the Heads of Executive Departments and Agencies, and the Department of Health and Human Services Tribal Consultation Policy, the Secretary hereby pledges that the Indian Health Service will conduct all relations with the Navajo Nation and Co-Signers on a government-to-government basis.

Section 3 – Applicable Law and Forums. The parties agree that the laws of the United States shall apply to any dispute between the United States and the Co-Signers arising out of the Compact or any Funding Agreement.

ARTICLE II – TERMS, PROVISIONS AND CONDITIONS

Section 1 – Term and Resolutions.

(a) Term. The term of this Compact begins as to each Co-Signer, after execution by both parties, and on the effective date of the Co-Signer's first Funding Agreement and shall extend thereafter as to each Co-Signer throughout the period authorized by Title V of the ISDEAA, and any subsequent amendment thereto, provided the Co-Signer has a Funding Agreement in effect. The Compact shall remain in effect for so long as is permitted by federal law and Navajo Nation Council Resolution(s) or until terminated by mutual written agreement, retrocession, or reassumption pursuant to 25 U.S.C. § 458aaa-3(d).

(b) Resolutions from the Navajo Nation. Each Co-Signer must be sanctioned by a duly authorized resolution from the Navajo Nation to enter into this Compact and associated Funding Agreement on or before the date the Compact and the applicable Funding Agreement is signed by the applicable Co-Signer.

(c) Resolution from Other Tribes. Co-signers, if properly authorized by a duly authorized resolution of other affected Indian tribe(s), may provide services to those Indian tribe(s), and include related funding under this Compact and associated Funding Agreement(s).

Section 2 – Effective Date.

(a) Once this Compact and the associated Funding Agreement are approved and signed by the Co-Signer and the Secretary, they shall be effective as of the date signed by the Secretary and Co-Signer or another mutually agreed upon date set forth in the applicable Funding Agreement. Subsequent Funding Agreements will be effective on the mutually agreed upon date.

(b) During the term of this Compact, any authorized Co-Signer which has not previously negotiated a Funding Agreement may do so. All Funding Agreements shall be subject to, and all the activities thereunder shall be governed by, the terms of this

Compact to the same extent as the initial Funding Agreements. New Funding Agreements will be effective on a mutually agreed upon date.

(c) Each Funding Agreement negotiated under this Compact is deemed to be incorporated by reference into this Compact for the purposes of the respective Co-Signer and the United States. In the event of inconsistency between the Compact and any subsequent Funding Agreement, the provisions of the Compact shall prevail.

Section 3 – Program Standards. Each Co-Signer is committed to and shall strive to provide quality health services that meet applicable standards.

Section 4 – Funding Amount. The Secretary shall provide the total amounts specified in the Funding Agreements, and the Navajo Nation and each Co-Signer is hereby assured that future funding of subsequent Funding Agreements shall only be reduced pursuant to the provisions of 25 U.S.C. § 458aaa-7(d)(1)(C)(ii).

Section 5 – Payment.

(a) Payment Schedule. Payment shall be made expeditiously and shall include financial arrangements to cover funding during periods under continuing congressional resolutions to the extent permitted by such resolutions. For each fiscal year covered by the Compact, the Secretary shall make available the funds specified for that year under the associated Funding Agreements by paying the respective total amount as provided for in each Funding Agreement in advance lump sum, as permitted by law, or such other payments as provided in the schedule set forth in each Funding Agreement. 25 U.S.C. § 458aaa-7.

(b) Interest on Advances. Co-Signers receiving funds under applicable Funding Agreements pursuant to this Compact shall be permitted to retain interest earned on funds pending disbursement as authorized by law. Interest earned on advances shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in the year earned or in any subsequent fiscal year. All funds transferred under Funding Agreements pursuant to this Compact shall be managed using the prudent investment standard pursuant to 25 U.S.C. § 458aaa-7(h).

Section 6 – Reports to Congress. In accordance with 25 U.S.C. § 458aaa-13, the Secretary shall submit to the Senate Committee on Indian Affairs and the House Resources Committee a written report no later than January 1 of each year on the administration of Title V. Each report shall include a detailed analysis of the level of need being presently funded or unfunded for the Navajo Nation and each Co-Signer. The contents of each report shall comply with 25 U.S.C. § 458aaa-13(b). In compiling the reports, the Secretary may not impose any reporting requirements on Co-Signers not otherwise provided in Title V. The Secretary shall provide each Co-Signer with a draft of each report required to be submitted to Congress under this provision for a thirty (30) day comment period prior to the submission of the report to Congress so that the Co-Signers

may comment on the report. The Secretary shall include each Co-Signer's comments in the final reports to Congress.

Section 7 – Audits

(a) Single Audit. Each Co-Signer that has executed a Funding Agreement pursuant to this Compact shall provide to the National External Audit Review Center (or its successor), which is the designee of the Secretary for the purposes of this section, an annual single organization-wide audit as prescribed by the Single Audit Act of 1984, as amended, 31 U.S.C. Section 7501, *et seq.* A copy of the audit will be sent simultaneously to the Federal Audit Clearinghouse; 25 U.S.C. § 458aaa-5(c)(1); 42 C.F.R. §§ 137.171 and 137.172.

(b) Cost Principles. Each Co-Signer shall apply cost principles under the applicable OMB Circular, except as modified by 25 U.S.C. § 450j-1, which section is hereby incorporated into this Compact, other provisions of law or by any exemptions subsequently granted by OMB. No other audit or accounting standards shall be required by the Secretary. Any claim by the federal government against any Co-Signer receiving funds under a Funding Agreement based on any audit under this section shall be subject to the provisions of 25 U.S.C. § 450j-1(f). 25 U.S.C. § 458aaa-5(c)(2).

Section 8 – Records. Each Co-Signer's practices relating to record disclosure and record-keeping associated with this Compact shall be in accordance with applicable law and as may be set forth in its respective Funding Agreement.

Section 9 – Property.

(a) In General The provisions of 25 U.S.C. § 458aaa-11(c) and section 1(b)(8) of the Model Agreement set forth in 25 U.S.C. § 450l, are hereby incorporated into this Compact.

(b) Access to Federal Property. To the extent the Indian Health Service has been provided notice of the availability of Federal property that may be made available to Tribes under the Act, the Secretary shall provide notice of such to the Co–Signers.

(c) Access to Property Subject to Destruction. Prior to the destruction of federal property which would otherwise be declared surplus or excess and which is located within the service area of a Co-Signer, the Secretary shall provide notice of such proposed destruction to the Co-Signer. Such notice shall inform the Co-Signer of the name and address of the official responsible for determining whether such property will be destroyed or declared surplus or excess. If the Secretary is the responsible official, the Secretary will consider information provided by the Co-Signer regarding transfer of the property, rather than destruction, and, if not the responsible official, the Secretary will assist the Co-Signer in communicating information to the responsible official.

(d) Use of Federal Property. Pursuant to 25 U.S.C. § 458aaa-11(c)(1) a Co-Signer may use federal property under such terms and conditions as may be agreed upon by the Secretary and Co-Signer for its use and maintenance.

(e) Leases of Tribally-Owned or Leased Facilities . Upon the request of a Co-Signer the Secretary shall enter into a lease with the Co-Signer in accordance with 25 U.S.C. § 450j(l)(1).

(f) Participation in "Project Transam". The Co-Signers shall be notified of and authorized (to the extent Indian Health Service has authority to provide authorization) to participate in property screenings associated with "Project Transam" (or any similar successor project) by Indian Health Service Headquarters. Related to the foregoing, Indian Health Service shall notify the Co-Signers of scheduled lotteries to be conducted relevant to "Project Transam" whereby the Co-Signers are authorized to observe and participate in the process.

Section 10 – Regulatory Authority. The Secretary and the Co-Signers agree to utilize the following procedures governing the establishment and application of program rules and regulations under this Compact:

(a) Program Rules. No Co-Signer is required to comply with any agency circular, policy, manual, guidance or rule adopted by the Indian Health Service other than the eligibility provisions of ISDEAA § 105(g), 25 U.S.C. § 450j(g), and those identified in this section or expressly incorporated by reference in the individual Co-Signer's Funding Agreement, as provided in 25 U.S.C. § 458aaa-16(e).

(b) Federal Regulations.

(1) Applicable Federal Regulations. The Co-Signers, in carrying out the provisions of this Compact and applicable Funding Agreements, will be required to comply only with applicable federal regulations, which include regulations promulgated under 25 U.S.C. § 458aaa – 16 unless waived as provided in 25 U.S.C. § 458aaa – 11(b).

(2) Waiver of Federal Regulations. The Secretary and the Co-Signer will seek to identify federal regulations promulgated pursuant to 25 U.S.C. § 458aaa – 16 or under the authorities specified in 25 U.S.C § 458aaa – 11(b) which may require waiver in order to effectively carry out this Compact or any Funding Agreement. Waivers of regulations shall be submitted and addressed in accordance with the procedures set forth in 25 U.S.C § 458aaa – 11(b).

Section 11 – Disputes.

(a) Application of Title V. All disputes between the Indian Health Service and any Co-Signer or between the Indian Health Service and all Co-Signers under this Compact shall be subject to Title V and 25 U.S.C. § 450m-1, and all remedies provided for therein shall be available to each Co-Signer of this Compact. Actions and proceedings to enforce the Co-Signer's rights and the Secretary's obligations under this Compact shall be subject to the Equal Access to Justice Act, Public Law 96-481, as amended, to the same extent as are actions and proceedings involving Public Law 93-638 contracts.

(b) Administrative Dispute Resolution Act. In the alternative, the Indian Health Service and the Co-Signers may use the processes authorized and encouraged in the Administrative Dispute Resolution Act, 5 U.S.C. § 581, for more informal resolution of disputes arising under this Compact and associated Funding Agreements.

Section 12 – Retrocession. The retrocession provisions of 25 U.S.C. § 458aaa – 5(f) shall apply if the Navajo Nation or a Co-Signer decides to retrocede a portion or all of the programs contained in the applicable Funding Agreement. Retrocession shall be in accordance with the procedures and timelines included in that Co-Signer's Funding Agreement. Retrocession by a Co-Signer of a portion or all of one Co-Signer's PSFAs under its Funding Agreement shall not affect other Co-Signers' PSFAs under other Funding Agreements.

Section 13 – Subsequent Funding Agreements.

(a) Initiation of Negotiations. Negotiations for subsequent Funding Agreements, as provided for in Article VI, Section 2, shall begin no later than 120 days in advance of the conclusion of the preceding Funding Agreement. The Secretary agrees to prepare and supply relevant information, and promptly to comply with the Co-Signers' requests for information reasonably needed to determine the funds that may be available for a subsequent Funding Agreement as provided for in Article VI, Section 2 of this Compact.

(b) Continuation of Compact and Funding Agreement. If the Secretary and a Co-Signer are unable to conclude negotiation of a subsequent Funding Agreement, the terms of this Compact and the existing Funding Agreement shall, at the option of the applicable Co-Signer, continue until a subsequent Funding Agreement is agreed to. As provided in 25 U.S.C. § 458aaa-4(e), the terms of the subsequent Funding Agreement will become retroactive to the end of the term of the preceding Funding Agreement. Any increases in funding to which the Co-Signers are entitled by law or which have been made available by Congress, or increases which Co-Signers subsequently negotiate, shall be included in each Co-Signer's subsequent Funding Agreement.

Section 14 – Health Status Reports. In accordance with 25 U.S.C. § 458aaa-6(a)(1), Co-Signers shall provide the Secretary a health status and service delivery report to the extent that relevant data is not otherwise available to the Secretary and specific funds for this purpose are provided to the Co-Signer in its Funding Agreement. Such reporting may impose only minimal burdens on the Co-Signer and shall be consistent with regulations promulgated under 25 U.S.C. § 458aaa-16.

Section 15 – Secretarial Approval. Pursuant to 25 U.S.C. § 458aaa-10, for the term of the Compact, the provisions of 25 U.S.C. § 81 and 25 U.S.C. § 476 shall not apply to attorney and other professional contracts of signatory Co-Signers operating under the Compact.

Section 16 – Other Federal Resources.

(a) Use of Motor Vehicles. Subject to agreement of the General Services Administration ("GSA"), the Secretary hereby authorizes each Co-Signer to obtain Interagency Motor Pool vehicles and related services for performance of any PFSAs under this Compact.

(b) Other Federal Resources. Federal resources shall be available to each Co-Signer in accordance with 25 U.S.C. § 458aaa – 7(e) and 458aaa – 15(a).

Section 17 – Limitation of Costs. Each Co-Signer shall not be obligated to continue performance that requires an expenditure of funds in excess of the amount of funds transferred under the Funding Agreement. In accordance with 25 U.S.C. § 458aaa - 7(k), if, at any time the Co-Signer has reason to believe that the total amount provided for a specific activity in the Compact or Funding Agreement is insufficient, the Co-Signer shall provide reasonable notice of insufficiency to the Secretary. If the Secretary does not increase the amount of funds transferred under the Funding Agreement, the Co-Signer may suspend performance of the activity until such time as additional funds are transferred.

