



Morongo Basin Health Care District
Community Health Center
GOVERNING BOARD MEETING

MINUTES of Thursday, March 5, 2026, at 4:45 p.m.

This meeting convened on the District's campus at 6530 La Contenta Road, Suite 400, Yucca Valley, CA 92284. The meeting was also accessible by Microsoft Teams remote platform.

Mission Statement: *To improve the health and wellness of the communities we serve.*

Vision Statement: *A healthy Morongo Basin.*

Core Values: *Commitment, Collaboration, Accountability, Dignity, Integrity, and Equity*

PRESENT:

- Cody Briggs (*present*)
- Esther Watson (*present*)
- Gloria Cabrera (*present*)
- Hermoine Gutierrez Rios (*absent*)
- Jackie Todd (*present*)
- Marc Greenhouse (*present*)
- Lisa Ryan (*absent*)
- Pat Cooper (*present*)
- Sean Loomis (*present*)

GUEST: Todd Brown (guest of Dianne Markle-Greenhouse)

STAFF:

- Angie Villaluz, Quality Manager (*remote*)
- Beverly Krushat, Board Clerk (*present*)
- Cindy Schmall, CEO (*present*)
- Debbie Anderson, CFO (*present*)
- Dianna Anderson, *Community Programs Manager* (*absent*)
- Fredi Levitt, BH Manager (*absent*)
- JJ Greer, SR Site Supervisor (*remote*)
- Janeen Duff, Director Strategic Initiatives (*remote*)
- Jill Goodwin, Clinical Services Manager (*present*)
- Kelly Hedges-Wehner, Patient Care Services Director (*present*)
- Kim Harrison, Business Office Services Director (*present*)
- Mia Fisher, Dental Manager (*present*)
- Sheri Tincher, Patient Financial Manager (*present*)
- Tina Huff, Integrated Health Services Director (*present*)
- Tricia Gehrlein, CPE/CO (*remote*)

CALL TO ORDER – Board meeting was called to order by Sean Loomis at 4:45 p.m.

ROLL CALL - Beverly Krushat called roll call and confirmed there is a quorum.

OBSERVANCES – Sean Loomis led the Pledge of Allegiance and read the Core Values.

PUBLIC COMMENTS – There were no public comments.

APPROVAL OF MEETING AGENDA -

Motion 26-146: MSC (Greenhouse/Markle-Greenhouse) 7/0/2 motion carried to approve March 5, 2026, agenda.

APPROVAL OF CHC CONSENT AGENDA –

Motion 26-147: MSC (Greenhouse/Markle-Greenhouse) 7/0/2 motion carried to approve consent agenda.

Q4 & YEAR END QUALITY REPORT – *Tricia Gehrlein, CPE/CO*

The Q4 and Year End Quality report were presented at the February 5, 2026 CHC board meeting but were not agendaized with a motion.

Motion 26-148: MSC (Greenhouse/Todd) 6/1/2 motion carried to accept and file the Q4 and Year End Quality Report. Cody Briggs abstained from voting.

NEEDS ASSESSMENT PRESENTATION – *Tricia Gehrlein, CPE/CO*

The Needs Assessment Presentation was presented at the February 5, 2026 CHC board meeting but was not agendaized with a motion. CPE/CO Gehrlein explained that if there was anyone that did not see the presentation at the February board meeting, she would be happy to review it with them.

Motion 26-149: MSC (Greenhouse/Todd) 5/2/2 motion carried to accept and file the Needs Assessment presentation. Cody Briggs and Esther Watson abstained from voting.

CARE TEAM PRESENTATION – *Jill Goodwin, Care Team Manager*

The Care Team assists patients by navigating the healthcare system, providing community resources, processing referrals and medication prior authorizations, ER/hospital follow-up, phone triage & urgent appointment needs, interdisciplinary team meetings, patient education, follow-up for chronic diagnosis, and additional needs as they arise.

The Care Team communicates directly with the providers as needed, while also working with medical, dental, and behavioral health internally. They continue to work in conjunction with outside care providers. The Team meets monthly with external care management and complex care management teams along with participating in community based initiatives to assist with care and resources for our patient population.

