April 30th, 2026, 5:00 pm
Pivotal Conference Room

I. **Approval of Agenda** *Welcome & Preliminaries: the focus for our meeting.*

II. **Public Comment:** *Guests and visitors can comment, with a maximum of 3 mins. per person.*

III. **Board Work on Ends, Linkage Activities, and Board Education** (*L. Rosado)*
   a. **Financial Audit Report –** RPC pg 1

IV. **Board Decisions (Motions) Actions:** *Only the Board has the authority to make them.* (*L. Rosado)*
   a. **Selection of Officers ***

V. **Consent Agenda** *Ratification and approval of minutes & non-debatable items ** (Board President)*
   a. Contracts April 2026 pg 15
   b. Check Register March 2026 pg 16
   c. Meeting Minutes March 2026 pg 19

VI. **Monitoring Reports** *Assuring Executive and Organizational Performance* (C. Bullock)
   a. **Public Executive Limitations:** *Is the organization operating within the boundaries the Board sets?*
      1. **EL V.02** – Treatment of Consumers* pg 23
      2. **EL V. 05** – Financials* pg 26
         a. Cashflow Analysis pg 32

VII. **Performance on Ends:** *Is the organization on track with its vision?* (C. Bullock)
   a. Report on Ends Accomplishments – Subpart 2 * pg 33
   b. Discussion on Implication of Ends Report- N/A

VIII. **Board Policy Review:** *Do our existing policies reflect the board's current values (Board President)*
   a. **VI.01** – Global Governance Commitment – E. Roberts pg 44
   b. **VI.02** – Board Job Description – Z. Reed. pg 45

IX. **Board Decisions (Motions) Actions:** *Only the Board has the authority to make them. (Board President)*
   a. **Compliance Plan *** pg 47
   b. **July Board Meeting**

X. **Board Work on Ends, Linkage Activities, and Board Education** *(Board President)*
   a. **Mental Health Code Check** – J. Cupp

XI. **Communications:** *Keep the Board current on significant events and operations.* (C. Bullock)
   a. **Directors' Report April 2026** pg 60
   b. **Strategic Plan Update Q2** pg 62
   c. **Attendance Calendar Year 26** pg 68
   d. **Customer Advisory Council Minutes April 2026** pg 70
   e. **Affinity House Advisory Board Agenda April 2026** pg 71

XII. **Process Review and Adjourn:** *How did we use our time, discuss relevant information, and make decisions according to our policies? What will we do in the next meetings to improve our preparation, debate, and process for decision-making? **

***Motion required **Roll Call Vote**
Recess is Available upon request.
IF YOU ARE UNABLE TO ATTEND, PLEASE GET IN TOUCH WITH THE BOARD OFFICE (269-467-1001 x 395). NEXT REGULAR MEETING: May 26th, 2026, 5 PM PIVOTAL BOARD ROOM.

Pivotal

Financial Statements
September 30, 2025

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

Independent Auditor's Report

To the Members of the Board
Pivotal
Centreville, Michigan

Report on the Audit of the Financial Statements

Opinions
We have audited the accompanying financial statements of the business-type activities and each major fund of Pivotal (the CMHSP) as of and for the year ended September 30, 2025, and the related notes to the financial statements, which collectively comprise the CMHSP's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and each major fund of the CMHSP as of September 30, 2025, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions
We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the CMHSP and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the CMHSP's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions.

Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the CMHSP's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the CMHSP's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 31, 2026, on our consideration of the CMHSP's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the CMHSP's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMHSP's internal control over financial reporting and compliance.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

March 31, 2026

Pivotal
Statement of Net Position
September 30, 2025

Current assets		
Cash and cash equivalents - unrestricted	$	3,766,909
Investments		6,054,752
Accounts receivable		44,685
Due from other governmental units		4,188,360
Prepaid expenses		257,555
Total current assets		14,312,261
Noncurrent assets		
Cash and cash equivalents - restricted		295,004
Capital assets not being depreciated		621,329
Capital assets being depreciated, net		1,668,196
Total noncurrent assets		2,584,529
Total assets		16,896,790
PY:		$12,645,030
Current liabilities		
Accounts payable		1,967,337
Accrued payroll and benefits		206,224
Incurred but not reported		132,284
Unearned revenue		15,976
Long-term liabilities, due within one year		354,604
Total current liabilities		2,676,425
Noncurrent liabilities		
Long-term liabilities, due beyond one year		1,044,157
Total noncurrent liabilities		1,044,157
Total liabilities		3,720,582
PY:		$4,084,969
Net position		
Net investment in capital assets		1,424,806
Unrestricted		11,751,402
Total net position	$	13,176,208
PY:		$8,560,061

The notes to the financial statements are an integral part of this statement.

Pivotal

Statement of Revenues, Expenses and Changes in Net Position

For the Year Ending September 30, 2025

Operating revenues		
Medicaid		$ 30,748,143
State and federal grants		1,941,461
County appropriations		257,268
Charges for services		677,732
Other		20,573
Total operating revenues		33,645,177
	PY:	$32,893,705
Operating expenses		
Salary and wages		6,748,149
Fringe benefits		2,328,057
Contracted services		18,634,392
Depreciation		280,061
Inpatient		42,812
Insurance		115,264
Local match drawdown		64,536
Miscellaneous		203,264
Professional fees		34,074
Rent		24,196
Repairs and maintenance		162,704
Supplies		155,739
Training and education		73,246
Travel		102,803
Utilities		125,221
Total operating expenses		29,094,518
	PY:	$30,327,167
Operating income (loss)		4,550,659
Nonoperating revenues (expenses)		
Gain/(loss) on sale of assets		4,500
Investment earnings/(loss)		88,789
Interest expense		(27,801)
Total nonoperating revenues (expenses)		65,488
Change in net position		4,616,147
	PY:	$2,624,872
Net position, beginning of year		8,560,061
Net position, end of year		$ 13,176,208

The notes to the financial statements are an integral part of this statement.

NOTE 4 - DUE FROM OTHER GOVERNMENTAL UNITS

Due from other governmental units as of September 30th consists of the following:

Description	Amount
Southwest Michigan Behavioral Health	4,116,171
State of Michigan	7,872
St. Joseph County	64,317
Total	4,188,360

NOTE 5 - CAPITAL ASSETS

A summary of changes in capital assets is as follows:

Description	Beginning Balance	Additions	Disposals	Transfers	Ending Balance
Capital assets not being depr/amort					
Land	309,398	-	-	-	309,398
Construction in process	67,097	244,834	-	-	311,931
Total capital assets not being depr/amort	376,495	244,834	-	-	621,329
Capital assets being depr/amort					
Buildings and improvements	2,756,446	-	-	-	2,756,446
Equipment and furnishings	315,579	31,127	-	-	346,706
Computers	178,900	-	-	-	178,900
Vehicles	181,115	140,977	(19,700)	-	302,392
Right to use – equipment	91,103	-	-	-	91,103
Right to use – building space	509,102	-	-	-	509,102
Total capital assets being depr/amort	4,032,245	172,104	(19,700)	-	4,184,649
Accumulated depr/amort					
Buildings and improvements	(1,543,711)	(113,927)	-	-	(1,657,638)
Equipment and furnishings	(165,376)	(19,721)	-	-	(185,097)
Computers	(178,900)	-	-	-	(178,900)
Vehicles	(125,880)	(26,372)	19,700	-	(132,552)
Right to use – equipment	(47,070)	(18,221)	-	-	(65,291)
Right to use – building space	(195,155)	(101,820)	-	-	(296,975)
Total accumulated depr/amort	(2,256,092)	(280,061)	19,700	-	(2,516,453)
Capital assets being depr/amort, net	1,776,153	(107,957)	-	-	1,668,196
Capital assets, net	2,152,648	136,877	-	-	2,289,525

NOTE 6 - UNEARNED REVENUE

The amount reported as unearned revenue represents revenues received in advance of the period earned as follows:

Description	Amount
Affinity House restricted donations	15,044
Other	932
Total	15,976

NOTE 7 - LONG-TERM LIABILITIES

Direct Borrowing
The detail of direct borrowings for the fiscal year is as follows:

Description	Original Borrowing	Interest Rate	Final Maturity	Outstanding at Year-end
2021 Building refinance	1,165,815	2.49%	2029	609,183

The CMHSP's outstanding loans from direct borrowings related to mental health operations contains provisions that in an event of default, either by (1) unable to make principal or interest payments (2) false or misrepresentation is made to the lender (3) become insolvent or make an assignment for the benefit of its creditors (4) if the lender at any time in good faith believes that the prospect of payment of any indebtedness is impaired. Upon the occurrence of any default event, the outstanding amounts, including accrued interest become immediately due and payable.

Summary of long-term debt
The changes in the long-term liabilities are as follows:

Description	Beginning Balance	Additions	Reductions	Ending Balance	Due within one year
Compensated absences	294,786	283,474	(44,218)	534,042	80,106
Direct borrowing	753,560	-	(144,377)	609,183	148,049
Leases (NOTE 8)	375,610	-	(120,074)	255,536	126,449
Totals	1,423,956	283,474	(308,669)	1,398,761	354,604

The requirements to pay principal and interest on the direct borrowing outstanding at year-end are shown below:

	Direct Borrowings	
Year Ended September 30	Principal	Interest
2026	148,049	13,485
2027	151,778	9,756
2028	155,600	5,933
2029	153,756	2,014
Total	609,183	31,188

NOTE 8 – LEASES

The CMHSP is involved in agreements as a lessee that qualify as long-term lease agreements. Below is a summary of the nature of these agreements. These agreements qualify as intangible, right-to-use assets and not financed purchases, as the CMHSP will not own the assets at the end of the contract terms and the noncancelable terms of the agreements surpass one year.

The right-to-use assets and the related activity are included in the capital asset disclosure. The lease liabilities and related activity are presented in the changes in long-term debt table included in the LONG-TERM LIABILITIES disclosure.

Description	Issuance Date	Interest Rate	Original Amount	Ending Balance
2022 Equipment lease	3/20/2022	8.64%	91,103	29,905
2023 Building lease – Sturgis	11/1/2022	2.49%	179,767	77,467
2023 Building lease – Three Rivers	11/1/2022	2.49%	329,335	148,164
Total				255,536

The requirements to pay principal and interest on the long-term lease arrangements outstanding at year-end, are shown below:

	Leases	
Year Ended September 30	Principal	Interest
2026	126,449	6,195
2027	119,746	1,931
2028	9,341	32
Total	255,536	8,158

NOTE 9 – RETIREMENT PLANS

Defined Contribution Retirement Plan – Alternative Social Security Plan

Plan Description
Effective February 1, 1989, certain employees of the CMHSP participate in a tax qualified retirement plan in lieu of the Social Security Retirement System. All non-union employees of the CMHSP are eligible to participate in the plan. Employees not eligible to participate in this plan are covered by the federal social security system.

Eligibility
All non-union employees are eligible to participate in the plan.

Contributions
Employer and employee contributions to this plan are at the rate of 6.2% of gross wages.

Normal Retirement Age & Vesting
Retirement age as defined by the plan is 55 years of age. All contributions are 100% vested immediately.

Forfeitures
Contributions are 100% vested immediately. Therefore, there are no forfeitures.

For the year ended September 30th, employer contributions amounted to $110,311. Employee contributions amounted to $110,311. The outstanding liability to the plan at year-end was $0.

Defined Contribution Retirement Plan – Money Purchase Pension Plan

Plan Description
The CMHSP offers all employees a money purchase pension plan created in accordance with the Internal Revenue Code, Section 401(a). The name of the plan is the "Community Mental Health Services of St. Joseph County Money

NOTE 15 – ECONOMIC DEPENDENCE

The CMHSP receives over 90% of its revenues from the State of Michigan either directly from MDHHS or indirectly through the CMHSP's regional entity.

NOTE 16 – CONSTRUCTION COMMITMENTS

The CMHSP has active construction projects as of September 30th. The projects include construction of a building. At September 30th, the CMHSP's commitments with contractors are as follows:

Description	Spent-to-Date	Remaining Commitment
Diekema Hamann Architecture, Inc - Contract 2	230,449	32,262

NOTE 17 – SUBSEQUENT EVENTS

On October 3, 2025, the CMHSP secured a construction loan of $4,600,000 for a new building. The interest rate on the loan is 5.5%. Once construction of the building is completed, the loan will be converted to a full mortgage at 5.5% with a maturity date of September 1, 2051.

NOTE 18 - UPCOMING ACCOUNTING PRONOUNCEMENTS

GASB Statement No 103, *Financial Reporting Model Improvements*, was issued by the GASB in April of 2024 and will be effective for fiscal year 2026. This Statement establishes new accounting and financial reporting requirements—or modifies existing requirements—related to the following:

a. Management's discussion and analysis (MD&A);
    i. Requires that the information presented in MD&A be limited to the related topics discussed in five specific sections:
        1) Overview of the Financial Statements,
        2) Financial Summary,
        3) Detailed Analyses,
        4) Significant Capital Asset and Long-Term Financing Activity,
        5) Currently Known Facts, Decisions, or Conditions;
    ii. Stresses detailed analyses should explain why balances and results of operations changed rather than simply presenting the amounts or percentages by which they changed;
    iii. Removes the requirement for discussion of significant variations between original and final budget amounts and between final budget amounts and actual results;
b. Unusual or infrequent items;
c. Presentation of the proprietary fund statement of revenues, expenses, and changes in fund net position;
    i. Requires that the proprietary fund statement of revenues, expenses, and changes in fund net position continue to distinguish between operating and nonoperating revenues and expenses and clarifies the definition of operating and nonoperating revenues and expenses;
    ii. Requires that a subtotal for *operating income (loss) and noncapital subsidies* be presented before reporting other nonoperating revenues and expenses and defines subsidies;
d. Information about major component units in basic financial statements should be presented separately in the statement of net position and statement of activities unless it reduces the readability of the statements in which case combining statements of should be presented after the fund financial statements;
e. Budgetary comparison information should include variances between original and final budget amounts and variances between final budget and actual amounts with explanations of significant variances required to be presented in the notes to RSI.

GASB Statement No. 104, *Disclosure of Certain Capital Assets*, was issued by the GASB in September 2024 and will be effective for the fiscal year 2026. This Statement requires certain types of capital assets to be disclosed separately in the capital assets note disclosures required by Statement No. 34. Lease assets recognized in accordance with Statement No. 87, Leases, and intangible right-to-use assets recognized in accordance with Statement No. 94, Public-Private and Public-Public Partnerships and Availability Payment Arrangements, should be disclosed separately by major class of underlying asset in the capital assets note disclosures. Subscription assets recognized in accordance with Statement No. 96, Subscription-based Information Technology Arrangements, also should be separately disclosed. In addition, this Statement requires intangible assets other than those three types to be disclosed separately by major class. This Statement also requires additional disclosures for capital assets held for sale.

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

To the Members of the Board
Pivotal
Centreville, Michigan

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities and each major fund of Pivotal (the CMHSP) as of and for the year ended September 30, 2025, and the related notes to the financial statements, which collectively comprise the CMHSP's basic financial statements, and have issued our report thereon dated March 31, 2026.

Report on Internal Control over Financial Reporting
In planning and performing our audit of the financial statements, we considered the CMHSP's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the CMHSP's internal control. Accordingly, we do not express an opinion on the effectiveness of the CMHSP's internal control.

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

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

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

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

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

March 31, 2026

Communication with Those Charged with Governance at the Conclusion of the Audit

To the Members of the Board
Pivotal
Centreville, Michigan

We have audited the financial statements of the business-type activities and each major fund of Pivotal (the CMHSP) for the year ended September 30, 2025. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you during planning. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Accounting Practices
Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the CMHSP are described in the notes to the financial statements. No new accounting policies were adopted, and the application of existing policies was not changed during the year. We noted no transactions entered into by the CMHSP during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the CMHSP's financial statements were:

> Management's estimate of the payout of employee compensated absences is based on expected payout. We evaluated the key factors and assumptions used to develop the balance of compensated absences in determining that it is reasonable in relation to the financial statements taken as a whole.
>
> Management's allocation of current and noncurrent compensated absences is based on an estimate of the percentage of employee's use of compensated absences.
>
> Management's estimated lives of capital assets are based on the expected life of the asset. We evaluated the key factors and assumptions used to develop the estimated lives of capital assets in determining that they are reasonable in relation to the financial statements taken as a whole.
>
> Management's estimated incremental borrowing rate used to discount future lease payments under GASB 87 is based on the entity's current borrowing rate. We evaluated the key factors and assumptions used to develop the estimated intrinsic borrowing rate in determining that it is reasonable in relation to the financial statements taken as a whole.
>
> Management 's estimated IBNR liability is based on historical data adjusted for payment patterns, cost trends, service and benefit mixes, seasonality, utilization of health care services, internal processing changes, the amount of time it took to pay claims from prior periods, changes in the past few months in the claims adjudication procedures, changes in benefits, events that would lead to excessive claims, large increases or decreases in membership, and other relevant factors.

The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit
We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements
Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to each opinion unit's financial statements taken as a whole.

Disagreements with Management
For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations
We have requested certain representations from management that are included in the management representation letter.