ARTICLE III – OBLIGATIONS OF EACH CO-SIGNER

Section 1 – Compact Programs. The health PSFAs that are the responsibility of each Co-Signer under this Compact are identified in each Co-Signer's Funding Agreement.

Section 2 – Amount of Funds. The total amount of funds that the Secretary shall make available and pay to each Co-Signer shall be determined in accordance with 25 U.S.C. § 458aaa - 7(c) and shall be set forth in the respective Funding Agreements between the Secretary and each Co-Signer.

Section 3 – Eligibility for Services. In determining eligibility for services, the Co-Signers shall comply with applicable eligibility provisions set forth in federal law and regulations.

Section 4 - Consolidation of Contracts into the Compact. Each Co-Signer will be responsible for performing the PSFAs as specified in Section 1 of this Article III and in their respective Funding Agreements, as provided for in Article VI, Section 2 of this Compact. To the extent a PSFA transferred to a Co-Signer in its respective Funding Agreement is included within a self-determination contract entered into pursuant to Title I of the Act, or is subject to any obligation arising from such contract, that contract shall be terminated or modified (so long as there is no duplication as prohibited by 25 U.S.C. § 458aaa-5(h) by execution of the appropriate document(s) and the parties' obligations shall be governed by this Compact and the associated Funding Agreement. All funds under the ISDEAA, Title I, contract that have already been paid to the Co-Signer will be retained by the Co-Signer under the Title V Funding Agreement, and spent under the authorities of Title V. Any funds obligated or due to the Co-Signer under its ISDEAA, Title I, contract for PSFAs now incorporated into the Title V Funding Agreement, not paid prior to the effective date of the Title V Funding Agreement, shall be paid under the Title V Funding Agreement. Such terminated contracts shall be identified by contract number in each Funding Agreement.

Section 5 – Reallocation, Redesign and Consolidation. In accordance with 25 U.S.C. § 458aaa-5(e), a Co-Signer may redesign or consolidate PSFAs (or portions thereof) included in a Funding Agreement and reallocate or redirect funds for such PSFAs (or portions thereof) in any manner in which the Co-Signer deems to be in the best interest of the health and welfare of the community being served, provided, however, that any such redesign or consolidation cannot have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable federal law.

Section 6 – Consolidation with Other Programs. Each Co-Signer may consolidate PSFAs and associated funds identified in its Funding Agreement with other PSFAs provided with its own funds or funds from other sources, provided that the PSFAs may be included in a Funding Agreement under 25 U.S.C. § 458aaa-4. When PSFAs are consolidated in a Funding Agreement by a Co-Signer in accordance with the terms of the Funding Agreement and Title V, the Co-Signer and its employees carrying out those PSFAs may receive Federal Tort Claims Act coverage in accordance with the statutory provisions and regulations cited in the Compact. Whether the Federal Tort Claims Act applies in any particular case is decided on an individual case-by-case basis by the United States Department of Justice and subsequently by the Federal courts. In cases in which a Co-Signer consolidates PSFAs under this section, the Co-Signer shall not be required to segregate funds or PSFAs so long as the Co-Signer can provide sufficient data to permit an acceptable program and financial audit to be conducted.

Section 7 – Program Income, including Medicare/Medicaid Reimbursements. All Medicare, Medicaid or other program income earned by a Co-Signer shall be treated as additional supplemental funding to that negotiated in the Funding Agreement and the Co-Signer may retain all such income, including Medicare/Medicaid, and expend such funds in the current year or in future years. Such funds shall not result in any off-set or reduction in the negotiated amount of the Funding Agreement. Medicare/Medicaid collections of a Co-Signer reimbursed under Title IV of the IHCIA, as amended, shall be used by the Co-Signer in accordance with any applicable statutory restrictions on the use of such funds.

Section 8 – Carryover. All funds paid to a Co-Signer in accordance with this Compact or an associated Funding Agreement shall remain available until expended. Funds carried over from one year to the next shall not diminish the amount of funds the Co-Signer is authorized to receive under its Funding Agreement in that or any subsequent fiscal year as provided in 25 U.S.C. § 458aaa – 7(i). Any such funds, and the corresponding PSFAs, shall not be subject to the provisions of the previous Funding Agreement; however, such funds shall be expended in accordance with the applicable provisions of the Funding Agreement in effect at the time of expenditure.

Section 9 – Matching Funds. Funds provided under this Compact and associated Funding Agreements may be used to meet matching and other cost participation requirements under any other federal or non-federal program pursuant to 25 U.S.C. § 458aaa-11(d).

ARTICLE IV – OBLIGATIONS OF THE UNITED STATES

Section 1 – Trust Responsibility. In accordance with 25 U.S.C. §§ 458aaa – 6(g) and 458aaa – 14(b), nothing in this Compact waives, modifies, or diminishes in any way the trust responsibility of the United States with respect to the Navajo Nation or individual members of the Navajo Nation which exists under treaty, executive orders, acts of Congress, and court decisions.

Section 2 - Programs Retained.

(a) Secretarial Responsibility. The Secretary hereby retains the responsibility for the PSFAs that are not specifically assumed by the Co-Signers acting individually through their applicable Funding Agreements and the Co-Signers shall continue to be entitled to the full benefit of those PSFAs retained by the Indian Health Service in accordance with 25 U.S.C. § 450l(c).

(b) Information Regarding Indian Health Service Programs. At the written request of a Co-Signer, within 30 days of such request, the Indian Health Service shall provide the Co-Signer with a written list of the directly operated retained PSFAs relevant to health care provided by the Indian Health Service to the Navajo Nation for the upcoming fiscal year. If the requested information cannot be or is not provided within 30 days, the Secretary will provide the Co-Signer, in writing, a reasonable timeline for providing the requested information. To the fullest extent permitted by law, the Secretary shall provide any requesting Co-Signer access to, and copies of, all documents and other information relevant to any retained PSFAs so as to assist the Co-Signer with evaluations the Co-Signer wishes to conduct. The Secretary will cooperate with each Co-Signer to facilitate the assumption of PSFAs in future Funding Agreements of those Co-Signers.

(c) Eligibility for New Programs, Service Increases, and Non-Recurring Resources. In accordance to 25 U.S.C. § 458aaa-5(h), each Co-Signer shall be eligible for new PSFAs and associated funding, service or funding increases and non-recurring resources of the Secretary and the Indian Health Service on the same basis as

other Tribes and Tribal Organizations. The Indian Health Service in consultation with the Co-Signers, may reorganize to sustain its ability to provide, in the most effective and efficient manner, all PSFAs for which the Co-Signers would otherwise be eligible to compact but that have not been included in the Funding Agreement. The Secretary shall notify the Co-Signers' Designated Official of any such new PSFAs, and associated funding, service increases and non-recurring funding to which the Co-Signers may be entitled.

Section 3 – Financial and Other Information.

(a) To assist the Co-Signers in monitoring compliance with 25 U.S.C. § 458aaa – 7(c), the Secretary shall promptly provide to the extent permitted by law, to Co-Signers, upon a written request, complete and accurate financial information including budget allocations and historical expenditure information which are relevant to the determination of amounts due under 25 U.S.C. § 458aaa-7(c). This will include but not be limited to:

(1) Table #1: Congressional Changes to IHS Appropriations;

(2) Table #2: Breakdown of Appropriations, Allowances to Areas and through Headquarters;

(3) Table #3: Breakdown of Headquarter Allowances, Detailed Headquarters Accounts and Categories for Tribal Shares; and

(4) Table #4: Headquarters PSFAs; and

(b) The Secretary shall prepare and promptly supply relevant financial reports and comply with each Co-Signer's written request for information needed to determine funds that may be available for a successor Funding Agreement.

Section 4 – Savings. To the extent the PSFAs carried out under Title V Funding Agreements and this Compact result in a reduction to the administrative or other responsibilities of the Secretary, with respect to the operation of Indian programs, and thereby result in savings that have not otherwise been included in the amount of tribal shares and other funds determined under 25 U.S.C. § 458aaa-7(c), the Secretary shall make such savings available to the Co-Signers for the provision of additional services in accordance with 25 U.S.C. § 458aaa-6(f).

ARTICLE V – OTHER PROVISIONS

Section 1 – Designated Officials. On or before the effective date of this Compact, both the Secretary and each Co-Signer shall provide a written designation of an individual as their representative/liaison. The Secretary shall direct all communications about the Compact, and relevant Funding Agreement, to the Co-Signer's designee. Reference herein to Co-Signers or the Secretary shall include the respective Designated Official thereof.

Section 2 – Indian Preference in Employment, Contracting and Sub-Contracting. The Co-Signers will comply with the Indian preference provisions of sections 7(b) and 7(c) of ISDEAA, Title I, 25 U.S.C. § 450e(b) and (c).

Section 3 – Federal Tort Claims Act Coverage; Insurance.

(a) The Co-Signers are deemed by statute to be part of the Public Health Service ("PHS"), and the employees of the Co-Signers are deemed by statute to be part of or employed by the PHS, for purposes of coverage under the Federal Tort Claims Act, while performing PSFAs under this Compact and described in the applicable Co-Signer's Funding Agreement (including new and existing PSFAs as provided under Article III, Section 5 or 6, or supported with income received in accordance with Article III, Section 7), including coverage for any acts or omissions that may occur in the course of providing services to eligible Indian beneficiaries, as well as those persons served pursuant to IHCIA sections 813(a) and (b), 25 U.S.C. §§ 1680c(a) and (b), as more fully described in 25 C.F.R. Part 900 Subpart M, and incorporated by reference herein, and section 102(d) of ISDEAA, as required by 25 U.S.C. § 458aaa – 15(a).

(b) The status of a Co-Signer, or an employee's status as an employee of a Co-Signer, as part of the Public Health Service, is not affected by the source of the funds used by the Co-Signer to carry out the PSFAs or to pay the employee's salary and benefits as long as the employee does not receive any additional compensation for the performance of covered services from anyone other than the Co-Signer.

(c) The Co-Signer's employee may, while performing under this Compact and applicable Funding Agreement and as a condition of employment, be required by the Co-Signer to provide services to non-Indian Health Service beneficiaries in order to meet the obligations under this Compact either in facilities of the Co-Signer or in facilities other than those of the Co-Signer.

(d) Funds provided under a Funding Agreement may be used to purchase such additional liability and other insurance as is prudent in the judgment of a Co-Signer performing under this Compact and Funding Agreement for its protection and the protection of its employees.

(e) Personal services contracts shall be covered under this provision to the extent provided under section 102(d) of ISDEAA.

Section 4 – Compact Amendments.

(a) Any request for an amendment of this Compact must be communicated in writing to all Co-Signers and to the Indian Health Service. To be effective, any amendment of this Compact shall be in the form of a written amendment to the Compact and shall require written consent of each of the Co-Signers and the Secretary.

(b) This provision shall not apply to amendment of the Compact to include additional Co-Signers. Such amendment shall only require the authorization of the Navajo Nation and the concurrence of the additional Co-Signer, and the Secretary.

Section 5 – Construction. This Compact shall apply to funds included in the facilities category of Indian Health Service appropriations. A Co-Signer may assume construction projects or programs under the authorities of ISDEAA, Titles I or V, or P.L. 86-121. In doing so, the Co-Signer elects to comply with the regulations of the elected statutory provision.

Section 6 – Covenant Against Contingent Fees. The parties warrant that no person or selling agency has been employed or retained to solicit or secure any contract executed pursuant to this Compact upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business.

Section 7 – Penalties. The parties agree that the criminal penalties set forth in 25 U.S.C. § 450d apply to all activities conducted pursuant to this Compact.

Section 8 – Use of Federal Employees. Section 104 of ISDEAA shall apply to this Compact and to any individuals assigned or detailed to any Co-Signer performing functions under this Compact or leaving federal employment to perform services under this Compact, including assignments either on detail or on leave without pay and with or without reimbursement by the Co-Signer for the travel and transportation expenses to or from the place of assignment and for the pay, or supplemental pay, or a part thereof, of the employee during assignment.

Section 9 – Extraordinary or Unforeseen Events. This Compact obligates each Co-Signer to carry out all usual and ordinary functions respecting the PSFAs it is assuming under its Funding Agreement. In the event major unforeseen or extraordinary events occur, as jointly identified by an individual Co-Signer and the Secretary, with consequences beyond the control of the Co-Signer, the Co-Signer shall have access to additional services and funding amounts for its Funding Agreement as described in its Funding Agreement. The parties will seek to ensure that funds available to the Co-Signer to deal with the unforeseen circumstance will not be less than would have been available to non-Compact Tribes or the Indian Health Service had they encountered a similar circumstance. Each Co-Signer's participation in the Indian Health Service Catastrophic Health Emergency Funds will be identified in the Co-Signer's Funding Agreement.

Section 10 – Mature Contractor Status upon Compact Termination. In accordance with 25 U.S.C. § 458aaa – 5(g)(3), should any Co-Signer elect to or otherwise be required to convert all or some of the programs operated under the Compact back to contract status under P.L.93-638 such conversion shall not affect the Co-Signer's status as having operated a mature contract within the meaning of section 4(h) of ISDEAA. Such conversion would occur only on a date mutually acceptable to the Co-Signer and the Secretary, or as otherwise provided in this Compact, and will be implemented in a

manner which avoids any interruption of services to individual tribal members. If the Compact is terminated or the Navajo Nation or a Co-Signer determines that it will retrocede any PSFA operated under the Compact, the Co-Signer shall not lose its mature contractor status under section 4(h) as provided above.