The referral process will come from a primary care provider after a visit and can also come from an internal specialist, behavioral health provider, or a dental provider. A referral can also be created after “pre-screening” for a new patient or an annual visit or from an incoming call to licensed staff (RN or LVN) indicating a higher need for continued assistance.

EVALUATE EFFECTIVENESS & NOMINAL CHARGES OF THE SLIDING FEE DISCOUNT PROGRAM – *Debbie Anderson, CFO*

- Flat rates were set in place back on 4/1/2021, which switched the sliding fee discounts from a percentage to a flat rate. This was done because it was easier on patients and staff to understand and calculate amounts due at each visit. No adjustments have been made since that time except to the amount charged for medical Slide A (the nominal amount) which went from \$10 to \$15 on 8/1/2022.
- CFO Anderson reviewed the HRSA rules, which state that the setting of a flat nominal charge would be nominal from the perspective of the patient and would not reflect the actual cost of the service being provided. With regards to services provided, it usually means a very small charge that is significantly lower than the actual value or cost of the service. The nominal charges can't recoup the actual cost of the service being provided and should be reviewed in conjunction with the type of service being provided. For example, \$200 being considered 'nominal' should be compared against the normal charges of the services being provided. \$200 for a normal bill of \$200 would not be considered nominal. However, \$200 against a normal charge of \$3,000 could be considered nominal. Context does matter.

- ONLY the Slide A gets set with a nominal charge. The other levels, Slide B-D, are at the discretion of the board. HRSA rules state that partial discounts are to be provided to individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG and no discounts are to be provided to individuals and families with annual incomes greater than 200 percent of the FPG.

The discussion needed from the CHC board is whether the nominal fees (if raised for Slide A) would be considered nominal and if Slide B-D fees were raised, would the new fees be appropriate for slides B-D. No fees have been raised (except Slide A medical) since April 2021; however costs have gone up significantly in that time.

Board Comments

Esther Watson asked what is the current federal poverty level?

Manager Sheri Tincher responded \$15,000 but it goes up depending on the amount of people in your household.

CFO Anderson directed the Board to page 44 in the board packet where it shows the federal poverty guidelines for 2026.

CEO Schmall informed the board that we also have payment plans in which the billing department can assist with setting up.

Cody Briggs stated that the increase is highly appropriate and because we haven't had an increase in 5 years he approves.

Jackie Todd commented that we have to stay solvent to hire doctors.

Gloria Cabrera asked if this included children also.

CFO Anderson stated that it does include children; the federal poverty level and sliding fee policy are based on the very distinct definitions of what constitutes a household.

MEDICAL

Medical billing varies significantly, and patients are used to a "co-pay" structure. The medical sliding fee incorporates that. Since the nominal fee was raised back on 8/1/22, staff is recommending increasing the other sliding fee levels by \$5. See Table 1.

Table 1

Medical Sliding Fee	Current	Increase	New
Slide A (0%-100% FPL)	15.00	-	15.00
Slide B (101%-150% FPL)	25.00	5.00	30.00
Slide C (151%-175% FPL)	50.00	5.00	55.00
Slide D (176%-200% FPL)	75.00	5.00	80.00

** All Imaging/Labs/Vaccines/ are included in the Office Visit Copay**

DENTAL

Dental is bit more complex. We currently have 3 sliding fees for dental because the charges for services vary quite a bit depending upon the type of service being done. Table 2 shows the current charges & table 3 shows the proposed charges.

