



REDWOOD COAST MEDICAL SERVICES, INC
BOARD OF DIRECTORS - MEETING AGENDA
In person: Elaine Jacob Center | Online: Zoom
April 29, 2026 5:00 PM – 7:00 PM

Business Item	Person	Vote(s) Required	Page #
AGENDA & MINUTES <ul style="list-style-type: none"> Review and vote on acceptance of Meeting Agenda and the Minutes of March 25, 2026 	Leslie Bates	Vote	Page 1-4
OPERATIONS & HUMAN RESOURCES REPORT <ul style="list-style-type: none"> Update 	Laura Curtis		Page 5
MEDICAL TEAM REPORT <ul style="list-style-type: none"> Update 	Kalev Golubjatnikov		
DEVELOPMENT, GRANTS, OUTREACH & RISK/COMPLIANCE REPORT <ul style="list-style-type: none"> Updates grant, outreach, and Risk Compliance activities Review updated Medication Refill Policy and vote on acceptance Board Training: HRSA Compliance Ch. 19 & 20 	Dawn McQuarrie	Vote	Page 6-36
COMMUNICATIONS COMMITTEE REPORT <ul style="list-style-type: none"> Updates 	Hall Kelley (Ext.)		
CEO REPORT <ul style="list-style-type: none"> Organizational Update 	Linda Royal		
CAPITAL CAMPAIGN COMMITTEE REPORT <ul style="list-style-type: none"> Update 	Jim Nybakken Kimberley Lakes		
FINANCE COMMITTEE REPORT <ul style="list-style-type: none"> Report on March Financials Vote on acceptance of the March Financials 	Drew McCalley	Vote	Page 37-50
MENDONOMA HEALTH ALLIANCE REPORT <ul style="list-style-type: none"> Update 	Janis Dolphin		
EXECUTIVE COMMITTEE REPORT <ul style="list-style-type: none"> Update 	Leslie Bates		
PUBLIC COMMENT/SHOUT OUTS	Leslie Bates		

BOARD CLOSED SESSION

The mission of Redwood Coast Medical Services (RCMS) is to provide high quality, family-oriented, community based medical care, dental care and behavioral health services, including a broad range of preventive health services to residents and visitors within the coastal areas of Southern Mendocino and Northern Sonoma Counties. Services are designed to meet identified needs of the communities served, are integrated with other existing health care services and systems and are evaluated on a regular basis to assure that community health needs are being met. As a non-profit corporation receiving public funds, RCMS provides services to qualifying individuals on a sliding fee scale as well as to patients with MediCal and MediCare coverage, private insurance or self pay status. RCMS plays a special role as the sole provider of medical care in the community and in responding to public health emergencies.



Redwood Coast Medical Services, Inc.
 Board of Directors Meeting – Zoom Online Meeting
Meeting Minutes of March 25, 2026

BOARD MEMBER	P	A/E	BOARD MEMBER	P	A/E
Leslie Bates	X		Drew McCalley	X	
Janis Dolphin	X		Jim Nybakken	X	
Susan Hamlin	X		Andrea Polk		X
Hall Kelley	X		Laurie Voss	X	
Kimberley Lakes		X	Harriet Wright	X	
Patricia Lynch	X				

STAFF PRESENT	
Linda Royal	
Tom Bertolli	
Laura Curtis	
Dawn McQuarrie	
Karen Wilder	

Public Attendees: 1

CALL TO ORDER: Leslie Bates called the meeting to order at 5:00 pm.

APPROVAL OF AGENDA AND MINUTES: After review and minor correction, Susan Hamlin moved to accept the agenda and the minutes of February 25, 2026. Seconded: McCalley. Vote: Unanimously accepted.

DEVELOPMENT, GRANTS, OUTREACH, AND RISK/COMPLIANCE REPORT: Dawn McQuarrie, Programs Manager

- The annual Uniform Data System (UDS) report was accepted on March 10.
- The annual Federal Torts Claims Act (FTCA) reapplication is opened February 27 and continuing to compile everything needed well ahead of the June deadline.
- Continuing to apply for other grant opportunities as appropriate and attending all grant meetings.
- Continuing to work on the Risk Management report to present next month.
- Reviewed the Patient Origin graph from the recent UDS report looking at patient populations by zip code. Discussed possibility of reviewing the same information from Mendonoma Health Alliance.

Board Training: Ch.9 Sliding Fee Discount Program:

- RCMS maintains a Sliding Fee Discount Program to ensure that no patient is denied services due to inability to pay, with fees adjusted based on income and family size in accordance with Federal Poverty Guidelines.
- The program is governed by board-approved policies and includes standardized processes for determining eligibility, applying discounts, and informing patients of available financial assistance.
- RCMS regularly evaluates the effectiveness of the program to ensure it reduces financial barriers to care and supports access for all patients.

HUMAN RESOURCES COMMITTEE REPORT: Laura Curtis, Director of Operations & Human Resources

- Busy with recruitment and getting ready to interview two provider candidates. Both Family Nurse Practitioners, one with more ER experience, and one with more experience with children and families.
- The Medical Assistant Coordinators (MAC) team has been fully staffed. The team will be helping care teams identify preventative measures and other care initiatives appropriate for that patient ahead of their visit.
- Front Desk will now be referred to as the Patient Services Team and will be training to increase their scope and work in conjunctions with the other teams (such as knowing the why behind the Sliding Fee form, etc.). The Patient Services Team is also working closely with the Billing Manager to better understand how to enter payors and other details helping to improve the internal billing processes.
- Marla Rutledge, RN has been hired as a Refill Nurse.
- Jennifer Black has officially started into her role as the Director of Clinical Operations.
- Jennifer Paige, FNP is doing great, connecting with teams and patients, and will be on through May.
- First Year turnover rate went down by 10% - doing good with hiring and onboarding.
- Health Information Team is starting to work on converting all paper files to digital if they need to be converted.

MEDICAL TEAM REPORT: Tom Bertolli, Interim CMO

- Addressed the concerns about all of the change in the organization and that it is unsettling for some staff.
- Discussed the possibility of creating more space in Point Arena so that another provider can join the team.

COMMUNICATIONS COMMITTEE REPORT: Hall Kelley, External Committee

- Hall Kelley reported on the actions of the external communications committee:
 - Thank you Linda for helping to create a budget for committee projects.
 - Barbara Brittell's contribution is much appreciated.

MAXWELL IT PRESENTATION: Mary Ledbury V-CIO

- Provided a background on Maxwell IT – started in 2005 helping people transition from paper to digital.
- Exclusive NextGen Support for MCC since 2013 transitioning into full IT support since then.
- Full IT support includes hardware and software.
- Helped RCMS to purchase servers at a discounted cost.
- Helping to review and enhance technology workflows.
- Improve speed so that technology can move in tandem with the improved workflows.
- Working on how to make paying bills online possible for patients.
- Overall working to get people, processes and technology working together.
- Discussed monthly training for cyber security as well as developing policies and procedures to protect RCMS.
- Discussed transition from Zoom to Teams.

CEO REPORT: Linda Royal, CEO

- The Leadership Team has formed and meeting every other week. Tying a lot of the different team projects back to the overall strategic plan.
- The collaboration happening amongst the new clinical teams has been going well.
- Working on the facilities – general clean-up going through paper medical and accounting records.
- Continuing to streamline operations in the clinic.
- Next all staff meeting coming up in April.
- Managers will be intimately involved in the budget development process.
- Pleased with the recruitment firm candidates and being involved in the provider recruitment process.

CAPITAL CAMPAIGN COMMITTEE REPORT: Jim Nybakken, Committee Chair

- Facility Modernization Project:
 - Continuing planning with the California Coastal Commission and with the California Department of Fish and Wildlife for approvals on proposed parking lot expansion and modernization project.
 - Further studies will be required to move forward and should be completed within 6-8 weeks.
- Solar & Battery Backup Program:
 - Finalizing glare and flight path studies before moving forward with installation and design plans.
 - Permit review process will delay project completion to December 2026.
- Capital Campaign Committee:
 - Thank you Patricia Lynch for joining the group.
 - Donor profiles are being completed.
 - Meeting with Campaign Consultants in April and will be reviewing their role going forward.

FINANCE COMMITTEE REPORT: Drew McCalley, Treasurer

- RCMS remains in a strong financial position, despite patient service visits trailing budget estimates.
- The Committee expressed appreciation for the level of detail and analysis the CEO is bringing to the budget development process.
- Early results of cost-containment efforts are being observed through reduced expenses.
- The CEO is exploring options to re-establish an on-site pharmacy to strengthen 340B revenue.



- Balance sheet ratios remain on track, meeting or exceeding benchmark goals.
- Patient visits are trending upward and were close to budget projections, despite current provider shortages.
- The CEO is conducting a detailed review of all budget line items to ensure accuracy and necessity.
- Loan funds for the solar project have been received and are reflected as restricted cash and long-term debt.
- Elisabeth Watson was appointed to the Finance Committee.

Recommendation to Adopt February 2026 Financials

On behalf of the Finance Committee, Drew McCalley made the recommendation for the Board to accept the February 2026 financial statements as presented.

Motion: Nybakken Second: Bates

Vote: Motion passed unanimously.

Recommendation to Appoint Finance Committee Member

On behalf of the Finance Committee, Drew McCalley made the recommendation for the Board to accept the appointment of Elisabeth Watson to the RCMS Finance Committee.

Motion: Bates Second: Nybakken

Vote: Motion passed unanimously.

AUDIT COMMITTEE REPORT: Drew McCalley

- The annual audit was clean with no findings.
- Will go out to the board for email approval.

MENDONOMA HEALTH ALLIANCE REPORT: Janis Dolphin, MHA Board Member

- Mobile Clinic operating on the same schedule: Manchester - Tues & Thurs and Point Arena - Mon.
- Hired a new Primary Care Provider, Stephanie Hsieh with a background in street medicine.
- Continuing to see Medi-Cal patients over 19 years old, assigned by Partnership Health Plan.
- Continuing to provide women’s health care and medication assisted treatment support.
- Enhanced Care Management enrollment at MHA has increased to 88 clients.
- Starting a new Healthy Living with Chronic Conditions course in spring.
- Very active in addiction support services.
- Working on inhouse anti-stigma video to use in outreach.
- Narcan distribution quote from a grateful client –thanks for saving lives.

EXECUTIVE COMMITTEE REPORT: Leslie Bates, Board Chair

- Report on the topics that were discussed in the Closed Session meeting:
 - Authorized Linda Royal CEO, to further research the expansion of existing facilities.

Recommendation to Adopt Report of the 02/25/2026 Closed Session Meeting

On behalf of the Executive Committee, Patricia Lynch made the recommendation for the Board to accept the Minutes of the February 25, 2026 Closed Session as presented.

Motion: Lynch Second: Hamlin

Vote: Motion passed unanimously.

PUBLIC COMMENT/SHOUT OUTS:

- Susan Hamlin: Thank you, Marla Rutledge who I saw as a patient last week, she was kind and very professional.... Seconded by Janis Dolphin.
- Susan Hamlin: Thank you Ina and the other team member who made my visit very pleasant.

Meeting adjourned at 6:48 PM.

Ops & HR Report – March 2026

Prepared by: Laura Curtis, Director of Operations and Human Resources

Recruitment

Open Positions:

Primary Care MD/DO | Urgent Care MD/DO | APP | Charge Nurse (RN) |
Urgent Care RN | Environmental Services | Home Health RN | MA

- We have two more provider site visits scheduled to happen in June.

Workforce

- Welcomed to our new Patient Services Representative (PSR- Front Desk) Ksyteen Terlouw.
- We extended an offer to one of the FNP candidates we did a site visit with.
- We are in discussion with a past RCMS provider to come in to do a temporary assignment to fill over the summer.
- Launched the “Employee Hub” on the shared drive – a centralized resource for employee information, including benefits materials, Paylocity guidance, and the employee handbook.

Turnover Trends and Retention Goals

- First Year Turn Over: 22.2% (April 2025 –March 2026 timeframe) Turnover increased by 5.54 percentage points month-over-month.
- Overall Turnover: 21.8%, up 4 percentage points from last month

Compliance

- Our lab has it’s every 2 year COLA inspection upcoming on May 7

Operations

- Launched Patient Services training to support consistency and help staff work at the top of their roles.
- In the demo phase for a few platforms and tools to make front-end processes more seamless for both patients and staff.
- Enhanced our existing Third Thursday training by incorporating a 30-minute agency-wide update segment to strengthen communication, alignment, and organizational awareness.