Section 11 – Limitation of Liability. Any liability to the United States or to any third party incurred by a Co-Signer under it's Funding Agreement shall be the obligation only of that Co-Signer and shall not be the obligation of any Co-Signer of this Compact which did not participate in such performance or expenditure.

Section 12 – Contracting Rights. Nothing in this Compact or in any Funding Agreement shall be construed to preclude a Co-Signer from contracting with the Secretary to perform a PSFA under ISDEAA, Title I, subject, however, to constraints against duplication pursuant to 25 U.S.C. § 458aaa – 5(h).

Section 13 – Sovereign Immunity. Nothing in this Compact or in any Funding Agreement shall be construed to affect the sovereign immunity of the Navajo Nation or any sovereign immunity of a Co-Signer to which it may be entitled by law.

Section 14 – Interpretation of Federal Law. In the implementation of this Compact, the Secretary, to the extent feasible, shall interpret all federal laws, executive orders, and regulations and this Compact in a manner that effectuates and facilitates the purposes of this Compact and achievement of the Co-Signers' health goals and objectives in accordance with 25 U.S.C. § 458aaa – 11(a).

Section 15 – Effect on Non-Signatory Navajo Area IHS Service Units, and Title I Programs.

(a) Nothing in this Compact or associated Funding Agreements shall be construed to limit or reduce in any way the service, contracts or funds that any non-signatory Navajo Area IHS operated Service Unit or tribally operated ISDEAA, Title I, program is eligible to receive.

(b) The Compact shall not be construed to limit or curtail the right of any non-signatory Navajo Area IHS operated Service Unit or tribally operated ISDEAA, Title I, program to pursue a contract under ISDEAA Title I or individual participation in this Compact under Title V.

Section 16 – Severability. This Compact shall not be considered invalid, void, or voidable if any section or provision of this Compact is found to be invalid, unlawful or unenforceable by a court of competent jurisdiction. Should such a court make such a finding, the parties will seek agreement to amend, revise or delete any such invalid, unlawful or unenforceable section or provision, in accordance with the provisions of this Compact.

Section 17 – Applicability of Title I Provisions. Provisions of ISDEAA, Title I, shall apply to this Compact as provided in 25 U.S.C. § 458aaa-15(a) and 42 CFR § 137.47-137.49.

Section 18 – Purchases from the Indian Health Service. With respect to functions transferred by the Indian Health Service to a Co-Signer under this Compact or an applicable Funding Agreement, the Indian Health Service shall provide goods and services to a Co-Signer, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Co-Signer pursuant to this section, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

Section 19 – Counterpart Signatures. This Compact may be signed in counterparts, each of which shall be an original and all of which shall constitute together the same document.

ARTICLE VI – ATTACHMENTS

Section 1 – Approval of Compact. The resolution(s) of the Navajo Nation authorizing this Compact for each Co-Signer are attached as part of Exhibit A.

Section 2 – Funding Agreements. Once executed, each Co-Signer's Funding Agreement shall be attached hereto as Exhibit B, C and D.

ARTICLE VII - COUNTERPART SIGNATURES

FOR THE UNITED STATES OF AMERICA, DEPARTMENT OF HEALTH AND HUMAN SERVICES:

for Yvette Roubideaux, M.D., Director
Indian Health Service

7-6-11
Date

FOR THE TUBA CITY REGIONAL HEALTH CARE CORPORATION:

Grey Farrell, Jr. President, Board of Directors, TCRHCC

3/8/11
Date

FOR THE WINSLOW INDIAN HEALTH CARE CENTER, INC.:

Robert Salabye, President, Board of Directors, WIHCC

3/8/11
Date

FOR THE UTAH NAVAJO HEALTH SYSTEM, INC.:

Wilfred Jones, Chairperson, Board of Directors, UNHS

03/08/11
Date

TO'NANEES'DIZI LOCAL GOVERNMENT
"An Enterprise of the Navajo Nation"
P.O. Box 727, Tuba City, Arizona 86045
Telephone: 928-283-3284 Fax: 928-283-3288
http://www.tubacity.nndes.org
Email: tonaneesdizi@navajochapters.org

Aniidi Legislation# TND-04-__01___-2018

RESOLUTION OF TO'NANEES'DIZI LOCAL GOVERNMENT

SUPPORTING THE EXTENSION OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION'S DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL

WHEREAS:

1. The To'Nanees'Dizi Council of Naat'aanii pursuant to Resolution No. TCDC# TCDC-18-04 is a certified and recognized chapter of the Navajo Nation Council, vested with the authority and responsibility to provide and address local planning within its community; and

2. Pursuant to 26 N.N.C. Section 1(B) is vested with the authority to review all matters affecting the community and to make appropriate correction when necessary and make recommendation to the Navajo Nation and other local agencies for appropriate actions; and

3. The To'Nanees'Dizi Local Government recognizes and supports business economic, and community development opportunities and creation of employment, goods and services for the Navajo people. To'Nanees'Dizi Chapter is in support of community enhancement through positive business and economic development; and

4. The To'Nanees'Dizi Local Government of the Navajo Nation is provided health care services by the Tuba City Regional Health Care Corporation ("TCRHCC"); and

5. The TCRHCC has successfully provided health care programs, functions, services and activities to the To'Nanees'Dizi Chapter since September 1, 2002; and

6. By previous resolutions the To'Nanees'Dizi Local Government has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of To'Nanees'Dizi Chapter and others in the southwest region of the Navajo Nation; and

7. By the To'Nanees'Dizi Local Government resolution, the To'Nanees'Dizi Local Government supports TCRHCC to include planning, design, and construction projects within each tribal organizations service area; and

8. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and

9. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED THAT:

The To'Nanees'Dizi Local Government supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, including planning design, and construction projects within each tribal organizations service area in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

CERTIFICATION

We, hereby certify that the foregoing resolution was duly considered by the To'Nanees'Dizi Local Government, at a duly called meeting at To'Nanees'Dizi Chapter (Navajo Nation), Arizona, at which a quorum was present and the same passed by a vote of 3 in favor, 0 opposed, and 2 abstained on this 1st day of April 2018.

Motioned by: Joetta Goldtooth

Seconded by: Velma M. Begaye

Gerald Keetso, Chapter President

Angie Williams, Council Member

Joetta Goldtooth, Chapter Vice President

Helen Webster, Council Member

Velma Maloney-Begaye, Chapter Sec/Treasurer

TO' NIHALII'

President: Sarah Slim
Vice President: Marie Acothley
Secretary/Treasurer: Delores Claw

District One - Western Navajo Agency
Tonalea Chapter
P.O. Box 207
Tonalea, Arizona 86044-0207
Phone: (928) 283.3430
Email: tonaleachapt

Council Delegate: Tauchoney Slim ,Jr.
Grazing Official: Vicki R. Kee
Fax: (928) 283.3435

RESOLUTION OF THE TONALEA CHAPTER
WESTERN NAVAJO AGENCY
RESOLUTION NO: TN18-04-01

A RESOLUTION IN SUPPORT OF EXTENDING THE TUBA CITY REGIONAL HEALTH CARE CORPORATION's DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL.

WHEREAS:

1. The Navajo Nation, since time immemorial, has exercised its sovereign rights of self-government on behalf of the Navajo people; and
2. The Navajo Nation is a federally recognized Indian Tribe with a historic and ongoing government to government relationship with the United States of America; and
3. The TONALEA Chapter is a chapter of the Navajo Nation and is provided health care services by the Tuba City Regional Health Care Corporation ("TCRHCC"); and
4. The TCRHCC has successfully provided health care programs, functions, services and activities to the TONALEA Chapter since September 1, 2002; and
5. By previous Chapter resolutions, the TONALEA Chapter has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the TONALEA Chapter and others in the southwest region of the Navajo Nation; and
6. By TONALEA resolution, the TONALEA Chapter supports TCRHCC to include planning, design, and construction projects within each tribal organizations service area; and
7. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and
8. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW, THEREFORE BE IT RESOLVED:

The TONALEA Chapter supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, including planning design, and construction projects within each tribal organizations service area in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

CERTIFICATION

We hereby certify that the foregoing resolution was duly considered at a duly called meeting of the TONALEA Chapter at which a quorum was present and that the same was passed by a vote of **49** in favor, **0** opposed, and **02** abstained, that **28** day of **April**, 2018.

Motion By: **Linda Chee**

Second By: **Rodger Manygoats**

Sarah Slim, President

Marie Acothley, Vice-President

Delores Claw, Secretary/Treasurer

Vicki Kee, Grazing Official

KB3QTR-01-04/18

The Resolution of K'ai'Bii'Tó Chapter

P.O. Box 1761 * Kaibeto, AZ 86053 Phone#: (928)673-5850/5851 Fax#: (928)673-5853

SUPPORTING OF EXTENDING THE TUBA CITY REGIONAL HEALTH CARE CORPORATION's DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF-DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL.

WHEREAS:

1. The Navajo Nation, since time immemorial, has exercised its sovereign rights of self-government on behalf of the Navajo people; and
2. The Navajo Nation is a federally recognized Indian Tribe with a historic and ongoing government to government relationship with the United States of America; and
3. The K'ai'Bii'To Chapter is a Chapter of the Navajo Nation and is provided health care services by the Tuba City Regional Health Care Corporation ("TCRHCC"); and
4. The TCRHCC has successfully provided health care programs, functions, services and activities to the K'ai'Bii'To Chapter since September 1, 2002; and
5. By previous Chapter resolutions, the K'ai'Bii'To has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the K'ai'Bii'To and others in the southwest region of the Navajo Nation; and
6. By K'ai'Bii'To resolution, the K'ai'Bii'To Chapter supports TCRHCC to include planning, design, and construction projects within each tribal organizations service area; and
7. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and
8. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED THAT:

1. The K'ai'Bii'To Chapter supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, including planning design, and construction projects within each tribal organizations service area in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

CERTIFICATION

We hereby certify that the foregoing resolution was duly considered at a duly called meeting of the K'ai'Bii'To at which a quorum was present and that the same was passed by a vote of 34 in favor, 02 opposed, and 02 abstained, that 8th day of April, 2018.

Motion By: Sally Johnson Second By: Lariat William

Franklin Fowler, Chapter President

COALMINE CANYON CHAPTER

WESTERN NAVAJO AGENCY – NAVAJO NATION
PO Box 742, Tuba City, AZ 86045
Marian Bowman-Community Service Coordinator
Kristen Charley-Account Maintenance Specialist

RESOLUTION OF THE COALMINE CANYON CHAPTER
CCC-04-0196-18

APPROVING TO SUPPORT EXTENDING THE TCRHCC DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN HEALTH SELF DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL.

WHEREAS;

1. Pursuant to 26 N.N.C, Section 3, and 11 N.N.C., Section 10, the Coalmine Canyon Chapter is a duly recognized chapter of the Navajo Nation Government; and,

2. Pursuant to N.N.C., Chapter 1: Navajo Nation Chapter, Section 1., (B) (1) & (2), The Navajo Nation Council Delegated to Chapter Governmental authority with respect to local matters consistent with Navajo Law, including custom and tradition and allows chapter to make decisions to govern with responsibility and accountability to community membership; and,

3. The Navajo Nation is a federally recognized Indian Nation with a historic and ongoing government to government relationship with the United States of America and has exercised its sovereign rights of self-government on behalf of the Navajo People; and,

4. The TCRHCC has successfully provided health care programs, functions, services and activities to the Coalmine Canyon Chapter since September 1, 2002 and by previous chapter resolutions has supported TCRHCC in contracting and compacting with Indian Health Service pursuant to the Indian Self-Determination Act; and,

5. The TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant Navajo Nation Council Resolution CJY-33-10; and,

6. The TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED THAT:

1. The Coalmine Canyon Chapter hereby approves to support extending the TCRHCC designation as a tribal organization and authorization to compact under Title V of the Indian Health Self Determination Act with the Indian Health Service pursuant to Navajo Nation Council resolution CJY-33-10 beyond September 30, 2020, unless rescinded by the Navajo Nation Council.

CERTIFICATION

We, hereby certify that the foregoing resolution was duly considered by the Coalmine Canyon Chapter, Navajo Nation, Arizona, at which a quorum was present and that the same was passed by a vote of 22 in favor, 0 opposed, and 5 abstained, this 8th day of *April 2018*,

Motion to Approve: Howard Begay
Second: Floyd Joe

Dorothy Dale, President

Augusta Gillwood, Secretary/Treasurer

Phillip Kahne, Vice-President

Harry J Goldtooth, Grazing Official

Walter Phelps, Council Delegate

RUSSELL BEGAYE
NAVAJO NATION PRESIDENT

JONATHAN NEZ
NAVAJO NATION VICE PRESIDENT

WALTER PHELPS
COUNCIL DELEGATE

CAMERON CHAPTER

LILTON TSO
CHAPTER PRESIDENT

EMMETT KERLEY
CHAPTER VICE PRESIDENT

MARIE FRANKLIN
SECRETARY / TREASURER

CAMERON CHAPTER
RESOLUTION OF CAMERON CHAPTER
NAVAJO NATION, COCONINO COUNTY ARIZONA

CAMAPR-12-18 #2 SUPPORTING AND REQUESTING THE REAUTHORIZATION AND EXTENSION OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION'S DESIGNATION AS A TRIBAL ORGANIZATION UNDER TITLE V OF THE INDIAN SELF DETERMINATION AND EDUCATION ASSISTANCE ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 IN COORDINATION WITH WINSLOW INDIAN HEALTH CARE CENTER, INC. AND UTAH NAVAJO HEALTH SYSTEMS, INC.