Table 2 Current schedule of charges for dental

	Diagnostic and Preventative exams, cleanings, x-rays, sealants, SRP	Basic Restorative Services fillings, extractions, RCT	Major Services crowns, partials, dentures + lab fees**
Slide A	\$20	\$40	\$80
Slide B	\$40	\$60	\$100
Slide C	\$60	\$80	\$120
Slide D	\$80	\$100	\$140
Slide E/Full Fee	100%	100%	100%

** Lab fees are the responsibility of the patient. Lab fees are passed on to the patient at MBCHC's cost.

Table 3 proposed dental fees

	Diagnostic and Preventative exams, cleanings, x-rays, sealants, SRP	Basic Restorative Services fillings, extractions, adjustments, etc.	Major Services crowns, partials, dentures + lab fees**
Slide A	\$25	\$40	\$80
Slide B	\$50	\$70	\$135
Slide C	\$80	\$100	\$195
Slide D	\$105	\$140	\$265
Slide E/Full Fee	100%	100%	100%

** Lab fees are the responsibility of the patient. Lab fees are passed on to the patient at MBCHC's cost.

To help with this discussion, the average dental claim (by type) is presented below in Table 4, along with the current slide, the proposed increase to the slide amount, and the slide percentages of the average bill, both current and proposed.

Table 4 Slide A

Description	Avg Claim	Slide A Now	Proposed \$	Slide A New	Slide A % Now	Slide A % New
Diag/Prevent	261.54	20.00	5.00	25.00	7.65%	9.6%
Basic Restorative	343.05	40.00	-	40.00	11.66%	11.7%
Major Services	658.86	80.00	-	80.00	12.14%	12.1%

Table 4 Slide B

Description	Avg Claim	Slide B Now	Proposed \$	Slide B New	Slide B % Now	Slide B % New
Diag/Prevent	261.54	40.00	10.00	50.00	15.29%	19.1%
Basic Restorative	343.05	60.00	10.00	70.00	17.49%	20.4%
Major Services	658.86	100.00	35.00	135.00	15.18%	20.5%

Table 4 Slide C

Description	Avg Claim	Slide C Now	Proposed \$	Slide C New	Slide C % Now	Slide C % New
Diag/Prevent	261.54	60.00	20.00	80.00	22.94%	30.6%
Basic Restorative	343.05	80.00	20.00	100.00	23.32%	29.2%
Major Services	658.86	120.00	75.00	195.00	18.21%	29.6%

Table 4 Slide D

Description	Avg Claim	Slide D Now	Proposed \$	Slide D New	Slide D % Now	Slide D % New
Diag/Prevent	261.54	80.00	25.00	105.00	30.59%	40.1%
Basic Restorative	343.05	100.00	40.00	140.00	29.15%	40.8%
Major Services	658.86	140.00	125.00	265.00	21.25%	40.2%

Slide A is structured so the patient pays around 10%-12%. Slide B is structured so the patient pays around 20%. Slide C is structured so the patient pays around 30%. And Slide D is structured so the patient pays around 40%.

CFO Anderson is requesting that the board determines if the staff recommendation for increasing Slide Fee A – D is to be implemented and if Slide A fee amounts are considered nominal in relation to the service being provided and the normal fees that would be charged.

EVALUATE EFFECTIVENESS OF THE SLIDING FEE DISCOUNT PROGRAM – UTILIZATION OF THE PROGRAM

It is the Board’s authority to determine if the SFDP is effective in eliminating barriers to care for our population. Table 5 shows various metrics about the uninsured population and the utilization of the Sliding Fee program by the uninsured population from calendar year 2022 – calendar year 2025.

Table 5

Description	2025 UDS	Uninsured	SSF	No Slide	% SSF to Uninsured
1. 100% AND BELOW	2,957.00	60.00	47.00	13.00	78.3%
2. 101% - 150%	1,453.00	47.00	39.00	8.00	83.0%
3. 151% - 200%	988.00	24.00	24.00	-	100.0%
4. Over 200%	1,664.00	23.00	-	23.00	
5. Unknown	2,159.00	16.00	-	16.00	
	9,221.00	170.00	110.00	60.00	84.0%
\$ of SF writeoffs for 2025			176,552.89		
Average SSF per patient			1,605.03		
Uninsured % to Total Population		1.84%			