Anniversaries:

Teresa Heinzelman 14 years | Dr. Thomas Lowell 12 years | Edith Ochoa 10 years | Joyce Holloway 6 years | Celeste Carbajal 5 years | Molly Behrens 2 years | Hayley Murphy 1 year

Grants, Development, Outreach, and Compliance Report

April 29, 2026

Grants/Funding

- Uniform Data Systems report finalized April 24
- Federal Torts Claim Act (FTCA) – opened February 27 – in process
- Looking at potential grants
- Attended meetings for all grants

Marketing

- We are leveraging print media, social media, flyers, radio, TV monitors, and The Pulse
- We respond to all messages received via Facebook and website

Surveys

- None to report

Compliance

- Continuing to update and streamline PnPs
- Attending meeting and trainings

Risk Management

- None to report

Other/Policies and Procedures

- Medication Refill

Board Training

Chapter 19: Board Authority

Chapter 20: Board Composition



Medication Refill Policy and Procedure

Department	Clinic	First Approval Date	February 4, 2016
Scope	Entire Clinic	Previous Approval Date	November 13, 2017
BoD Adoption Date		Committee Approval Date	April 16, 2026-QI
Next Review Date		Date(s) Announced to Staff	

Purpose / Policy	It is the policy of RCMS to allow qualified Registered Nurse (RN) or Licensed Vocational Nurse (LVN) to refill non-controlled substance medications under the authority of standardized procedure (Business and Professional Code, Nursing Practice Act Section 2725 and California Code of Regulation (CCR) 1480).
Mandated by	
Definitions	<p>A. Provider order</p> <ol style="list-style-type: none"> a. Verbal order is an order spoken by the provider directly to the RN or L VN. Must be documented in "Telephone Call" template. Refill nurse should then send a task to the ordering provider to send the new prescription for the first time. b. Written order may be found in telephone call template. <p>B. New Medication</p> <ol style="list-style-type: none"> a. A new medication is defined as any medication the patient has not been on previously or for a period greater than a year or a medication that has been previously prescribed by a provider outside of Redwood Coast Medical Services. <p>C. Controlled Substance</p> <ol style="list-style-type: none"> a. Section 812 of the Controlled Substances Act (CSA) (21 U.S.C. §801 et seq.) CSA lists substances which were controlled in 1970 when the CSA was enacted. The current list of controlled substances can be found in section 1308 of the most recent issue of Title 21 Code of Federal Regulations (CFR) Part 1300 to end (21 CFR §1308) and the final rules which were published in the Federal Register subsequent to the issuance of the CFR.
Attachments / References	<p>ATTACHMENT Medication Category List and Guidelines</p> <p>RESOURCES Board of Pharmacy Laws http://www.pharmacy.ca.gov/laws_regs/ http://www.pharmacy.ca.gov http://pharmacy.ca.gov/licensees/curres.shtml</p> <p>http://medscape.com/viewarticle/587412</p> <p>Board of Registered Nursing</p>

Business and professional practice code 2725
Calif 1443.5 Standards of Competent practice

National Patient Safety Goals

Heep://www.mass.edu/mcncps/orientation/m2NatlPatientSafety.asp

PROCEDURES

- A. Functions the RN or LVN may perform:
- a. Review medication refill requests in fax folder, EMR inbox and on voicemail, checking voicemails received every 2-3 hours.
 - b. Substitute medication within same classification of drug after confirming equivalent dosage with the Provider. Document in the patient's medication module and on a telephone communication note the reason for the substitution (e.g. insurance formulary change) and the approval by the provider of the change.
 - c. Advise patient and provider need for appropriate laboratory tests using the Medication Category List and Guidelines.
Document in the patient's chart any verbal order from the provider using the telephone template and send task to the provider to verify the order prior to sending the new prescription.
- B. Circumstances under which RN or LVN may perform function:
- a. The refill RN or LVN may work remotely or at RCMS.
 - b. The refill nurse may operate independently within the constraints and criteria of this policy.
 - c. The refill nurse must consult the Medication Category List and Guidelines regarding parameters and requirements for the next refill.
 - d. Patient requesting medication refill must be a patient of RCMS and with previous history of taking the medication.
- C. Other
- a. The refill nurse must always consider the immediate risk to the patient of an abrupt cessation of medication such as asthma, hypertension, or diabetes medications.
 - b. The refill nurse considers the patient's condition, other medications prescribed, laboratory tests completed or needed, and other factors including, but not limited to, recent urgent care appointments, hospitalizations, and past clinical appointments which may influence a decision to refill or not refill a particular medication.
 - c. If refill criteria for laboratory test, provider visits, and/or clinical considerations are not met, the RN or LVN must consider the implications of stopping the medication. If deemed at risk to patient to stop taking the medication, the refill nurse will facilitate scheduling the patient to be seen with the Patient Service Representatives, and send a refill of the medication adequate to prevent the patient running out of medication prior to the scheduled appointment with the provider.
 - d. Special considerations for early refill due to vacations, or gaps caused by mail order pharmacy shipping delay will be addressed under this protocol if a patient is unable to resolve the issue with their pharmacy directly. There must be documentation in the patient's chart under medication module and/or a telephone template to explain the early fill or emergency override
 - e. All controlled substances requests must be tasked to the provider except in situations where the provider will require that the patient be seen in person. In this case, the refill nurse again facilitates appointment scheduling for the patient with the Patient Service Representatives.

- f. Any new prescription must be entered to medication module by utilizing the “Prescribe New” function. A telephone note should then be sent to the primary care provider of the patient asking that they review the new medication and then send it to the pharmacy for the first fill. Subsequent refills can then be sent by the refill nurse independently provided the requirements for medication refill have been satisfied. This process should be followed when the patient asks that his/her provider at RCMS assumes prescribing of a medication previously sent for them by one of their providers/specialists outside of RCMS.

Nursing Practice

- A. Subjective information will include but is not limited to:
 - a. Relevant health history reported by the patient or documented in the medical record
 - b. Patient reports of possible side effects
- B. Objective information will include but is not limited to:
 - a. Laboratory reports
 - b. Documentation of prescriptions in the medical record
 - c. Patient visit history at RCMS
 - d. Appointments for future visits

Record keeping

- A. Any changes in patient's medications, any communication by the RN or L VN to patient/family, pharmacist, and/or provider, patient/family education and other relevant information shall be documented in the patient's chart as a telephone note.

Requirements for Registered Nurse (RN) or Licensed Vocational Nurse (LVN)

- A. RN or LVN must have a California license and be in good standing with the respective Board.
- B. Training
 - a. The RN or LVN must be trained by a staff member experienced in medication refills following policy and procedure.
 - b. The RN or LVN must be fully trained in the use of the EMR.
 - c. Competence must be assessed annually.
- C. Experience
 - a. A minimum of six months experience as an RN or LVN is required.

Development and Approval of the Standardized Procedure

- A. The procedure must be reviewed annually by refill RN or LVN and providers and will be submitted for review and approval to Quality Improvement Committee (QI).

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
Alcohol Deterrent <ul style="list-style-type: none"> • Campral-Acamprosate calcium 		Within 12 months	None	None
Analgesic <ul style="list-style-type: none"> • Acetaminophen (Tylenol) 		Within 12 months	None	None
Anti-Alzheimer <ul style="list-style-type: none"> • Donepezil hydrochloride (Aricept) • Memantine hydrochloride (Namenda) 		Within 12 months	None	None
Antianginals Nitrates <ul style="list-style-type: none"> • Isosorbide dinitrate • Isosorbide mononitrate • Nitroglycerin 		Within 12 months	None	None
Antiarrhythmics <ul style="list-style-type: none"> • Amiodarone Hydrochloride (Cardarone, Pacerone) • Sotalol Hydrochloride (Betapace) 	Sotalol-nonselective beta blocker	Amiodarone- within 6 months Sotalol-within 12 months	Amiodarone- none Sotalol-BMP- annually	Amiodarone-Manufacturer recommends chest x-ray and pulmonary function test every 6 months; ophthalmic exams annually Average BP should be 135-80 or below for diabetics, 140/90 or below for all others; otherwise should see clinician within 2 months of refill
Antiasthmatic/COPD/Respiratory allergies PO Meds <ul style="list-style-type: none"> • Accolate • Montelukast sodium (singular) 	See also antihistamines	Within 12 months	None- exceptions see below	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<ul style="list-style-type: none"> • Theophylline preparations <p>Inhalers</p> <ul style="list-style-type: none"> • Advair • Albuterol (Proventil, Ventolin, Proair) • Budesonide (Pulmicort) • Combivent (ipratropium bromide + Albuterol) • Levalbuterol (Xopenex) • Nasonex • QVAR • Tiotropium bromide (Spiriva) <p>Spacers for inhaled medications</p>	<p>Corticosteroid</p> <p>Corticosteroid</p> <p>Corticosteroid</p>		<p>Theophylline level within 6 months for age 13 and under; within 12 months for age 14 and up</p>	
<p>Anticoagulant</p> <ul style="list-style-type: none"> • Coumadin 			<p>Coumadin- updated PT/INR log in chart</p>	<p>Coumadin-RN only under separate standardized procedure</p>
<p>Antiplatelet</p> <ul style="list-style-type: none"> • Aspirin • Eliquis (Apixaban) • Plavix (Clopidogrel Bisulfate) • Ticlid 		<p>Within 12 months</p>		
<p>Anticonvulsants</p> <ul style="list-style-type: none"> • Carbamazepine (Tegretol) 		<p>Within 12 months</p>	<p>Tegretol- Tegretol level within 6 months</p>	<p>Tegretol-Additional drug level may be ordered PRN if patient unstable on current dose</p>

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<ul style="list-style-type: none"> • Gabapentin (Neurontin) • Lamotrinine (Lamictal) • Levetiracetam (Keppra) • Oxcarbazepine (Trileptal) • Phenytoin Sodium (Dilantin) • Primidone (Mysoline) • Topiramate (Topamax) • Valproate Sodium (Depakote) • Valproic Acid 	<p>Neurontin-Bipolar-antianxiety and nerve pain</p> <p>Lamictal-Bipolar-antidepressant/mood regulator</p> <p>Primidone-Barbiturate analogue</p> <p>Topamax-Bipolar mood regulator</p> <p>Depakote-Bipolar mood regulator</p>		<p>Dilantin-Dilantin level within 12 months</p>	<p>For Psych use: Check PCP and Behavioral Health notes regarding follow up appointments. If missed or cancelled appointments give one month amount and contact patient for follow up appointment as soon as possible.</p>
<p>Antidepressants</p> <p>Tricyclics</p> <ul style="list-style-type: none"> • Amitriptyline Hydrochloride (Elavil) • Imipramine Hydrochloride (Tofranil) • Mirtazapine (Remeron) • Nortriptyline Hydrochloride (Avently/Pamelor) 		<p>Within 12 months</p>	<p>None</p>	<p>None</p>
<p>Selective Serotonin Reuptake Inhibitors (SSRI)</p>		<p>Within 12 months</p>	<p>None</p>	<p>Check PCP and Behavioral Health notes regarding</p>