Management Consultations with Other Independent Accountants
In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the CMHSP's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the CMHSP's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters
We applied certain limited procedures to management's discussion and analysis which is required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Restriction on Use
This information is intended solely for the information and use of the Board and management of the CMHSP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

Contracts for Board Meeting 4/30/2026

Clinical Contracts

Provider Direct	Staff Responsible	Type of Service	Annual Budget Per Diem Cost	Explanation	Contract Dates	Board Approved
Flatrock	J. Cupp	Specialized Residential	H2015: $5.65-$12.25 H2016: $400-$800 T1020: $142.39-$375.51 T1017: $77.25	New Home	3/10/26-9/30/26	

Non-Clinical Contract

Provider Direct	Staff Responsible	Type of Service	Annual Budget Per Diem Cost	Explanation	Contract Dates	Board Approved
Miracle Lawn Service	C. Bullock	Lawn Care	Centreville Mowing: $65 per week Centreville Weed and Feed: $100 Centreville Spring Cleanup: $325 Centreville Fall Cleanup: $400 Centreville Garden Bed: $175 per month Three Rivers Mowing: $45 per week Three Rivers Weed and Feed: $60 Three Rivers Spring Cleanup: $225 Three Rivers Fall Cleanup: $300 Three Rivers Garden Bed: $100 per month	Centreville and Three Rivers Locations	Spring/Summer/Fall 2026	

PIVOTAL
Disbursements
March 2026

Payment Date	Check/RM #	Vendor	Amount	Description
03/06/26	RM-02044	BRANDI BELCHER	425.00	Contract-UM & Access
03/06/26	RM-02045	CAROL NACCARATO	208.00	Board Member
03/06/26	RM-02046	CRETSINGER CARE HOMES LTD	15,460.04	Specialized Residental
03/06/26	RM-02047	PARMETER AFC	8,455.72	Specialized Residental
03/06/26	RM-02048	PINE REST CHRISTIAN MHS	508.00	Inpatient Services
03/06/26	RM-02049	JETSY BEAN LLC	480.00	Contract-Mobile Crisis
03/06/26	RM-02050	TRAYBEE LLC	665.00	Contract-Mobile Crisis
03/06/26	RM-02051	KIF LLC	1,200.00	Contract-Mobile Crisis
03/06/26	RM-02052	MICHELLE CRITTENDEN LLC	1,400.00	Contract-Mobile Crisis
03/06/26	RM-02053	AMANDA MILLER	50.00	Board Member
03/06/26	RM-02054	DEAR COUNTRY AFC	13,340.00	Specialized Residental
03/06/26	RM-02055	GREAT LAKES CLEANING SERVICE	1,150.00	Janitorial Services
03/06/26	RM-02056	STACY LINIHAN	50.00	Board Member
03/06/26	RM-02057	LUIS ROSADO	50.00	Board Member
03/06/26	RM-02058	GIDDINGS AFC II	10,434.20	Specialized Residental
03/06/26	RM-02059	INSPIRATION STUDIO DESIGNS	2,225.91	Marketing/Supplies
03/06/26	RM-02060	AUTISM OF AMERICA LLC	3,055.50	Autism Services
03/06/26	RM-02061	NYUMBANI AFC	11,143.44	Specialized Residental
03/06/26	RM-02062	KONICA MINOLTA PREMIER FINANCE	1,875.25	Printer/Copier Lease
03/06/26	RM-02063	GIDDINGS AFC HOME LLC	11,480.00	Specialized Residental
03/06/26	RM-02064	LIFETREE BEHAVIORAL HEALTH LLC	83,460.28	Autism Services
03/06/26	RM-02065	ELISABETH ROBERTS	50.00	Board Member
03/06/26	RM-02066	CERTASITE LLC	1,260.60	Maintenance
03/06/26	RM-02067	RILEY PUMPKIN FARM	299.00	Snow Removal
03/06/26	RM-02068	RIPPLE EFFECTS AUTISM LEARNING CENTER	42,168.00	Autism Services
03/06/26	RM-02069	AUTISM SPECTRUM THERAPIES LLC	4,647.00	Autism Services
03/06/26	RM-02070	GAGAN S PC	16,112.00	Contract-Medical Director
03/06/26	RM-02071	PLEASANT PINES	35,067.40	Specialized Residental
03/06/26	RM-02072	DATA GUARDIAN	97.00	Utilities
03/06/26	RM-02073	BCA - STONECREST CENTER	891.00	Inpatient Services
03/06/26	RM-02074	HR ALLIANCE 1 INC	3,696.72	Fiscal Intermediary
03/06/26	RM-02075	CATHI ABBS	68.85	Board Member
03/06/26	RM-02076	KATHERINE DECKER	71.75	Board Member
03/06/26	RM-02077	PLEASANT ACRES LLC	40,531.20	Specialized Residental
03/06/26	RM-02078	THE MEADOWS	33,993.40	Specialized Residental
03/06/26	RM-02079	FALCO CORPORATION	9,229.92	Specialized Residental
03/06/26	RM-02080	SPECTRUM COMMUNITY SERVICES	11,038.20	Autism Services
03/06/26	RM-02081	MEYERS MOVING & STORAGE INC	183.06	Storage Fee
03/06/26	RM-02082	ADAPT INC	12,679.19	Specialized Residental
03/06/26	RM-02083	AGAPE AFC HOME	15,152.76	Specialized Residental
03/06/26	RM-02084	KONICA MINOLTA BUSINESS SOLUTIONS	812.45	Printer/Copier Lease
03/06/26	RM-02085	TWIN COUNTY COMMUNITY PROBATION CENTER	2,499.00	DRC Reimbursement
03/06/26	RM-02086	ST JOSEPH COMMUNITY CO-OP INC	15,252.86	Specialized Residental
03/06/26	RM-02087	STUART WILSON, CPA PC	15,729.80	Fiscal Intermediary
03/06/26	RM-02088	BRONSON-ACADIA JOINT VENTURE LLC	4,090.00	Inpatient Services
03/06/26	RM-02089	QLER PHYSICIAN MEDICAL GROUP	7,375.00	Contract-Psychiatry
03/06/26	RM-02090	WINGS OF HOPE LLC	42,778.81	Autism Services
03/06/26	RM-02091	WINGS OF HOPE - STURGIS	22,436.99	Autism Services
03/06/26	RM-02092	IRIS TELEHEALTH MEDICAL GROUP	19,776.00	Contract-Outpatient
03/06/26	RM-02093	CLARK LOGIC CAPITAL LLC	265.20	Lease-Three Rivers
03/06/26	RM-02094	HARDLINE SOLUTIONS LLC	3,050.00	Maintenance
03/06/26	RM-02095	MRC INDUSTRIES INC	5,146.54	CLS Services
03/06/26	RM-02096	HEATHER TEADT LLC	2,340.00	Contract-Mobile Crisis
03/06/26	RM-02097	LOCUMTENENS.COM LLC	1,792.00	Contract-Outpatient
03/06/26	065581	CITY OF THREE RIVERS	129.32	Utilities
03/06/26	065582	SEMCO ENERGY GAS COMPANY	1,114.37	Utilities
03/06/26	065583	LRS, LLC	180.50	Utilities
03/06/26	065584	HAVENWYCK HOSPITAL	954.00	Inpatient Services
03/06/26	065585	FIDELITY SECURITY LIFE (Eye Med)	1,068.83	Employee Benefits
03/06/26	065586	VERIZON WIRELESS	3,747.87	Utilities
03/06/26	065587	COMCAST	249.92	Utilities
03/06/26	065588	MICHIGAN GAS UTILITIES	222.42	Utilities

PIVOTAL
Disbursements
March 2026

03/06/26	065589	CINTAS CORP	204.95	Supplies
03/06/26	065590	FOUNTAIN HOUSE INC	5,000.00	Employee Training
3/6/2026	065591	SCHOOL OF SOCIAL WORK-CONTINUING EDUCATION	75.00	Employee Training
03/13/26	RM-02098	GRYPHON PLACE	703.30	Contract-After Hours Emergency
03/13/26	RM-02099	MICHIGAN ORGANIZING COMMITTEE 925	1,480.45	Union Dues
03/13/26	RM-02100	ST JO CO UNITED WAY	204.00	Employee Donations
03/13/26	RM-02101	HOLLY LAGO LLC	2,790.00	Contract-Mobile Crisis
03/13/26	RM-02102	JETSY BEAN LLC	1,260.00	Contract-Mobile Crisis
03/13/26	RM-02103	ISOLVED BENEFIT SERVICES	82.69	Employee Benefits
03/13/26	RM-02104	GREAT LAKES CLEANING SERVICE	940.00	Janitorial Services
03/13/26	RM-02105	MIRACLE'S LAWN SERVICE	1,800.00	Snow Removal
03/13/26	RM-02106	CERTASITE LLC	3,115.92	Maintenance
03/13/26	RM-02107	THE TM GROUP INC	3,195.09	IT Subscription
03/13/26	RM-02108	GAGAN S PC	8,586.00	Contract-Medical Director
03/13/26	RM-02109	AMN HEALTHCARE LANGUAGE SERVICES INC	962.04	Interpretive Service
03/13/26	RM-02110	KENDRICK STATIONERS INC	285.99	Office Desk
03/13/26	RM-02111	BRIDGETTE MULVANEY LMSW LLC	6,090.00	Contract-Mobile Crisis
03/13/26	RM-02112	KATHLEEN MORRILL	700.00	Contract-Supervision
03/13/26	RM-02113	LOCUMTENENS.COM LLC	15,000.00	Contract-Outpatient
03/13/26	065592	WEX BANK	1,048.08	Gas Cards
03/13/26	065593	CHASE CARD SERVICES	17,401.62	Credit Card
03/13/26	065594	FRONTIER	490.07	Utilities
03/13/26	065595	HOSPITAL NETWORK HEALTHCARE SERVICES	66.78	Medical Waste Removal
03/13/26	065596	COMCAST	419.70	Utilities
03/13/26	065597	SUMMIT POINTE	2,000.00	Contract-Customer Service
03/13/26	065598	CLIENT	250.00	Client Refund
03/20/26	RM-02114	LYNELLE GIRTON-THRASHER	250.00	Contract-Supervision
03/20/26	RM-02115	ST JO CO TRANSPORTATION AUTHORITY	2,910.00	Clubhouse Transportation
03/20/26	RM-02116	TRAYBEE LLC	1,080.00	Contract-Mobile Crisis
03/20/26	RM-02117	DEAR COUNTRY AFC	14,342.80	Specialized Residental
03/20/26	RM-02118	KRISTI MERRILLS PLC	2,340.00	Contract-Mobile Crisis
03/20/26	RM-02119	GREAT LAKES CLEANING SERVICE	1,150.00	Janitorial Services
03/20/26	RM-02120	GREATER HEIGHTS AFC	9,759.96	Specialized Residental
03/20/26	RM-02121	AUTISM OF AMERICA LLC	15,327.00	Autism Services
03/20/26	RM-02122	MAPLECREST LLC	8,254.76	Lease-Sturgis
03/20/26	RM-02123	LIFETREE BEHAVIORAL HEALTH LLC	56,826.40	Autism Services
03/20/26	RM-02124	AUNALYTICS INC	504.00	IT Subscription
03/20/26	RM-02125	RIPPLE EFFECTS AUTISM LEARNING CENTER	34,059.00	Autism Services
03/20/26	RM-02126	GAGAN S PC	9,222.00	Contract-Medical Director
03/20/26	RM-02127	FLATROCK MANOR	46,487.76	Specialized Residental
03/20/26	RM-02128	ERICA A SAGE	382.50	Contract-OBRA
03/20/26	RM-02129	RESIDENTIAL OPPORTUNITIES INC	97,293.00	Specialized Residental
03/20/26	RM-02130	COMMUNITY LIVING OPTIONS	25,660.69	Specialized Residental
03/20/26	RM-02131	ADAPT INC	352,546.86	Specialized Residental
03/20/26	RM-02132	KONICA MINOLTA BUSINESS SOLUTIONS	3,000.00	Printer/Copier Lease
03/20/26	RM-02133	BEACON SPECIALIZED LIVING SERVICES INC	12,600.00	Specialized Residental
03/20/26	RM-02134	ST JOSEPH COMMUNITY CO-OP INC	2,956.36	Specialized Residental
03/20/26	RM-02135	STUART WILSON, CPA PC	3,649.16	Fiscal Intermediary
03/20/26	RM-02136	KENDRICK STATIONERS INC	1,727.98	Office Desks
03/20/26	RM-02137	REBEKAH WAGAMAN	2,250.00	Contract-Mobile Crisis
03/20/26	RM-02138	BRONSON-ACADIA JOINT VENTURE LLC	32,200.00	Inpatient Services
03/20/26	RM-02139	WINGS OF HOPE LLC	3,390.00	Autism Services
03/20/26	RM-02140	BLUE CARE NETWORK OF MICHIGAN	134,585.46	Employee Benefits
03/20/26	RM-02141	RADIANT AFC	11,764.50	Specialized Residental
03/20/26	RM-02142	WINGS OF HOPE - STURGIS	4,682.28	Autism Services
03/20/26	RM-02143	KINGDOM REST CENTER LLC	56,000.00	Specialized Residental
03/20/26	RM-02144	HARDLINE SOLUTIONS LLC	1,275.00	Maintenance
03/20/26	RM-02145	MRC INDUSTRIES INC	1,277.55	CLS Services
03/20/26	RM-02146	GOD'S WILL AFC	20,440.00	Specialized Residental
03/20/26	RM-02147	AR ENGINEERING LLC	2,151.00	Parking Lot Redesign
03/20/26	065599	CITY OF STURGIS	2,179.12	Utilities
03/20/26	065600	WASTE MANAGEMENT OF MICHIGAN	260.06	Utilities
03/20/26	065601	ALTERNATIVE CHOICES	3,602.40	Specialized Residental
03/20/26	065602	STATE OF MICHIGAN	18,912.50	DFA Payment #2

PIVOTAL
Disbursements
March 2026

Date	Check/RM	Payee	Amount	Description
03/20/26	065603	HAVENWYCK HOSPITAL	6,678.00	Inpatient Services
03/20/26	065604	COMMUNITY MENTAL HEALTH ASSOC OF MICHIGAN	15,150.00	2026 Special Assessment
03/20/26	065605	VERIZON WIRELESS	112.03	Utilities
03/20/26	065606	INDIANA MICHIGAN POWER	454.01	Utilities
03/20/26	065607	VILLAGE OF CENTREVILLE	719.44	Utilities
03/20/26	065608	MEDICAL BEHAVIORAL HOSPITAL OF MICHIGAN LLC	1,061.00	Inpatient Services
03/20/26	065609	SCHOOL OF SOCIAL WORK-CONTINUING EDUCATION	1,275.00	Employee Training
03/27/26	RM-02148	BRANDI BELCHER	100.00	Contract-Access
03/27/26	RM-02149	TRACEY COLE	100.00	Employee Reimbursement
03/27/26	RM-02150	VICKY MERRILLS	28.00	Employee Reimbursement
03/27/26	RM-02151	ST JO CO UNITED WAY	204.00	Employee Donations
03/27/26	RM-02152	RML3 LLC	1,500.00	Contract-Mobile Crisis
03/27/26	RM-02153	HOLLY LAGO LLC	450.00	Contract-Mobile Crisis
03/27/26	RM-02154	TRAYBEE LLC	665.00	Contract-Mobile Crisis
03/27/26	RM-02155	GREAT LAKES CLEANING SERVICE	1,150.00	Janitorial Services
03/27/26	RM-02156	AMERICAN UNITED LIFE INSURANCE COMPANY	4,205.69	Employee Benefits
03/27/26	RM-02157	RILEY PUMPKIN FARM	370.00	Snow Removal
03/27/26	RM-02158	GAGAN S PC	8,374.00	Contract-Medical Director
03/27/26	RM-02159	KONICA MINOLTA BUSINESS SOLUTIONS	180.00	Printer/Copier Lease
03/27/26	RM-02160	KENDRICK STATIONERS INC	272.00	Office Furniture
03/27/26	RM-02161	CLARK LOGIC CAPITAL LLC	6,509.28	Lease-Three Rivers
03/27/26	RM-02162	HEATHER TEADT LLC	2,851.90	Contract-Mobile Crisis
03/27/26	RM-02163	PAUL DELMARK	56.46	Employee Reimbursement
03/27/26	065610	FRED'S PHARMACY	692.89	ACT Clients Pharmacy
03/27/26	065611	DELTA DENTAL	8,278.84	Employee Benefits
03/27/26	065612	FARMERS STATE BANK	15,406.45	Mortgage
03/27/26	065613	GRIFFIN PEST SOLUTIONS	132.00	Maintenance
03/27/26	065614	CINTAS CORP	756.95	Supplies
		Total Amount of Non-Void Checks/RMs	1,694,549.99	
03/03/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	223.86	Employee Benefits
03/04/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	14.00	Employee Benefits
03/05/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	66.88	Employee Benefits
03/09/26	Electronic Debit	PAYCOR INC	3,230.56	Employee Payroll
03/12/26	Electronic Debit	PAYCOR INC	192,536.43	Employee Payroll
03/12/26	Electronic Debit	PAYCOR INC	62,034.99	Employee Payroll
03/12/26	Electronic Debit	PAYCOR INC	651.12	Employee Payroll
03/12/26	Electronic Debit	PAYCOR INC	169.89	Employee Payroll
03/12/26	Electronic Debit	EMPOWER	12,940.20	Employee Benefits
13/12/26	Electronic Debit	EMPOWER	8,877.80	Employee Benefits
03/12/26	Electronic Debit	EMPOWER	16,589.39	Employee Benefits
03/13/26	Electronic Debit	OPTUM BANK	8,435.92	Employee Benefits
03/19/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	144.16	Employee Benefits
03/20/26	Electronic Debit	TRIZETTO PROV SO DIRECT PAY	864.27	ACH Fees
03/20/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	66.00	Employee Benefits
03/24/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	700.00	Employee Benefits
03/26/26	Electronic Debit	PAYCOR INC	195,875.78	Employee Payroll
03/26/26	Electronic Debit	PAYCOR INC	62,113.72	Employee Payroll
03/26/26	Electronic Debit	PAYCOR INC	651.12	Employee Payroll
03/26/26	Electronic Debit	PAYCOR INC	169.89	Employee Payroll
03/26/26	Electronic Debit	EMPOWER	12,464.42	Employee Benefits
03/26/26	Electronic Debit	EMPOWER	8,886.50	Employee Benefits
03/26/26	Electronic Debit	EMPOWER	16,791.41	Employee Benefits
03/26/26	Electronic Debit	TRANSFER TO FLEX BENEFITS ACCOUNT	52.00	Employee Benefits
03/27/26	Electronic Debit	OPTUM BANK	8,625.92	Employee Benefits
03/31/26	Electronic Debit	CENTURY BANK ACH FEES	29.24	ACH Fees
		Total Amount of Electronic Debits	613,205.47	
		Total Disbursements	2,307,755.46	

MEETING MINUTES OF MARCH 31ST, 2026

PIVOTAL CONFERENCE ROOM

OFFICERS PRESENT: Luis Rosado - Chair (arrived 5:03), Cathi Abbs - Vice Chair, Kay Decker - Secretary

MEMBERS PRESENT: Zach Reed, Damon Knapp, Amanda Miller, Stacy Linihan, Carol Naccarato, Rick Shaffer

MEMBERS ABSENT: Raul Morales, Elisabeth Roberts, Darci Skrzyniarz

VISITORS: Stacey Delmark, Alan Boulter – CMHA, Representative Steve Carra, Greg Deeds

CALL TO ORDER

Cathi Abbs, Vice Chair, called the meeting to order at 17:00

REVIEW OF AGENDA

GUESTS, VISITORS & PUBLIC COMMENTS

N/A

BOARD WORK ON ENDS, LINKAGE ACTIVITIES AND BOARD EDUCATION

Alan Bolter, CMHA, presented.