WHEREAS:

1. Tuba City Regional Health Care Corporation ("TCRHCC") is a 501(c)(3) non-profit corporation organized under Navajo Nation law and governed by a Board of Directors ("Board") that is strongly committed to the mission of providing safe, accessible, quality, compassionate health care, and promoting healthy lifestyles; *and*

2. Pursuant to Navajo Nation Council Resolution CJY-33-10 (July21,2010),TCRHCC, Winslow Indian Health Care Center, Inc. ("WIHCC") and Utah Navajo Health Systems, Inc. ("UNHS") were designated by the Navajo Nation Council as Tribal Organizations for the purpose of executing a Compact with the Indian Health Service ("IHS") under Title V of the Indian Self Determination and Educational Assistance Act, P.L. 93-638 ("ISDEAA"); *and*

3. TCRHCC, WIHCC, and UNHS are separate entities and operate separate medical facilities but are all parties to the same Compact with IHS; *and*

4. The Navajo Nation Council's authorization for TCRHCC, WIHCC, and UNHS to operate as Tribal Organizations under Title V of ISDEAA expires in 2020; *and*

5. TCRHCC's current Funding Agreement with IHS expires this year on September 30, 2018,

P.O. BOX 669
CAMERON, ARIZONA 86020

Na Ní á Hasání
cameron@navajochapters.org

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and the new funding agreement is yet to be negotiated; *and*

6. The Board has met with representatives of WIHCC and UNHS to discuss pursuing at least 25 years' reauthorization with two 25 year options for extension of such authorization as Tribal Organizations under Title V of ISDEAA by jointly submitting legislation to the Health Education and Human Services and Naabik'íyáti Committees of the Navajo Nation Council; *and*

NOW, THEREFORE, BE IT RESOLVED THAT:

1. Cameron Chapter hereby , supports and requests at least 25 years' reauthorization with two 25 year options for extension of such authorization of the Tuba City Regional Health Care Corporation's designation as a Tribal Organization under Title V of the Indian Self-Determination and Education Assistance Act with the Indian Health Service pursuant to Navajo Nation Council Resolution CJY-33-10 in coordination with Winslow Indian Health Care Center, Inc. and Utah Navajo Health Systems, Inc.

2. Cameron Chapter supports Management to compile appropriate documentation for such reauthorization, including Chapter supporting resolutions, drafting such legislation, finding appropriate co-sponsors for the legislation, and having such legislation dropped in the Navajo Nation Speaker's Office and take any such additional actions as are necessary and proper to carry out the intent of this Resolution.

CERTIFICATION

We hereby, certify that the foregoing resolution was duly considered by Cameron Chapter at a duly called meeting in Cameron, Navajo Nation, Arizona, at which a quorum was present and the same was passed by a vote of 35 in favor, 0 opposed and 3 abstained on the 12th day of April, 2018.

Motioned: Beatrice Pete **Second:** Alden H. Charley

Milton Tso, President

Emmett Kerley, Vice-President

Mable H. Franklin, Secretary/Treasurer

James Beard, Grazing Representative

Walter Phelps, Council Delegate

COPPERMINE CHAPTER

CHAPTER PRESIDENT
Sid Whitehair
CHAPTER VICE PRESIDENT
Lola Smith
CHAPTER SECRETARY/TREASURER
Valerie Fowler

THE NAVAJO NATION
Western Navajo Agency- District One
P.O. Box 1323 Page, Arizona 86040
Telephone No. (928) 691 - 1109

COUNCIL DELEGATE
Tuchoney Slim Jr.
GRAZING MEMBER
Calvin Begay
COMMUNITY SERVICE COORDINATOR
Duane S. Tsinigine

CO-04-054-18

RESOLUTION OF THE COPPERMINE CHAPTER OF THE NAVAJO NATION IN SUPPORT OF EXTENDING THE TUBA CITY REGIONAL HEALTH CARE CORPORATION's DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL

WHEREAS:

1. Pursuant to 26 N.N.C., Section 3, and 11 N.N.C., Section 10, The Coppermine Chapter is a duly recognized and certified chapter of the Navajo Nation Government; and
2. Pursuant to N.N.C., Chapter 1: Navajo Nation Chapter, Section 1., (B) (1) & (2), The Navajo Nation Council Delegated to Chapter Governmental authority with respect to local matters consistent with Navajo Law, including custom and tradition and allows chapter to make decisions to govern with responsibility and accountability to community membership; and
3. The Navajo Nation, since time immemorial, has exercised its sovereign rights of self-government on behalf of the Navajo people; and
4. The Navajo Nation is a federally recognized Indian Tribe with a historic and ongoing government to government relationship with the United States of America; and
5. The Coppermine Chapter is a chapter of the Navajo Nation and is provided health care services by the Tuba City Regional Health Care Corporation ("TCRHCC"); and
6. The TCRHCC has successfully provided health care programs, functions, services and activities to the Coppermine Chapter since September 1, 2002; and
7. By previous Chapter resolutions, the Coppermine Chapter has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the Coppermine Chapter and others in the southwest region of the Navajo Nation; and
8. By the Coppermine Chapter resolution, the Coppermine Chapter supports TCRHCC to include planning, design, and construction projects within each tribal organizations service area; and
9. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and
10. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED THAT:

The Coppermine Chapter hereby supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, including planning design, and construction projects within each tribal organizations service area in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

#CO-04-054-18

CERTIFICATION

We, hereby certify that the forgoing resolution was duly considered at a duly-called meeting of the Coppermine Chapter, Coppermine (Navajo Nation), Arizona, at which a quorum was present and the same was passed by a vote of 52 in favor, 00 opposed, 04 abstained on this 10th day of APRIL 2018.

Motion: Paul Begay Jr.

Second: Jack Stevens

Sid Whitehair,
PRESIDENT

Valerie Fowler,
SECRETARY/TREASURER

Lola Smith,
VICE-PRESIDENT

NOT AVAILABLE FOR SIGNATURE
Calvin Begay,
GRAZING OFFICAL

BODAWAY/GAP CHAPTER

An Enterprise of the Navajo Nation

P.O. Box 1546 ~ The Gap, AZ 86020
Phone: (928) 283-3493 Fax: (928) 283-3496
Email: bodaway@navajochapters.org

Raymond Yellowman, President
Leonard Sloan, Vice-President
Bessie Zahne, Secretary-Treasurer

Lee Yazzie, Grazing Official
Tuchoney Slim, Council Delegate

VACANT, Chapter Manager
VACANT, Administrative Assistant

WESTERN NAVAJO AGENCY

RESOLUTION OF THE BODAWAY/GAP CHAPTER

Naaltsoos Bee Adah Nahoditaahii

Resolution No: BA-005-036-18

SUPPORTING THE EXTENSION OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION's DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF-DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL.

WHEREAS:

1. Pursuant to Title 26 NNC the Navajo Nation Local Governance Act, the Navajo Nation Council certified Bodaway/Gap Chapter to address and exercise governmental authority with respect to local matters, including health related issues and matters; and

2. The Navajo Nation, since time immemorial, has exercised its sovereign rights of self-government on behalf of the Navajo people; and

3. The Navajo Nation is a federally recognized Indian Tribe with a historic and ongoing government to government relationship with the United States of America; and

4. The Bodaway/Gap Chapter is a Chapter of the Navajo Nation and is provided health care services by the Tuba City Regional Health Care Corporation ("TCRHCC"); and

5. The TCRHCC has successfully provided health care programs, functions, services and activities to the Bodaway/Gap Chapter since September 1, 2002; and

6. By previous Chapter resolutions, the Bodaway/Gap Chapter has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the Bodaway/Gap Chapter and others in the southwest region of the Navajo Nation; and

7. By Bodaway/Gap Chapter resolution supports TCRHCC to include planning, design, and construction projects within each tribal organization service area; and

8. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and

9. TCRHCC desires to extend its existing authority to compact with the Indian Health Service for twenty-five (25) years with an option to re-new for two (2) options of 25 years, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED THAT:

The Bodaway/Gap Chapter supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, including planning design, and construction projects within each tribal organization service area in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

********** CERTIFICATION **********

We hereby certify that the foregoing resolution was duly considered at a duly called regular meeting of the Bodaway/Gap Chapter, Gap (Navajo Nation) Arizona, at which a quorum was present and that same was passed by a vote of 36 in favor, 01 opposed, and 11 abstained, this 16th day of May, 2018.

Motion By: Franklin Martin Second By: Larry Hanks

Raymond D. Yellowman, President

Leonard Sloan, Vice President

Bessie Zahne, Secretary/Treasurer

Lee Yazzie, Jr., Grazing Official

Absent

Tuchoney Slim, 23rd Navajo Nation Council Delegate

BODAWAY-GAP HEALTH CENTER STEERING COMMITTEE

P.O. BOX 368 · KAYENTA, AZ 86033 · T: (928) 697-4041 · F: (928) 697-4145

RESOLUTION OF THE
BODAWAY-GAP HEALTH CENTER STEERING COMMITTEE
RESOLUTION NO: BGHC-SC19-18

REQUESTING IN SUPPORT OF EXTENDING THE TUBA CITY REGIONAL HEALTH CARE CORPORATION's DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF-DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL

WHEREAS:

1. Pursuant to Resolution GSCJY-10-08, the Navajo Nation Council approved the Plan of Operation which authorized the Bodaway-Gap Health Center (BGHC) Steering Committee, (aka "Gap Steering Committee") to advocate, to secure funds and to ensure the planning documents are completed, design is developed and construction is implemented for the BGHC project; and
2. In support of the Phase I Site Selection Evaluation Report (SSER), Gap Steering Committee acknowledges that four (4) potential construction sites were evaluated by I.H.S. along with members of the local communities in 2005; and
3. The top site recommended is one mile north of Gap Primary School on NR-20; some determining factors in the selection are: (a) easy access for the communities of Bodaway-Gap Service Area from Highway 89 and NR-20; (b) there is sufficient available land for the health center, staff quarters and sewage lagoon; and (c) water and electric utilities are within the one mile radius that can be extended to health center site; and
4. Since its inception, Gap Steering Committee has maintained a decisive effort to push forwards for the proposed BGHC project; it recognizes the need for an advanced comprehensive health delivery system in this far remote area of the Navajo Nation in the Western Agency; and
5. Tuba City Regional Health Care Corporation desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THERFORE BE IT RESOLVED THAT:

The Bodaway-Gap Health Center Steering Committee hereby approves the support of extending Tuba City Regional Health Care Corporation's designation as a Tribal Organization and authorization to compact under Title V of the Indian Self-Determination Act with Indian Health Service pursuant to the Navajo Nation Council Resolution CJY-33-10 beyond September 30, 2020, unless rescinded by the Navajo Nation Council.

CERTIFICATION

We, hereby, certify the foregoing resolution was considered by the Bodaway-Gap Health Center Steering Committee at a duly called meeting at Coppermine, (Navajo Nation), ARIZONA, at which a quorum was present and that same was passed by a vote of **4** in favor, **0** opposed, and **0** abstained, this **14th** day of **May 2018**.

Motion: Kimberlee Williams

Second: Millie Brockie

CONCURRENCE:

Lola Smith

Lola Smith, President

LeChee Chapter

P.O. Box 4720 • Page, Arizona • 928•698•2805 • 928•698•2803 fax

RESOLUTION OF THE LECHEE CHAPTER

A RESOLUTION IN SUPPORT OF EXTENDING THE TUBA CITY REGIONAL HEALTH CARE CORPORATION's DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF_DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL.

WHEREAS:

1. The Navajo Nation, since time immemorial, has exercised its sovereign rights of self-government on behalf of the Navajo people; and

2. The Navajo Nation is a federally recognized Indian Tribe with a historic and ongoing government to government relationship with the United States of America; and

3. The LeChee Chapter is a chapter of the Navajo Nation and is provided health care services by the Tuba City Regional Health Care Corporation ("TCRHCC"); and

4. The TCRHCC has successfully provided health care programs, functions, services and activities to the LeChee Chapter since September 1, 2002; and

5. By previous Chapter resolutions, the LeChee has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the LeChe Chapter and others in the southwest region of the Navajo Nation; and

6. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and

7. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

LeChee Chapter

P.O. Box 4720 • Page, Arizona • 928•698•2805 • 928•698•2803 fax

NOW THEREFORE BE IT RESOLVED THAT:

1. The LeChee Chapter supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

CERTIFICATION

We hereby certify that the foregoing resolution was duly considered at a duly called meeting of the LeChee Chapter at which a quorum was present and that the same was passed by a vote of 30 in favor, 0 opposed, and 3 abstained, that 9th day of April, 2018.