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<ul style="list-style-type: none"> • Citalopram Hydrochloride (Celexa) • Escitalopram Oxalate (Lexapro) • Fluoxetine (Luvox) • Paroxetine Hydrochloride (Paxil) • Sertraline Hydrochloride (Zoloft) <p>Selective Serotonin-Norepinephrine Reuptake Inhibitors (SSNRI)</p> <ul style="list-style-type: none"> • Cymbalta • Venlafaxine Hydrochloride (Effexor) <p>Aminoketone</p> <ul style="list-style-type: none"> • Bupropion Hydrochloride (Wellbutrin) <p>Zyban</p> <ul style="list-style-type: none"> • Bupropion Hydrobromide (Aplenzin) 				follow up appointments. If missed or cancelled appointments give one month amount and contact patient for follow up appointment.
<p>ADHD (Attention Deficit Hyperactivity Disorder)</p> <ul style="list-style-type: none"> • Atomoxetine Hydrochloride (Strattera) 		Within 6 months	None	None
<p>Antidiabetics</p> <p>PO Medications</p> <ul style="list-style-type: none"> • Glimepiride • Glipizide • Glyburide • Metformin Hydrochloride (Glucophage) • Pioglitazone Hydrochloride (Actos) • Repaglinide (Prandin) • Rosiglitazone Maleate (Avandia) 		Within 6 months for all meds in classification	HgbA1c within 6 months for all meds in classification Glucophage-annual creatinine	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<p>Hypoglycemia</p> <ul style="list-style-type: none"> • Glucagon <p>Injections</p> <ul style="list-style-type: none"> • All Insulins • Exenatide (Byetta) • Liraglutide (Victoza) <p>Supplies</p> <ul style="list-style-type: none"> • Glucometer • Blood glucose test strips • Lancets • Syringes with or without needles: extra needles 				<p>Blood glucose strips-always mark DAW, so patient gets appropriate strips for their glucometer.</p> <p>Syringes need to be ordered based on quantity of insulin being injected, for accurate measurements, and pen needles need to be ordered for pre-filled pen syringes, which is how most insulin is now prescribed.</p>
<p>Antiemetic</p> <ul style="list-style-type: none"> • Metoclopramide Hydrochloride (Reglan) • Meclizine Hydrochloride (Antivert) • Ondansetron Hydrochloride (Zofran) • Prochlorperazine Maleate (Compazine) • Promethazine Hydrochloride (Phenergan) • Scopolamine Hydrochloride • Scopolamine Hydrobromide 		Within 12 months	None	None
<p>Antifungals</p>				

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<p>Oral</p> <ul style="list-style-type: none"> • Ketoconazole (Nizoral) • Nystatin, all forms <p>Vaginal Creams</p> <ul style="list-style-type: none"> • Femstat • Gynazole • My Celeb 		Within 12 months	None	<p>If 3 or more requests for refill within 6 month period patient should be seen prior to further refills.</p> <p>For Vaginal Creams – if 3 or more requests for refill within 6 month period, patient should be seen prior to further refills.</p>
<p>Antigout</p> <ul style="list-style-type: none"> • Allpurinol (Zyloprim) • Colchicine (Colcrys) • Probenecid 		<p>Within 12 months</p> <p>Colchicine- within 6 months</p> <p>Probenecid- within 12 months</p>	<p>None</p> <p>Probenecide- annual BUN and renal function tests</p>	None
<p>Antihistamines</p> <ul style="list-style-type: none"> • Cetirizine Hydrochloride • Chlorpheniramine Maleate • Clemastine (Tavist) • Desloratadine • Diphenhydramine Hydrochloride (Benadryl) • Fexofenadine Hydrochloride (Allegra) • Loratadine • Promethazine Hydrochloride 		Within 12 months	None	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<p>Antihypertensives</p> <p>ACE Inhibitor</p> <ul style="list-style-type: none"> • Acupril • Benazepril • Captopril • Enalapril Maleate (Vasotec) • Lisinopril • Ramipril (Altace) <p>Angiotenin II Receptor Blockers</p> <ul style="list-style-type: none"> • Irbesartan • Losartan Potassium • Lomesartan Medoxomil (Benicar) • Telmisartan (Micardis) • Valsartan <p>Beta Blockers</p> <ul style="list-style-type: none"> • Atenolol (Tenormin) • Bisoprolol (Zebeta) • Carvedilol • Metoprolol Succinate • Metoprolol Tartrate • Nebivolol Hydrochloride (Bystolic) 		12 months for all meds in antihypertensive classification	BMP annually for all meds in antihypertensive classification	<p>ACE Inhibitors-average BP should be 135/80 or below for diabetics, 140/90 or below for all others; otherwise should see clinician within 2 months of refill May refill for 6 to 12 months if protocol requirements are met depending on when patient next labs and/or appointment is due.</p> <p>Angiotensin II Receptor Blockers-average BP should be 135/80 or below for diabetics, 140/90 or below for all others; otherwise should see clinician within 2 months or refill.</p> <p>Beta Blockers-average BP should be 135/80 or below for diabetics, 140/90 or below for all others; otherwise should see clinician within 2 months or refill.</p>

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
Combinations <ul style="list-style-type: none"> • Benicar HCT=Olmesartan Medoxomil + HCTZ • Diovan-Valsartan + Hydorchlorothiazide • Hyzaar=Losartan + HCTZ • Lotrel=Amlodipine + Benezepiril 	Angiotensin II receptor blockers with a thiazide			
Antilipemics <ul style="list-style-type: none"> • All Statins • Ezetimibe (Zetia) • Fenofibrate (Tricor) • Gemfibrozil (Lopid) Combo <ul style="list-style-type: none"> • Vytorin=Zetia + Simvastain 		Within 12 months	Liver function tests 3 months after initial RX, then annually with annual Lipid panel	None
Antimalarial <ul style="list-style-type: none"> • Hydroxychloroquine Sulfate (Plaquenil) 		Within 12 months	None	None
Antimanic/Mood Stabilizer Depakote Lamictal Lithium		Within 12 months	Lithium level within 6 months or check notes for more frequent required levels if just starting or patient is unstable on current dose	Check notes for plan regarding follow up visits with PCP or Behavioral Health.
Antimigraine Ergot Alkaloide <ul style="list-style-type: none"> • Cafergot (Ergotamine with caffeine) • Frobatriptan Succinate (Frova) 	Frova-Seratonin 5-HT1 receptor agonist	Within 12 months	None	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<ul style="list-style-type: none"> • Rizatriptan Benzoate (Maxalt) • Sumatriptan Succinate (Imitrex) • Zolmatriptan (Zomig) 	Imitrex-Serotonin 5-HT1 receptor agonist			
Antisteoporotic <ul style="list-style-type: none"> • Actonel • Alendronate Sodium (Fosamax) • Boniva 		Within 12 months	None	None
Antiparkinsonians Amantadine (Symmetrel) Benztropine Mesylate (Cogentin) Levodopa+Carbidopa=Sinemet Pramipexole Dihydrochloride (Mirapex) Ropinirole Hydrochloride (Requip)		Within 12 months	None	None
Antipsychotic <ul style="list-style-type: none"> • Abilify • Haloperidol (Haldol) • Olanzapine (Zyprexa) • Paliperidone (Invega) • Quetiapine (Seroquel) • Risperidone (Risperdal) • Ziprasidone Hydrochloride (Geodon) 		Within 12 months	None	Some insurance would only pay for specific name brand
Antispasmodic Anticholinergic/Antimuscarinic <ul style="list-style-type: none"> • Darifenacin Hydrobromide (Enablex) • Dicylomine Hydrochloride (Bentyl) Urinary <ul style="list-style-type: none"> • Oxybutynin (Ditropan) • Solifenacin (Vesicare) 		Within 12 months	None	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
Antiulcer <ul style="list-style-type: none"> • Carafate H2 Receptor Antagonist <ul style="list-style-type: none"> • Cimetidine (Tagamet) • Famotidine (Pepcid) • Ranitidine Hydrochloride (Zantac) 	See also Proton Pump Inhibitors	Within 12 months	None	None
Antivertigo <ul style="list-style-type: none"> • Meclizine Hydrochloride • Antivert • Bonine 		Within 12 months	None	None
Antiviral <ul style="list-style-type: none"> • Acyclovir (Zovirax) • Valacyclovir Hydrochloride (Valtrex) 	For Herpes Zoster infection	Within 12 months	None	None
Anxiolytics <ul style="list-style-type: none"> • Bupiroine Hydrochloride • Hydroxyzine (Atarax) 		Within 12 months	None	None
Corticosteroids PO <ul style="list-style-type: none"> • Prednisone Inhaler <ul style="list-style-type: none"> • Azmacort Creams/Ointments <ul style="list-style-type: none"> • Triamcinolone (Kenalog) 		Within 12 months for all meds in this classification	None	None
Benign Prostatic Hyperplasia (BPH) <ul style="list-style-type: none"> • Dutasteride (Avodart) • Finasteride (Proscar) 		Within 12 months	None	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<ul style="list-style-type: none"> Tamsulosin (Flomax) 				
Diuretics Loop <ul style="list-style-type: none"> Furosemide (Lasix) Potassium-Sparing <ul style="list-style-type: none"> Aldactone (Spironolactone) Thiazides and Thiazide-like <ul style="list-style-type: none"> Hydrochlorothiazide (HCTZ) Metolazone (Zaroxolyn) Microzide Combinations <ul style="list-style-type: none"> Dyazide=Triamterene + HCTZ 	Lasix-antihypertensive	PCP visit within 12 months	Annual BMP	Lasix-patient may require potassium supplement
Erectile Dysfunction <ul style="list-style-type: none"> Sildenafil (Viagra) Tadalafil (Cialis) Vardenafil Hydrochloride (Levitra) 		Within 12 months	None	None
Estrogens, Conjugated <ul style="list-style-type: none"> Bio identical hormone replacement Cenestrin Climara Enjuvia Estrace Medroxyprogesterone Acetate (Depo-Provera) Premarin Prempro 		Within 12 months	Normal Pap	Refill if up to date based on RCMS cervical screening guidelines; if not up to date refill for 1 month and have patient scheduled for appointment. If patient still has uterus and is on estrogen/progesterone combo, she must have annual exam.

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
Hypnotic <ul style="list-style-type: none"> • Ramelteon (Rozerem) 		Within 12 months	None	None
Inotropics <ul style="list-style-type: none"> • Digoxin 		Within 12 months	Digitalis level within 12 months	None
Laxatives <ul style="list-style-type: none"> • Dulcolax • Lactulose • Stool Softeners <p>All preparations</p>		Within 12 months	None	None
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) <ul style="list-style-type: none"> • Aspirin • Celecoxib (Celebrex) • Diclofenac Epolamine • Diclofenac Potassium • Diclofenac Sodium (Voltaren) • Ibuprofen • Indomethacin • Indomethacin Sodium Trihydrate • Ketoprofen • Meloxicam (Mobic) • Nabumetone • Naproxen 		Within 12 months	None	None
Oral Contraceptives		Within 12 months	Normal Pap	Pap exam must be done per RCMS screening guidelines for age; otherwise refill for 1 month and have patient

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
				scheduled for annual exam and pap exam.
Ointments <ul style="list-style-type: none"> • Cortisporin (Hydrocortison/Neomycin/Polymixin B) • Lidocaine Skin Ointment (Lidoderm) 		Within 12 months	None	None
Ophthalmic Solutions <ul style="list-style-type: none"> • Azelastine Hydrochloride 0.05% Solutions (Optivar) • Lumigan • Moxifloxacin Hydrochloride (Vigamox) 	Vigamox-antibiotic for bacterial conjunctivitis	Within 12 months	None	None
Proton Pump Inhibitors <ul style="list-style-type: none"> • Dexlansoprazole (Kapidex, Dexilant) • Esomeprazole Magnesium (Nexium) • Omeprazole (Prilosec) • Pantoprazole (Protonix) 		Within 12 months	None	None
Skeletal Muscle Relaxants <ul style="list-style-type: none"> • Baclofen (Lioresal) • Cyclobenzaprine Hydrochloride (Flexeril) • Methocarbamol (Robaxin) • Tizanidine (Zanaflex) 		Baclofen-within 12 months Flexeril-within we months for this problem and regional Rx written for >3 weeks Zanaflex-within 12 months	None	None
Smoking Cessation <ul style="list-style-type: none"> • Chantix • Nicotine Gum and Patches 		Within 12 months	None	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
Supplements <ul style="list-style-type: none"> • Calcium (all forms) • Fluoride (all forms) • Folic Acid (Fa-8) • Fortical (Calcitonin) • ICaps (Beta Caratene) • Iron (all preparations) • Methylsulfonylmethane (MSM) • Multivitamins • Potassium (all form KCL) • Pyriodoxine (Vitamin B6) • Slo-Niacin (Niaspan) • Vitamin B12 Injection 	Potassium-partner with Laxix (diuretic)	Within 12 months	Potassium-BMP annually	None
Thyroid Hormone All natural and synthetic preparations		Within 12 months	TSH annually	None
Wound Care Supplies		Within 12 months	None	None
Miscellaneous <ul style="list-style-type: none"> • Ddavn • Epipen • Guaifenesin (Mucinex) • Polytrim Ophthalmic=Trimethoprim Sulfate + Polymixin B Sulfate 	Hemostatic posterior pituitary hormone Epipen-anaphylactic shock Mucinex-expectorant	Within 12 months	None	None

Medication Category List and Guidelines

Classifications	Secondary Classifications	PCP Visit Requirements	Lab Requirements	Special Considerations
<ul style="list-style-type: none"> • Pyridium • Pseudoephedrine Hydrochloride (Sudafed) 	<p>Pyridium used for pain associated with urinary tract infection</p> <p>Sudafed-decongestant</p>			

Combination medications: if both medications are on the list, the combination medication may be refilled; the most restrictive standard for visits, lab, or clinical considerations should be followed.