Representative Steve Carra presented.

CONSENT AGENDA:

a. Contracts March 2026
b. Check Register March 2026, $2,304,355.30
c. Meeting Minutes February 2026

A MOTION WAS MADE BY SHAFFER, SECONDED BY DECKER, TO APPROVE THE CONSENT AGENDA. ROLL CALL VOTE. ALL IN FAVOR/NONE OPPOSED. MOTION CARRIED.

MONITORING REPORTS - EXECUTIVE LIMITATIONS

EL V. 09 – COMMUNICATION AND SUPPORT TO THE BOARD

Bullock, CEO, presented.

A MOTION WAS MADE BY SHAFFER, SECONDED BY ABBS, TO APPROVE EL V. 09, COMMUNICATION AND SUPPORT TO THE BOARD. ALL IN FAVOR/NONE OPPOSED. MOTION CARRIED

EL V. 05 - FINANCIALS – CASHFLOW ANALYSIS

E. Versteeg, CFO, presented.

A MOTION WAS MADE BY KNAPP, SECONDED BY MILLER, TO APPROVE EL V. 05, FINANCIALS – CASHFLOW ANALYSIS. ALL IN FAVOR/NONE OPPOSED. MOTION CARRIED.

PERFORMANCE ON ENDS

Report On Ends Accomplishments – N/A
Discussion on Implication of Ends Report – N/A

BOARD POLICY REVIEW

III.02 – UNITY OF CONTROL - Carol Naccarato presented.

III.03 – ACCOUNTABILITY TO THE CEO - Damon Knapp presented.

III.04 – DELEGATION TO THE CEO - Rick Shaffer presented.

BOARD DECISIONS (MOTIONS) ACTIONS

PARKING LOT GMAX

Bullock, CEO, presented. Greg Deeds of Frederick Construction commented. The Pivotal Parking and Storm Improvements Bid Package Award Recommendations report was reviewed with the board. The board agreed to allow the CEO to sign and approve the project portions as needed to complete the project.

A MOTION WAS MADE BY KNAPP, SECONDED BY REED, TO APPROVE THE PARKING LOT GMAX NOT TO EXCEED $909,837.80. ROLL CALL VOTE. ALL IN FAVOR/NONE OPPOSED. MOTION CARRIED.

BOARD REAPPOINTMENTS

Bullock, CEO, presented. Amanda Miller, Zach Reed, Damon Knapp, and Elisabeth Roberts all indicated a desire to remain on the board. Upon board approval, Bullock, CEO, will submit to the county commissioners for reapproval.

A MOTION WAS MADE BY NACCARATO, SECONDED BY DECKER, TO APPROVE THE BOARD REAPPOINTMENTS OF MILLER, REED, KNAPP, AND ROBERTS. ALL IN FAVOR/NONE OPPOSED. MOTION CARRIED.

COMMUNICATIONS

Bullock, CEO, presented the following from the board packet:

a. Board skip-level meeting.
b. Director's report – March 2026.
c. Letter to MDHHS.
d. April is Board Executive level reappointments.

MEETING ADJOURNED AT: 18:23

Signature_________________________________ ____________________
Kay Decker, Secretary Date

BOARD POLICY V.02

AREA:	Governance		
POLICY TYPE:	Executive Limitations	PAGE:	1 of 1
POLICY TITLE:	TREATMENT OF CONSUMERS	EFFECTIVE: REVIEWED:	09/28/2022 04/30/2026

POLICY:

With respect to interactions with consumers or those applying to be consumers, the CEO will not cause or allow conditions, procedures, or decisions that are unsafe, undignified, or unnecessarily intrusive.

The CEO will not

1. Elicit information for which there is no clear necessity.

Executive Officer Response: It is a priority at Pivotal to handle the information I access with the utmost care, ensuring we meet our commitment to providing exceptional support for our clients while strictly protecting their privacy. I only share these details when it is truly essential for someone's care or operations, making sure that sensitive data never reaches anyone without a direct and legitimate reason to see it. To keep us aligned with HIPAA and all privacy laws, I work closely with our team and our Chief Compliance Officer to uphold the high standards of confidentiality our community expects from us.

2. Use methods of collecting, reviewing, transmitting, or storing client information that fail to protect against improper access to the material elicited.

Executive Officer Response: To keep our sensitive information secure at Pivotal, we use several layers of protection that help us maintain the trust of those we serve. For instance, our email system is set up to encrypt any health information we send to authorized partners, ensuring that data stays private even in transit. We also secure our hardware by equipping every laptop with BitLocker encryption, which means no one can even get to the login screen without the proper credentials.
Behind the scenes, we keep our server access strictly limited to the IT team to prevent any unauthorized entry. Within our PCE electronic health record system and our remote email access, we require two-step verification to add an extra level of certainty about who is logging in. To stay ahead of potential risks, we also make it a point to update our passwords at least every 90 days. All

of these steps work together to create a reliable environment where client data remains safe and sound.

3. Operate facilities without appropriate accessibility and privacy.

Executive Officer Response: We are committed to making sure our services are reachable for everyone, and nearly all of our locations are currently fully ADA accessible. The Board has recently approved expansive updates to our Centreville locations to ensure that we are up to date with current ADA standards. We are actively working on a solution for our Sturgis office to ensure it meets those same accessibility standards.

While the property owner has declined to fund the $13,000 in necessary upgrades, we believe it isn't appropriate for us to invest in permanent structural improvements for a building we do not own. To prioritize our clients' needs in the meantime, we have put a workaround in place that allows us to provide accessible care while we continue to advocate for a more permanent fix at that site. This workaround included the removal of a door to the entryway and a doorbell that rings at reception to be able to assist with any persons who may need additional help.

4. Allow consumers to be unaware of what may be expected and what may not be expected from services.

Executive Officer Response: When someone begins their journey with us at Pivotal, we make it a priority to ensure they have all the information they need to feel empowered and informed. We provide every client with a rights booklet, either a physical copy or clear instructions on how to access it online, so they fully understand their protections and options.

Our treatment plans are designed to be transparent, clearly outlining exactly which services will be provided and the specific goals we are working toward together. To help new clients settle in, we also provide a comprehensive welcome booklet. This includes a detailed guide to our services, information regarding any upcoming appointments, and easy ways to get in touch with us if any other questions come up.

5. Leave consumers uninformed of this policy, or without a way to be heard for persons who believe they have not been accorded a reasonable interpretation of their protections under this policy.

Executive Officer Response: We make it a priority to keep our operations transparent and accessible to everyone we serve. Our board policies are available online for anyone to review, and we share our meeting minutes and board packets publicly so you can stay informed about our decision-making process. To make it easier for community members to join us, our board meetings are held at consistent, pre-scheduled times to prevent any confusion caused by last-minute changes.

We also want to ensure that every voice is heard, which is why we have a dedicated customer grievance and appeals department. If you have a concern, a specialized staff member will personally review your case and provide thoughtful recommendations based on a thorough review

of the facts. It's important to us that you have a clear, reliable way to share your feedback and see it acted upon

BOARD POLICY V.05

AREA:	Governance		
POLICY TYPE:	Executive Limitations	PAGE:	1 of 2
POLICY TITLE:	FINANCIAL CONDITIONS/ACTIVITIES (APRIL '26)	EFFECTIVE: REVIEWED:	09/28/2022 04/30/2026

POLICY:

With respect to the actual, ongoing financial condition and activities, the CEO will not cause or allow the development of fiscal jeopardy or material deviation of actual expenditures from board priorities established in Ends policies.

The CEO will not

1. Expend more funds than have been received in the fiscal year to date, with the exception of federal, state, and local required services.

Executive Officer Response: We are currently underspent in Medicaid at just over $659k, and in the Health Michigan Plan, we are overspent by $230k. For a total Medicaid surplus of just under $430k. We are still $1.3 million short of revenue expectations from Milliman.

2. Use any long-term reserves.

Executive Officer Response- No long-term reserves have been expended.

3. Allow payroll and debts to be settled in an untimely manner.

Executive Officer Response- All debts have been settled in a timely manner.

4. Allow tax payments or other government-ordered payments or filings to be overdue or inaccurately filed.

Executive Officer Response- Tax payments are paid for through Paycor as an automatic process.

5. Make a single purchase or commitment of greater than $20,000. Splitting orders to avoid this limit is not acceptable.

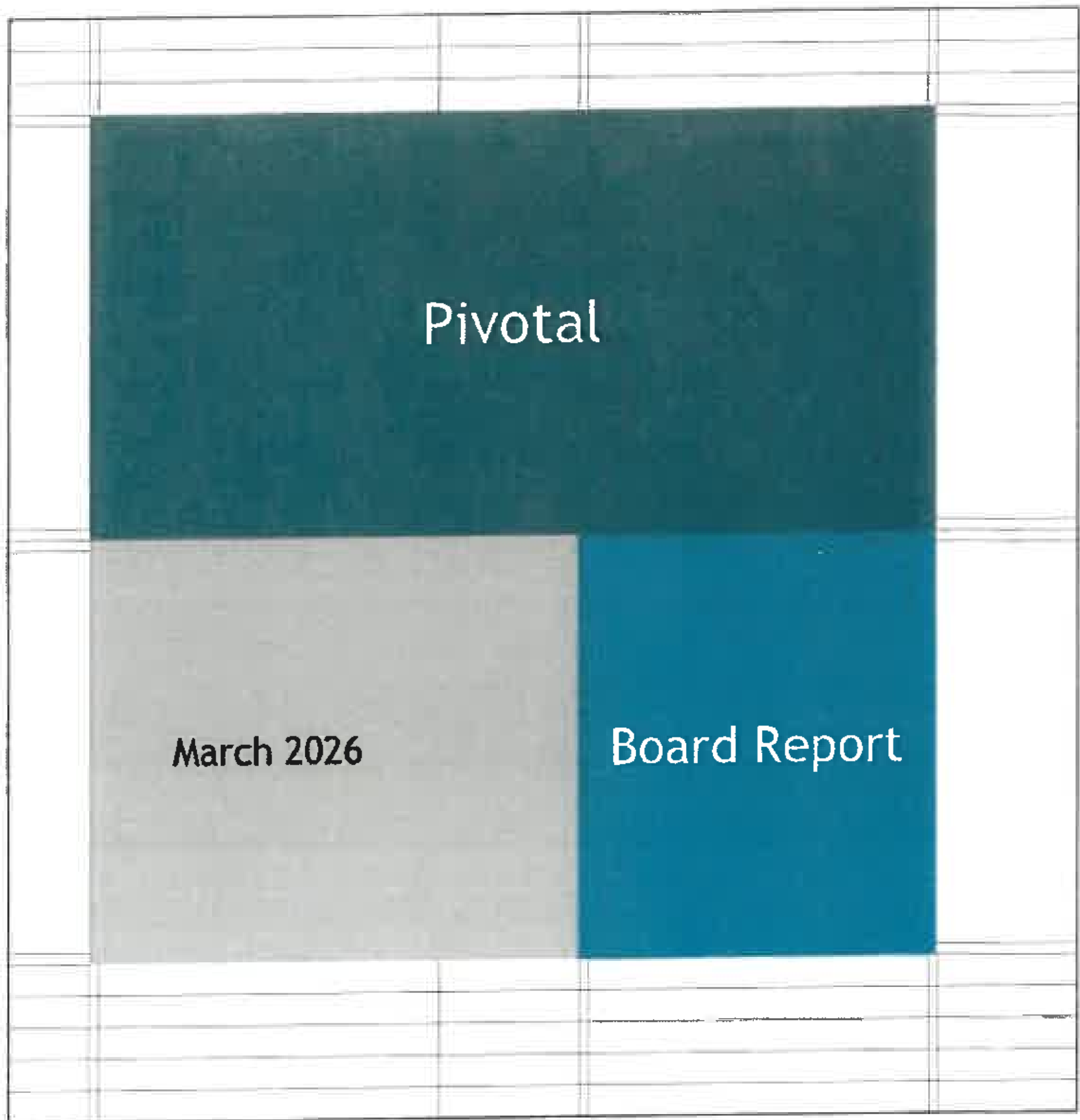
Executive Officer Response- No purchases greater than $20,000 occurred.

6. Acquire, encumber or dispose of real estate.

Executive Officer Response- No real estate transactions have taken place.

7. Allow receivables to be unpursued after a reasonable grace period.

Executive Officer Response- Policies of uncollected funds are being followed and adhered to. Should the board wish to aggressively pursue collections, such as collection agencies, I will do so. However, current practices require you to bill repeatedly for 4 months, and if you can't or don't pay, the bill is then written off.


Pivotal
March 2026
Board Report

Pivotal

Statement of Activities
October 1, 2025 through March 31, 2026

	Operating Fund	Projected Total Activities	Prior Year Total Activities	Favorable (Unfavorable)
Operating revenue				
SWMBH Funding				
Medicaid capitation	$ 9,378,247	$ 18,756,494	$ 19,122,295	$ (365,801)
Medicaid capitation - Settlement	659,118	1,318,236	660,144	658,092
Healthy Michigan Plan	859,153	1,718,306	2,290,308	(572,002)
Healthy Michigan Plan - Settlement	(230,272)	(460,544)	47,880	(508,424)
CCBHC FFS Payments	4,429,488	8,858,976	5,349,080	3,509,896
CCBHC FFS Payments	1,560,977	3,121,954	2,741,514	380,440
SUD Block Grant	60,499	120,998	81,152	39,846
Federal & State Sources				
State general fund	521,280	1,042,560	1,042,561	(1)
State general fund - Settlement	-	-	-	-
Federal and state grants	301,413	602,826	794,952	(192,126)
Local revenue				
County appropriation	128,634	257,268	257,268	-
Client fees	221,440	442,880	410,087	32,793
Performance Based Incentive Progr	-	-	817,404	(817,404)
Rent revenue	6,060	12,120	9,960	2,160
Other revenue	29,178	58,356	113,865	(55,509)
Total operating revenue	17,925,215	35,850,430	33,738,469	2,111,961
Operating expenses				
Administration	2,538,993	5,077,986	4,730,862	347,124
Internal Services	3,309,046	6,618,092	6,113,513	(504,579)
Provider claims	9,021,320	18,042,640	16,827,204	(1,215,436)
Grant expenses	221,619	443,238	796,626	353,388
Vehicles	30,131	60,262	53,759	(6,503)
Facilities	356,717	713,434	600,356	(113,078)
Total operating expenses	15,477,826	30,955,652	29,122,320	(1,139,083)
Change in net position	2,447,389	4,894,778	4,616,149	278,629
Net position, beginning of year	13,176,209	13,176,209	8,560,060	
Net position, end of year	$15,623,598	$ 18,070,987	$ 13,176,209	

Pivotal

Statement of Position
Proprietary Funds
March 31, 2026

	Operating Fund	Balance September 30 2025	Favorable (Unfavorable)
ASSETS			
Cash position	$ 4,574,596	$ 4,061,913	$ 512,683
Investments	6,057,705	6,054,752	2,953
Receivables:			
Accounts receivable	49,779	44,685	5,094
Due from State of Michigan	1,578,485	7,872	1,570,613
Due from SWMBH	4,595,572	286,881	4,308,691
Due from other governments	64,317	64,317	-
Prepaid items	283,369	257,555	25,814
Capital assets not being depreciated	-	-	-
Capital assets being depreciated, net	2,201,615	2,289,525	(87,910)
Total assets	19,405,438	13,067,500	6,337,938
LIABILITIES			
Accounts payable	2,272,925	2,099,620	173,305
Due to MDHHS	-	-	-
Due to SWMBH	-	(3,829,290)	3,829,290
Accrued liabilities	229,408	206,224	23,184
Unearned revenue	17,150	15,976	1,174
Long-term debt:			
Due within one year	-	-	-
Due in more than one year	535,610	609,183	(73,573)
Lease liability	192,705	255,536	(62,831)
Accrued sick and vacation	534,042	534,042	0
Total liabilities	3,781,840	(108,709)	3,890,549
NET POSITION			
Net investment in capital assets	1,666,005	1,680,342	1,680,342
Unrestricted	13,957,593	11,495,867	2,461,726
Total net position	$ 15,623,598	##########	$ 2,447,389