Motion By: Denis Tsosie

Seconded By: Irvin Nez

Jerry Williams, LeChee Chapter President

Tauchoney Slim Jr., Honorable Council Delegate

UPPER VILLAGE OF MOENKOPI COUNCIL
VILLAGE COUNCIL RESOLUTION
RESOLUTION UVM-005-2018

Support of Extending the Tuba City Regional Health Care Corporation's designation as a tribal organization and authorization to compact under Title V of the Indian Self Determination Act with the Indian Health Service Pursuant to Navajo Nation Council Resolution CJY-33-10 beyond September 30, 2020, unless rescinded by the Navajo Nation Council

WHEREAS:

1. The Upper Village of Moenkopi and the members of the Hopi Nation obtain health services by Tuba City Regional Health Care Corporation (TCRHCC); and

2. The Tuba City Regional Health Care Corporation has successfully provided health care programs, functions, service and activities to the Upper Village of Moenkopi since September 1, 2002; and

3. The Upper Village of Moenkopi acknowledges the quality health care services provided through the Tuba City Regional Health Care Corporation through partnership with the local communities; and

4. The Upper Village of Moenkopi approves the furtherance of the mission statement of Tuba City Regional Health Care Corporation as a Title V Self-Governance regional health system through partnership with the Navajo Chapters, the Hopi Tribe and the San Juan Southern Paiute Tribe; and

5. By previous tribal council resolutions, the Upper Village of Moenkopi has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the Upper Village of Moenkopi and others in the southwest region of the Navajo Nation; and

UPPER VILLAGE OF MOENKOPI COUNCIL
VILLAGE COUNCIL RESOLUTION
RESOLUTION UVM- 005-2018

6. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and

7. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT FINALLY RESOLVED THAT:

The Upper Village of Moenkopi supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

CERTIFICATION

The foregoing Resolution was duly adopted by the Upper Village of Moenkopi council at a duly called meeting in Moenkopi, Arizona at which a quorum was present and the same was passed by a vote of 5 in favor, 1 opposed, 0 abstained on the 10th day of April 2018.

Date: 04/11/18

Leroy Sumatzkuku, Governor

ATTEST:

Doris Honanie

Doris Honanie, Council Secretary

THE HOPI TRIBE

Timothy L. Nuvangyaoma
CHAIRMAN

Clark W. Tenakhongva
VICE-CHAIRMAN

June 29, 2018

Lynette Bonar, Chief Executive Officer
Tuba City Regional Health Care Center
P.O. Box 600
Tuba City, AZ 86045

Dear Ms. Bonar,

On June 25, 2018, the Hopi Tribal Council by motion and majority vote approved Action Item #054-2018 and Resolution H-055-2018.

By this action, the Hopi Tribal Council supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, in NNC Resolution CJY-3-10, beyond September 30, 2020, unless rescinded by the Navajo Nation Council.

If you should have any questions, you may contact me at (928) 734-3131.

Sincerely,

Theresa A. Lomakema, Tribal Secretary
Hopi Tribal Council

c: Office of the Chairman
Office of the Vice Chairman
Office of the Treasurer
Office of Financial Management
Office of Executive Director
Office of General Counsel
File

HOPI TRIBAL COUNCIL
RESOLUTION
H-055-2018

WHEREAS the Hopi Tribal Council is the governing body of the Hopi Tribe, pursuant to the Constitution and By-Laws of the Hopi Tribe, ARTICLE VI-POWERS OF THE TRIBAL COUNCIL, SECTION 1 (a), the Hopi Tribal Council is authorized "To represent and speak for the Hopi Tribe in all matters for the welfare of the Tribe, …"; and

WHEREAS, the Hopi Tribal Council acknowledges the quality health care services provided through the Tuba City Regional Health Care Corporation through partnership with the local communities; and

WHEREAS, the Hopi Tribal Council approves the furtherance of the mission statement of Tuba City Regional Health Care Corporation as a Title V Self-Governance regional health system through partnership with the Navajo Chapters, the Hopi Tribe and the San Juan Southern Paiute Tribe; and

WHEREAS, the TCRHCC has successfully provided health care programs, functions, services and activities to the Hopi Tribal members since September 1, 2002; and

WHEREAS, by previous tribal council resolution, the Hopi Tribal Council has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the San Juan Southern Paiute Tribe and others in the southwest region of the Navajo Nation; and

WHEREAS, the Hopi Tribal Council supports TCRHCC to include planning, design, and construction projects within each tribal organization's service area; and

HOPI TRIBAL COUNCIL
RESOLUTION
H-055-2018

WHEREAS, TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and

WHEREAS, TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED that the Hopi Tribal Council supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

BE IT FINALLY RESOLVED that this resolution shall supersede and replace all prior resolutions of the Hopi Tribal Council that are inconsistent, or in conflict with the intent, purpose and provision of this Resolution.

HOPI TRIBAL COUNCIL
RESOLUTION
H-055-2018

CERTIFICATION

The Hopi Tribal Council duly adopted the foregoing Resolution on June 25, 2018 at a meeting at which a quorum was present with a vote of 14 in favor, 2 opposed, 0 abstaining (Chairman presiding and not voting) pursuant to the authority vested in the Hopi Tribal Council by ARTICLE VI-POWERS OF THE TRIBAL COUNCIL, SECTION 1 (a) of the Hopi Tribal Constitution and By-Laws of the Hopi Tribe of Arizona, as ratified by the Tribe on October 24, 1936, and approved by the Secretary of Interior on December 19, 1936, pursuant to Section 16 of the Act of June 18, 1934. Said Resolution is effective as of the date of adoption and does not require Secretarial approval.

Timothy L. Nuvangyaoma, Chairman
Hopi Tribal Council

ATTEST:

Theresa A. Lomakema, Tribal Secretary
Hopi Tribal Council

RESOLUTION OF THE
SAN JUAN SOUTHERN PAIUTE TRIBAL COUNCIL
2018-30

A RESOLUTION IN SUPPORT OF EXTENDING THE TUBA CITY REGIONAL HEALTH CARE CORPORATIONS' DESIGNATION AS A TRIBAL ORGANIZATION AND AUTHORIZATION TO COMPACT UNDER TITLE V OF THE INDIAN SELF DETERMINATION ACT WITH THE INDIAN HEALTH SERVICE PURSUANT TO NAVAJO NATION COUNCIL RESOLUTION CJY-33-10 BEYOND SEPTEMBER 30, 2020, UNLESS RESCINDED BY THE NAVAJO NATION COUNCIL.

WHEREAS:

1. The San Juan Southern Paiute Tribe is a federally recognized Indian Tribe exercising its powers of self-government through its Tribal Council and pursuant to the duties and powers afforded in article IV and V of the Constitution of the San Juan Southern Paiute Tribe approve by the Secretary of the Interior on September 13, 1996. The San Juan Southern Paiute Tribal Council is the governing body of the San Juan Southern Paiute Tribe; and

2. The San Juan Southern Paiute Tribal Council is the governing body of the San Juan Southern Paiute Tribe; and

3. The San Juan Southern Paiute Tribal Council recognizes the importance of an effective government to government relationship through a liaison activities; and

4. The Tribal Council acknowledges the quality health care services provided through the Tuba City Regional Health Care Corporation through partnership with the local communities; and

5. The Tribal Council approves the furtherance of the mission statement of Tuba City Regional Health Care Corporation as a Title V Self-Governance regional health system through partnership with the Navajo Chapters, the Hopi Tribe and the San Juan Southern Paiute Tribe; and

6. The TCRHCC has successfully provided health care programs, functions, services and activities to the San Juan Southern Paiute Tribe since September 1, 2002; and

7. By previous tribal council resolutions, the San Juan Southern Paiute Tribe has supported TCRHCC in contracting and compacting with the Indian Health Service pursuant to the Indian Self-Determination Act to provide programs, services, functions and activities to the residents of the San Juan Southern Paiute Tribe and others in the southwest region of the Navajo Nation; and

8. The Tribal Council supports TCRHCC to include planning, design, and construction projects within each tribal organizations service area; and

9. TCRHCC is currently designated as a tribal organization and authorized to compact with the Indian Health Service through September 30, 2020 pursuant to NNC Resolution CJY-33-10; and

10. TCRHCC desires to extend its existing authority to compact with the Indian Health Service indefinitely, subject to the authority of the Navajo Nation to rescind such authority.

NOW THEREFORE BE IT RESOLVED THAT:

The San Juan Southern Paiute Tribe supports Tuba City Regional Health Care Corporation extending the designation as a tribal organization and authorization to compact pursuant to the Indian Self-Determination Act with the Indian Health Service for all programs, functions, services and activities, in NNC Resolution CJY-33-10, beyond September 30, 2020, and unless rescinded by the Navajo Nation Council.

CERTIFICATION

THE FOREGOING RESOLUTION, WAS DULY ADOPTED BY THE SAN JUAN SOUTHERN PAIUTE TRIBAL COUNCIL AT A DULY CALLED MEETING IN TUBA CITY, ARIZONA, AT WHICH A QUORUM WAS PRESENT AND THE SAME WAS PASSED BY A VOTE OF 7 IN FAVOR, 0 OPPOSED, AND 0 ABSTAINED ON THE 6TH DAY OF APRIL 2018.

Motioned by: Lora Preston, Southern Tribal Council
Seconded by: Tashina Williams, Southern Tribal Council

Tamara Talaswaima, Secretary
Tribal Council Meeting Recorder

Carlene C. Yellowhair, President
San Juan Southern Paiute Tribe

NAVAJO NATION
CORPORATION CODE

CERTIFICATE OF GOOD STANDING

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, the Director of the Business Regulatory Department, DO HEREBY CERTIFY that

TUBA CITY REGIONAL HEALTH CARE CORPORATION
File Number: 100558

a Corporation organized under the laws of the Navajo Nation Corporation Act, did incorporate on January 19, 2001 .

I FURTHER CERTIFY that this corporation has filed all affidavits and annual reports and has paid all annual filing fees required to date and, therefore, is in good standing within the Navajo Nation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Navajo Nation Corporation Code. Done at Window Rock, the Capital of the the Navajo Nation, this 12th day of March, 2018 A.D.

Beverly J. Coho
Director, Business Regulatory
Division of Economic Development

7306 BUTLER'S

NAVAJO NATION
CORPORATION CODE

CERTIFICATE OF GOOD STANDING

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, the Director of the Business Regulatory Department, DO HEREBY CERTIFY that

TUBA CITY REGIONAL HEALTH CARE CORPORATION
File Number: 100558

a Corporation organized under the laws of the Navajo Nation Corporation Act, did incorporate on January 19, 2001 .

I FURTHER CERTIFY that this corporation has filed all affidavits and annual reports and has paid all annual filing fees required to date and, therefore, is in good standing within the Navajo Nation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Navajo Nation Corporation Code. Done at Window Rock, the Capital of the the Navajo Nation, this 27th day of February 2017 A.D.

Clarence Chee
Director, Business Regulatory
Division of Economic Development

7306 BUTLER'S

NAVAJO NATION
CORPORATION CODE

CERTIFICATE OF GOOD STANDING

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, the Director of the Business Regulatory Department, DO HEREBY CERTIFY that

TUBA CITY REGIONAL HEALTH CARE CORPORATION
File Number: 100558

a Corporation organized under the laws of the Navajo Nation Corporation Act, did incorporate on January 19, 2001 .

I FURTHER CERTIFY that this corporation has filed all affidavits and annual reports and has paid all annual filing fees required to date and, therefore, is in good standing within the Navajo Nation.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Navajo Nation Corporation Code. Done at Window Rock, the Capital of the the Navajo Nation, this Second day of March, 2015 A.D.

Director, Business Regulatory
Division of Economic Development

7306 BUTLER'S

MOU-159

FILE COPY

MEMORANDUM OF UNDERSTANDING

THE NAVAJO NATION
DIVISION OF HEALTH
PO BOX 1390
WINDOW ROCK, ARIZONA 86515

AND

TUBA CITY REGIONAL HEALTH CARE CORPORATION
PO BOX 600
TUBA CITY, ARIZONA 86045

I. PURPOSE AND SCOPE

This collaborative agreement is to provide for the mutual sharing of office and parking space in the Tuba City Regional Health Care Corporation by the Health Programs of the Navajo Nation, (hereinafter referred to as Navajo Nation Health Programs (NNHP) and the Tuba City Regional Health Care Corporation (TCRHCC). This Agreement establishes guidance for ongoing collaboration between the NNHP and the TCRHCC. This Agreement delineates expectations and responsibilities, and establishes protocol in support of the parties' mutual mission to deliver quality health care services and enhance the health of Navajo people in the TCRHCC service area. The NNHP covered by this Agreement are identified in Exhibit A attached hereto.

TCRHCC has specified the office and parking spaces to be used by the NNHP in Exhibit B which is attached hereto and made a part hereof (hereinafter the "premises"). TCRHCC and NNHP have taken this action in accordance with the approved Program Justification Document (PJD) and the Program of Requirements (POR) for the TCRHCC and as approved by Indian Health Service (IHS). There will be no rental or lease costs charged by the TCRHCC for the approved space occupied by the NNHP and TCRHCC in the performance of the NNHP and TCRHCC IHS approved programs. The justification for this no-fee occupancy of space by the NNHP is justified in the PJD. The POR for these facilities, which was developed and approved by the IHS and subsequently funded by Congress, included office space for the NNHP and TCRHCC.