Description	2024 UDS	Uninsured	SSF	No Slide	% SSF to Uninsured
1. 100% AND BELOW	3,445.00	81.00	50.00	31.00	61.7%
2. 101% - 150%	930.00	50.00	37.00	13.00	74.0%
3. 151% - 200%	640.00	37.00	27.00	10.00	73.0%
4. Over 200%	1,105.00	25.00	-	25.00	
5. Unknown	2,680.00	38.00	-	38.00	
	8,800.00	231.00	114.00	117.00	67.9%
\$ of SF writeoffs for 2025			142,115.03		
Average SSF per patient			1,246.62		
Uninsured % to Total Population		2.63%			

4/1/23 meet with reg specialist	2023 UDS	Uninsured	SSF	No Slide	% SSF to Uninsured
1. 100% AND BELOW	4,851.00	130.00	86.00	44.00	66.2%
2. 101% - 150%	780.00	53.00	50.00	3.00	94.3%
3. 151% - 200%	509.00	46.00	40.00	6.00	87.0%
4. Over 200%	775.00	26.00		26.00	
5. Unknown	1,557.00	25.00		25.00	
	8,472.00	280.00	176.00	104.00	76.9%
\$ of SF writeoffs for 2025			218,845.36		
Average SSF per patient			1,243.44		
Uninsured % to Total Population		3.31%			

4/1/22 started backup for income	2022 UDS	Uninsured	SSF	No Slide	% SSF to Uninsured
1. 100% AND BELOW	5,096.00	217.00	177.00	40.00	81.6%
2. 101% - 150%	778.00	113.00	112.00	1.00	99.1%
3. 151% - 200%	509.00	69.00	64.00	5.00	92.8%
4. Over 200%	663.00	58.00		58.00	
5. Unknown	1,672.00	46.00		46.00	
	8,718.00	503.00	353.00	150.00	88.5%
\$ of SF writeoffs for 2025			441,516.57		
Average SSF per patient			1,250.76		
Uninsured % to Total Population		5.77%			

Every year the percentage of uninsured patients to total insured patients has decreased. The average sliding fee discount per patient has generally remained the same for 2022-2024 and then it jumped in 2025. It appears that patients are increasing the utilization of the sliding fee program with repeat visits (visit are usually between \$200-\$400).

The percentage of uninsured patients utilizing the sliding fee program has trended downward as we updated the sliding fee program in 2022 & 2023, however, now it appears to be rebounding and the numbers are increasing again.

We are doing well at identifying those patients that are uninsured and then working with them to get them on Medi-Cal.

In conclusion, staff has determined that the SSF program is helping to reduce the barriers to care, both in being utilized and by the uninsured population and in identifying those patients not on insurance.

Board Comments

Cody Briggs asked to explain the ratio on how we are getting at 84% utilization.

CFO Anderson replied that we have 170 uninsured of the 170, a 110 are on the sliding fee and you take the 110 and divide by 170, this is the 84%.

Esther Watson asked what happened in 2022 where the sliding fee was used so often.

CFO Anderson explained that there were a couple of changes made to the program, including requiring verification of income .

Esther Watson commented that with the changes occurring the Care Team that a lot more people will know about the program. She feels people are doing a good job and the numbers are up.

Marc Greenhouse commented that with the changes to the federal programs there will be a lot more uninsured.

CFO Anderson replied that it is definitely a consideration. These numbers will probably go up this next year because HRSA gives us \$1.5 million, and this amount has not increased for many years despite growing costs. We have brought the uninsured population numbers down, and we do have room in the system to absorb legitimate people who need to go onto the sliding fee program.

Marc Greenhouse stated that both Medicare and Medical is going to be affected as well.

CFO Anderson responded that anyone who comes off of insurance can go on the sliding fee program.

Motion 26-150: MSC (Briggs/Greenhouse) 7/0/2 motion to approve the updated Sliding Fee Discount Program Evaluation as presented.