Pivotal

Statement of Activities

Budget to Actual - October 1, 2025 through March 31, 2026

	Original Budget	YTD Budget	YTD Actual	Over (Under) Budget
Operating revenue				
SWMBH Funding				
Medicaid capitation	$21,525,540	$ 10,762,770	$ 9,378,247	$ (1,384,523)
Medicaid capitation - Settlement	-	-	659,118	659,118
Healthy Michigan Plan	2,309,457	1,154,729	859,153	(295,576)
Healthy Michigan Plan - Settlement	-	-	(230,272)	(230,272)
CCBHC FFS Payments	6,057,205	3,028,603	4,429,488	1,400,886
CCBHC Accrual Estimate	-	-	1,560,977	1,560,977
SUD Block Grant	78,968	39,484	60,499	21,015
Federal & State Sources		-		
State general fund	1,042,560	521,280	521,280	-
State general fund - Settlement	-	-	-	-
Federal and state grants	758,742	379,371	301,413	(77,958)
Local revenue		-		
County appropriation - St Joseph County	257,268	128,634	128,634	-
Client fees	401,842	200,921	221,440	20,519
Performance Based Incentive Program	-	-	-	-
Rent revenue	2,160	1,080	6,060	4,980
Other revenue	225,000	112,500	29,178	(83,322)
Total operating revenue	32,658,742	16,329,371	17,925,215	1,595,844
Operating expenses				
Administration	5,400,000	2,700,000	2,538,993	(161,007)
Internal Services	6,700,000	3,350,000	3,309,046	(40,954)
Provider claims	19,000,000	9,500,000	9,021,320	(478,680)
Grant expenses	758,742	379,371	221,619	(157,752)
Vehicles	200,000	100,000	30,131	(69,869)
Facilities	600,000	300,000	356,717	56,717
Total operating expenses	32,658,742	16,329,371	15,477,826	(851,545)
Change in net position	-	-	2,447,389	2,447,389
Net position, beginning of year	13,176,209	13,176,209	13,176,209	-
Net position, end of year	$13,176,209	$ 13,176,209	$ 15,623,598	$ 2,447,389

	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
SWMBH	$ 1,623,616.83	$ 1,736,874.35	$ 1,731,252.07	$ 1,750,991.30	$ 1,420,584.92	$ 2,074,635.27
CCBHC	$ -	$ 942,597.90	$ 774,784.15	$ 833,836.25	$ 900,489.68	$ 974,416.60
Settlement	$ -	$ -	$ -	$ -	$ -	$ -
General Fund	$ 86,880.00	$ 86,880.00	$ 86,880.00	$ 86,880.00	$ 86,880.00	$ 86,880.00
Other	$ 78,537.04	$ 49,514.60	$ 144,949.75	$ 80,292.31	$ 76,790.34	$ 83,120.80
County Approp	$ 64,317.00	$ -	$ -	$ 64,317.00	$ -	$ -
Total Revenue	$ 1,853,350.87	$ 2,815,866.85	$ 2,737,865.97	$ 2,816,316.86	$ 2,484,744.94	$ 3,219,052.67
Payroll/Fringe	$ 706,614.84	$ 713,442.33	$ 1,236,109.74	$ 720,229.24	$ 757,136.21	$ 770,385.40
External	$ 2,048,912.31	$ 1,686,386.00	$ 1,827,907.87	$ 2,059,795.83	$ 1,568,935.03	$ 1,541,686.59
Total Expenses	$ 2,755,527.15	$ 2,399,828.33	$ 3,064,017.61	$ 2,780,025.07	$ 2,326,071.24	$ 2,312,671.99
Net	$ (902,176.28)	$ 416,038.52	$ (326,151.64)	$ 36,291.79	$ 158,673.70	$ 906,380.68
Beg Cash	$ 3,785,563.20	$ 2,883,386.92	$ 3,299,425.44	$ 2,973,273.80	$ 3,009,565.59	$ 3,168,239.29
End Cash	$ 2,883,386.92	$ 3,299,425.44	$ 2,973,273.80	$ 3,009,565.59	$ 3,168,239.29	$ 4,074,619.97
Investments	$ 6,075,025.48	$ 6,096,922.03	$ 6,100,537.62	$ 6,102,113.90	$ 6,122,014.84	$ 6,077,606.16
Total Available Cash	$ 8,958,412.40	$ 9,396,347.47	$ 9,073,811.42	$ 9,111,679.49	$ 9,290,254.13	$ 10,152,226.13

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
SWMBH	$ 1,722,992.46	$ 1,722,992.46	$ 1,722,992.46	$ 1,722,992.46	$ 1,722,992.46	$ 1,722,992.46
CCBHC	$ 737,687.43	$ 737,687.43	$ 737,687.43	$ 737,687.43	$ 737,687.43	$ 737,687.43
Settlement	$ -		$ 2,741,514.00			$ 710,009.00
General Fund	$ 86,880.00	$ 86,880.00	$ 86,880.00	$ 86,880.00	$ 86,880.00	$ 86,880.00
Other	$ 85,534.14	$ 85,534.14	$ 85,534.14	$ 85,534.14	$ 85,534.14	$ 85,534.14
County Approp	$ 64,317.00	$ -	$	$ 64,317.00	$ -	$ -
Total Revenue	$ 2,697,411.03	$ 2,633,094.03	$ 5,374,608.03	$ 2,697,411.03	$ 2,633,094.03	$ 3,343,103.03
Payroll/Fringe	$ 817,419.63	$ 817,419.63	$ 817,419.63	$ 817,419.63	$ 817,419.63	$ 817,419.63
External	$ 1,788,937.27	$ 1,788,937.27	$ 1,788,937.27	$ 1,788,937.27	$ 1,788,937.27	$ 1,788,937.27
Total Expenses	$ 2,606,356.90	$ 2,606,356.90	$ 2,606,356.90	$ 2,606,356.90	$ 2,606,356.90	$ 2,606,356.90
Net	$ 91,054.13	$ 26,737.13	$ 2,768,251.13	$ 91,054.13	$ 26,737.13	$ 736,746.13
Beg Cash	$ 4,074,619.97	$ 4,165,674.10	$ 4,192,411.23	$ 6,960,662.36	$ 7,051,716.48	$ 7,078,453.61
End Cash	$ 4,165,674.10	$ 4,192,411.23	$ 6,960,662.36	$ 7,051,716.48	$ 7,078,453.61	$ 7,815,199.74
Investments	$ 6,077,606.16	$ 6,077,606.16	$ 6,077,606.16	$ 6,077,606.16	$ 6,077,606.16	$ 6,077,606.16
Total Available Cash	$ 10,243,280.26	$ 10,270,017.39	$ 13,038,268.52	$ 13,129,322.64	$ 13,156,059.77	$ 13,892,805.90

Key
Actual
Estimate

BOARD POLICY IV.01

AREA:	Governance		
POLICY TYPE:	Ends Statements	PAGE:	1 of 1
POLICY TITLE:	**ENDS FOR INDIVIDUALS SERVED (SP2 RESPONSE)**	EFFECTIVE: REVIEWED:	09/30/2022 04/30/2026

MEGA END STATEMENT

Children, adults, and families in St. Joseph County will have access to quality behavioral health services that are trauma informed, person centered and results in improved quality of life.

Sub End Statements:

1. Individuals will have access to care
2. **Individuals served will demonstrate improved functioning.**

Specialized Residential and CLS/SIP/SIL:

In the Fiscal Year 2025, we continued our rigorous evaluation of medical necessity for individuals receiving services within our Specialized Residential and Community Living Services (CLS), Specialized Independent Program (SIP), and Supported Independent Living (SIL) programs. This evaluation aimed to ensure strict adherence to the Medicaid manual's criteria for service authorization and level of care determination. A comprehensive, retrospective review of client records and service utilization data was performed to assess the appropriateness of current placements relative to individual needs and functional abilities.

We currently have 69 individuals in Specialized residential, with a few more that we are looking to step down soon. The application of standardized medical-necessity criteria, as stipulated in the Medicaid manual, enabled Pivotal to transition 15 individuals from a high level of care to a less restrictive level. Specifically, these individuals demonstrated sufficient capacity for independent living skills, reduced need for intensive support, or a combination thereof, suggesting the appropriateness of transition to:

- **CLS/SIP/SIL Programs:** Individuals who, while requiring ongoing support, could benefit from a less intensive residential setting within the CLS/SIP/SIL continuum.
- **Independent Living:** Individuals possessing the requisite skills and supports to reside independently in their own apartments, with agency-provided community-based supports.
- **Adult Foster Care (AFC) with Agency Supports:** Individuals who could thrive in a general AFC setting, supplemented by agency-provided support services to address specific needs and

promote community integration.

This analysis underscores the organization's commitment to:

- **Person-Centered Care:** Tailoring service delivery to individual needs and promoting client autonomy.
- **Resource Optimization:** Ensuring efficient allocation of resources by aligning service intensity with assessed medical necessity.
- **Evidence-Based Practice:** Utilizing standardized assessment tools and adhering to established clinical guidelines.
- **Continuum of Care:** Facilitating seamless transitions across various levels of care to promote optimal client outcomes.
- **Adherence to Regulatory Standards:** Maintaining strict compliance with Medicaid manual guidelines.

The identified transitions represent a significant opportunity to enhance the client's quality of life, promote independence, and optimize the utilization of healthcare resources.

Appointments Kept:

	Show Rates by Main Departments		
	FY 24	FY 25	% Change
MIA Outpatient	71.11	70.01	-1.10%
Med Clinic	68.48	70.96	+2.48
MIC Outpatient	74.71	73.76	-0.95
SUD	66.36	64.50	-1.86
Intakes	66.29	63.58	-2.71

The data reveals a generally negative trend in appointment show rates across several main departments from FY 2024 to FY 2025.

Specifically:

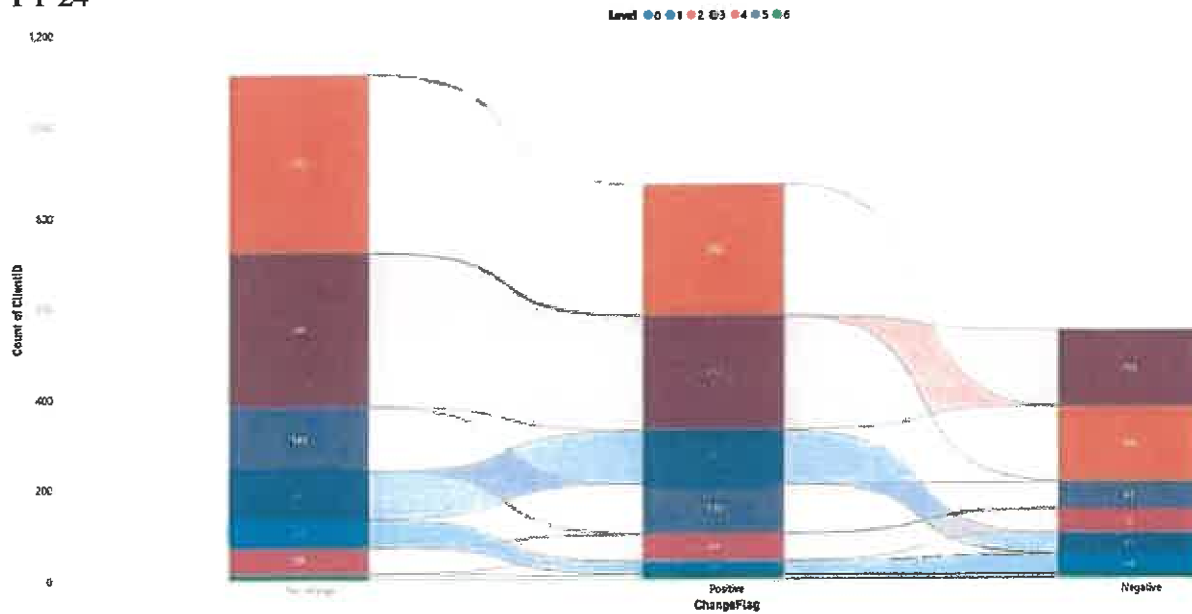
- **Med Clinic saw an increase in their show rates.** This indicates improved client engagement and adherence to scheduled appointments within these departments.
- **MIA Outpatient, MIC Outpatient, SUD, and Intakes all saw a decrease in their show rates.**
  - **Intakes:** Several strategies have or will be implemented to help increase the show rate. We have started offering community Intakes, where our clinicians go to the consumer. We have housed an intake worker at our Three Rivers office to facilitate easier intakes for the Twin Counties Probation Center. We call clients who are no-shows to get them to reschedule or see if there are barriers to coming in.
  - **MIC/MIA Outpatient and SUD:** We will be performing a Kaizen event in the next quarter to review factors that may be influencing clients' inability to make it to appointments. External factors may include transportation, forgetting appointments, emergencies, etc. We do currently utilize PCE to send appointment reminders; we will be exploring another external resource to see if we can engage with clients to prevent no-shows and utilize existing resources.

LOCUS -Adults

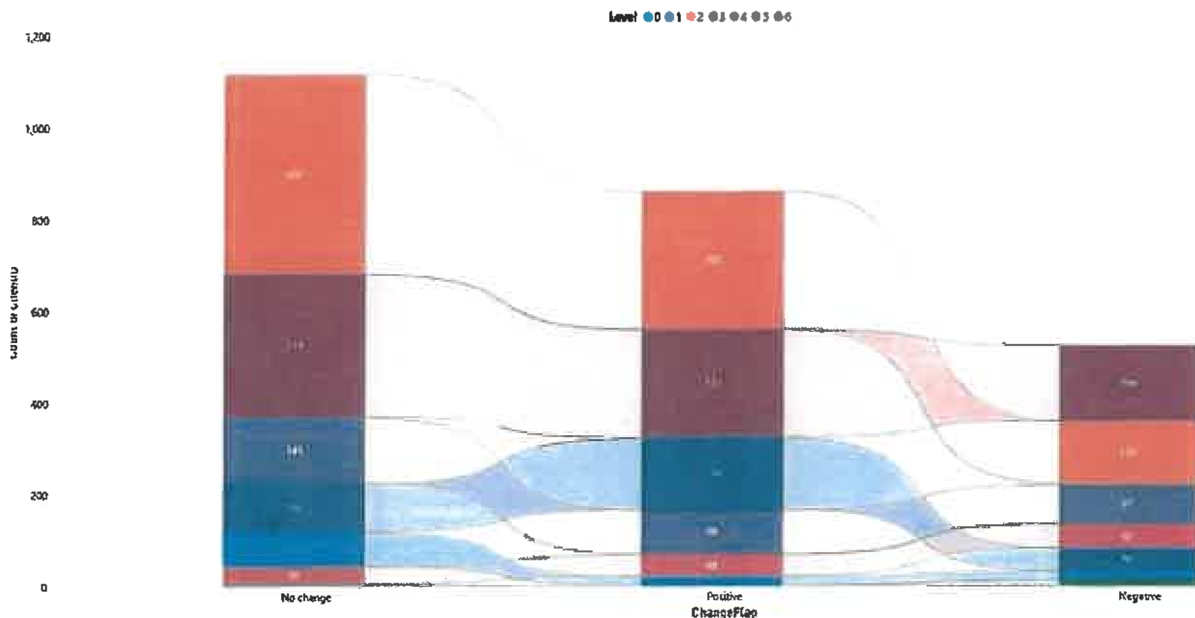
Level Of Care Utilization System:

An assessment and placement instrument developed by American Association of Community Psychiatrists (AACP) Helps guide assessments by asking and evaluating relevant data. Helps with Continued stay criteria, clinical outcomes, and impact of treatment. (dbh.dc.gov)

FY 24



FY 25



Positive Movement Trends

Positive outcomes show a mix of stability and minor fluctuations.

- **Level 2 (Orange):** This group continues to be the largest contributor to positive changes, increasing slightly from 290 to 302 successful transitions.
- **Level 3 (Purple):** There was a minor dip here, moving from 253 down to 237 positive changes.
- **Level 1 (Dark Blue):** This level saw a healthy jump in positive flags, rising from 117 to 156, indicating better progress for clients at this lower level.

Negative Movement and Risk

The "Negative" column represents clients experiencing regressions or unfavorable shifts.

- **Level 3 (Purple):** This remained almost static, moving from 168 to 166. It is consistently the group with the highest count of negative flags.
- **Level 2 (Orange):** There is a positive trend here, as negative changes for this group dropped from 166 to 138.
- **Level 5 (Dark Purple/Navy):** This group saw an increase in negative outcomes, rising from 61 to 87.

Factors Contributing to LOCUS Score Fluctuations:

- **Changes in Mental Health Status:**
  - Exacerbation of symptoms: Increased severity of depression, anxiety, psychosis, or other mental health conditions can elevate a LOCUS score.
  - Decompensation: A decline in an individual's ability to function due to their mental health condition.
  - Crisis situations: Suicidal ideation, self-harm, or aggressive behaviors can necessitate a higher level of care.