Accordingly, the space for the NNHP occupancy in the TCRHCC is generally on par with that of programs operated by the TCRHCC. The NNHP have reviewed this space as described in Exhibit B and acknowledge and agree that it is suitable as set forth in the foregoing sentence.

A. The Navajo Nation shall identify in writing a person who shall be identified as the Navajo Nation Health Program Coordinator, (coordinator) who will act as a Point-of-Contact to coordinate the day-to-day activities between the TCRHCC and the NNHP at TCRHCC, their organizational structure, and individual program supervision.

B. The TCRHCC and the NNHP shall enforce a "no soliciting provision" in accordance with 41 C.F.R. § 102-74.410. TCRHCC shall provide a copy of this document and provide orientation to the NNHP employees.

C. Tort claims for damages arising out of alleged negligent or wrongful acts or omissions committed by TCRHCC employees or NNHP employees operating under P.L. 93-638 contract while acting within the scope of their employment will be governed by the Federal Tort Claims Act, 28 U.S.C. §§ 2671-2780 and 42 U.S.C.§ 233. Non-contract (P.L. 93-638) NNHP shall have general liability, workmen's compensation, medical, and property coverage through the Navajo Nation Tribal Government insurance policies.

II. **AUTHORITY:**

This agreement is made under the authority of Section 327A of the Public Health Service Act (42 U.S.C. § 254a).

III. **RESPONSIBILITIES:**

The parties to this agreement agree as follows:

A. Administrative Supervision and Organizations:

1) The NNHPs occupying space in TCRHCC will be under the administrative supervision of the Chief Operating Officer (COO) TCRHCC for the use and occupancy of space at TCRHCC. The Navajo Nation Health Program Coordinator (identified in Section V of this document) and the NNHPs shall operate their health programs in accordance with their program requirements, tribal organizational structure, and Navajo Nation Policies.

2) The NNHP staff will not be considered TCRHCC employees for any purpose except as provided through any pertinent Navajo Nation P.L. 93-638 contract with the IHS.

B. Technical Assistance or Information Protocol:

The process for requesting technical assistance, services, or information between the TCRHCC and NNHP is to be coordinated through respective supervisors, as follows:

1) **Procedure for NNHP Requesting Assistance from TCRHCC:**

a. The NNHP will submit the request for technical assistance, services or information in writing and via the NNHP Coordinator addressed to the Chief Operating Officer, TCRHCC. The written request shall specify the type of service, information, or assistance that is needed from the TCRHCC. Request shou.d be concise, including timelines, scope of work, costs, and supporting documents.

b. The COO, after consultation with the appropriate department, will approve or deny the request. If approved, the request shall be forwarded to the TCRHCC department supervisor of the personnel or staff necessary to comply with the request. If the request is denied, the COO shall notify the NNHP Coordinator in writing and state the reason(s) for denial.

c. Upon notification that the request has been approved, the TCRHCC department of personnel involved in the request will contact the NNHP making the request to

coordinate, develop a schedule and task(s) necessary to complete the project, presentation, or task.

d. Upon completion, a brief close out report (authored by the NNHP) shall be submitted to the COO and NNHP Coordinator.

2) **Procedure for TCRHCC Requesting Assistance from NNHP:**

a. The TCRHCC will submit the request for technical assistance, services, or information in writing and via the COO, TCRHCC to the NNHP Coordinator. The written request shall specify the type of service, information, or assistance that is needed from the NNHP. Request should be concise, including timelines, scope of work, costs, and supporting documents.

b. The NNHP Coordinator, after consultation with the appropriate NNHP, will notify the COO on the decision regarding the request. If approved, the request shall be assigned to the NNHP program or employees involved in the request. If the request is denied, the NNHP Coordinator shall notify the COO, who will advise the TCRHCC Department that made the request. The request denial shall be in writing and state the reason(s) for denial.

c. Upon notification that the request has been approved, the NNHP employees involved in the request will contact the TCRHCC Department making the request to coordinate, develop a schedule and task(s) necessary to complete the project, presentation, or task.

d. Upon completion, a short close out report (authored by the TCRHCC Department) shall be submitted to the COO and NNHP Coordinator.

C. **Human Resource Issues:**

1) To address disputes and grievances between programs and personnel of the involved parties, it shall be mandatory for each to document incidents, misconduct, and violations of established policies and procedures. This documentation will be submitted through established organizational channels to the supervisor of the employee(s) committing said violation/misconduct for corrective action through the respective (TCRHCC or NNHP) Human Resource Management system.

2) The TCRHCC shall issue employee identification (name) badges, which are to be worn at all times by employees while on duty at the facility. Identification badges shall include the employee's photograph. Completed background investigations may be required prior to issuing identification badges (Section III(C)(4)). NDOH (NNHP) employees shall comply with the Homeland Security President Mandate 12 (HSPD-12) Personal Identity Verification PIV Cards. TCRHCC and NDOH (NNHP) staff shall be assessed a fee for lost PIV Cards.

3) Both parties must comply with the TCRHCC Employee Health Plan requirement (including immunizations and other infectious disease control measures).

4) Each party will be responsible for performing background investigations of their employees as required for compliance with the Indian Child Protection and Family Violence Prevention Act (P.L. 101-630) in accordance with the respective established policies and procedures of the Indian Health Service and the Navajo Nation. Additional checks may be required by the U.S. Department of Homeland Security. Completed background investigations on employees shall be required prior to issuance of the required employee identification badges. If an employee does not pass a background investigation, the employee shall be excluded from the facility. NDOH (NNHP) employees shall comply with the Homeland Security President Mandate 12 (HSPD 12) Personal Identity Verification PIV Cards. TCRHCC and NDOH (NNHP) staff shall be accessed a fee for lost PIV Cards.

D. Parking:

All employees will park personal vehicles in the designated employee parking lot of the TCRHCC per the diagram attached hereto as Exhibit B. Government (TCRHCC and NN) vehicles may be parked in the designated secure area of the TCRHCC after hours of service. Loading and unloading zones shall be designated by the TCRHCC.

E. Access to the Premises:

1) Employees of TCRHCC and NNHP will be allowed access to their work areas in accordance with procedures established to safeguard the security and safety of employees and the facility. Access after normal tour of duty will need prior approval by the COO.

2) Employees of the TCRHCC and NNHP will be issued keys, if required, for access to areas necessary to carry out their duties. Keys are not to be duplicated and must be returned when the employee is no longer employed, through termination, voluntary resignation or otherwise.

3) NDOH (NNHP) employees shall comply with the Homeland Security Presidents Mandate 12 (HSPD-12) Personal Identity Verification PIV Cards. TCRHCC and NDOH (NNHP) staff shall be assessed a fee for lost PIV Cards.

4) NNHP shall be restricted to the areas set forth in Exhibit B. The facility wherein the premises are located is the repository for TCRHCC materials and supplies which are strictly controlled through Medicare or Medicaid and other federal programs. Any loss of these materials or supplies create substantial, potential liability in the form of fines, penalties and damages for TCRHCC and any other person or entity, including NNHP responsible for the loss. Therefore, NNHP's use must be strictly limited to the areas set forth in Exhibit B and NNHP shall refrain from entry into other areas of the facility.

F. Equipment Safety:

1) All program or personal electrical equipment and furniture used in the TCRHCC, whether by the TCRHCC or the NNHP, before initial use must be safety checked and cleared by the TCRHCC Bio-med and/or Maintenance Department. Equipment will be checked and tagged on a case-by-case basis.

2) Equipment must meet all Life Safety Codes, NFPA, NEC and Underwriters Laboratory standards. All documentation shall be accessible by TCRHCC Bio-med.

3) The arrangement or placement of equipment and furniture in all spaces of the TCRHCC shall be routinely inspected by TCRHCC for compliance with applicable safety standards and codes.

G. **General Safety:**

1) NNHP employees shall participate in all fire and other safety exercises.

2) NNHP employees shall be observant and report all unsafe conditions of hazardous situation(s) to the TRCHCC Safety Officer.

3) NNHP managers shall report all accidents that occur in the TCRHCC facility or on the grounds via the TCRHCC WedCident (TCRHCC will provide access to this electronic format) reporting system. Report(s) shall be submitted electronically to the TCRHCC Safety Officer on all occupational, employee, patient, or visitor injuries.

4) Security breaches, violence on the property, property damage, alcohol or other substance abuse, and hazardous conditions shall be reported by NNHP staff to the TCRHCC security.

5) An Employee may be excluded from the facility for reasons including but not limited to pertinent court orders, inability to pass a background investigation (Section III(C)(4)), threats made against other employees or clients, alcohol consumption or substance abuse that occurs on the premises, lewd behavior, gross misuse of government property, etc.

6) Information Technology (IT) Incident Reporting should be coordinated with and reported immediately to the local Information Systems Security Officer (ISSO) representative.

H. **Housekeeping, Grounds-keeping, and Security:**

1) Housekeeping of common areas, grounds-keeping, and security services shall be provided by the TCRHCC to all departments and programs, since resources for these services are appropriated by Congress on the basis of the gross square meters. The NNHP shall be responsible for maintaining general order and cleanliness relative to their designated area as set forth on Exhibit B.

2) Any of these services which are beyond what is normally provided shall be reimbursable to TCRHCC.

I. **Utilities:**

1) Utilities costs (electricity, water, sewer, heating fuel, and trash) shall be paid by the TCRHCC for all departments and programs, since resources for utility costs are appropriated by Congress on the basis of the gross square meters.

2) Any cost of utilities which are beyond what is normally provided shall be reimbursable by TCRHCC.

J. **Maintenance:**

1) All essential construction, maintenance, and repair shall be provided by the TCRHCC to all departments and programs, since resources for maintenance are appropriated by Congress on the basis of the gross square meters.

2) The NNHP is responsible to pay for damages to the premises, over and above routine wear and tear, caused willfully or through neglect or unauthorized actions.

K. **Trash:**

1) Access to normal trash disposal shall be provided by the TCRHCC to all departments and programs, since resources for this service are appropriated by Congress on the basis of the gross square meters; however, NNHP shall be responsible for the day-to-day cleaning and trash removal to the disposal site.

2) Any costs for trash disposal which are beyond what is normally provided shall be reimbursable to TCRHCC.

L. **Equipment and Furniture:**

1) The NNHP may continue to use system furniture that it has been using and shall be provided with telephone equipment, compatible with the TCRHCC telephone system, by TCRHCC prior to occupancy. NNHP shall procure from their own respective budgets and maintain other necessary or special equipment and furniture required to operate the respective NNHP, including computer equipment, copiers, fax machines, desks, workstations, tables, chairs, file cabinets, calculators, shelving, etc.

2) The NNHP is responsible for inventory control of TCRHCC supplied furniture and equipment, in accordance with the TCRHCC established policies and procedures.

M. **Supplies:**

1) The NNHP shall procure from their own respective budgets, store, and be accountable for all office supplies, educational supplies, and other materials required for operations of the NNHP, including but not limited to toner and printer cartridges, paper, stationery, envelopes, writing instruments, mailing supplies, desktop items, filing paraphernalia, etc.

2) Additional space for storage is not available beyond what is approved in the PJD/POR.

N. **Mail:**

1) The NNHP shall maintain their official U.S. Postal Service address at a U.S. Post Office of their choosing. The NNHP Programs shall arrange for pickup or sending of their own mail.

2) Mail with appropriate postage affixed or metered outgoing mail may be sent through the TCRHCC mail room. Unstamped or unmetered mail shall be returned to the NNHP.

3) Since various NNHPs are located in the TCRHCC, there will also be need for in-house mailboxes. The TCRHCC will, if needed, provide each Tribal program with a mailbox, where interdepartmental mail may be dispensed.

4) The NNHP shall forward mail addressed to the TCRHCC received at their mailboxes in the Tribal Office by depositing it in the designate Health Center mailboxes (e.g., patient bills from Contract Health Service vendors).

O. **Information Technology:**

1) The NNHP will have access to HHS electronic mail and TCRHCC internet services. The NNHP will be assessed a fee equal to the fee TCRHCC pays to DHHS for HHS electronic mail. All employees of the NNHP who use this service shall abide by all DHHS and TCRHCC policies.

   Both parties recognize and understand the absolute necessity for strict use limitations and confidentiality regarding the use of TCRHCC's internet and electronic information system. The TCRHCC agrees to provide internet connection for limited access to Tribal websites and TCRHCC intranet as may be further defined and controlled by the TCRHCC IS/IT Department, their policies and procedures and all other regulations and procedures including any TCRHCC internet use or electronic information system policies, rules and regulations. Failure to abide by these policies and procedures will be grounds for the removal of internet and EIS connectivity and use.

2) All network access (including HHS electronic mail) and all RPMS access will be requested through the TCRHCC IT Department in accordance with Section III (B) (1) of this Agreement. This will require use of the Information Technology Access Control (ITAC) form.