POLICY NO. CHC-FS-213 – SLIDING FEE DISCOUNT PROGRAM –
Debbie Anderson, CFO

CFO Anderson began with a summary of the changes proposed to the Sliding Fee Discount Program as a new sliding fee year begins on 4/1/2026:

- **Those who attest to living off savings will need to redo their SSF application after 3 months. The thought process is most folks don't have more than that in savings. And if they do, it's likely they don't need SSF. So this will ensure that we are re-evaluating patient income as it changes, which keeps us aligned with HRSA requirements.**
- **Household member is being expanded to include someone who supports the household at 50% or more, but may not live in the household. For example, if a child lives in a second residence owned by the parent, and the adult child states he/she doesn't work, it's likely the parent is supporting that adult child (even though the child doesn't live with said parent). The new definition would require the parent's income to be included in the household income calculation. This helps keep the integrity of the program intact by excluding those "households" that are being supported by someone not included in the calculation and thus inadvertently lowering the household income.**
- **The roommate agreement needs to be legally enforceable. A written or scrawled note will not suffice as a roommate agreement. A legal agreement delineates such things as lease amounts, lease terms, what is being rented, renewals, Occupancy rules, late charge rules, holdovers, sub-leasing, security deposits, improvements to property, condition upon surrender, inspection by landlord, and a multitude of other items.**
- **Language has been added for when we can deny sliding fee. In particular, if a person is on a Medi-Cal managed plan, Medi-Cal state requirement mandate that patient go to their Primary Care Physician (PC) and/or Dentist. Because this is a legal requirement, a person cannot use the SSF program to get around going to their PCP.**
- **SSF Fees are being recommended to be raised. Now please understand this is a recommendation but it is up to this board as to whether these fees are approved or not. This is to be discussed in the evaluating the effectiveness of the sliding fee program, but the policy has been updated for the recommendation. If the board changes the recommendation, this of course will be reflected.**

CFO Anderson informed the board that technically we only look at income, not assets for the sliding fee. If a person is living off of their savings, we would look at the interest earned off of the savings not the savings itself. Several discussions followed pertaining to the "50% support or more".

Motion 26-151: By a show of hands: 5 in favor/2 no/2 absent, motion to approve Policy No. FS-213 as presented passed.

FEE SCHEDULE AND METHODOLOGY – *Debbie Anderson, CFO*

CFO Anderson explained in detail the fee schedule and the methodology behind it to the CHC board. CEO Schmall reiterated that they would be approving two items via vote, the methodology and the actual fee schedule itself.

Motion 26-152: MSC (Briggs/Cabreras) 7/0/2 motion to approve the updated Sliding Fee Discount Program Evaluation as presented.

POLICY NO. CHC-FS-211 – FEE SCHEDULE – *Debbie Anderson, CFO*

CFO Anderson explained that there aren't a lot of changes to the policy. However, on the last page only certain designated individuals can update the Chargemaster. The CFO is the designated individual to update the Chargemaster. If the CFO is absent then the CEO or the Chief Patient Experience Compliance Officer may do so.

Motion 26-153: MSC (Briggs/Watson) 7/0/2 motion to approve the updated Policy No. CHC-FS-211 Fee Schedule as presented.

JANUARY 2026 FINANCIAL REPORT – *Debbie Anderson, CFO*

O ERVIEW

The clinic financials for the month of January show income of \$357,393 and year to date shows income of \$571,953. (See Table 2 & 3)

The fiscal year 24-25 audit has concluded and we have final numbers for the year. Table 1 shows the previously recorded change in net position that was presented to the board last July, along with the additional entries made that bring the net position to what is recorded in the audited financial statements.

Table 1

Description	Clinic
Previously reported change in net position	635,611
New GAAP Pronouncement Accrue Expected Sick Use	(51,144)
New GAAP Pronouncement Accrued Expected taxes on PTO & Sick Leave	(19,854)
Late Accounts Payable Entry that needed to be accrued	(506)
Allocations for the above entries	(45,981)
Adjust Cost Report Liability FY 21-22 NPI 1649708611 Pymt Rec	(14,885)
RVS Estimated contractals June (so we can updated for latest info)	685,915
Enter additional June Revenue & real contractals through June 30th	69,579
Enter Subsequent Patient Activity for June 2025 (Revenue & Contractals)	(576,222)
Enter June 2025 FINAL estimated CA, SSF & Bad Debt	(110,479)
Adjust Cost Report Liability FY 24-25	(227,950)
Adjust Cost Report Liability FY 24-25	(40,327)
	<u>(331,855)</u>
Final Net Position for FY 24-25	<u>303,756</u>