  - Conversely, improvement in mental health symptoms due to effective treatment can lower a LOCUS score.
- **Changes in Functional Abilities:**
  - Deterioration in activities of daily living (ADLs): Reduced ability to perform tasks like hygiene, eating, or dressing can increase the need for support.
  - Changes in cognitive functioning: Cognitive decline can impact an individual's ability to live independently.
  - Improvement in coping skills: Increased ability to manage daily tasks and stressors can lead to a lower LOCUS score.
- **Changes in Social Support and Environment:**
  - Loss of social support: The absence of family or friends can increase vulnerability and the need for more intensive services.
  - Changes in living situation: Homelessness, unstable housing, or unsafe environments can necessitate a higher level of care.
  - Increased social support: gaining support from family, or community programs can allow for a lower level of care.
- **Changes in Substance Use:**
  - Increased substance use: Active substance abuse can destabilize mental health and increase the need for intensive treatment.
  - Improved substance use control: Successful substance abuse treatment can decrease the need for intensive care.
- **Treatment Progress and Engagement:**
  - Response to treatment: Effective therapy, medication, or other interventions can lead to a reduction in symptoms and a lower LOCUS score.
  - Treatment non-adherence: Failure to follow treatment recommendations can result in worsening symptoms and a higher LOCUS score.
- **Life Stressors:**
  - Experiencing traumatic events, financial hardship, or other significant stressors can temporarily increase the need for support.

In essence, LOCUS scores fluctuate because the factors that influence an individual's behavioral health needs are also subject to change.

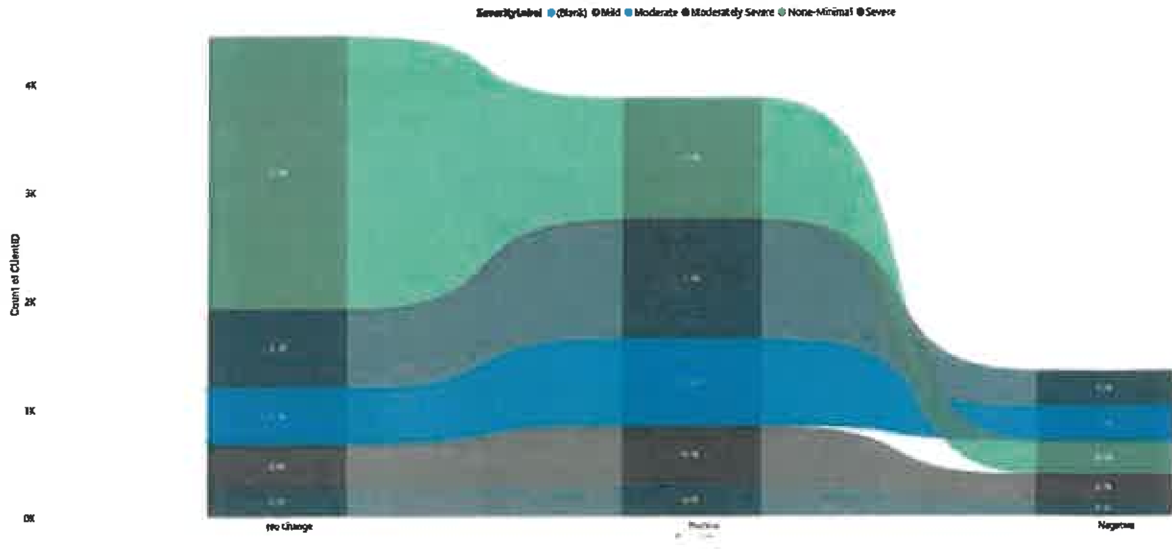
PHQ-9

The PHQ-9 is a valuable tool that helps us quickly and accurately assess depression levels in our clients. It helps us identify those who need support, track their progress, and ensure they're receiving the right level of care. It's a key part of our efforts to provide effective mental health services to our community. The questions in the PHQ-9 are directly linked to the official criteria doctors use to identify major depression. This makes it a reliable way to assess symptoms.

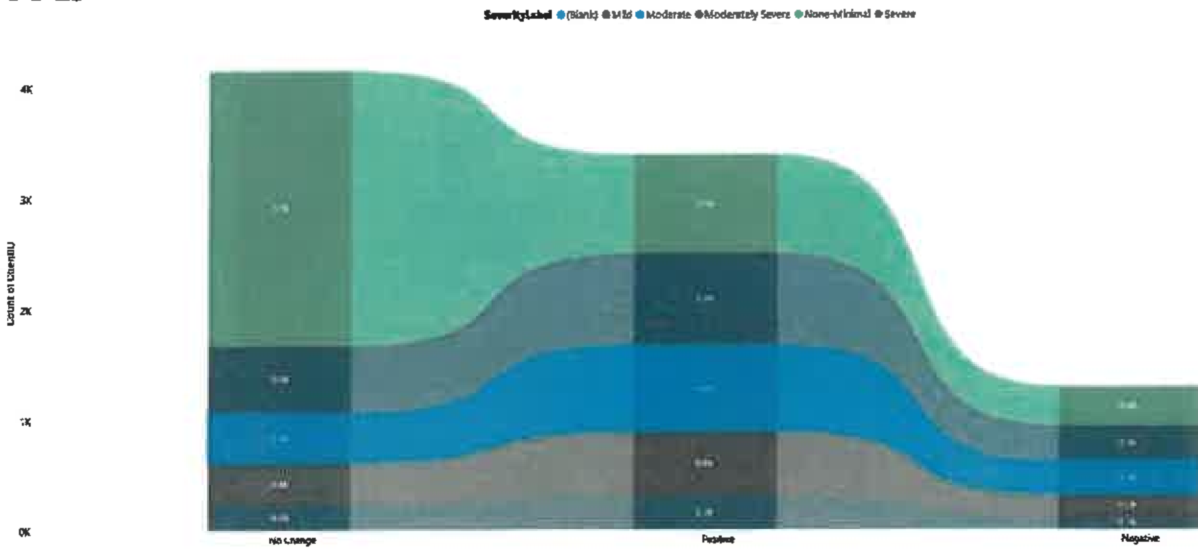
Used for ages 12+ and completed quarterly

(https://aims.uw.edu/resource-library/phq-9-depression-scale)

FY 24



FY 25



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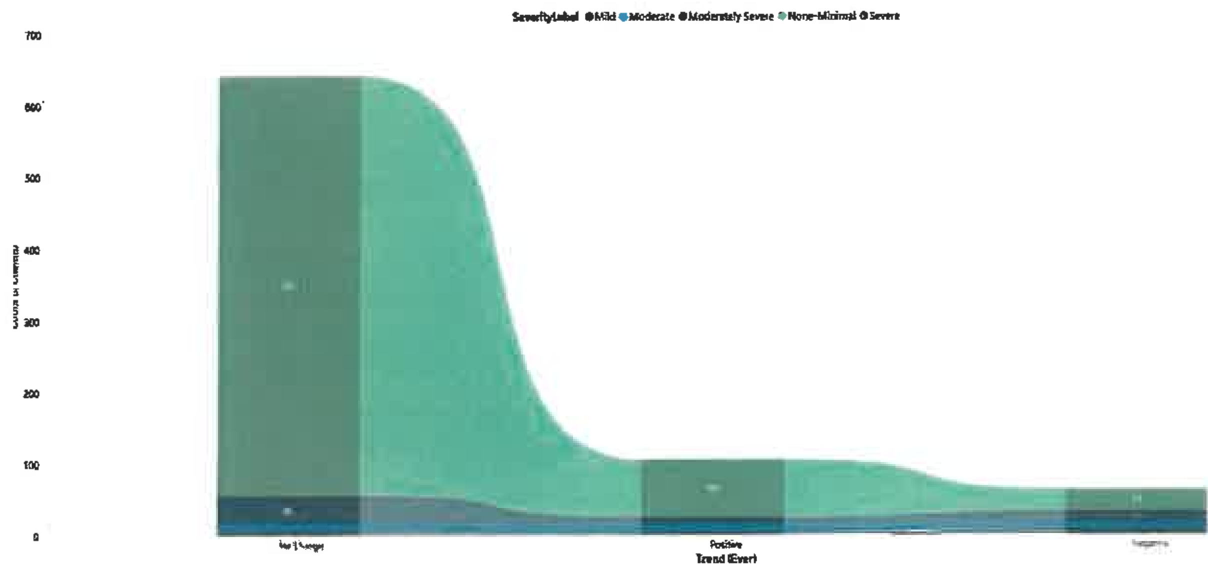
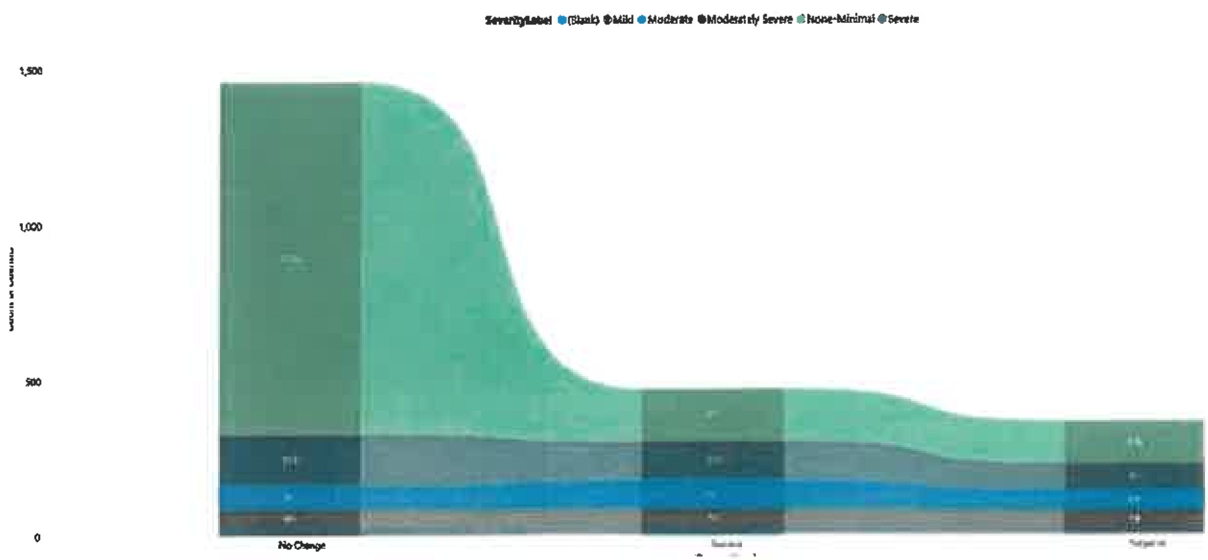
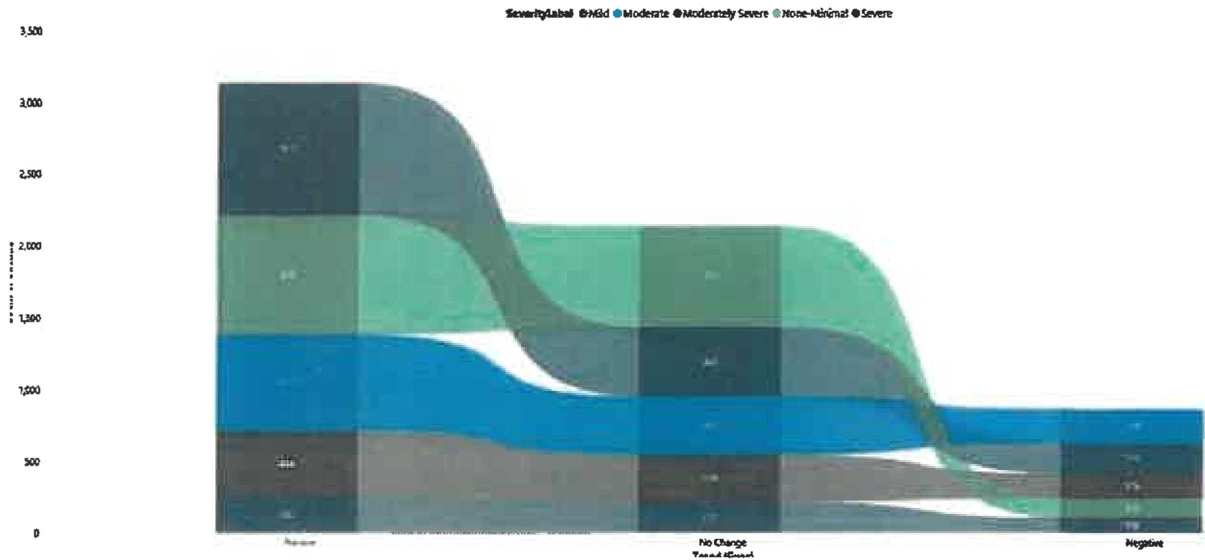


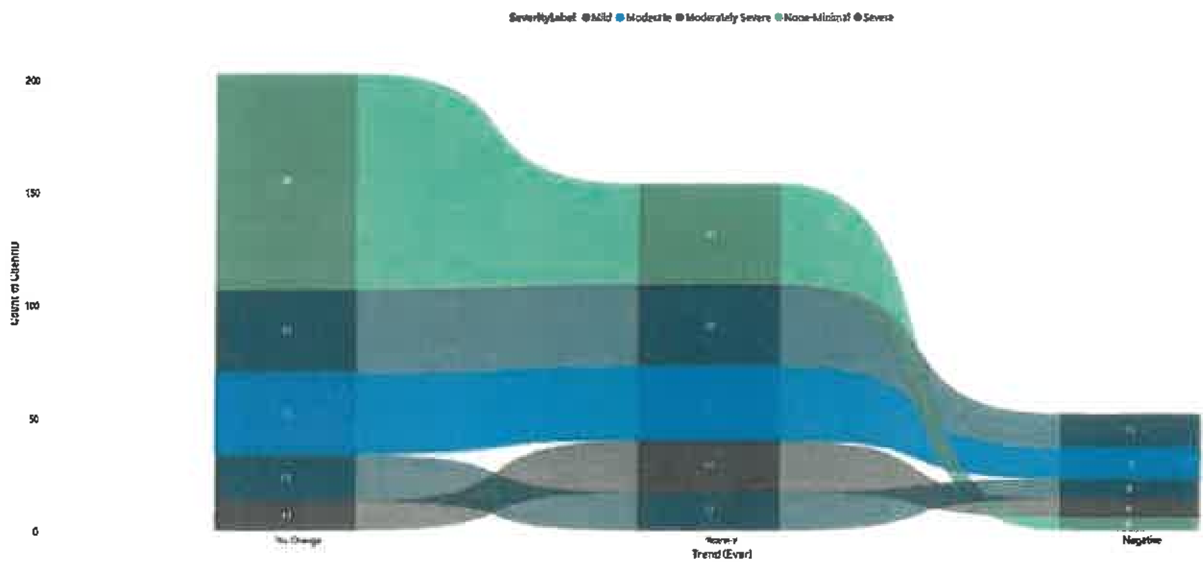
SED



MI



SUD



Reasons for PHQ-9 Score Fluctuations:

- **Treatment Response:**
  - Effective treatment, such as therapy or medication, should lead to a decrease in PHQ-9 scores as depressive symptoms improve.
  - Conversely, if treatment is ineffective or if an individual is non-compliant with their treatment plan, PHQ-9 scores may remain high or increase.
- **Life Stressors:**
  - Significant life events, such as job loss, relationship problems, financial difficulties, or the death of a loved one, can trigger or exacerbate depressive symptoms, leading to higher PHQ-9 scores.
  - Conversely, positive life events or the resolution of stressors can lead to lower scores.
- **Physical Health:**
  - Certain medical conditions and chronic illnesses can contribute to or worsen depressive symptoms.
  - Changes in physical health, such as the onset of a new illness or fluctuations in a chronic condition, can therefore influence PHQ-9 scores.
  - Also some medications can affect mood.
- **Sleep Patterns:**
  - Disrupted sleep, whether it's insomnia or excessive sleepiness, is a common symptom of depression and can also exacerbate it.
  - Changes in sleep patterns can therefore lead to fluctuations in PHQ-9 scores.
- **Substance Use:**
  - Alcohol and drug use can significantly impact mood and contribute to depressive symptoms.
  - Changes in substance use patterns can therefore lead to fluctuations in PHQ-9 scores.
- **Hormonal Changes:**
  - Hormonal fluctuations, such as those that occur during the menstrual cycle, pregnancy, or menopause, can affect mood and contribute to depressive symptoms.
- **Environmental Factors:**
  - Seasonal changes, such as those that occur with seasonal affective disorder (SAD), can affect mood.
  - Changes in social support networks.
- **Natural Variation:**
  - Even in individuals without clinical depression, mood can fluctuate from day to day. Therefore, some variation in PHQ-9 scores is to be expected.

In essence, because a wide array of ever-changing factors influence depression, the PHQ-9 scores that measure depressive symptoms will also change.

MichiCANs

The Michigan Care Improvement and Care Management System, commonly known as MICHICANS, serves as the standardized assessment tool designed to capture the specific needs and functional abilities of our behavioral health clients. For an organization like Pivotal, it functions as the primary mechanism for ensuring that the level of care we provide is directly aligned with the clinical complexity of the individuals we serve.