Medications not on the list that fit specifically into one of the categories maybe refilled following the requirements of the classification.

Chapter 19: Board Authority

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. [View the revisions.](#)

Authority

Section 330(k)(3)(H) of the PHS Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)

Requirements¹

- The health center must establish a governing board² that has specific responsibility for oversight of the Health Center Program project.
- The health center governing board must develop bylaws which specify the responsibilities of the board.
- The health center governing board must assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations.
- The health center governing board must hold monthly meetings^{3,4} and record in meeting minutes the board's attendance, key actions, and decisions.
- The health center governing board must approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO).
- The health center governing board must have authority for establishing or adopting policies for the conduct of the Health Center Program project and for updating these

¹ The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board authority requirements discussed in this chapter. Section 330(k)(3)(H) of the PHS Act.

² For public agencies that elect to have a [co-applicant](#), these authorities and functions apply to the co-applicant board.

³ Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

⁴ Boards of organizations receiving a Health Center Program award/designation only under [section 330\(g\)](#) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to health center patient migration out of the area. 42 CFR 56.304(d)(2).

policies when needed. Specifically, the health center governing board must have authority for:

- Adopting policies for financial management practices and a system to ensure accountability for center resources (unless already established by the public agency as the [Federal award](#) or designation recipient), including periodically reviewing the financial status of the health center and the results of the annual audit to ensure appropriate follow-up actions are taken;⁵
 - Adopting policy for eligibility for services including criteria for partial payment schedules;⁶
 - Establishing and maintaining general personnel policies for the health center (unless already established by the public agency as the Federal award or designation recipient), including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices; and
 - Adopting health care policies including quality-of-care audit procedures.
- The health center governing board must adopt health care policies including the:
 - Scope and availability of services to be provided within the Health Center Program project, including decisions to [subaward](#) or [contract](#) for a substantial portion of the services;^{7,8}
 - [Service site](#) location(s);⁹ and
 - Hours of operation of service sites.
 - The health center governing board must review and approve the annual Health Center Program project budget.¹⁰
 - The health center must develop its overall plan for the Health Center Program project under the direction of the governing board.
 - The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.

⁵ See Chapter 15: [Financial Management and Accounting Systems](#) for more information on the related requirements.

⁶ See Chapter 9: [Sliding Fee Discount Program](#) for more information on the related requirements.

⁷ See Chapter 4: [Required and Additional Health Services](#) for more information on the requirements associated with providing services within the HRSA-approved [scope of project](#).

⁸ See Chapter 12: [Contracts and Subawards](#) for more information on the requirements associated with such arrangements.

⁹ See Chapter 6: [Accessible Locations and Hours of Operation](#) for more information on the requirements associated with health center service sites and hours of operation.

¹⁰ See Chapter 17: [Budget](#) for more information on the requirements of the Health Center Program project budget.

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- The health center governing board must assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity [efficiency and effectiveness] of the center, and patient satisfaction.
- The health center governing board must ensure that a process is developed for hearing and resolving patient grievances.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

- a. The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:
 - The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;¹¹
 - In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved [scope of project](#), such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
 - For public agencies with a [co-applicant](#) board;¹² the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.
- b. The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:
 - Holding monthly meetings;
 - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
 - Approving the annual Health Center Program project budget and applications;

¹¹ This does not preclude an executive committee from taking actions on behalf of the board in emergencies, on which the full board will subsequently vote.

¹² Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements.

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- Approving health center services and the location and hours of operation of health center sites;
 - Evaluating the performance of the health center;
 - Establishing or adopting policy¹³ related to the operations of the health center; and
 - Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.
- c. The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:
- Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
 - Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
 - Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;
 - Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
 - Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;
 - Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and
 - Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management,¹⁴ and ensuring appropriate follow-up actions are taken regarding:
 - Achievement of project objectives;
 - Service utilization patterns;
 - Quality of care;
 - Efficiency and effectiveness of the center; and
 - Patient satisfaction, including addressing any patient grievances.

¹³ The governing board of a health center is generally responsible for establishing and/or approving policies that govern health center operations, while the health center's staff is generally responsible for implementing and ensuring adherence to these policies (including through operating procedures).

¹⁴ For more information related to the production of reports associated with these topics, see Chapter 18: [Program Monitoring and Data Reporting Systems](#), Chapter 15: [Financial Management and Accounting Systems](#), and Chapter 10: [Quality Improvement/Assurance](#).

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- d. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: [Sliding Fee Discount Program](#), [Quality Improvement/Assurance](#), and [Billing and Collections](#).¹⁵
- e. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the [recipient](#) of the Health Center Program Federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center board determines how to carry out required responsibilities, functions, and authorities in areas such as the following:
 - Whether to establish standing committees, including the number and type of such committees (for example, executive, finance, quality improvement, personnel, planning).
 - Whether to seek input or assistance from other organizations or subject matter experts (for example, joint committees for health centers that collaborate closely with other organizations, consultants, community leaders).
 - How often the Project Director/CEO performance is evaluated.
- The health center determines how to set quorum for board meetings consistent with state, territorial or other applicable law.
- The health center board determines the format of its long-range/strategic planning.
- For public agencies with co-applicant boards, the co-applicant board and the public agency determine how to collaborate in carrying out the Health Center Program project (for example, shared project assessment, public agency participation on board committees, joint preparation of grant applications).

¹⁵ Policies related to billing and collections that require board approval include those that address the waiving or reducing of amounts owed by patients due to inability to pay, and if applicable those that limit or deny services due to refusal to pay.

Chapter 20: Board Composition

Authority

Section 330(k)(3)(H) of the PHS Act; and 42 CFR 51c.304 and 42 CFR 56.304

Requirements^{1,2}

- The health center’s governing board must consist of at least 9 and no more than 25 members.³
- The majority [at least 51 percent] of the health center board members must be patients⁴ served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender.
- Non-patient health center board members must be representative of the community served by the health center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
- Of the non-patient health center board members, no more than one-half may derive more than 10 percent of their annual income from the health care industry.⁵
- A health center board member may not be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee.⁶ The project

¹ The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board composition requirements discussed in this document. Section 330(k)(3)(H) of the PHS Act.

² For public agencies that elect to have a [co-applicant](#), these board composition requirements apply to the co-applicant board.

³ 42 CFR 51c.304(a) and 42 CFR 56.304(a) permit that the requirement regarding board size may be waived by the Secretary for good cause shown. HRSA will not grant such waivers except where the health center has demonstrated to HRSA an inability to meet the requirement.

⁴ Patient board members are also often referred to as “user” or “consumer” board members. However, for the purposes of this chapter, only the term “patient” or “non-patient” board member will be used for ease of reference.

⁵ Per the regulations in 42 CFR 56.304, for health centers awarded/designated solely under [section 330\(g\)](#) of the PHS Act, no more than two-thirds of the non-patient board members may derive more than 10 percent of their annual income from the health care industry.

⁶ While no board member may be an employee of the health center, 42 CFR 51c.107 permits the health center to use [Federal award](#) funds to reimburse board members for these limited purposes: 1) reasonable expenses actually incurred by reason of their participation in board activities (e.g., transportation to board meetings, childcare during board meetings); or 2) wages lost by reason of participation in the activities of such board members if the member

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director [Chief Executive Officer (CEO)] may be a non-voting, ex-officio member of the board.

- The health center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process must ensure that the governing board is representative of the health center patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.
- In cases where a health center receives an award/designation under section [330\(g\)](#), [330\(h\)](#) and/or [330\(i\)](#) and does not receive an award/designation under section 330(e), the health center may request approval from HRSA for a waiver of the patient majority board composition governance requirement by showing good cause.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

- a. The health center has bylaws or other relevant documents that specify the process for ongoing selection and removal of board members. This board member selection and removal process does not permit any other entity, committee or individual (other than the board) to select either the board chair or the majority of health center board members,⁷ including a majority of the non-patient board members.⁸
- b. The health center has bylaws or other relevant documents that require the board to be composed as follows:
 - Board size is at least 9 and no more than 25 members,⁹ with either a specific number or a range of board members prescribed;
 - At least 51 percent of board members are patients served by the health center. For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health

is from a family with an annual family income less than \$10,000 or if the member is a single person with an annual income less than \$7,000. For section 330(g)-only awarded/designated health centers, 42 CFR 56.108 permits the use of grant funds for certain limited reimbursement of board members as follows: 1) for reasonable expenses actually incurred by reason of their participation in board activities (e.g., transportation to board meetings, childcare during board meetings); 2) for wages lost by reason of participation in the activities of such board members. Health centers may wish to consult with their legal counsel and auditor on applicable state law regarding reimbursement restrictions for non-profit board members and implications for IRS tax-exempt status.

⁷ An outside entity may only remove a board member who has been selected by that entity as an organizational representative to the governing board.

⁸ For example, if the health center has an agreement with another organization, the agreement does not permit that organization to select either the chair or a majority of the health center board.

⁹ For the purposes of the Health Center Program, the term "board member" refers only to voting members of the board.

- center visit, where both the service and the [site](#) where the service was received are within the HRSA-approved [scope of project](#);
- Patient members of the board, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender;
 - Non-patient members are representative of the community served by the health center or the health center's [service area](#);
 - Non-patient members are selected to provide relevant expertise and skills such as:
 - Community affairs;
 - Local government;
 - Finance and banking;
 - Legal affairs;
 - Trade unions and other commercial and industrial concerns; and
 - Social services;
 - No more than one-half of non-patient board members derive more than 10 percent of their annual income from the health care industry; and
 - Health center employees,^{10,11} and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members.
- c. The health center has documentation that the board is composed of:
- At least 9 and no more than 25 members;
 - A patient¹² majority (at least 51 percent);
 - Patient board members, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender, consistent with the demographics reported in the health center's [Uniform Data System \(UDS\)](#) report;¹³

¹⁰ For the purposes of health center board composition, an employee of the health center would include an individual who would be considered a “common-law employee” or “statutory employee” according to the Internal Revenue Service criteria, as well as an individual who would be considered an employee for state or local law purposes.

¹¹ In the case of public agencies with co-applicant boards, this includes employees or immediate family members of both the co-applicant organization and the public agency component (for example, department, division, or sub-agency) in which the Health Center Program project is located.

¹² A legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient may also be considered a patient of the health center for purposes of board representation. Students who are health center patients may participate as board members subject to state laws applicable to such non-profit board members.

¹³ For health centers that have not yet made a [Uniform Data System \(UDS\)](#) report, this would be assessed based on demographic data included in the health center's application.

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- Representative(s) from or for each of the [special population\(s\)](#)¹⁴ for those health centers that receive any award/designation under one or more of the special populations section 330 subparts, 330(g), (h), and/or (i); and
 - As applicable, non-patient board members:
 - Who are representative of the community in which the health center is located, either by living or working in the community, or by having a demonstrable connection to the community;
 - With relevant skills and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, or social services within the community; and
 - Of whom no more than 50 percent earn more than 10 percent of their annual income from the health care industry.¹⁵
- d. The health center verifies periodically (for example, annually or during the selection or renewal of board member terms) that the governing board does not include members who are current employees of the health center, or immediate family members of current health center employees (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage).
- e. In cases where a health center receives an award/designation under section [330\(g\)](#), [330\(h\)](#) and/or [330\(i\)](#), does not receive an award/designation under section 330(e), and requests a waiver of the patient majority board composition requirements, the health center presents to HRSA for review and approval:
- “Good cause” that justifies the need for the waiver by documenting:
 - The unique characteristics of the population ([homeless](#), [migratory or seasonal agricultural worker](#), and/or [public housing](#) patient population) or service area that create an undue hardship in recruiting a patient majority; and
 - Its attempt(s) to recruit a majority of special population board members within the past three years; and
 - Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following elements:
 - Collection and documentation of input from the special population(s);
 - Communication of special population input directly to the health center governing board; and

¹⁴ Representation could include advocates for the health center’s section 330 (g), (h), or (i) patient population (for example, those who have personally experienced being a member of, have expertise about, or work closely with the current special population). Such advocate board members would count as “patient” board members only if they meet the patient definition set forth in this chapter.