3) NNHP employees that access RPMS will sign the Computer Access Agreement forms provided by TCRHCC IT and complete the TCRHCC computer security on-line training. This will require use of the Information Technology Access Control (ITAC) form.

4) All software and hardware utilized by the NNHP for network and/or RPMS access will comply with TCRHCC specifications for compatibility. Software/hardware that does not comply with the TCRHCC specifications for compatibility will not be allowed on the IHS network. Non-registered, entertainment, or game software will NOT be allowed on the TCRHCC network.

5) TCRHCC and Acquisition staff will be available for guidance and recommendations in regard to new equipment and software purchases.

6) The TCRHCC staff will install and support all appropriate RPMS database packages which are able to interface safely with the TCRHCC electronic information system and related software and hardware and as may be required by the NNHP. This will require Class 3 Software approval from OIT and NAO with NDOH (NNHP) software install. This will also require use of the Information Technology Access Control (ITAC) form.

7) The NNHP agree to timely and thoroughly report to TCRHCC data for established Government Performance Results Act (GPRA) indicators, Performance Assessment Rating Tool (PART) measures and other patient utilization information (PCC) via RPMS data entry or other available systems.

8) NNHP Coordinator will notify the TCRHCC IT Department immediately when an employee that had computer access is suspended or no longer employed in their respective programs.

9) NNHP employees will be offered the opportunity to participate in required software training when provided in the TCRHCC and/or at the Area Office.

10) NNHP may request technical support and assistance from the TCRHCC IT Department for TCRHCC provided hardware and software by submitting, via IT Work Order, the work order form to be supplied by TCRHCC. The TCRHCC IT Department will support normal IT network (hardware and system software) necessary to operate the TCRHCC network. All NNHP specific hardware and software to be connected to the TCRHCC IT network must be approved by TCRHCC prior to installation. Failure to comply with any of the items stated above may result in the removal of network privileges.

11) TCRHCC and NCOH (NNHP) staff will insure that proper Anti-Virus software and updates are installed.

12) TCRHCC and NDOH (NNHP) staff will mitigate and address any infected Personal Computers (PCs) immediately. Infected PCs may be disconnected and removed from the TCRHCC facility if required by the local TCRHCC ISSO.

13) TCRHCC and NDOH (NNHP) staff will jointly coordinate ongoing inventories of all Software and Hardware for NDOH (NNHP) staff.

P. Telecommunications (Voice/Data/Video):

1) The TCRHCC shall provide at no cost local telecommunication services (telephone and fax) and repair/replace TCRHCC provided telephone sets. Local telecommunication service is identified as being within the same telephone pre-fixed dialing area.

2) The TCRHCC shall provide telecommunication services (telephone and fax) on a cost reimbursement (for long distance service) basis to the NNHP.

3) Training on how to use the telecommunications system including but not limited to voice mail will be provided by the TCRHCC to the NNHP.

4) Nonpayment of long distance fax and telephone charges for three (3) months or more may result in termination of those services to the NNHP.

5) The TCRHCC shall provide gateway hardware for the telephone system; however, the NNHP shall establish their own telephone answering system and personnel to operate that system through their separate and independent telephone numbers.

Q. Patient Services:

1) The NNHP agree to provide direct care services at the TCRHCC, consistent with the requirements of 42 C.F.R. § 136.23, regarding "Persons to whom health services will be provided."

2) TCRHCC will provide interpretation, guidance, or assistance on eligibility issues upon request. The NNHP shall remain responsible for compliance with the direction and performance of their services pursuant to 42 C.F.R. § 136.23 regarding "persons to whom health services will be provided." The parties acknowledge that patient service is extremely critical to both parties and both parties should strive to eliminate patient complaints regarding the performance of their services.

3) The TCRHCC will carry out program operations in accordance with provisions of other Federal or State health care grants or awards. Misconduct, negligence, or mismanagement by the NNHP in carrying out these services may result in the termination of the right to occupy space at TCRHCC.

4) Patient concerns and complaints will initially be addressed by NNHP and remain their responsibility, but shall also be immediately reported through the TCRHCC Risk Management Program. Complaints submitted to either party will be forwarded to TCRHCC Risk Management Program for resolution. When both parties (TCRHCC & NNHP) are named in the patient complaint, both will investigate and issue a report so the patient can receive a coordinated response from both the TCRHCC and the NNHP via the TCRHCC Risk Management Program.

5) The NNHP may generate and maintain client information required for NNHP program purposes independent of the TCRHCC medical record.

R. Privacy and Confidentiality of Patient Information:

1) Both parties, the NNHP and TCRHCC, will follow all Indian Health Service and DHHS procedures concerning security, privacy, and confidentiality of patient information

2) TCRHCC and NNHP agree to abide by Health Insurance Portability and Accountability Act (HIPAA), Federal Privacy Act, associated regulations and internal policies and procedures, as applicable. Orientation on such regulations, policies, and procedures shall be provided by TCRHCC. The NNHP must also abide by the Navajo Nation Privacy and Access to Information Act.

3) Breach of privacy and/or confidentially requirements may be grounds for termination of the right to occupy space at TCRHCC.

4) Employees of both parties who operate information technology equipment in the TCRHCC will complete both the TCRHCC Computer Security and HIPPA on-line training annually.

5) All employees and agents of the NNHP shall take the annual mandatory compliance proficiency exam to ensure compliance with HITECH, HIPPA, EMTALA and all other regulatory, privacy and confidentiality rules and regulations.

6) Each of the entities comprising the NNHP shall separately and independently sign a Business Associate Agreement relative to HITECH and said agreements shall be collectively attached as Exhibit C to this Agreement.

S. Accreditation:

1) Both parties, the TCRHCC and the NNHP, will comply with all safety, infection control, health and technical standards, codes, and regulations required to maintain accreditation of TCRHCC and programs operating within the TCRHCC.

2) TCRHCC and NNHP, agree to cooperate, coordinate, and participate with the TCRHCC Safety Officer and Infection Control Officer and Infection Control Officer when conducting surveys and inspections for safety and infection control compliance within the TCRHCC.

3) NDOH (NNHP) employees shall comply with the HHS/IHS Certification and Accreditation (C&A) process mandates.

T. Required Training for TCRHCC and NNHP Employees:

The TCRHCC will coordinate mandatory training and maintain documentation required for accreditation purposes for both TCRHCC and NNHP employees. Mandatory training may include but not be limited to the following:

1) Safety
2) Infection Control
3) Freedom of Information Act (FOIA)
4) Federal Privacy Act, Health Insurance Portability and Accountability Act (HIPAA)
5) Equal Employment Opportunity (EEO)
6) Information Security Awareness (ISA) Training completed annually before the set due date or deadline of May 15th of each year unless otherwise changed by TCRHCC.
7) Joint Commission Compliance
8) Patient Rights
9) Ethics
10) Abuse Reporting
11) Operation of telecommunications and voice mail systems

12) Emergency Management
13) Rules of Behavior (ROB)

U. Quarters for NNHP Employees

Federal quarters/housing is not available and shall not be assigned to the NNHP staff. Federal quarters are Reserved for Federal employees and are not available for assignment to NNHP employees.

IV. DISPUTE RESOLUTION:

A. In the event that a dispute should arise with regard to performance or interpretation of any of the terms of this agreement, the NNHP and the TCRHCC agree to meet and confer in good faith to resolve such problems or disputes that may arise under this agreement at the local level. If the dispute cannot be resolved locally, it will be forwarded to the TCRHCC Board of Directors and the Navajo Nation for resolution in a government to government forum. In the event of a conflict between any term(s) of this agreement, applicable federal laws and statues will prevail.

B. All provisions of this Agreement are subject to applicable Federal laws and regulations. Such laws include, but are not limited to the Privacy Act, 5 U.S.C. § 552a, the Indian Child Protection and Family Violence Act, P.L. 101-630, the Anti-Deficiency Act, 31 U.S.C. § 1341, the Indian Health Care Improvement Act, 25 U.S.C. § 1601 et seq., the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450 et. Seq., Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), Stark Law, 42 U.S.C. § 1395nn, and the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. Nothing in this Agreement may be interpreted to authorize or obligate an employee of the Indian Health Service to act outside the scope of his or her official duties.

V. RESPONSIBLE OFFICIAL FOR EACH ORGANIZATION:

For: The Navajo Nation:

Robert I. Nakai, E.D.
Division Director, NDOH
P.O. Box 1390
Window Rock, Arizona 86515

For: Tuba City Regional Health Care Corporation:

Lynette Bonar, COO
Chief Operating Officer, TCRHCC
P.O. Box 600
Tuba City, Arizona 86045

VI. PERIOD OF AGREEMENT:

Period of performance shall be effective upon signature of all parties involved in the agreement and shall remain in force until terminated in accordance with Section VII.

VII. **TERMINATION:**

This Agreement may be terminated, with our without cause, by ether party upon thirty (30) days written notice to the other. Termination shall be deemed given when notice is deposited in the United States mail, postage prepaid, addressed to the COO, TCRHCC, or NNHP Coordinator.

VIII. **AMENDMENT OF AGREEMENT:**

This Agreement may be amended from time-to-time by mutual agreement of the parties through a written amendment which is signed and dated by both parties and attached to this agreement. Both parties agree to give reasonable consideration of all requests to amend this agreement.

IX. **DISCLAIMERS: NO PARTNERSHIP OR AGENCY:**

The parties hereto shall not by virtue of this Agreement be deemed to be partners or joint ventures in providing health care services. It is further understood that both parties to this Agreement shall maintain their separate independence and neither party shall be considered as the agent of the other party for any warranties or representations made on behalf of the other party.

X. Nothing herein shall be construed as a waiver, expressed, or implied, of either party's Sovereign Immunity.

XI. **SIGNATURE OF EACH PARTY:**

FOR THE NAVAJO NATION:

Date: FEB 0 2 2011

Ben Shelly, President
Navajo Nation
P.O. Box 9000
Window Rock, Arizona 86515

FOR THE TUBA CITY REGIONAL HEALTH CARE CORPORATION:

Date: Feb 11, 2011

Joseph Engelken, CEO
Tuba City Regional Health Care Corporation
P.O. Box 600
Tuba City, Arizona 86045

EXHIBIT A

THE NAVAJO NATION HEALTH PROGRAMS COVERED BY THE MEMORANDUM OF UNDERSTANDING

BETWEEN

THE NAVAJO NATION
DIVISION OF HEALTH
PO BOX 1390
WINDOW ROCK, ARIZONA 86515

AND

TUBA CITY REGIONAL HEALTH CARE CORPORATION
PO BOX 600
TUBA CITY, ARIZONA 86045

1. Health Education Program including HIV prevention and teen pregnancy prevention programs.
2. Community Health Representative Program including its outreach programs tuberculosis control and social hygiene.
3. Breast and Cervical Cancer Program

EXHIBIT C

ADDENDUM TO THE
MEMORANDUM OF UNDERSTANDING

BETWEEN

THE NAVAJO NATION
DIVISION OF HEALTH
P.O. BOX 1390
WINDOW ROCK, ARIZONA 86515

AND

TUBA CITY REGIONAL HEALTH CARE CORPORATION
P.O. BOX 600
TUBA CITY, ARIZONA 86045

PROTECTED HEALTH INFORMATION ADDENDUM

This Addendum is made to the Navajo Nation Health Programs ("Agreement") entered into on the ___ day of January, 2011 between the Tuba City Regional Health Care Corporation (TCRHCC) and Navajo Nation Health Programs ("Business Associate") and is incorporated and made part thereof by reference.

This Addendum ensures that the Business Associate will appropriately safeguard Protected Health Information (PHI) that it will use or disclose when performing functions, activities or services for TCRHCC, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulation, the Standards for Privacy and Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, Subparts A and E, and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009

1. Definitions:

   a. Business Associate. "Business Associate" shall mean Navajo Nation Health Programs
   b. Covered Entity. "Covered Entity" shall mean TCRHCC.
   c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
   d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, Subparts A and E.
   e. Protected Health Information. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
   f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
   g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

h. Breach. "Breach" shall mean the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

i. Unsecured Protected Health Information. "Unsecured Protected Health Information" shall mean protected health information that is not secured through the use of a technology or methodology specified by the Secretary under the HITECH Act that render protected health information unusable, unreadable or indecipherable to unauthorized individuals.

j. Discovery of Breach. A breach shall be treated as discovered by a covered entity or a Business Associate as of the first day on which such breach is known to such entity or associate, respectively (including any person, other than the individual committing the breach, this is an employee, officer, or other agent of such entity or associate, respectively) or should have been known to such entity or associate (or person) to have occurred.