The biggest adjustments were for the patient revenue activity (which we go back and look at in September) and then the cost report liabilities. Since the cost reports were completed prior to the audit being done, we were able to use real numbers instead of estimates. As a reminder, net position for the Clinics had PPS adjustments recognized for year, which helped give the clinics a positive net position.

CLINIC CHANGE IN NET POSITION

Table 2 Clinics January 2026

Clinics	Actual Mth	Budget Mth	Over/(Under)	% of Budget
Patient services (net)	741,898	634,474	107,425	16.93%
Grant Revenue	454,460	127,742	326,718	255.76%
340B Revenue	38,890	28,521	10,369	36.36%
Capitation Fees	182,650	180,832	1,818	1.01%
Records & Interest	138	146	(8)	-5.73%
Cost Report Adjustments	(136,945)	(137,360)	416	0.30%
Quality	73,286	21,042	52,244	248.29%
Other/Misc	20,000	-	20,000	100.00%
	1,374,377	855,396	518,981	60.67%
Salaries - Clinic	474,314	511,976	37,662	7.36%
Fringe - Clinic	96,318	113,350	17,031	15.03%
Phys Fees - Clinic	89,220	69,765	(19,455)	-27.89%
Purchases Services - Clinic	67,018	62,458	(4,559)	-7.30%
IT, Network & Phones - Clinic	26,789	24,459	(2,330)	-9.52%
Supplies - Clinic	40,746	31,519	(9,227)	-29.27%
Supplies - 340B	30,317	24,155	(6,162)	-25.51%
R&M - Clinic	8,360	6,404	(1,956)	-30.54%
Leases/Rentals - Clinic	200	142	(58)	-41.18%
Utilities - Clinic	6,942	6,254	(688)	-11.00%
Ins - Clinic	287	302	14	4.75%
Other - Clinic	6,634	7,654	1,021	13.34%
Depreciation	16,045	18,792	2,747	14.62%
	863,190	877,230	14,040	1.60%
Operating Income/(Loss) before Allocation	511,188	(21,834)	533,021	2441.26%
Allocation of Overhead for Health Centers	(153,794)	(177,457)	23,662	13.33%
Change in Net Position	357,393	(199,290)	556,684	279.33%

Table 3 Clinics Year to Date

Clinics	Actual YTD	Budget YTD	Over/(Under)	% of Budget
Patient services (net)	4,972,456	4,471,529	500,927	11.20%
Grant Revenue	1,533,263	919,723	613,541	66.71%
340B Revenue	306,559	201,006	105,553	52.51%
Capitation Fees	1,288,839	1,265,823	23,016	1.82%
Records & Interest	1,378	1,030	347	33.73%
Cost Report Adjustments	(961,108)	(961,524)	416	0.04%
Quality	539,409	147,292	392,117	266.22%
Other/Misc	45,000	-	45,000	100.00%
	7,725,796	6,044,878	1,680,918	27.81%

Table 3 (continued)