¹⁵ For example, in a 9 member board with 5 patient board members, there could be 4 non-patient board members. In this case, no more than 2 non-patient board members could earn more than 10 percent of their income from the health care industry.

- Incorporation of special population input into key areas, including but not limited to: selecting health center services;¹⁶ setting hours of operation of health center sites;¹⁷ defining budget priorities;¹⁸ evaluating the organization’s progress in meeting goals, including patient satisfaction;¹⁹ and assessing the effectiveness of the sliding fee discount program.²⁰
- f. For health centers with approved waivers, the health center has board minutes or other documentation that demonstrates how special population patient input is utilized in making governing board decisions in key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization’s progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- Within the range of 9 to 25 board members, the health center determines the appropriate board size for its organization.
- In addition to race, ethnicity, and gender, the health center determines other relevant demographic or geographic factors to consider when selecting patient or non-patient board members.
- In cases where language or literacy may present a barrier to board members’ evaluation of written materials, the health center determines how to make accommodations to ensure the meaningful participation of such board members.
- The health center board determines whether to include non-voting, ex-officio members including, for example, the Project Director/CEO, other health center staff members, or community members on the board, consistent with what is permitted under other applicable laws.

¹⁶ See Chapter 4: [Required and Additional Health Services](#) for more information on providing services within the HRSA-approved scope of project.

¹⁷ See Chapter 6: [Accessible Locations and Hours of Operation](#) for more information on health center service sites and hours of operation.

¹⁸ See Chapter 17: [Budget](#) for more information on the Health Center Program project budget.

¹⁹ See Chapter 19: [Board Authority](#) for more information on the health center board’s required authorities.

²⁰ See Chapter 9: [Sliding Fee Discount Program](#) for more information on requirements for health center sliding fee discount programs.

- The health center determines within its policies how to define “health care industry” for purposes of board composition and how to determine the percentage of annual income of each non-patient board member derived from the health care industry.
- For health centers with a HRSA-approved waiver, the health center board determines which strategies²¹ to use for receiving input from the special population and ensuring the special population’s participation in the direction and ongoing governance of the health center.

²¹ For example, a health center could utilize an advisory council of special population representatives, could conduct regular focus groups with the special population, or could have one or more patients from the special population serving on the board.

REDWOOD COAST MEDICAL SERVICES, INC.

EXECUTIVE SUMMARY

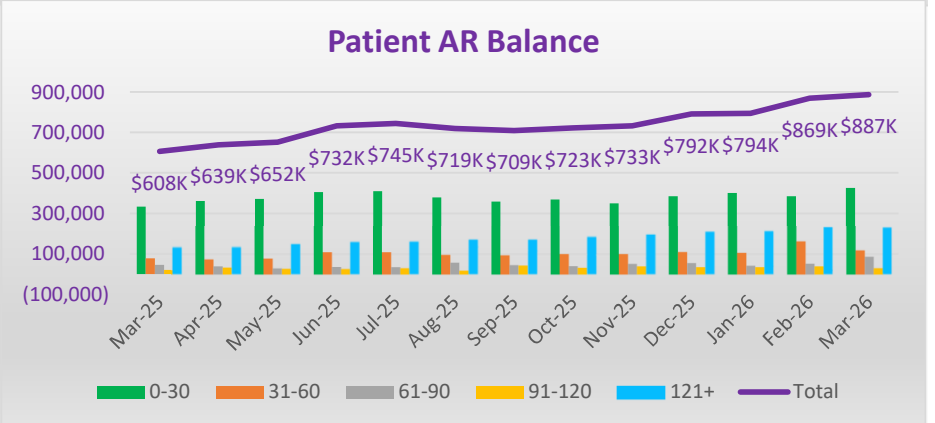
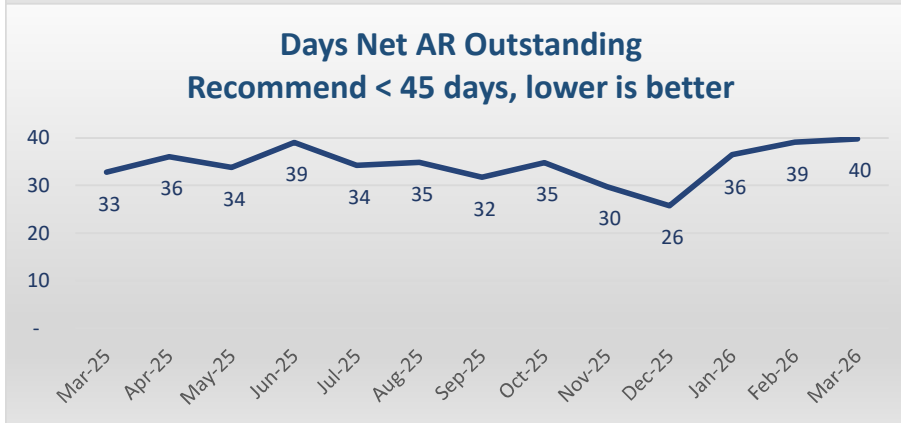
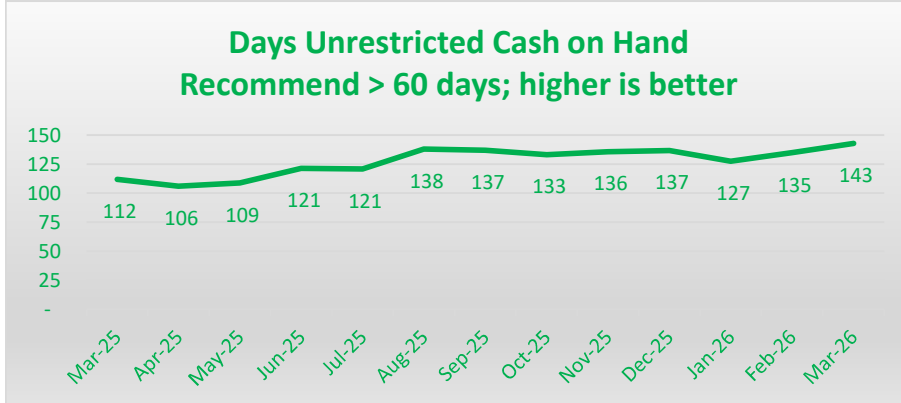
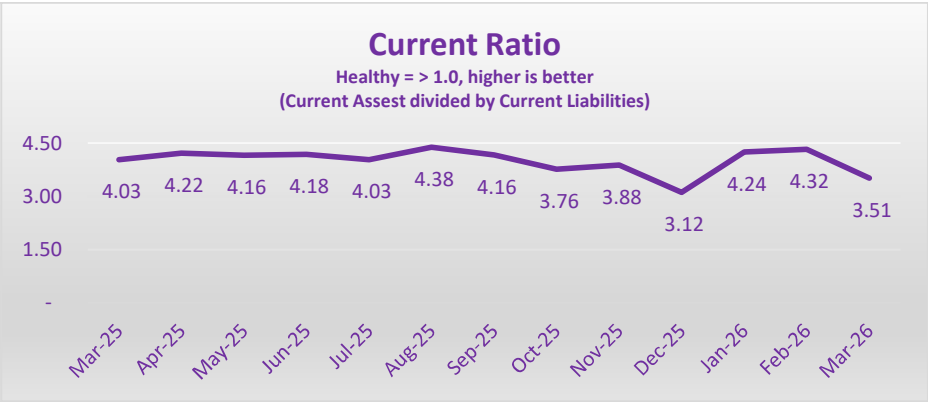
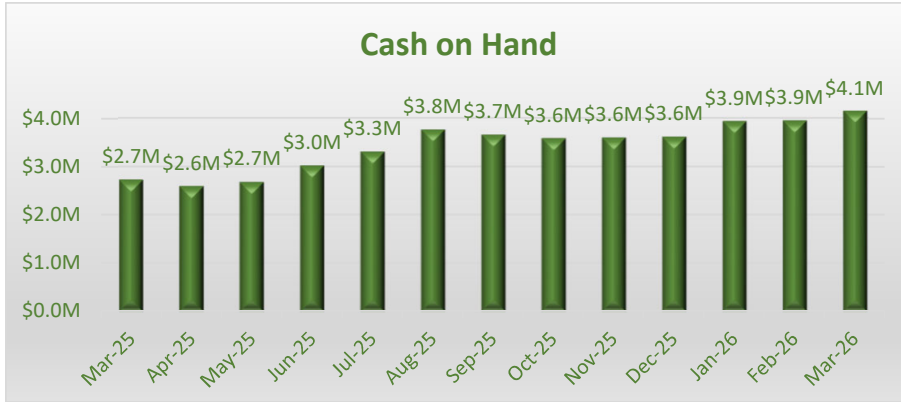
March 2026

STATEMENT OF FINANCIAL POSITION					
ASSETS	Mar-26	Mar-25	Change	Feb-26	Change
Current Assets	4,967,246	3,458,313	43.63%	3,876,090	28.15%
Long-Term Assets	3,014,747	2,841,589	6.09%	2,958,662	1.90%
TOTAL ASSETS	7,981,993	6,299,901	26.70%	6,834,752	16.79%
LIABILITIES AND NET ASSETS					
Current Liabilities	991,612	810,685	22.32%	882,867	12.32%
Estimated Medi-Cal Liabilities	423,706	47,346	794.92%	44,038	862.14%
Long-Term Leases	568,480	-	N/A	97,844	481.00%
Total Liabilities	1,983,797	858,031	131.20%	1,024,749	93.59%
Net Assets	5,998,196	5,441,871	10.22%	5,810,003	3.24%
TOTAL LIABILITIES AND NET ASSETS	7,981,993	6,299,901	26.70%	6,834,752	16.79%
STATEMENT OF ACTIVITIES - YTD					
REVENUES	Actual	Budget	Variance	Prior Year	Change
Patient Service Revenue	3,812,569	4,444,286	-14.21%	3,247,798	17.39%
Grant & Other Revenue	3,614,632	2,563,985	40.98%	2,680,790	34.83%
NET REVENUE	7,427,201	7,008,271	5.98%	5,928,588	25.28%
OPERATING EXPENSES					
Salaries and Benefits	5,232,022	5,365,511	-2.49%	4,835,544	8.20%
Contracted Services	44,268	44,561	-0.66%	48,767	-9.23%
Facility Costs	180,544	194,751	-7.29%	192,720	-6.32%
Supplies	361,334	386,883	-6.60%	377,393	-4.26%
Depreciation & Amortization	129,113	133,245	-3.10%	135,802	-4.93%
Other Operating Expenses	1,322,623	1,262,132	4.79%	1,222,060	8.23%
TOTAL OPERATING EXPENSES	7,269,903	7,387,083	-1.59%	6,812,286	6.72%
OPERATING EXCESS/(DEFICIENCY)	157,298	(378,812)	-141.52%	(883,698)	-117.80%
Net Capital Income/(Expenses)	323,183	375,992	-14.05%	509,135	-36.52%
TOTAL EXCESS/(DEFICIENCY)	480,481	(2,820)	-17138.33%	(374,563)	-228.28%