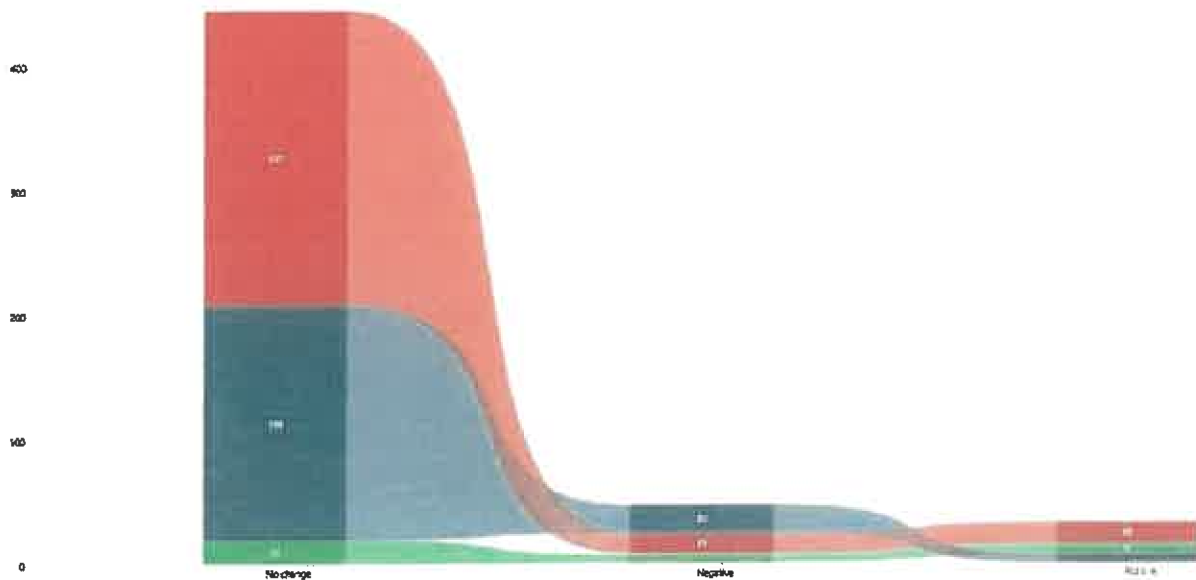
At the lower levels (Mild/Moderate), we typically see individuals who are relatively stable and have a strong support system. Their needs might involve periodic therapy or medication management to maintain their current quality of life. The focus here is on prevention and maintaining the progress they have already made.

As we move into the moderate levels (Severe/Serious), the complexity increases. These clients might be experiencing more significant challenges in their daily lives, such as difficulty maintaining employment or housing, or more frequent symptoms that interfere with their routine. At this stage, our intervention becomes more active, often involving case management and more frequent clinical contact to prevent a crisis.

The highest levels (Crisis) of MICHICANS are reserved for our most vulnerable clients. These individuals often face multiple, overlapping challenges—serious mental illness, co-occurring substance use disorders, and significant social instability. For clients at this level, we provide the most intensive services, often including 24/7 support, frequent home visits, and close coordination among care providers to ensure their safety and well-being.

This first started on 10/1/2024, so we only have one year's worth of clinical data to report.

FY 25



3. Individuals served will demonstrate improved quality of life
4. Individuals will have access to a variety of effective treatment options

BOARD POLICY VI.01

AREA:	Governance		
POLICY TYPE:	Governance Process	PAGE:	1 of 1
POLICY TITLE:	**GLOBAL GOVERNANCE COMMITMENT**	EFFECTIVE: REVIEWED:	09/28/2022 04/30/2026

POLICY:

The purpose of the board, on behalf of Pivotal, is to see to it that Pivotal (a) achieves appropriate results for appropriate persons at an appropriate cost (as specified in board Ends policies), and (b) avoids unacceptable actions and situations (as prohibited in board Executive Limitations policies).

BOARD POLICY VI.02

AREA:	Governance		
POLICY TYPE:	Governance Process	PAGE:	1 of 1
POLICY TITLE:	**GOVERNING STYLE**	EFFECTIVE: REVIEWED:	09/28/2022 04/30/2026

POLICY:

The board will govern lawfully with an emphasis on (a) outward vision rather than an internal preoccupation, (b) encouragement of diversity in viewpoints, (c) strategic leadership more than administrative detail, (d) clear distinction of board and chief executive roles, (e) collective rather than individual decisions, (f) future rather than past or present, and (g) proactivity rather than reactivity.

Accordingly:

1. The board will cultivate a sense of group responsibility. The board, not the staff, will be responsible for excellence in governing. The board will be the initiator of policy, not merely a reactor to staff initiatives. The board will not use the expertise of individual members to substitute for the judgment of the board, although the expertise of individual members may be used to enhance the understanding of the board as a body.

2. The board will direct, control and inspire the organization through the careful establishment of broad written policies reflecting the board's values and perspectives. The board's major policy focus will be on the intended long-term impacts outside the staff organization, not on the administrative or programmatic means of attaining those effects.

3. The board will enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policymaking principles, respect of roles, and ensuring the continuance of governance capability. Although the board can change its governance process policies at any time, it will observe those currently in force scrupulously.

4. Continual board development will include orientation of new board members in the board's governance process and periodic board discussion of process improvement.

5. The board will allow no officer, individual or committee of the board to hinder or be an excuse for not fulfilling group obligations.

6. The board will monitor and discuss the board's process and performance at each meeting. Self-monitoring will include comparison of board activity and discipline to policies in the Governance Process and Board-Management Delegation categories.

CORPORATE COMPLIANCE PROGRAM
FY 25-26

CORPORATE COMPLIANCE PROGRAM

I. INTRODUCTION

It is the responsibility of Pivotal to manage its Medicaid and CCBHC program in full compliance with all laws and regulations, including operating all services within the boundary of ethical integrity and legal practice. As such, it is the duty of each board member, director, employee, contractor, subcontractor or agent operating within the Pivotal provider network to always render services in an ethical and legal manner, and to immediately report any person (or entity) who knowingly presents (or causes to be presented) a false or fraudulent claim for payment, or who falsifies a record or statement in order to get a claim paid.

II. PURPOSE

Pivotal is committed to identifying and complying with local, state, and federal laws and regulations. The purpose of this Compliance Program is to outline the ways in which Pivotal employees and partners can ensure their provider network operates in compliance with applicable laws and regulations. We recognize that some areas of health care law, including certain statutes and regulations, may be contradictory or unclear. Pivotal will use reasoned review and seek assistance from regulatory authorities when appropriate and available. As guidance on these laws and regulations continues to unfold, Pivotal will respond in a manner that fosters legal and ethical compliance.

A. Context

Establishing the Pivotal *Compliance Program* is a response to federal requirements to ensure the agency operates its specialty behavioral healthcare network within the legal framework and intent of the law. In developing the enclosed *Compliance Program,* reference was made to the Office of Inspector General (OIG) and later new mandates under the Affordable Care Act of 2010 (P.L. 111-148 and P.L. 111-152), as an entity under direct federal contract, which operationalizes the provisions of the Deficit Reduction Act of 2005 (DRA).

Under these federal laws, the DRA requires any entity that has a direct federal contract and that annually receives or pays out more than $5.0 million in Medicaid/Medicare federal funds to have a fully functional compliance program. The Affordable Care Act (ACA), and, in particular, Section 6401 of that Act, requires that each health plan have a functional compliance program that prevents, monitors, and reports fraud, waste, and abuse (FWA) for its Medicaid and Medicare programs, and that the Compliance Program also pertains to their respective providers, vendors, and suppliers. In short, under the ACA, compliance is now required of all healthcare providers, and any suspicion, let alone identification of fraud, waste, or abuse, must be systemically reported, managed, and addressed.

Efforts to uncover fraudulent practices in the healthcare industry and to encourage public reporting of them were originally mandated in the 1996 Health Insurance Portability and Accountability Act (HIPAA). Following findings of fraud in several locations by the Office of the Inspector General (OIG), the components of a Corporate Compliance program acceptable to the Federal government were articulated in several OIG Advisories and subsequently promulgated into law under the aforementioned DRA and the ACA. The purposes and elements of regulatory

compliance programs are similarly articulated in all advisories and form the basis of the Region's Compliance Program. These elements are:

- Designating a Chief Compliance Officer to oversee the Compliance Program
- Designating a Compliance Committee to assist the Chief Compliance Officer in managing the program
- Implementing written policies, procedures, and standards of conduct
- Conducting effective training and education
- Developing open lines of communication
- Enforcing standards through well-publicized disciplinary guidelines
- Conducting internal monitoring and auditing
- Conducting external monitoring and auditing of contracted providers post-payment
- Responding promptly to detected offenses and developing corrective action

B. Values

To facilitate continuous compliance with legal, ethical, and accreditation standards applicable to its activities, Pivotal hereby formally states its mission, vision, and values as a member of the health care community:

MISSION:
To enhance the lives of the individuals we serve by delivering integrated services that jointly address medical and behavioral health needs, including substance use disorder and primary care screening services.

VISION:
To enhance the lives of the citizens we serve by providing a range of individualized mental health, substance abuse, wellness, and recovery services.

STATEMENT OF ORGANIZATIONAL VALUES:
We will ensure that services are delivered in a manner that is:

- *Customer-centered*
- *Community-based*
- *Welcoming and accessible*
- *Outcome-based and valued by customers*
- *Offered by competent, friendly, and helpful employees*
- *Respectful of, and responsive to, cultural diversity*
- *Trauma Informed*

Pivotal's values reflect our concern for our Regional Partners, our provider network, our communities, and our commitment to clinical practices that follow high standards of legal, moral, and ethical integrity. These values serve as the foundation for our corporate business decisions and relationships, as well as the guiding tenets of our Compliance Program. To achieve this end, Pivotal will take immediate steps to correct any violation of the Compliance Program, including reporting as appropriate, refunding overpayments, implementing indicated systemic changes, and taking any necessary disciplinary action.

C. Code of Ethics

It is in accordance with the following ethical principles that:

1. Ethical Principles

All Pivotal business shall be carried out using the following ethical principles:

a. *Honesty* – we will be truthful in all our endeavors, to be honest and forthright with one another and with our consumers, service providers, and community partners.
b. *Respect* – we will treat one another with dignity and fairness, appreciating the diversity within our community and the uniqueness of each individual. Staff will use language that communicates respect.
c. *Trust* – we will build confidence through teamwork and open, candid communication at all levels of the organization.
d. *Responsibility* – we will speak up and allow others to speak without fear of retribution and report concerns within the organization, including any violation of law, regulation, ethical standard, and Pivotal policy.
e. *Citizenship* – we will obey the laws of the land, work to make our community more productive, and act with pride and confidence as a representative of Pivotal.
f. *Competency* – we will have and maintain the required competencies and credentials for carrying out job responsibilities (for clinical staff, refer to policies 2.05 Credentialing and Re-credentialing of Individual Providers and 16.07 Clinical Qualifications).

2. The Pivotal employee ethical code of conduct has been established using the six principles noted above. Policy **10.08** on Code of Ethics and Exhibit A Employee Code of Ethics details the specific Pivotal code of ethics.

D. Reporting Violations

Employees are expected to report violations or suspected violations of this or any policy or the Code of Ethics to their supervisor, Chief Compliance Officer, Recipient Rights Officer or the Human Resources Director for investigation. Employees reporting violations, participating in hearings, investigations, legislative inquiries, or court actions are protected, and there is to be no retaliation or retribution against the employee. If the individual also believes the alleged unethical conduct violates state or federal law, he or she may file a complaint with the proper authorities (i.e., law enforcement, Recipient Rights, DHS, violator's certifying professional board/organization, etc.) See **10.09** Ethics Complaint policy. Suspected violations may be reported to Pivotal's Chief Compliance Officer via email, phone, in person, or anonymously via the black boxes in each office. They may also be reported directly to SWMBH Compliance at 800-783-0914, or OIG (800) HHS-TIPS [(800) 447-8477].

E. Reporting Violations to the PIHP

In accordance with SWMBH Policy 10.08, Pivotal will report actual and suspected compliance issues to the SWMBH CCO within three (3) business days or less when one or more of the following criteria are met:

1. Circumstances are consistent with the definition of fraud, waste, or abuse as stated in this policy and/or applicable state or federal law;

2. During an inquiry by the participant CMHSP compliance officer or contracted provider staff, there is determined to be (reasonable person standard) Medicaid or Medicare fraud, waste or abuse as defined by federal statute, CMS, HHS OIG, and/or applicable Michigan statute, regulation or PIHP contract definition and as included in this policy; or

3. Prior to any self-disclosure to any federal Medicare or state of Michigan Medicaid authority. In no way is this intended to nor should it be interpreted as a requirement or request to violate the letter or spirit of federal or Michigan reporting and whistleblower statutes or related regulations.

4. When as a result of fraud, abuse or waste the participant CMHSP makes a material revision to prior reported financial statements to the PIHP;

5. When a participant CMHSP knows or should have known that an action or failure to take action, either within the participant CMHSP organization itself or with a network provider, could result in the improper application or improper retention of Medicaid or Medicare funds; or

6. When a network provider knows or should have known that an action or failure to take action in the organization could result in the improper receipt or retention of Medicaid or Medicare funds.

III. AGENCY RESPONSE TO A REPORT OF SUSPECTED VIOLATION

A. All reports of suspected ethics violations will be investigated. The type of violation will determine the procedures for the suspected violation. Recipient Rights issues will be investigated by the Office of Recipient Rights (as per Recipient Rights policies and/or procedures in sections 24, 25 & 26). Regulatory Management (i.e., Medicaid Fraud and Abuse) issues will be investigated by the Chief Compliance Officer (as Corporate Compliance policies and procedures in section 10). The Chief Compliance Officer will also investigate any Code of Conduct violations. If any reports of suspected ethical violations are brought against the Chief Compliance Officer while acting as Interm Director of Utilization Management, or the Chief Compliance Officer, the investigation shall be handled by the Pivotal Compliance Committee minus the Chief Compliance Officer, or the PIHP; currently Southwest Michigan Behavioral Health.

B. At a minimum, such an investigation will involve a review of written documentation and supervisory interviews with the complainant, alleged violator, and witness. The investigation and report will be completed according to the guidelines with the applicable Recipient Rights or Corporate Compliance policies and procedures. When no timelines are established, the investigation and report will be completed within 30 calendar days of the reported violation.

C. If the investigation finds that an ethics violation did occur, the agency may report such a violation to the violator's certifying professional board or organization. Such a report will be made if the employee's misconduct is considered severe or if there is a pattern of repeated violations.

D. The agency will, within the limits of state and federal law, cooperate with any investigation that may be conducted by the police, other local, state, or federal agency, certifying board, or organization.

E. Compliance in all areas of business is a subject we take seriously. We encourage open communication with our employees and suggest to them: "When in doubt, ask". Whenever they have a question or concern, are unsure about what the appropriate course of action is, or believe that a violation of the law has occurred, ask your immediate supervisor or any member of management with whom you feel comfortable.

F This Compliance Program applies to all Pivotal employees, directors, and officers, including the Chief Executive Officer, and also all provider organizations. It is the intent that every person working for or within the Pivotal provider network and its specialty healthcare system be aware of this Compliance Program and abide by it.

IV. FOUNDATION AND LEGAL BASIS FOR PROGRAM

A. Legal Foundation

The Pivotal Corporate Compliance Program is founded on a) the ethical principles that are the basis of corporate culture, b) a body of laws that defines actions that constitute criminal behavior and establish civil and criminal penalties, and c) regulations that implement Federal and State law and prescribe financial sanctions, and/or civil and criminal penalties for violation.

- The **Affordable Care Act** (2010). This Act requires the PIHP to have a written and operable Compliance Program capable of preventing, identifying, reporting, and ameliorating fraud, waste, and abuse across the PIHP's provider network. All programs funded by the PIHP's Medicaid program, including CMHs, sub-contract provider organizations, practitioners, board members, and others involved in rendering Medicaid program services, fall under the purview and scope of the PIHP's compliance program.

- The **Federal False Claims Act** (1863; 1986). This Act applies when a company or person knowingly presents (or causes to be presented) to the Federal Government (or any entity on its behalf) a false or fraudulent claim for payment; knowingly uses (or causes to be used) a false record or statement to get a claim paid; Conspires with other to get a false or fraudulent claim paid; or knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal Government (or its designated entity). The Act also permits individuals to bring action against parties that have defrauded the government and provides for an award of ½ the amount recovered. The Act provides protection from recrimination against those who report, testify, or assist in the investigation of alleged violations, and it provides a broad definition of 'knowingly' billing Medicaid or Medicare

for services that were not provided, were not provided according to requirements for receiving payment, or were unnecessary.

- The **Michigan False Claims Act** (Act 72 of 1977). An ACT to prohibit fraud in the obtaining of benefits or payments in conjunction with the Medicare/Medicaid assistance program; to prohibit kickbacks or bribes in connection with the program to prohibit conspiracies in obtaining benefits or payments; and to authorize the attorney general of the state of Michigan to investigate alleged violations of this Act.

- The **Anti-Kickback Statute** prohibits the offer, solicitation, payment or receipt of remuneration, in cash or in kind, in return for or to induce a referral for any service paid for or supported by the federal government or for any good or service paid for in connection with consumer service delivery.

- The **Stark Laws (Self-Referral Prohibitions)** prohibit referral by physicians to entities in which the physician or immediate family has a financial interest.

- **HIPAA (1996)** expands the definition of 'knowing and willful conduct' to include instances of 'deliberate ignorance' such as failure to understand and correctly apply billing codes.

B. Federal and State Regulations

There are numerous federal and state regulations that impact the Compliance Program. Some of these laws not referenced above include but are not limited to:

- Regulations implementing the **Balanced Budget Act of 1997** with respect to the Management of Medicaid Managed Care Programs, especially the federal **Code of Regulations** 42 CFR § 438
- **Social Security Act**, specifically 1903(m)(95)(i)
- **Civil False Claims Act of 1863** (Amended 1986)
- **Michigan False Claims Act** (Act 72 of 1977)
- **Whistleblowers Protection Act** of 1980
- **Sarbanes – Oxley Act** of 2002
- **Civil Monetary Penalties Law** of 1981
- **HITECH Act** of 2009
- **Healthcare Fraud and Abuse Commission Act** of 1993
- **Michigan Medical Records Access Act,** Public Act 47 of 2004
- **Rehabilitation Act** of 1973
- **Americans with Disabilities Act** of 1990
- **HHS-OIG Advisories** issued by the HHS Office of the Office of Inspector General (OIG) for the conduct of Fraud and Abuse Compliance Programs
- **Guidelines for Addressing Medicaid Fraud and Abuse in Managed Care,** issued by the Department of Health and Human Services
- **Michigan Mental Health Code (1974;1996)**
- **MDCH/MDHHS Mental Health Administrative Rules,** as promulgated by the State of Michigan

V. COMPLIANCE PROGRAM PURPOSE

A. Pivotal *Compliance Program* is designed to provide safeguards to ensure both the agency and the provider network compliance with laws and regulations relating to fraud and abuse, as well as to prevent members of management, employees, contractors, subcontractors and agents from (i) using their positions for purposes that are, or giving the appearance of being, motivated by a desire for private financial gain or themselves or others such as those whom they have family, business or other ties; and (ii) from violating their duty to the agency from disclosing confidential information.