Clinics	Actual YTD	Budget YTD	Over/(Under)	% of Budget
Salaries - Clinic	3,310,625	3,583,828	273,203	7.62%
Fringe - Clinic	724,212	801,368	77,156	9.63%
Phys Fees - Clinic	601,885	491,676	(110,209)	-22.41%
Purchases Services - Clinic	437,088	432,149	(4,939)	-1.14%
IT, Network & Phones - Clinic	158,311	171,216	12,906	7.54%
Supplies - Clinic	332,564	222,137	(110,427)	-49.71%
Supplies - 340B	212,174	169,929	(42,246)	-24.86%
R&M - Clinic	82,903	44,931	(37,972)	-84.51%
Leases/Rentals - Clinic	800	992	192	19.33%
Utilities - Clinic	55,039	52,591	(2,448)	-4.65%
Ins - Clinic	2,011	2,112	100	4.75%
Other - Clinic	68,511	53,810	(14,701)	-27.32%
Depreciation	124,569	131,540	6,972	5.30%
	6,110,693	6,158,280	47,587	0.77%
Operating Income/(Loss) before Allocation	1,615,103	(113,402)	1,728,505	1524.23%
Allocation of Overhead for Health Centers	(1,043,718)	(1,250,646)	206,928	16.55%
Operating Income/(Loss) after Allocation	571,385	(1,364,048)	1,935,433	141.89%
Non-Operating	568	-	568	-100.00%
	568	-	568	-100.00%
Change in Net Position	571,953	(1,364,048)	1,936,001	141.93%

Grant revenue variance is due to spending for the ARP capital and HIV grant that was not budgeted (the supplies – clinic line is also higher because some of the expenses for this grant spending is in this line). 340B revenue is higher because we anticipated a trend of more restrictions on the program for the budget period. Quality is higher because we anticipated cuts to quality because the cuts will take another year before they are realized. Other/Misc revenue variance is due to grant monies for the MAT program. Physician fees are higher due to increased services being done by all providers. 340B supplies expense is higher due to drug manufacturer restrictions. R&M is higher than budgeted due to clinics replacing some windows at the various buildings, which individually don't meet the criteria for capitalization.

Chart A – Visits History Chart

Month	FY 18-19	FY 19-20	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25	FY 25-26
Jul	2,942	3,283	3,091	2,877	2,670	2,758	3,030	3,467
Aug	3,766	3,587	3,015	3,425	3,315	3,195	2,975	3,099
Sep	3,043	3,501	3,065	3,134	3,256	2,593	3,041	3,346
Oct	3,551	3,892	3,264	3,282	3,071	3,027	3,697	3,296
Nov	3,229	3,353	2,627	3,116	2,936	2,928	2,952	2,595
Dec	2,858	3,304	2,976	2,705	2,881	2,556	3,027	3,000
Jan	3,698	4,010	2,921	2,925	3,001	3,226	3,316	3,210
Feb	3,198	3,763	3,190	3,068	2,882	2,980	3,303	-
Mar	3,515	2,927	3,516	3,332	3,33	3,032	3,338	-
Apr	3,660	2,066	3,460	3,094	2,896	3,016	3,648	-
May	3,662	2,200	3,043	3,239	3,247	3,143	3,564	-
Jun	3,344	2,786	3,082	3,218	2,939	2,652	3,275	-
Total	40,466	38,672	37,250	37,415	36,425	35,106	39,166	22,013
Total YTD	23,087	24,930	20,959	21,464	21,130	20,283	22,038	22,013

Motion 26-154: MSC (Watson/Briggs) 7/0/2 motion to approve the January 2026 Financial report as presented.

CEO REPORT – Cindy Schmall, CEO

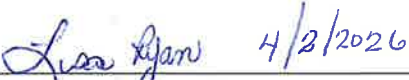
- We are still awaiting completion of the Split Rock project by Southern California Edison (SCE). Additionally, we have a Western Joshua Tree on the site and part of the requirements from City of 29 Palms include the installation of a bicycle lane that would run directly to the tree which is now protected.
- Remodeling of the BH department and Yucca Valley Adults has begun. These are capital projects of the District and will result in better patient flow and revitalized space.
- We are still looking for a full time nurse practitioner and a full time MD.
- We have a new HRSA representative and Tricia Gehrlein, Debbie Anderson and myself met with him recently.
- We have filled a full-time LCSW and NP role, both will start next week.

CALENDAR REVIEW – Cindy Schmall, CEO

CEO Schmall reviewed the calendars with the board members, discussing the upcoming events and talks.

BOARD MEMBER COMMENTS – None

ADJOURN MEETING – Meeting adjourned at 6:05 p.m.

 4/2/2026

Lisa Ryan, Secretary