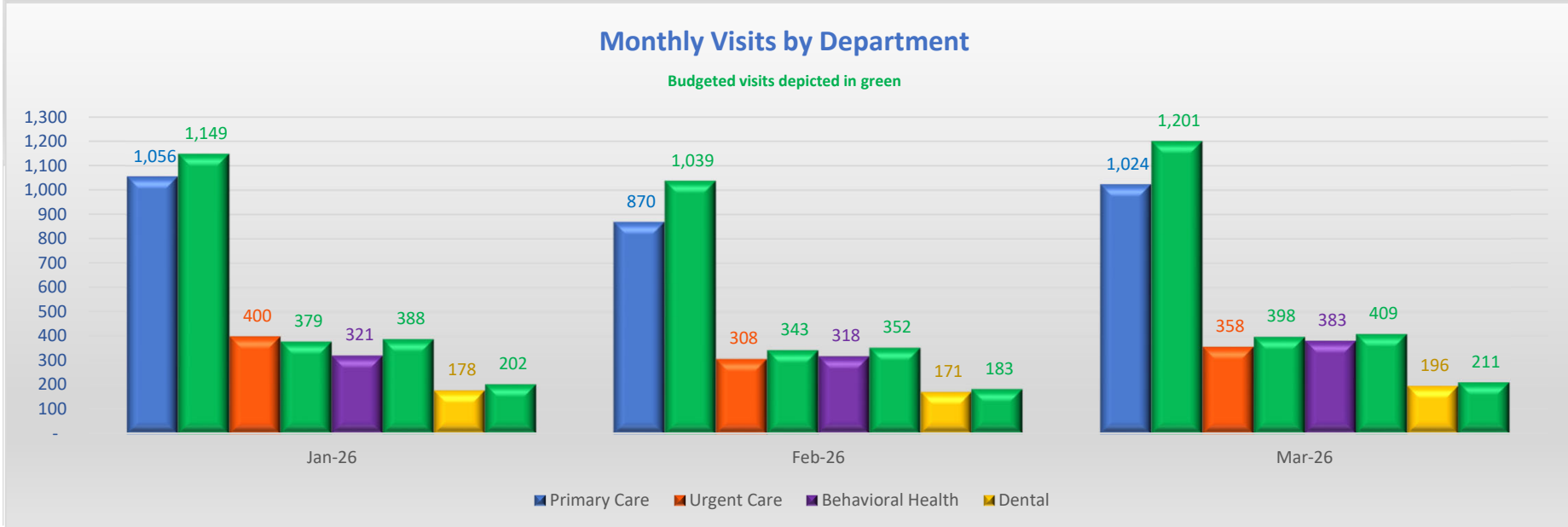
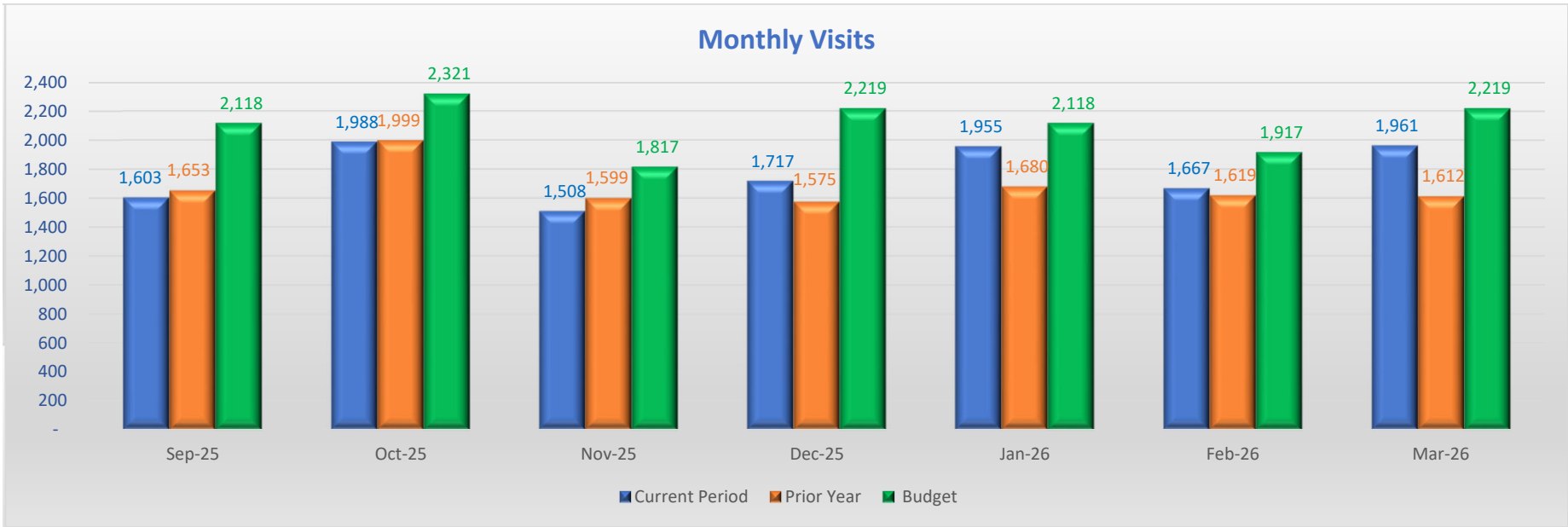
REDWOOD COAST MEDICAL SERVICES, INC.

EXECUTIVE SUMMARY - PRELIMINARY

March 2026



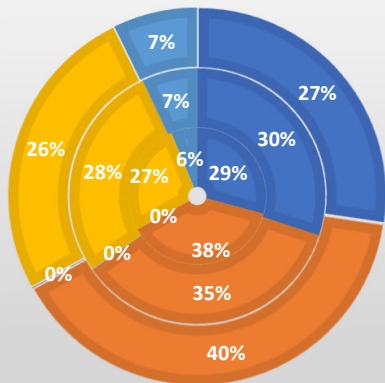
REDWOOD COAST MEDICAL SERVICES, INC.
 EXECUTIVE SUMMARY - PRELIMINARY
 March 2026



REDWOOD COAST MEDICAL SERVICES, INC.
 EXECUTIVE SUMMARY - PRELIMINARY
 March 2026

YTD PAYOR MIX

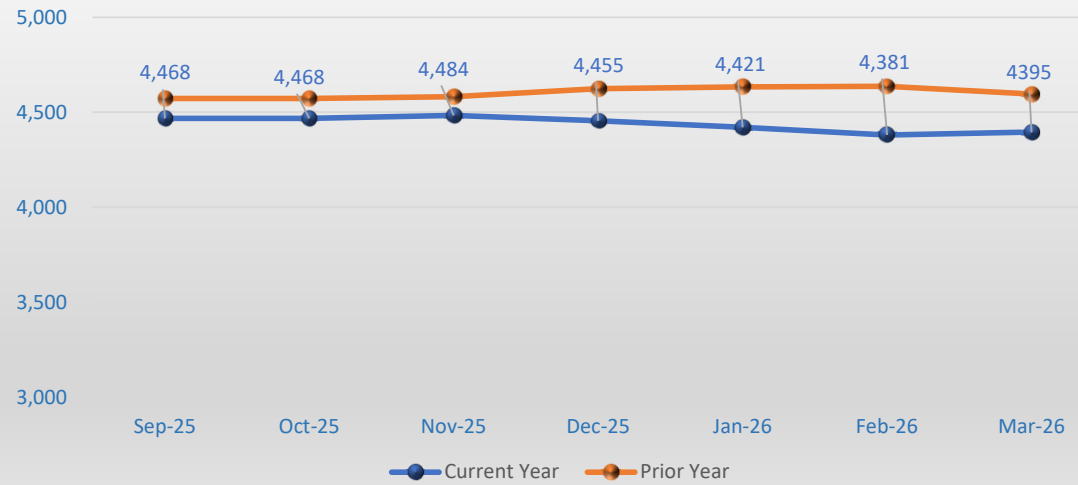
OUTER LAYER = CURRENT YEAR
 MID LAYER = PRIOR YEAR
 INNER LAYER = BUDGET



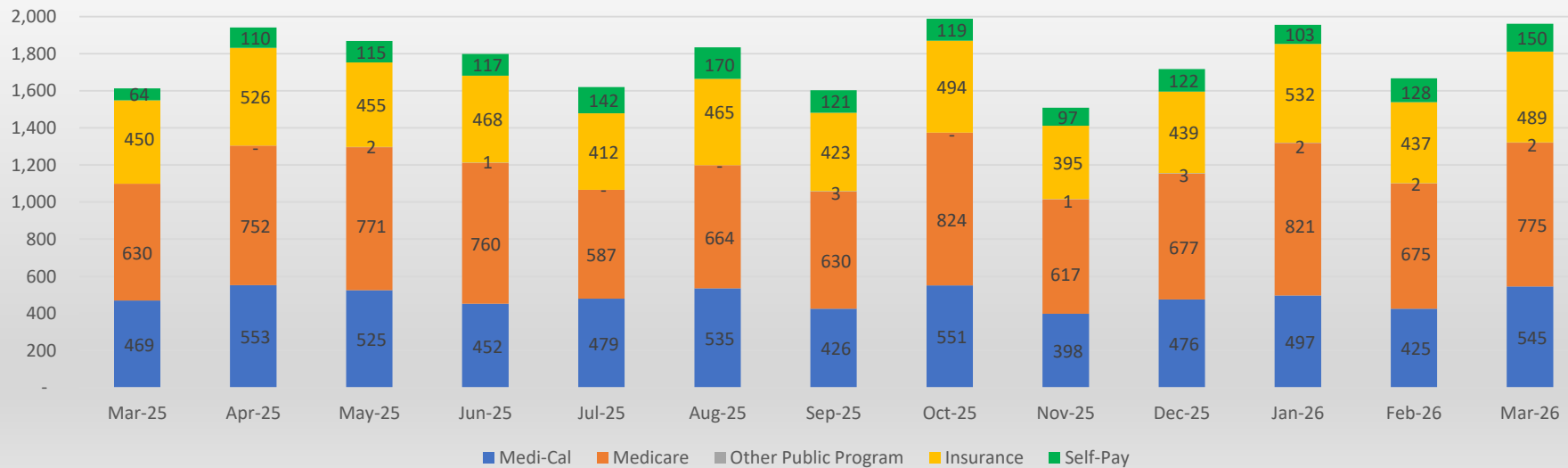
- Medi-Cal
- Medicare
- Other Public Program
- Insurance
- Self-Pay

Unduplicated Patients

SAC = 5,000



Monthly Visits by Financial Class



FINANCIAL NARRATIVE - PRELIMINARY March 2025

Financial results:

We recorded a bottom-line loss of \$42,293 for March, which was \$35,711 less than the budgeted loss of \$6,582. Our year-to-date bottom-line profit was \$480,481, which was \$483,301, better than the budgeted bottom-line loss of \$2,820.

- Net Patient Revenue (NPR) of \$487,519 was \$29,787 less than the budgeted NPR of \$517,306.

NPR Variance	\$ (29,787.37)
Due to higher/(lower) visits	\$ (60,146.44)
Due to higher/(lower) rate per visit	\$ 30,359.07

- March visits of 1,961 were 258 fewer than budgeted visits of 2,219.
 - The average rate per visit of \$248.61 was \$15.48 higher than the budgeted average rate per visit of \$233.13.
- Grants and Other Revenue of \$329,694 were \$60,366 higher than budgeted.
 - Other Grant Revenue was \$80,253 higher than budgeted due to Kaiser & Partnership grants.
 - 340B revenue was \$11,472 lower than budgeted due to the local pharmacy closure.
 - ARCH QIP revenue was \$6,282 lower than budgeted.
 - Rental revenue was \$2,308 less than budgeted due to a tenant vacating.
- Fundraising and Capital Activity Revenue of (\$61,501) was \$105,424 lower than budgeted.
 - Net Fundraising activity of \$9,155 was \$34,319 lower than budgeted.
 - Our overall investment value increased by \$71,155 during the month.
- Operating Expenses of \$798,005 were \$39,164 lower than budgeted.
 - Total compensation was \$20,153 less than budgeted due to vacant positions.
 - Right of use (ROU) amortization was \$2,411 less than budgeted.

- Rent expense was \$3,790 more than budgeted.
- Facility Repairs and Maintenance were \$2,596 less than budgeted.
- Audit fees were \$18,750 more than budgeted due to the timing of the audit
- Consulting fees were \$3,043 more than budgeted.
- Accounting fees were \$7,115 less than budgeted
- Government compliance fees were \$3,063 less than budgeted
- Employee recognition expenses were \$2,041 less than budgeted.
- Interest expenses were \$3,431 more than budgeted due to interest on the Capital Fund loan.
- Recruiting expenses were \$2,824 less than budgeted.
- Clinical supplies were \$17,770 under budget due to changes in supply ordering processes.
- Pharmaceutical supplies were \$2,157 less than budgeted.
- Transcription services were \$3,842 less than budgeted
- Travel and conference expenses were \$3,443 more than budgeted due to Partnership conference travel.

Changes in financial position:

- Total Cash and Investments were \$4,147,718 as of the end of March.
 - Unrestricted cash (including Management Restricted) Cash and Investments were \$3,727,779.
 - Cash and Investments increased by \$203,708 during the month.
 - Days Unrestricted Cash on Hand were 143 as of the end of February.