B. In this context, the overall purpose of the Corporate Compliance Program is:
   1. To prevent noncompliance with applicable laws, whether accidental or intentional
   2. To detect any noncompliance initiative(s) which may occur
   3. To ensure the discipline of individuals and entities when involved in non-compliance, including the institution of formal sanctions and/or disbarment when warranted
   4. To prevent the recurrence of noncompliance

VI. PROGRAM SCOPE

A. The scope of the *Compliance Program* extends to all activities funded by the agency. Compliance is a job duty for all employees. Each employee, provider, contractor, subcontractor, and/or agent operating with the provider network is expected, through its direct employment by the agency or contractual involvement in the provider network, to initiate corporate compliance activities.

B. Pursuant to OIG advisories, all health care entities (regardless of size) are subject to the laws and regulations that form the focus of compliance programs. There is an explicit division of responsibilities to ensure that activities carried out are comprehensive, but not duplicative, and that the risk assumed by Pivotal is appropriately managed.

C. At the provider-level, each health care entity is required to have internal compliance processes and safeguards that ensure compliance with all of Pivotal's compliance program, including all policies, processes, and staff training requirements. All organizational provider compliance practices and processes must be integrated into the Pivotal program for compliance reporting, monitoring and correction purposes.

D. Compliance Responsibilities

1. Chief Compliance Officer

   Pivotal shall directly employ a **Chief Compliance Officer**. The Chief Compliance Officer shall have direct access to the Board and its Executive Director.

   The **Chief Compliance Officer** shall oversee and coordinate all compliance activities for the agency and its provider network, including:

   - Serve as the primary point of contact for all corporate compliance activities and issues for the provider network
   - Overseeing and monitoring the implementation of the Compliance Program

- Establishing methods, such as periodic audits, to improve the efficiency and quality of services, and to reduce the vulnerability to fraud and abuse
- Periodically revising the *Compliance Program* in light of changes in the needs of the agency, or changes in the law and in the standards and procedures of public sector payor health plans
- Ensuring the development of a *Compliance Plan* for the Pivotal and annually reviewing it for updates as needed.
- Developing necessary compliance program *Policies and Procedures* for the agency.
- Developing, coordinating, and participating in a compliance program Training Program that focuses on the components of the compliance and risk management program; seek to ensure that training materials are appropriate and that training is aligned with the OIG initiative to be Ongoing, Innovative, and Effective.
- Ensuring that all current and new employees are informed of their compliance duties and are screened against the OIG's list of Excluded Individuals and Entities, and the System for Awards Management (SAM's) List of Parties Debarred from Federal Programs
- Investigating any report or allegation concerning possible unethical behavior or improper business practices, and monitoring subsequent corrective action and/or compliance

2. Compliance Committee

The **Compliance Committee** will advise the Chief Compliance Officer and assist in the implementation of the Compliance Program, including:

- Identifying areas of risk
- Monitoring audits and investigations, and HIPAA breaches
- Developing Policies and Procedures
- Implementing the Compliance Program
- Developing Compliance Strategies
- Reviewing resources devoted to compliance to ensure adequacy for maintaining the Compliance Program's overall effectiveness

The Chief Compliance Officer shall ensure the Compliance Committee meets at least semi-annually, or more frequently if necessary, to review and resolve compliance issues and advise regarding its compliance program.

3. The Chief Compliance Officer at Pivotal may also have other duties or job titles in addition to Chief Compliance Officer. In these instances, any investigations into the Chief Compliance Officer's other job functions shall be handled by either 1) the Corporate Compliance Committee at Pivotal or 2) the local PIHP; currently, Southwest Michigan Behavioral Health. This is done to ensure proper firewalls and safeguards remain in place and to minimize any potential conflict of interest.

4. Compliance Plan

Corporate Compliance is a functional program. As such, the Compliance Committee is charged with developing, reviewing the plan annually, and revising the Compliance Plan as needed, including specific outcome goals and compliance improvement/assessment activities to be undertaken either by the Compliance Coordinator, Compliance Committee, or providers. The Compliance Plan is ultimately finalized and approved by the Board.

5. Compliance Program versus Contract Compliance

It must be noted that while the methods used to prevent, detect, and remediate corporate compliance issues are similar to the methods used to promote Contract Compliance and/or Quality Improvement, there are significant differences between Contract Compliance, Quality Improvement, and Corporate Compliance. These differences may be summarized as follows:

- Corporate Compliance deals with the prevention, detection, and disposition of violations of law or regulations that have the force of law. Consequently, contract compliance issues between Pivotal and MDHHS, or between Pivotal and its contracted providers, are corporate compliance issues only when the statute or regulation is specifically the issue.
- Corporate Compliance issues may involve civil or criminal penalties as provided for within specific laws. These penalties are frequently applied to individual employees and may involve substantial financial penalties and/or prison sentences. Quality Improvement issues, on the other hand, generally involve negotiated improvement activities or, ultimately, contract-specific financial penalties to the organization or termination of the contract itself.

VII. PROGRAM FUNCTIONS

The functions of the Compliance Program shall operate on the basis of the **seven (7) fundamental** elements of an effective compliance program identified by the OIG. This includes ongoing activities in the following areas.

A. Assessment of Risk and Establishing Audit Priorities

The Chief Compliance Officer is responsible for ensuring that practices within the agency and its contracted Medicaid service providers are conducted in a manner that understands and minimizes the risk of fraud and abuse. The Chief Compliance Officer begins this activity by identifying areas within the agency and provider networks that pose potential legal exposure. This function involves an ongoing assessment of both existing and planned activities to identify potential risks and their levels. Many areas of risk begin as failures to perform under existing contracts adequately, or policies and procedures; however, if not stopped or when combined with other undesirable practices, they may be considered fraud. Significant areas of potential risk for Pivotal include an assessment of the following:

- ✓ Written policies and procedures and their claims submission practices. In particular, the Chief Compliance Officer should pay close attention to contracting issues, including the potential that subcontractors have inadequate or falsified provider credentials, have falsified solvency requirements, engage in bid rigging or collusion among providers, or violate standards related to conflicts of interest or principal-agent requirements. Pivotal is also at risk of having a service array that has inadequate capacity to provide the scope, intensity, and duration of services required by Medicaid regulations, or of paying for services at rates that have inadequate economic justification.
- ✓ Inappropriate Utilization issues. When practices result in a pattern of denying eligible persons necessary services on a timely basis, it may be considered Medicaid waste or abuse. Examples include delay in providing services, defining 'appropriate care' in a manner not consistent with standards of care, inappropriate Utilization Review Guidelines, inhibiting the appeal process for beneficiaries, an ineffective grievance process, unreasonable prior authorization standards, provider incentives to limit care, and routine denial of claims. If such issues arise, investigations into inappropriate utilization issues shall be handled by Pivotal's Compliance Committee or the regional PIHP compliance team.
- ✓ Claims Submission and Billing Procedures. Examples include up-coding or inflating claims, double-billing, billing for ineligible consumers or for services not rendered, and billing for unnecessary services.
- ✓ Failure to meet other requirements of Federal or State law and regulations, including the Balanced Budget Act, and HIPAA.

Although embezzlement and theft are clear violations of the law, they are generally not within the scope of the compliance program unless one of the risk areas defined above is the mechanism for carrying out the embezzlement/theft.

Both the Compliance Committee and Officer will assess the effectiveness of the *Compliance Program* to identify areas of risk and, if necessary, identify measures to address them.

Functional Responsibilities will include conducting an annual risk assessment across the agency under the direction of the Chief Compliance Officer.

B. Monitoring Audits and Investigations

The Compliance Office, with input and review from the Compliance Committee, monitors the results of both internal and external audits to identify potential risk areas and recommends and implements appropriate follow-up actions, incorporating these activities into its annual Compliance Plan.

- ✓ Internal Audit Reports to be reviewed by the Chief Compliance Officer and/or Compliance Committee include but are not limited to: Risk Assessment Audit (Annual); Utilization Review (UR) reports (i.e. case-record reviews); Compliant Management System Reports (Quarterly/Annual); ORR system reports; IT Compliance Reports (i.e. HIPAA security assessments; ISCATs, etc); Service Activity Log (SAL) audits; Critical Incident Report including Sentinel Events; QM Reports; Claims Review (CR) reports; Credentialing/Profiling (Suspension/Revocation) reports; HR system performance issue reports, and other risk management monitoring functions identified by the Compliance Committee.
- ✓ External Reports may include, but not be limited to: MDHHS Audit Reports; EQRO Audit Reports; Accreditation Body Report; PIHP monitoring reports of Pivotal, etc.

Additionally, the Compliance Committee should review the outcomes of any compliance investigations and, if necessary, make recommendations for future detection and prevention.

C. Policy and Procedure Review, Revision, and Development

Pivotal shall be the responsible entity to develop corporate compliance policies, processes, protocols, and forms to be used across the provider network to ensure adherence to this Compliance Program.

Policies and procedures are subject to the provider network's initial and ongoing organizational assessment and are thus considered high-risk areas.

D. Prevention Activities (Training Staff and Dissemination of Information Regarding Corporate Compliance Program and Expectations)

The Chief Compliance Officer conducts initial orientation and training activities.

The Chief Compliance Officer organizes ongoing training sessions to ensure all employees receive the necessary Corporate Compliance training. Gaps and issues are communicated to the Chief Compliance Officer for follow-up. Each new employee shall be afforded the required training and, if requested, provided with written information; otherwise, digital information, and discussion as part of the new employee orientation.

The Compliance Program is a value-based, ethics-oriented program. Consequently, training and orientation programs focus not only on the content of law and regulation but on conducting business in a manner that results in doing what is right for consumers and the community.

The Chief Compliance Officer disseminates the contact information for 1) Pivotal's Chief Compliance Officer, 2) SWMBH's compliance hotline, 3) the OIG, and 4) the Michigan OIG to Pivotal's Provider Network and members annually.

E. Ensuring that Information regarding Current Law and Regulations is disseminated

The Chief Compliance Officer, with the assistance of the Compliance Committee and other experts, is responsible for reviewing all new compliance-related laws, regulations, and official interpretations issued by State and Federal agencies for the network. The Chief Compliance Officer shall take the lead in disseminating any new regulatory laws, rules, and guidelines to the provider network.

Regulatory review shall be conducted through regular monitoring of websites such as those of the Centers for Medicare & Medicaid Services, the Office of the Inspector General, and the Michigan Department of Health and Human Services, and through Policy Alerts to employees and to the Executive Director and/or Chief Compliance Officer. PIHP Compliance relevant alerts are also issued as necessary.

VIII. APPROVAL

As per the board, the Corporate Compliance Program was subsequently reviewed and approved at a regular meeting on November 11th, 2025.

April 2026

Administrative

- Attended HSC
- Presented at the Upjohn Institute on Mental Health in the workplace.
- The sprinkler system has been having issues. I had a fire alarm go off both Saturday and last night. We are ordering a Knox Box for Police/Fire to be able to enter our building if we are not here with the appropriate key cards/keys. I have told them to do our 5-year maintenance early, because we cannot have this happen twice in one week, much less ongoing.
- Attended Statewide Disaster Mental Health Meeting
- Met with the CMHA Small Groups Provider Partnership meeting
- Met with Jean Skalski, who is organizing a stamp out Mental Health Stigma on May 2
- Attended the Director Forum for two days in Lansing.
- Attended Ops Comm
- Met with Beacon Health Systems to see how we can partner with them in Infant Mental Health prospects/barriers
- Attended CMHA Guidance Group, as well as CMHA Small group CMSHP/PIHP/Provider partnerships
- Review costing and coding in the agency.
- Attended the Sturgis Chamber of Commerce Board Meeting
- Attended Finance/Regular Board Meeting at Covered Bridge.
- Met with Venture Resourcing to help with Leadership activities in the agency

Clinical

- **SWMBH Audit was this week. Scores below:**
    - Access: 93.3%
    - Claims: 100%
    - Compliance: 100%
    - Credentialing: 100%
    - Customer Service 72.2%
    - Grievance and Appeals: 90.6%
    - Provider Network:100%
    - Quality: 90.9%
    - Staff Training: 97.5%
    - SUD Admin: 100%
    - Clinical Review was not scored this year; there were recommendations that needed to be fixed, and clinical supervisors will be reviewing them with the affected departments.

Human Resources

Open Positions:

- Outpatient Therapist
- Home-Based Therapist
- Adult Case Manager (New Position)
- SA Case Management (New Position)
- Med Clinic Supervisor (New Position)

Pending:

- Supported Employment
- Care Coordinator (New Position)

Transfers:

- BHUC Nurse – Stacy Delmark

Resignations:

- Kristy Barkley (June 5th Retirement)
- Kim Fultz (April 30th Retirement)

THEME 1: IMPROVED OUTCOMES FOR CLIENTS - 25/26

Objective 1.1: Enhance access to timely, high-quality, integrated care for all community members, especially underserved populations.

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Expand physical and administrative space (Affinity House expansion) to increase service capacity and create welcoming environments. Utilizing new space to repurpose for expanded clinical offerings	CEO	Q1-Q3	Quarterly updates of building progress, grand opening for affinity house, transfer of Affinity House to new location. Number of increased clients attending on average per quarter at Clubhouse	**Q1:** Progress is not moving nearly as fast as anticipated. Currently 2 months behind schedule hopes to have this rectified with better weather. **Q2:** More movement. Pushed back opening to 8/20/26.
Implement and grow telehealth offerings to overcome geographic and transportation barriers, particularly for rural residents.	CEO, Director of IT, Chief Clinical Officer	Ongoing	Reduction in average wait times for initial appointments and ongoing services across all programs. Increase in client intake numbers, specifically tracking growth from identified underserved populations (e.g., veterans, justice-involved individuals, rural residents, Spanish-speaking residents, low-income individuals, youth, older adults, LGBTQI+ persons, persons with disabilities). Client satisfaction surveys reflecting improved access and perceived quality of care, including specific feedback from diverse populations. Utilization rates of telehealth services, increase usage of CEHR, demonstrating reduced geographic and transportation barriers. Tracking of emergency department visits for behavioral health concerns to measure the impact of 24/7 psychiatric support and Turning Point	**Q1:** Working with LocumTennums to bring on additional staff. Currently brainstorming additional ways to add extra slots with the staff we currently have. Meeting with the CTA to see if there are ways to impact our community's ability to add additional bus routes to increase transportation options in St. Joseph County. For Q1, we had 21 consumers utilizing the BHUC. **Q2:** CTA has decided not to pursue our ask. 59 People have used our BHUC this last quarter. We have increased our outpatient clinicians by 3. And are actively looking for more to help with decreasing the time.
Adjust Turning Point Behavioral Health Urgent Care hours based on community needs assessment findings (e.g., preference for early morning and late morning services) to ensure accessibility and responsiveness.	Chief Clinical Officer, Access Director	Ongoing	Q1: Revise, review, and determine staffing levels necessary for revised hours. **Q2:** Promote new hours, Start tracking new data, change BHUC purpose. Q3/Q4: Report on usage and times utilized to determine the effectiveness on new times.	**Q1:** We have identified a nurse to join our team, they will not be able to start until February/March and from there, once trained, we will expand TurningPoint hours. **Q2** Internal staff transferred to BHUC Nursing position, actively working to backfill. Hoping to move forward with new hours in Q3.
Implement PCE waitlist option to allow clients wanting quicker appointments to utilize the "waitlist" feature to take advantage of no-show appointments	Chief Clinical Officer, CEO	Q1-Q2 Implementation	Implementation of service, number of no-show slots % each quarter, productivity increase	**Q1:** This is a bit more user intensive than originally expected, with CARF, ICSS, and new CCBHC handbook implementation this has taken a backseat at the moment. **Q2:** Ultimately, this was not what we were hoping for, in the midst of all our other projects, we have stepped back from this, and may pursue an additional software MEND to address this issue.

Objective 1.2: Strengthen care coordination and integration across health systems to provide comprehensive, person-centered care and address multimorbidity.

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Establish stronger formal partnerships with primary care providers, hospitals, social service agencies, and criminal justice entities to create seamless pathways of care	CEO, CCBHC Director, Clinical Directors	Ongoing	Number of formal care coordination agreements and active partnerships established with external agencies.	**Q1:** CJ- clinician working with drug treatment courts, jail liaison engaging in family treatment court, CHW- meeting with PCP to create a pathway. **Q2:** Therapist working with ADTC and FTC weekly to improve relationship with courts. Jail Liaison working closely with courts.
Reinforce the role of care coordinators and community health workers in addressing social drivers of health (e.g., housing, employment, food insecurity) and integrating behavioral health with primary care.	CEO, CCBHC Director, Clinical Directors	Ongoing	Reduction in emergency department utilization and inpatient hospitalization rates for individuals with behavioral health diagnoses and multimorbidity's. Client outcomes demonstrating improved physical health markers for individuals with co-occurring behavioral and chronic physical conditions.	**Q1:** CHW- meeting with PCP's to create pathways **Q2:** CHW meetings with PCP's continue. Recently attended a Beacon Health Partners Lunch-in. This past quarter, our external referrals rose 300%.