2. Obligations and Activities of Business Associate

a. Business Associate shall request, use and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use or disclosure, in accordance with 42 U.S.C. § 17935(b). and agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law

b. Business Associate shall comply with the prohibition on the sale of Electronic Health Records and Protected Health Information as set forth in 42 U.S.C. §17935(d).

c. Business Associate shall use and disclose Protected Health Information for marketing purposes only as expressly directed by the Covered Entity, and in accordance with 42 U.S.C. §17936(a)

d. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

e. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

f. Business Associate shall comply with the provisions of 45 C.F.R. §§164.308, 164.310, 164.312, and 164.316 relating to implementation of administrative, physical and technical safeguards with respect to Electronic PHI in the same manner that such provisions apply to the HIPAA covered entity.

g Business Associate shall also comply with any additional security requirements contained in the HITECH Act that are applicable to HIPAA covered entities.

h Business Associate agrees to notify the Covered Entity of any breach of the Protected Health Information not provided for by this Agreement within two (2) days of discovery of the breach. Such notification shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed during such breach.

i. Business Associate shall cooperate with Covered Entity in the risk assessment to determine whether notification to individuals of the breach is required.

j. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Addendum and Agreement to Business Associate with respect to such information.

k. Business Associate agrees to provide access, at the request of Covered Entity, and in within 5 business days to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.

l. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, within 10 business days.

m. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected

Health Information received from, or created or received by Business Associate on behalf of Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

n. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
o. Business Associate will assist Covered Entity in compliance with additional accounting requirements of 42 U.S.C. §17935(c) if and when applicable, and any additional information required under the HITECH Act and any implementing regulations.
p. Business Associate will assist Covered Entity in compliance with additional requirements of 42 U.S.C. §17935(e)(1), if and when applicable.
q. All other requirements of the HITECH Act which are applicable to Business Associates are incorporated by reference into this Addendum.

3. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Navajo Nation Health Programs, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

4. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.
d. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

5. Term and Termination

a. Term. The Term of this Agreement shall be effective as of January _____, 2011, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.
b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
    2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate Business Associate shall retain no copies of the Protected Health Information.
2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity making reasonable inquiry and confirming that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule, HIPPA and the HITECH Act.
c. Survival. The respective rights and obligations of Business Associate under Section 6c of this Addendum shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Addendum or Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

THE PARTIES WARRANT AND REPRESENT THAT THEY HAVE THE RIGHT, POWER AND AUTHORITY TO EXECUTE THIS ADDENDUM ON BEHALF OF THEIR RESPECTIVE ORGANIZATIONS.

Navajo Nation Health Programs

Business Associate

By: Ben Shelly

Ben Shelly, President
Navajo Nation

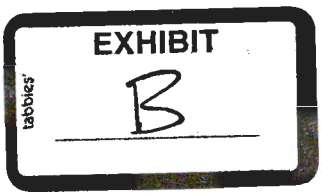
Date: [illegible] 2011

TUBA CITY REGIONAL HEALTH CARE CORPORATION (Covered Entity)

By J Engelken

Joe Engelken, Chief Executive Officer

Date: 2/11/2011



NAVAJO NATION CONDITIONS FOR DESIGNATION AS

TRIBAL ORGANIZATION FOR HEALTH CARE PURSUANT TO

INDIAN SELF-DETERMINATION ACT
(P.L. 93-638 AS AMENDED)

Navajo Nation Conditions for
Designation as Tribal Organization for Health Care Pursuant to the Indian Self-Determination Act (P.L. 93-638, as amended)

The Navajo Nation and the designated "Tribal Organizations" shall cooperate under the principles of Ké to ensure that the health care needs of all Navajo citizens are fully met.

The designation of "Tribal Organization" for participation in the Indian Self-Determination Act (P.L. 93-638 as amended) is a revocable designation and is conditioned on the continued, ongoing and full compliance with the terms and conditions as set forth below:

1. The designated "Tribal Organization"
   Must qualify as a participant under the Indian Self Determination Act (P.L. 93-638, as amended) as follows:
   (A) Completing, to the satisfaction of the Health, Education and Human Services Committee and the Naabik'iyati' Committee of the Navajo Nation Council, a planning phase as described under the Act and which includes:
      (1) Legal and budgetary research; and
      (2) Internal tribal government planning and organizational preparation relating to the administration of health care programs.
   (B) Requesting participation Title V, Self-Governance, by resolution of the Health, Education and Human Services Committee and the Naabik'iyati' Committee of the Navajo Nation Council; and
   (C) Demonstrating financial stability and financial management capability for the three (3) fiscal years immediately preceding the application for Title V, Self-Governance.
2. The designated Tribal Organization shall maintain its eligibility for third party payments under the Centers for Medicare and Medicaid Services (CMS).

3. The designated Tribal Organization shall maintain continued accreditation by a nationally recognized accreditation program.
4. The designated Tribal Organization shall operate and administer their Self-Governance Compact programs under the oversight of the Health, Education and Human Services Committee

5. The designated Tribal Organization shall appear before and report to the Health Education and Human Services Committee and the Naabik'iyati Committee of the Navajo Nation Council whenever requested to do so.

6. The designated Tribal Organization shall maintain compliance with all monitoring and reporting requirements duly established by the Health, Education and Human Services Committee, including:

(A) Submission to the Health, Education and Human Services Committee of copies upon receipt, of all final Federal Single Audit Act audit reports, including Audited Financial Statements, and final survey reports issued by its nationally recognized accreditation organizations(s) and all associated corrective action plans, with copies to the Navajo Nation Department of Health.

(B) Submission of copies of the Self-Governance Compact and all Annual Funding Agreements to the Navajo Nation Department of Health.

(C) Submission of copies of the designated "Tribal Organization's" Annual Report, upon acceptance of same by the "Tribal Organization", to the Health, Education and Human-Services Committee and to the Navajo Nation Department of Health. The format, criteria and due date of the Annual report shall be determined by the Health, Education and Human Services Committee.

(D) Submission of a listing of the Board of Directors-identified by Chapter, description of method of selection of Board, length of term and by-laws.

7. The designated "Tribal Organization" shall maintain continued compliance with all applicable Navajo Nation laws and regulations, including, but not limited to, the Navajo Preference in Employment Act and shall provide a report on employment compliance to the Health, Education and Human Services Committee annually and upon request.

8. The designated "Tribal Organization" shall maintain compliance with all applicable Navajo Nation Health care policies and priorities duly adopted by the Health and Social Services Committee and shall demonstrate the establishment and operation of a traditional medicine program as an integral component of the provision of health care.

9. The designated "Tribal Organization" will consult and cooperate with the Navajo Nation Department of Health concerning the public health needs and programs of the Navajo Nation.

10. The designated "Tribal Organizations" and Navajo Nation Department of Health shall timely develop and on-going written policy for consultation on matters of public health and have such policy approved by the Health, Education and Human Services Committee.

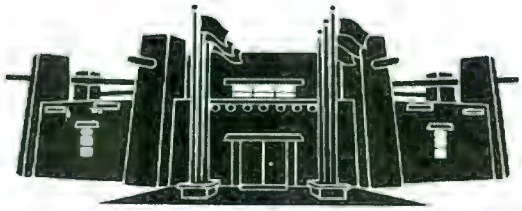
11. The designated "Tribal Organizations" and Navajo Nation Department of Health and Navajo Nation Department of Emergency Medical Service shall enter Memorandum of Understandings for the Navajo Nation's use and occupancy of the designated Tribal Organization's facilities as long as such use and occupancy does not interfere with direct care services.

12. The designated "Tribal Organization", in its dealings with the federal and state government, be it lobbying, advocacy, litigation, or negotiating efforts, shall only take positions or make arguments, consistent with official published Navajo Nation positions. The designated "Tribal Organization" shall report and consult with the Health, Education and Human Services Committee prior to such undertakings.

13. The designated "Tribal Organization" shall not directly charge any tribal member for health care services nor charge the Navajo Nation Employee Benefit Plan or Workers Compensation Plan for health care services provided to a covered tribal member unless the Indian Health Service would be able to charge the tribal member for the same service under the same circumstances unless otherwise authorized by the Naabik'iyati' Committee of the Navajo Nation Council.

14. The designated "Tribal Organization" shall provide direct patient care to all Native American eligible users unless otherwise authorized by the Naabik'iyati' Committee of the Navajo Nation Council.

Office of Legislative Counsel
Telephone: (928) 871-7166
Fax # (928) 871-7576



Honorable LoRenzo Bates
Speaker
23rd Navajo Nation Council

MEMORANDUM

TO: Honorable Lee Jack, Sr.
Navajo Nation Council

FROM: Edward A. McCool, Principal Attorney
Office of Legislative Counsel

DATE: September 21, 2018

SUBJECT: AN ACTION RELATING TO HEALTH, EDUCATION AND HUMAN SERVICES; RECOMMENDING FOR APPROVAL OF THE NAABIK'IYATI' COMMITTEE THE DESIGNATION OF THE TUBA CITY REGIONAL HEALTH CARE CORPORATION AS A NAVAJO NATION "TRIBAL ORGANIZATION" FOR A PERIOD OF TWENTY-FIVE (25) YEARS, FOR THE PURPOSES OF CONTRACTING WITH THE UNITED STATES INDIAN HEALTH SERVICE AND AUTHORIZING IT TO NEGOTIATE AND ENTER INTO TITLE I, INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED) CONTRACTS AND TITLE V SELF GOVERNANCE COMPACTS PURSUANT TO THE INDIAN SELF-DETERMINATION ACT (P.L. 93-638, AS AMENDED), SUCH DESIGNATION OF "TRIBAL ORGANIZATION" BEING REVOCABLE AND CONTINGENT ON COMPLIANCE WITH ALL TERMS AND CONDITIONS AS REQUIRED

As requested, I have prepared the above-referenced proposed resolution and associated legislative summary sheet pursuant to your request for legislative drafting. Based on existing law and review of documents submitted, the resolution as drafted is legally sufficient. As with any action of government however, it can be subject to review by the courts in the event of proper challenge. Please ensure that this particular resolution request is precisely what you want. You are encouraged to review the proposed resolution to ensure that it is drafted to your satisfaction.

The Office of Legislative Counsel confirms the appropriate standing committee(s) based on the standing committees powers outlined in 2 N.N.C. §§500, 501. Nevertheless, "the Speaker of the Navajo Nation Council shall introduce [the proposed resolution] into the legislative process by assigning it to the respective oversight committee(s) of the Navajo Nation Council having authority over the matters for proper consideration." 2 N.N.C. §164(A)(5).

If the proposed resolution is unacceptable to you, please contact me at the Office of Legislative Counsel and advise me of the changes you would like made to the proposed resolution.

THE NAVAJO NATION
LEGISLATIVE BRANCH
INTERNET PUBLIC REVIEW PUBLICATION

LEGISLATION NO: _0315-18__ **SPONSOR:** Lee Jack Sr.

TITLE: An Action Relating To Health And Education And Human Services; Recommending For Approval Of The NAABIK'IYATI' Committee The Designation Of The Tuba City Regional Health Care Corporation As A Navajo Nation "Tribal Organization" For A Period Of Twenty-Five (25) Years, For The Purposes Of Contracting With The United States Indian Health Service And Authorizing It To Negotiate And Enter Into Title I, Indian Self-Determination Act (P.L. 93-638, As Amended), Such Designation Of "Tribal Organization" Being Revocable And Contingent On Compliance With All Terms And Conditions And Required

***Date posted*: September 27, 2018 at 5:25 PM**

Digital comments may be e-mailed to comments@navajo-nsn.gov

Written comments may be mailed to:

Executive Director
Office of Legislative Services
P.O. Box 3390
Window Rock, AZ 86515
(928) 871-7586

Comments may be made in the form of chapter resolutions, letters, position papers, etc. Please include your name, position title, address for written comments; a valid e-mail address is required. Anonymous comments will not be included in the Legislation packet.

Please note: This digital copy is being provided for the benefit of the Navajo Nation chapters and public use. Any political use is prohibited. All written comments received become the property of the Navajo Nation and will be forwarded to the assigned Navajo Nation Council standing committee(s) and/or the Navajo Nation Council for review. Any tampering with public records are punishable by Navajo Nation law pursuant to 17 N.N.C. *§374 et. seq.*

THE NAVAJO NATION
LEGISLATIVE BRANCH
INTERNET PUBLIC REVIEW SUMMARY

LEGISLATION NO.: 0315-18

SPONSOR: Lee Jack Sr.

TITLE: An Action Relating To Health And Education And Human Services; Recommending For Approval Of The NAABIK'IYATI' Committee The Designation Of The Tuba City Regional Health Care Corporation As A Navajo Nation "Tribal Organization" For A Period Of Twenty-Five (25) Years, For The Purposes Of Contracting With The United States Indian Health Service And Authorizing It To Negotiate And Enter Into Title I, Indian Self-Determination Act (P.L. 93-638, As Amended), Such Designation Of "Tribal Organization" Being Revocable And Contingent On Compliance With All Terms And Conditions And Required

Posted: September 27, 2018 at 5:25 PM

5 DAY Comment Period Ended: October 2, 2018

Digital Comments received:

Comments Supporting (1)	**1. Evans Hollie, Montezuma Creek, UT**
Comments Opposing	***None***
Inconclusive Comments	***None***

Legislative Secretary II
Office of Legislative Services

10/3/2018 8:15am
Date/Time

Legislation #0315-18

Evans Hollie <staticghouls@gmail.com>

Tue 10/2/2018 3:12 PM

To:comments <comments@navajo-nsn.gov>;

My name is Evans Hollie from Montezuma Creek, Utah and I support 638s. Particularly, I support Utah Navajo Health System, Inc.

Sent from my iPhone