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Financial Position

As of 3/31/2026

	<u>Current Year</u>	<u>Prior Year</u>	<u>Change</u>
Current Assets			
Cash & Investments			
Cash on Hand	1,375,023.42	521,505.86	853,517.56
Mgmt Restricted Cash - Clinic Modernization	403,755.57	431,015.71	(27,260.14)
Investments	1,949,000.05	1,770,688.82	178,311.23
Total Cash & Investments	<u>3,727,779.04</u>	<u>2,723,210.39</u>	<u>1,004,568.65</u>
Restricted Cash			
Restricted Cash - Solar Project	419,939.41	0.00	419,939.41
Total Restricted Cash	<u>419,939.41</u>	<u>0.00</u>	<u>419,939.41</u>
Patient Accounts Receivable			
Accounts Receivable	885,719.89	611,474.04	274,245.85
Allowance for Doubtful Accounts	(331,697.00)	(223,127.00)	(108,570.00)
Total Patient Accounts Receivable	<u>554,022.89</u>	<u>388,347.04</u>	<u>165,675.85</u>
Other Current Assets			
Medi-Cal Receivable - Prior Year	32,965.03	42,036.13	(9,071.10)
Grants Receivable	4,824.00	17,377.00	(12,553.00)
QIP Receivable	96,550.00	157,083.39	(60,533.39)
Other Accounts Receivable	1,194.00	1,807.00	(613.00)
Prepaid Expenses	123,971.75	122,451.64	1,520.11
Other Assets	6,000.00	6,000.00	0.00
Total Other Current Assets	<u>265,504.78</u>	<u>346,755.16</u>	<u>(81,250.38)</u>
Total Current Assets	<u>4,967,246.12</u>	<u>3,458,312.59</u>	<u>1,508,933.53</u>
Long Term Assets			
Fixed Assets			
Property & Equipment	5,118,840.27	5,103,050.03	15,790.24
Accumulated Depreciation	(2,708,717.90)	(2,607,774.48)	(100,943.42)
Total Fixed Assets	<u>2,410,122.37</u>	<u>2,495,275.55</u>	<u>(85,153.18)</u>
Construction in Progress			
Construction in Progress	497,324.02	318,984.29	178,339.73
Total Construction in Progress	<u>497,324.02</u>	<u>318,984.29</u>	<u>178,339.73</u>
Right of Use Assets			
Right-of-Use Assets	223,943.76	230,106.00	(6,162.24)
Accumulated Amortization-ROU	(116,642.82)	(202,777.25)	86,134.43
Total Right of Use Assets	<u>107,300.94</u>	<u>27,328.75</u>	<u>79,972.19</u>
Total Long Term Assets	<u>3,014,747.33</u>	<u>2,841,588.59</u>	<u>173,158.74</u>
Total Assets	<u>7,981,993.45</u>	<u>6,299,901.18</u>	<u>1,682,092.27</u>

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Financial Position

As of 3/31/2026

	<u>Current Year</u>	<u>Prior Year</u>	<u>Change</u>
Current Liabilities			
Accounts Payable	152,890.63	128,335.79	24,554.84
Accrued Expenses	53,131.31	30,944.63	22,186.68
Patient Refunds Due	6,243.71	4,835.86	1,407.85
Accrued Compensation and Related Liabilities	509,220.29	496,752.50	12,467.79
Medi-Cal Payable - Current Year	150,635.35	17,414.71	133,220.64
Medi-Cal Payable - Prior Year	273,070.21	29,930.91	243,139.30
Other Liabilities	49,201.00	49,201.00	0.00
Current Portion of Long Term Debt	38,918.85	0.00	38,918.85
Current Portion of LT Leases	48,998.62	33,222.17	15,776.45
Deferred Revenue	133,007.40	67,392.99	65,614.41
Total Current Liabilities	<u>1,415,317.37</u>	<u>858,030.56</u>	<u>557,286.81</u>
Long Term Debt			
Leases Payable - Long Term	60,833.18	0.00	60,833.18
Notes Payable	507,646.67	0.00	507,646.67
Total Long Term Debt	<u>568,479.85</u>	<u>0.00</u>	<u>568,479.85</u>
Total Liabilities	<u>1,983,797.22</u>	<u>858,030.56</u>	<u>1,125,766.66</u>
Net Assets			
Unrestricted Net Assets	5,511,315.66	5,816,433.70	(305,118.04)
Net Assets with Donor Restrictions	6,400.00	0.00	6,400.00
Current Year Net Excess/Deficit	480,480.57	(374,563.08)	855,043.65
Total Net Assets	<u>5,998,196.23</u>	<u>5,441,870.62</u>	<u>556,325.61</u>
Total Liabilities & Net Assets	<u>7,981,993.45</u>	<u>6,299,901.18</u>	<u>1,682,092.27</u>

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Activities

From 3/1/2026 Through 3/31/2026

	<u>MTD Actual</u>	<u>MTD Budget</u>	<u>Variance</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>
Patient Revenue						
Medi-Cal	194,936.96	215,734.00	(20,797.04)	1,558,744.57	1,847,241.00	(288,496.43)
Medicare	215,222.99	191,915.00	23,307.99	1,561,249.61	1,641,192.00	(79,942.39)
Family Pact	314.89	258.00	56.89	2,864.06	2,322.00	542.06
Insurance	65,882.29	86,480.00	(20,597.71)	559,953.32	739,648.00	(179,694.68)
Self Pay & Other	42,508.00	38,597.00	3,911.00	331,552.15	325,794.00	5,758.15
Sliding Scale & Other Write-Offs	(31,259.52)	(15,261.00)	(15,998.52)	(245,693.23)	(128,158.00)	(117,535.23)
Cost Report & Other Settlements	0.00	0.00	0.00	36,929.00	20,000.00	16,929.00
Patient Refunds	(86.98)	(417.00)	330.02	6,969.66	(3,753.00)	10,722.66
Total Patient Revenue	<u>487,518.63</u>	<u>517,306.00</u>	<u>(29,787.37)</u>	<u>3,812,569.14</u>	<u>4,444,286.00</u>	<u>(631,716.86)</u>
Operating Expenses						
Operating Expenses	798,005.28	837,169.00	39,163.72	7,269,902.73	7,387,083.00	117,180.27
Total Operating Expenses	<u>798,005.28</u>	<u>837,169.00</u>	<u>39,163.72</u>	<u>7,269,902.73</u>	<u>7,387,083.00</u>	<u>117,180.27</u>
Net Before Other Revenue	<u>(310,486.65)</u>	<u>(319,863.00)</u>	<u>9,376.35</u>	<u>(3,457,333.59)</u>	<u>(2,942,797.00)</u>	<u>(514,536.59)</u>
Grants & Other Revenue						
Grant Revenue-Federal 330	154,629.00	154,628.00	1.00	1,391,645.00	1,391,652.00	(7.00)
Grant Revenue-USAC	0.00	1,633.00	(1,633.00)	0.00	14,697.00	(14,697.00)
Grant Revenue-Other	85,666.78	5,413.00	80,253.78	195,942.65	189,854.00	6,088.65
340B Revenue (net)	3,246.28	14,718.00	(11,471.72)	144,641.60	131,088.00	13,553.60
Contract Revenue-CLSD	66,666.66	66,667.00	(0.34)	599,999.94	600,003.00	(3.06)
Partnership QIP Revenue	3,958.00	4,083.00	(125.00)	31,770.00	36,747.00	(4,977.00)
ARCH QIP Revenue	6,218.00	12,500.00	(6,282.00)	54,522.00	112,500.00	(57,978.00)
QIP-Other	0.00	341.00	(341.00)	0.00	3,069.00	(3,069.00)
Rental Income	817.00	3,125.00	(2,308.00)	21,488.00	28,125.00	(6,637.00)
Other Income	0.00	0.00	0.00	1,069,160.21	0.00	1,069,160.21
Interest & Dividends Earned	8,492.30	6,250.00	2,242.30	105,462.23	56,250.00	49,212.23
Total Grants & Other Revenue	<u>329,694.02</u>	<u>269,358.00</u>	<u>60,336.02</u>	<u>3,614,631.63</u>	<u>2,563,985.00</u>	<u>1,050,646.63</u>
Net Operating Income/(Loss)	<u>19,207.37</u>	<u>(50,505.00)</u>	<u>69,712.37</u>	<u>157,298.04</u>	<u>(378,812.00)</u>	<u>536,110.04</u>
Fundraising & Capital Activity						
Fundraising Income	10,147.00	48,229.00	(38,082.00)	344,213.39	414,746.00	(70,532.61)
Fundraising Expense	(992.34)	(4,756.00)	3,763.66	(33,881.77)	(42,804.00)	8,922.23
Donations	500.00	450.00	50.00	17,229.61	4,050.00	13,179.61
Realized/Unrealized Gains/(Losses)	(71,155.19)	0.00	(71,155.19)	(4,378.70)	0.00	(4,378.70)
Total Fundraising & Capital Activity	<u>(61,500.53)</u>	<u>43,923.00</u>	<u>(105,423.53)</u>	<u>323,182.53</u>	<u>375,992.00</u>	<u>(52,809.47)</u>
Net Excess of Revenue over Expenses	<u>(42,293.16)</u>	<u>(6,582.00)</u>	<u>(35,711.16)</u>	<u>480,480.57</u>	<u>(2,820.00)</u>	<u>483,300.57</u>

REDWOOD COAST MEDICAL SERVICES, INC.

Schedule of Expenses

From 3/1/2026 Through 3/31/2026

	Actual	Budget	Variance	YTD Actual	YTD Budget	Variance
Salaries & Wages						
Salaries & Wages	492,201.21	505,366.00	13,164.79	4,421,365.47	4,502,395.00	81,029.53
Total Salaries & Wages	492,201.21	505,366.00	13,164.79	4,421,365.47	4,502,395.00	81,029.53
Benefits						
Payroll Taxes	37,288.46	36,446.00	(842.46)	319,972.71	324,702.00	4,729.29
Health Insurance	52,465.50	64,790.00	12,324.50	433,646.08	464,208.00	30,561.92
Workmans Compensation	4,897.42	5,390.00	492.58	34,487.68	48,018.00	13,530.32
Retirement	2,130.96	2,521.00	390.04	18,049.78	22,459.00	4,409.22
Other Benefits	500.00	425.00	(75.00)	4,500.00	3,729.00	(771.00)
Total Benefits	97,282.34	109,572.00	12,289.66	810,656.25	863,116.00	52,459.75
Contracted Services						
Contracted Physician	0.00	1,555.00	1,555.00	5,220.00	13,855.00	8,635.00
Contracted NP	8,677.17	2,227.00	(6,450.17)	32,610.18	19,844.00	(12,766.18)
Contracted Dentist Svcs	1,625.00	1,219.00	(406.00)	6,437.50	10,862.00	4,424.50
Total Contracted Services	10,302.17	5,001.00	(5,301.17)	44,267.68	44,561.00	293.32
Total Compensation	599,785.72	619,939.00	20,153.28	5,276,289.40	5,410,072.00	133,782.60
Facility Expenses						
Depreciation-Facility	6,410.13	6,302.00	(108.13)	57,434.73	56,718.00	(716.73)
Amortization-Facility ROU	4,126.97	6,538.00	2,411.03	53,892.33	58,842.00	4,949.67
Interest Expense-Facility ROU	545.24	703.00	157.76	5,841.86	6,768.00	926.14
Janitorial	2,320.72	2,834.00	513.28	24,361.22	25,506.00	1,144.78
Rent	7,660.00	3,870.00	(3,790.00)	37,780.00	34,830.00	(2,950.00)
Repairs & Maint-Facility	911.79	3,508.00	2,596.21	16,767.47	31,572.00	14,804.53
Utilities	10,440.38	8,983.00	(1,457.38)	79,851.51	80,847.00	995.49
Real Estate Taxes	2,422.68	1,692.00	(730.68)	15,941.88	15,228.00	(713.88)
Total Facility Expenses	34,837.91	34,430.00	(407.91)	291,871.00	310,311.00	18,440.00
Other Expenses						
Advice Line	1,710.00	1,959.00	249.00	18,030.00	17,631.00	(399.00)
Audit Fees	18,750.00	0.00	(18,750.00)	18,750.00	21,500.00	2,750.00
Bad Debt	0.00	267.00	267.00	753.51	2,403.00	1,649.49
Bank Charges	727.42	958.00	230.58	8,162.91	8,622.00	459.09
Board Expense	1,856.00	1,917.00	61.00	16,576.00	17,253.00	677.00
Billing Services	1,688.58	2,413.00	724.42	14,934.84	21,717.00	6,782.16
Computer Supplies & Support	48,708.13	49,906.00	1,197.87	458,078.73	449,154.00	(8,924.73)
Consulting Fees	8,284.65	5,242.00	(3,042.65)	40,164.83	47,178.00	7,013.17
Consulting Fees - Accounting	1,260.34	8,375.00	7,114.66	77,008.99	75,375.00	(1,633.99)
Consulting Fees - Government Compliance	5,229.33	2,166.00	(3,063.33)	28,184.34	19,494.00	(8,690.34)
Consulting Fees - CFO	3,672.58	1,958.00	(1,714.58)	10,248.42	17,622.00	7,373.58
Continuing Education	1,620.00	1,567.00	(53.00)	15,159.48	14,103.00	(1,056.48)
Depreciation Expense	1,929.14	1,965.00	35.86	17,785.56	17,685.00	(100.56)
Donations/Contributions	528.00	1,283.00	755.00	1,894.00	11,547.00	9,653.00
Dues & Subscriptions	1,814.24	2,342.00	527.76	19,279.86	21,078.00	1,798.14
Employee Recognition	(375.00)	1,666.00	2,041.00	880.00	14,994.00	14,114.00
Equipment Lease	1,951.93	2,308.00	356.07	22,855.80	20,772.00	(2,083.80)
Fundraising Allocation	(992.34)	(939.00)	53.34	(10,586.78)	(8,451.00)	2,135.78
Infectious Waste Disposal	2,171.00	1,767.00	(404.00)	12,079.19	15,903.00	3,823.81
Insurance-General	2,902.00	2,667.00	(235.00)	29,722.07	24,003.00	(5,719.07)
Insurance-D&O	2,615.10	2,550.00	(65.10)	26,349.22	22,950.00	(3,399.22)

REDWOOD COAST MEDICAL SERVICES, INC.

Schedule of Expenses

From 3/1/2026 Through 3/31/2026

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>
Insurance-Malpractice	1,123.63	1,108.00	(15.63)	10,112.67	9,972.00	(140.67)
Interest Expense	3,431.30	0.00	(3,431.30)	3,877.30	0.00	(3,877.30)
Lab Services	369.66	5,634.00	5,264.34	32,564.46	50,706.00	18,141.54
Legal Fees	2,250.00	4,167.00	1,917.00	144,534.30	37,503.00	(107,031.30)
Minor Equipment	0.00	600.00	600.00	1,797.07	5,400.00	3,602.93
Outreach & Hlth Ed Matls Exp	1,084.00	1,208.00	124.00	10,807.66	10,872.00	64.34
Payroll Service Fees	2,362.08	2,483.00	120.92	23,041.56	22,347.00	(694.56)
Penalties & Late Fees	158.87	0.00	(158.87)	1,420.34	0.00	(1,420.34)
Postage & Shipping	750.00	942.00	192.00	7,711.77	8,478.00	766.23
Publicity/Advertising	0.00	667.00	667.00	11,385.73	6,003.00	(5,382.73)
Recruiting Expense	93.12	2,917.00	2,823.88	35,700.36	26,253.00	(9,447.36)
Recruiting-Moving Expense	0.00	833.00	833.00	0.00	7,497.00	7,497.00
Provider Housing	2,248.06	3,417.00	1,168.94	26,181.31	30,753.00	4,571.69
Repairs & Maint-Equipment	1,702.97	3,043.00	1,340.03	25,363.76	27,387.00	2,023.24
Retirement Administration	226.78	483.00	256.22	3,223.54	4,347.00	1,123.46
Supplies-Office	2,167.96	4,067.00	1,899.04	42,303.11	36,603.00	(5,700.11)
Supplies-Clinical	13,949.72	31,720.00	17,770.28	261,086.51	285,480.00	24,393.49
Supplies-Vaccines	3,303.31	3,555.00	251.69	35,583.14	31,995.00	(3,588.14)
Supplies-Pharmaceutical	546.24	2,703.00	2,156.76	14,649.51	24,327.00	9,677.49
Taxes & Licenses	888.00	1,024.00	136.00	16,891.40	9,216.00	(7,675.40)
Telephone/Communication	6,603.61	7,158.00	554.39	64,196.67	64,422.00	225.33
Transcription Services	0.00	3,842.00	3,842.00	12,446.81	34,578.00	22,131.19
Travel & Conferences	8,101.07	4,658.00	(3,443.07)	46,999.14	41,922.00	(5,077.14)
X-Ray Expenses	5,970.17	4,234.00	(1,736.17)	43,553.24	38,106.00	(5,447.24)
Total Other Expenses	<u>163,381.65</u>	<u>182,800.00</u>	<u>19,418.35</u>	<u>1,701,742.33</u>	<u>1,666,700.00</u>	<u>(35,042.33)</u>
Total Operating Expenses	<u>798,005.28</u>	<u>837,169.00</u>	<u>39,163.72</u>	<u>7,269,902.73</u>	<u>7,387,083.00</u>	<u>117,180.27</u>
Total Operating Expenses After Allocation	<u>798,005.28</u>	<u>837,169.00</u>	<u>39,163.72</u>	<u>7,269,902.73</u>	<u>7,387,083.00</u>	<u>117,180.27</u>

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Cash Flows

As of 3/31/2026

	<u>Current Period</u>	<u>Current Year</u>
Operating Activities		
Change in Net Assets	(42,293.16)	480,480.57
Adjustments to Reconcile Change in Net Assets to Cash		
Depreciation and Amortization	12,466.24	129,112.62
(Increase)/Decrease in Accounts Receivable	(19,418.72)	(70,122.38)
(Increase)/Decrease in Grants Receivable	(11,454.00)	(15,153.81)
(Increase)/Decrease Estimated Medi-Cal Receivable	17,634.00	17,634.00
(Increase)/Decrease in Prepaid Expenses	(16,606.00)	38,561.83
Increase/(Decrease) in Accounts Payable	29,538.48	42,642.91
Increase/(Decrease) in Accrued Expenses	43,801.49	(130,040.28)
Increase/(Decrease in Estimated Medi-Cal Payable	76,400.56	198,693.56
Increase/(Decrease) in Deferred Revenue	131,250.00	122,225.00
Total Adjustments to Reconcile Change in Net Assets to Cash	<u>263,612.05</u>	<u>333,553.45</u>
Total Operating Activities	<u>221,318.89</u>	<u>814,034.02</u>
Cash Flows from Investing Activities		
Investing Activities		
Building Improvements	0.00	(6,400.00)
Construction in Progress	(17,000.00)	(173,743.29)
Total Investing Activities	<u>(17,000.00)</u>	<u>(180,143.29)</u>
Total Cash Flows from Investing Activities	<u>(17,000.00)</u>	<u>(180,143.29)</u>
Cash Flows from Financing Activities		
Financing Activities		
Increase/(Decrease) in Notes Payable	(3,053.48)	546,565.52
Increase/(Decrease) in Leases Payable	(3,957.76)	(52,685.14)
Total Financing Activities	<u>(7,011.24)</u>	<u>493,880.38</u>
Total Cash Flows from Financing Activities	<u>(7,011.24)</u>	<u>493,880.38</u>
Increase/(Decrease) in Net Assets with Donor Restrictions	6,400.00	6,400.00
Net Increase(Decrease) in Cash	<u>203,707.65</u>	<u>1,134,171.11</u>
Cash at Beginning of Period	3,944,010.80	3,013,547.34
Cash at End of Period	<u>4,147,718.45</u>	<u>4,147,718.45</u>

**RCMS Investment Portfolio
and operational funds at Schwab
Quarterly Report**

as of March 31, 2026

for April 27, 2026 Finance Committee meeting

	symbol	3/31/26 Total Invest Accts at Schwab		Target Allocation	12/31/25 Balances	3/31/25 Balances	Change in Balances		Operational Funds at Schwab
		market value	% of total	% of total			last quarter since 12/31/25	last year since 3/31/25	
Cash (Schwab Bank)		\$25,237.34	1.3%		\$25,188.04	\$10,347.01	\$49.30	\$14,890.33	\$0.14
Schwab Govt Money Market Fund	SNVXX	\$577,982.26	29.7%		\$574,008.92	\$308,946.24	\$3,973.34	\$269,036.02	\$19.80
Schwab US Treasury Money Market Fund	SUTXX								\$794,258.10
Treasury Bills (\$240K, 6 month, maturing 3/6/25)		\$0.00	0.0%		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Treasury Bills (\$250K, 6 month, maturing 6/12/25)		\$0.00	0.0%		\$0.00	\$247,902.50	\$0.00	(\$247,902.50)	\$0.00
Total Cash & Treasuries		\$603,219.60	31.0%	20%	\$599,196.96	\$567,195.75	\$4,022.64	\$36,023.85	\$794,278.04
Fixed Income Funds:									
Angel Oak Multi-Strategy	ANGLX	\$40,692.80	2.1%	3%	\$40,314.08	\$38,377.11	\$378.72	\$2,315.69	\$0.00
Pimco Income	PONAX	\$60,062.89	3.1%	4%	\$60,456.32	\$56,404.94	(\$393.43)	\$3,657.95	\$0.00
Pimco Mortgage Opportunities	PMZAX	\$71,977.08	3.7%	5%	\$71,796.69	\$68,290.30	\$180.39	\$3,686.78	\$0.00
River Canyon Total Return	RCTIX	\$61,465.29	3.2%	4%	\$61,532.34	\$58,284.13	(\$67.05)	\$3,181.16	\$0.00
Thornburg Strategic Income	TSIAX	\$57,605.09	3.0%	4%	\$57,633.77	\$55,014.37	(\$28.68)	\$2,590.72	\$0.00
Total Fixed Income Funds		\$291,803.15	15.0%	20%	\$291,733.20	\$276,370.85	\$69.95	\$15,432.30	\$0.00
Equity Funds & Equities:									
Vanguard Dividend Appreciation ETF	VIG	\$231,276.32	11.9%	13%	\$235,431.40	\$205,283.32	(\$4,155.08)	\$25,993.00	\$0.00
Vanguard International Dividend Appreciation ETF	VIGI	\$151,507.16	7.8%	10%	\$155,615.51	\$138,911.41	(\$4,108.35)	\$12,595.75	\$0.00
Vanguard Total Stock Market ETF	VTI	\$264,472.17	13.6%	14%	\$275,532.70	\$223,943.79	(\$11,060.53)	\$40,528.38	\$0.00
T. Rowe Price Dividend Growth	PRDGX	\$224,535.61	11.5%	13%	\$225,774.14	\$201,380.13	(\$1,238.53)	\$23,155.48	\$0.00
Parnassus Core Equity Investor	PRBLX	\$169,225.68	8.7%	10%	\$180,354.08	\$157,603.57	(\$11,128.40)	\$11,622.11	\$0.00
Exxon Mobil Corp	XOM	\$7,634.70	0.4%	0%	\$5,415.30	\$0.00	\$2,219.40	\$7,634.70	\$0.00
Apple Inc	AAPL	\$2,284.11	0.1%	0%	\$2,446.74	\$0.00	(\$162.63)	\$2,284.11	\$0.00
Taiwan Semiconductor	TSM	\$3,041.55	0.2%	0%	\$2,735.01	\$0.00	\$306.54	\$3,041.55	\$0.00
Total Equity Funds		\$1,053,977.30	54.1%	60%	\$1,083,304.88	\$927,122.22	(\$29,327.58)	\$126,855.08	\$0.00
Total Schwab Accounts		\$1,949,000.05	100.0%	100%	\$1,974,235.04	\$1,770,688.82	(\$25,234.99)	\$178,311.23	\$794,278.04

Investment Subcommittee Meeting
April 9, 2026

Attendees: Drew McCalley, Jim Nybakken, Michael Tilles, Boris Albul, Linda Royal

Recommended action items for review and approval by the Finance Committee and Board:

1. Amend Investment Policy to include Treasury securities in Permitted Investments.
2. Retain SNVXX as our money market fund in the Cash section of our investment portfolio.
3. Retain all five of our current funds in the Fixed Income section of our portfolio.
4. In the Equity section of our portfolio, replace Vanguard International Dividend Appreciation ETF (VIGI) and Parnassus Core Equity Fund (PRBLX) with iShares MSCI ACWI ETF (ACWI), in order to improve global diversification.
5. Retain all of our asset allocation targets, with the VIGI and PRBLX targets combined into the new ACWI target.
6. After approval by the Finance Committee and Board, rebalance the portfolio to align with the target allocations.