Implement strategies to address medication adherence challenges, particularly for antipsychotic and bipolar mood stabilizer medications, as identified in pharmacy utilization data.	**CEO, CCBHC Director, Clinical Directors**	**Ongoing**	Improvement in medication adherence rates for target behavioral health medications (e.g., antipsychotics) as per Relias Population Performance data.	**Q1:** Monthly report is run to identify all consumers that fall within that category. Then, consumer by consumer, we will audit the chart to ensure that they have an active medication supply, we request refills if necessary, and then notify clients that the medication is available for them to pick up. Pivotal also monitors quality metrics. This is done monthly, Quarter 1 metrics is averaged at 71%. **Q2:** Medication adherence metric continues to exceed the state benchmark of 65%.

THEME 2: INTEGRATED HEALTHCARE EXCELLENCE - 25/26

Objective 2.1: Advance the provision of integrated services to effectively manage co-occurring mental health, substance use disorders, and chronic physical health conditions.

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Expand services and specialized programs for individuals with co-occurring mental health and substance use disorders, given the high prevalence and comorbidity.	**Clinical Directors, Medical Director, Quality Improvement Team**	**Ongoing**	Increased percentage of clients with co-occuring disorders receiving integrated treatment.	**Q1:** Starting IOP Jan 2026, clinician engaging in family treatment and drug courts, increasing peer groups. **Q2:** Successful graduation of 8 IOP members. Currently have 8 IOP members enrolled.
Further implement and track the utilization of evidence-based practices such as Integrated Dual Disorder Treatment (IDDT), Medication-Assisted Treatment (MAT), and Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**Clinical Directors, Medical Director, Quality Improvement Team**	**Ongoing**	Utilization rates of IDDT and MAT services, and documented SBIRT interventions. Client outcomes demonstrating improvement in both mental health and substance use disorder symptoms.	**Q1:** BI Manager has been fully trained and has started creating and understanding the CMH system. Priority tasks have pushed this to the back burner a bit but once completed, will be implemented. **Q2:** This is still a priority, but ensuring other go-live systems with the BI manager still continue to take precedence.
Ensure robust primary care screening and monitoring are consistently provided and documented as part of CCBHC essential services.	**Clinical Directors, Medical Director, Quality Improvement Team**	**Ongoing**	Compliance with primary care screening and monitoring guidelines for behavioral health clients.	**Q1:** 95% of Pivotal Consumers have had a preventative or ambulatory care visit in the last 12 months. Unhealthy alcohol screened by Med Clinic is 97.5% 44% screened positive for tobacco use, and 99.3% received smoking cessation and interventions. 62% of metric-eligible consumers have received testing. 51% of metric-eligible consumers have received. **Q2:** 93% of Pivotal consumers have had a preventative or ambulatory care visit in the last 12 months. 97.5% of consumers screened for unhealthy alcohol use. 45% of consumers screened positive for tobacco use, with 89% of those consumers receiving education or cessation options.
Address the lack of higher-intensity SUD treatment services within the county (e.g., PIHP, residential, medically managed intensive inpatient services) through advocacy and regional partnerships.	**Clinical Directors, Medical Director, Quality Improvement Team**	**Ongoing**	Successful creation, or additional partnerships with SUD treatment services within St. Joseph County.	**Q1:** Clinician engaging in family treatment and drug courts, starting up IOP in January 2026. **Q2:** IOP, FDTC, and FTC are running smoothly.
CARF Recertification	**All Staff**	**FY 26**	Successful recertification of CARF Accreditation	**Q1:** Application submitted, waiting for dates from CARF for actual survey. **Q2:** Survey pushed back to August or September, still waiting for official date.

Objective 2.2: Strengthen organizational infrastructure and data systems to meet CCBHC model standards and enhance data-informed decision-making.

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Build and maintain robust HR systems for managing complex staffing requirements, credential tracking, continuous training, and onboarding protocols for a multidisciplinary team.	HR Director/Corporate Compliance Officer	Q3	Compliance rates with CCBHC staffing mandates and federal/state reporting requirements.	**Q1:** N/A **Q2:** N/A
Develop and implement data collection and reporting infrastructure to meet detailed encounter reporting, quality metrics, outcome measures, and service type tracking across the nine required CCBHC service areas.	CCBHC Director / BI Manager	Q2-Q4	Successful integration with MDHHS and other payers regarding CCBHC reimbursement. Number of encounter available to be sent (billable) vs accepted per quarter. Quarterly updates to board addressing EBPs, interventions, and outcomes.	**Q1:** N/A **Q2:** N/A
Utilize data from the Population Health Report (CY 2024) and ongoing analyses to inform service development, targeted outreach, and resource allocation.	CCBHC Director / BI Manager/ CCO	Q2-Q4	Demonstrable use of population health data in strategic planning and program adjustments. (needs specific target outcomes and population metrics)	**Q1:** N/A **Q2:** N/A

THEME 3: EMPLOYEE ENGAGEMENT AND RETENTION - 25/26				
Objective 3.1: Recruit, train, and retain a diverse, skilled, and culturally competent workforce.				
Action Steps	**Person Responsible**	**Time Frame**	**Method for Measurement**	**Progress/Updates**
Invest in comprehensive workforce development initiatives to address shortages of qualified behavioral health professionals, particularly in rural areas.	HR Director, Clinical Directors	Ongoing	Employee retention rates and turnover rates for clinical staff. Number of new hires, specifically tracking recruitment success for critical positions	**Q1:** Work has started with the staff satisfaction workgroup. Retention rate for Q1 is 100%. **Q2:** Retention rate for Q2 is 97%. 11 new positions created. HR/Clinical Director/CSM have attended 3 job fairs.
Provide continuous training on CCBHC standards, evidence-based practices (e.g., DBT, IMH, MI, PMTO, EMDR, TF-CBT, CBT, ACT, Zero Suicide, WRAP, TIP, MAT), and culturally/linguistically responsive care.	HR Director, Clinical Directors	Ongoing	Tracking of staff training hours and certifications in relevant evidence-based practices and culturally competent care.	**Q1:** DBT-A is currently ongoing. **Q2:** Children's team is looking to send additional outpatient therapists to TFCBT training but need to finish the DBT-A cohort first.
Address staff workload concerns and high caseloads to reduce burnout and improve retention, acknowledging the increased workload due to CCBHC implementation.	HR Director, Clinical Directors, CEO	Ongoing	Employee satisfaction survey results, particularly related to workload, professional development opportunities, and support from leadership.	**Q1:** CCO and CEO are currently exploring alternative options for additional compensation for additional caseloads. Hiring of Documentum staff to accommodate and reduce caseloads. High focus on clinicians' 60/90 reports to ensure accurate case load sizes. **Q2:** Hired an additional 3 outpatient clinicians. Staff satisfaction workgroup has completed individual department meetings and will be reporting to CEO in Q3.
Objective 3.2: Foster a supportive and engaging work environment that promotes staff well-being and professional growth.				
Promote flexible care options, such as possibly extending hours, weekends, etc. to empower staff in service delivery and meet diverse client needs.	HR Director, Clinical Directors, Employee Wellness Committee, CEO	FY 26	Employee feedback data demonstrating improved work environment, morale, and perceived support.	**Q1:** Work has started with the staff satisfaction workgroup. **Q2:** The staff satisfaction workgroup has completed individual department meetings and will be reporting to the CEO in Q3.
Gather regular feedback from employees through surveys and focus groups on challenges and opportunities related to CCBHC implementation and overall work environment.	HR Director, Clinical Directors, Employee Wellness Committee, CEO	Q1	Staff Satisfaction results	**Q1:** Work has started with the staff satisfaction workgroup. **Q2:** The staff satisfaction workgroup has completed individual department meetings and will be reporting to the CEO in Q3.

THEME 4: COMMUNITY ENGAGEMENT - 25/26

Objective 4.1 Increase community awareness of available behavioral health services and reduce stigma associated with seeking care.

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Conduct broad-based community education campaigns to reduce stigma, raise awareness of available services, and encourage help-seeking.	CEO, CCO, CCBHC Director	Ongoing	Number of events, locations, and topics discuses each quarter. Topics range on services offered, support groups, QPR, Mental Health First Aid, etc.	**Q1:** Updates on Pivotal are provided monthly at HSC. QPR is offered at various times, dates, and locations to accommodate the community. **Q2:** Onboarded a new staff member-Parent Support Partner and Family Education Specialist to be able to fill the gap left with the lack of Funding of Help Me Grow St. Joseph grant funding being lost.
Collaborate with justice system representatives for targeted outreach and information sharing.	CEO	Ongoing	CIT Training, # of officer trained, number of trainings offered.	**Q1:** 1 PSW is currently fully trained. Working with the Sheriff's department to work on offering our first training. **Q2:** Identified Sheriff Department collaborator for PSW. Working on the curriculum and the necessary infrastructure to provide the first training.
Proactively communicate on topics of community concern, such as suicide prevention and gun safety, using evidence-based approaches like the LOSS team and community education.	CEO, CCO, CCBHC Director	Ongoing	QPR Trainings, Mental Health First Aid. Number of trainings and people attended.	**Q1:** 27 people trained in QPR. **Q2:** 65 people trained in QPR
Increase peer run groups and access to 1st service appointments	CCO, Adult Services Director, Peers	Ongoing	Number of groups offer & number of quarterly attendance	**Q1:** New peer started, and a new group starting in January. **Q2:** Additional peer groups are currently on hold until new peer position gets filled and started due to turnover.
Increase Recovery Coach Groups and access to 1st Service appointments	CCO, SUD Services Director, Recovery Coaches	Ongoing	Number of groups offer & number of quarterly attendance	**Q1:** 34 First service appointments conducted. **Q2:** Recovery Coach is engaged in IOP. Hiring one more Recovery Coach to assist in current RC workload.

Objective 4.2: Foster continuous community input and collaboration to inform service planning and ensure responsiveness to evolving needs.

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Conduct annual reviews that integrate ongoing analysis of quantitative and qualitative data, including service utilization rates, waitlist trends, client satisfaction feedback, and key community health indicators (e.g., hospitalization rates, social drivers of health).	CEO, Data Analyst	Q3/Q4	Integration of community feedback into service development and strategic planning as evidenced by planning documents and program modifications.	**Q1:** N/A **Q2:** N/A
Actively advocate for the development of a local bus line to improve physical access to care.	CEO	Q1/Q2	Progress in advocacy for local transportation initiatives. (meetings, costs, etc.)	**Q1:** Met with the CTA twice to discuss partnering with Covered Bridge to offer a St. Jospeh County Line. Discussion are ongoing. **Q2:** CTA not interested in partnering with us for this endeavor.

THEME 5: FINANCIAL SOLVENCY - 25/26

Objective 5.1: Optimize Operational Efficiency

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
1. Conduct regular cost-benefit analyses to identify areas for cost reduction without compromising service quality. 2. Implement technologies for improved data management and streamlined workflows. 3. Monitor productivity among staff and departments	CEO/CFO/CCO	Ongoing	1/2. Quarterly reports of new technologies and areas where costs have been reduced and by how much. 3. Utilize productivity, SALs, and admission discharge data to determine increases and decreases in staffing matrixes.	**Q1:** N/A **Q2:** Contracted with Eleos to implement complaince oversight of documentation. Increase staffing based on client needs, specifically 3 outpatient clinicians, Peer Support and SUD Recovery Coach due to needs.

Objective5.2: Clean Financial Audit

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Monitor internal controls	CFO, Financial Specialist, Accountant	Ongoing	Clean financial Audits	**Q1:** Current Audit is ongoing, there is no known findings at this point in time. Audit will be presented to the board in April. **Q2:** Audit completed and turned in on March 31st. Compliance Audit scheduled to begin 5/4/2026

Objective 5.3: CCBHC State Direct Payment

Action Steps	Person Responsible	Time Frame	Method for Measurement	Progress/Updates
Enrollment in CHAMPS	CFO/Rehmann	Q1	Acceptance in the CHAMPS System	**Q1:** CHAMPS enrollment is complete. **Q2:** N/A

Accepting Payments from State reconciled to Monthly billing	**CFO**	**Ongoing**	Monthly Financial Reporting of Revenue Received	**Q1:** Oct $ 0.00 Nov $ 942,597.90 Dec $ 774,784.15 **Q2:** Jan $833,836.25 Feb $900,489.68 Mar $974,416.60
CCBHC Cost Settlement Report	**CFO**	**Q4**	Accepted CCBHC Cost Settlement report	**Q1:** N/A **Q2:** Working on the second observations from the state and will respond.

Pivotal 2026 Board Calendar Attendance List												
Name:	January	February	March	April	May	June	July	August	September	October	November	December
Board Members:												
Amanda Miller												
Carol Naccarato												
Cathi Abbs												
Damon Knapp												
Darci Skrzyniarz												
Elisabeth Roberts												
Raul Morales												
Kay Decker												
Luis Rosado												
Rick Shaffer												
Stacy Linihan												
Zach Reed												

Green = present
Red = absent
Black = not a member
Gray = no meeting

The Hope Garden

Yellow Tulips are a sign of hope

Help Smash The Stigma of Mental Health

- Talk openly
- Seek support
- Listen without judgement

May is Mental Health Month

Come join us on May 2

Circle Garden on Main Street
(Mural Mall)
Saturday, May 2 at 11:00

Let's start the conversations!

Sponsored by:
- Three Rivers Woman's Club
- Three Rivers DDA

Customer Advisory Council Minutes
April 13, 2026

Members present: Donnie K., Gail L., Isabella P., Jen H.
Facilitated by: Marie Cherry

The meeting was called to order at 10.30 a.m. and Isabella volunteered to take notes.

Announcements:

- Provided information about the SJCHSC Resource Roundtable.

Discussion:

- Would like to invite the new Pivotal Customer Service representative to serve on the committee pending completion of onboarding and Jarrett's approval.

Compliments, questions, and concerns:

- Services are going well overall; no additional comments at this time.
- Consider meeting in the Conference Room or offsite (possibly the group room at Nottawa Township Library) versus the East Group room as construction of the Administrative wing continues over the summer.

Next Month:

- Judging entries for the staff door decorating contest sponsored by the ERC in observance of Mental Health Month.
- Invite Stacy Linihan per member request to answer questions about health coverage and other topics.

The meeting was adjourned at 11:00 a.m.

Affinity House Advisory Board Agenda
April 15, 2026

Present: Jessica, Max, Rick, Travis, Adam, Holly, Gail, Cory
Absent: Liz R., Ron, Jo, Liz A., Jill, Luke

1. **Call to Order:** 12:09pm

2. **Approval of Agenda:** Adam motioned, Travis supported.

3. **Approval of Minutes:** Max motioned, Holly supported.

4. **Banking Account:**
   a. Total Cash on hand: $850.57
   b. Restricted Funds from Pivotal: $16,217.90
   c. FY '25/'26 Budget: $288,809.00

5. **Accreditation Updates:**
   a. No accreditation report from Clubhouse International yet.
   b. Still working on obtaining TEP's. See employment heading.
   c. Clubhouse has made significant changes to the social outings calendar, including starting the outings at 4pm and increasing the frequency of outings.

6. **Employment:**
   a. Holly continues to work on the TEP's with Beacon (Two positions: Dishwasher & Food Prep/plating food) in Three Rivers. They are running into some issues with HR and the union.
   b. Member Matthew will be re-starting his TEP at GOCC fitness center once the facility is open. Unsure when the facility will be open.
   c. Still in need of 1 more TEP

7. **Education:**
   a. No updates.

8. **Advisory Board:**
   a. Rick reached out to Luke. He is unable to fulfill his role as a board member and has requested to be off the board. Rick will reach out to see if Luke has a replacement.
   b. Holly will reach out to Liz Alderson if she is still interested in being a board member.
   c. Still in search of more board members to meet the requirements of the Clubhouse Standard.
      i. Rick will stop by the courthouse to see if Theresa and Melissa if they are interested.
      ii. Holly will reach out to Christina Yancey to see if she is interested in sitting on the board.
   d. Discussion of changing frequency of meetings: Once a month, bi-monthly, quarterly. Board will continue discussion at next meeting.
   e. Adam will send out digital meeting invites through email.

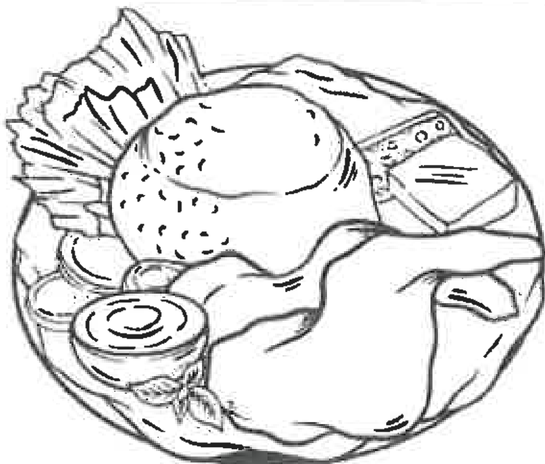
9. **Fundraising:**
   a. Pivotal hotdog fundraiser is in May.
   b. Working on setting up a carwash. Max brought up the idea of partnering with Sturgis carwash.
   c. Adam will reach out to Culvers to see if they would be interested in partnering with Clubhouse for a fundraiser.

10. **Advocacy:**
    a. Continuing to reach out to Sturgis Elk's, local schools, & Sherriff's Department. Waiting on responses.

AFFINITY CLUBHOUSE

LUNCH & Learn

WE STRONGLY ENCOURAGE YOU AS A CASE MANAGER, THERAPIST, DOCTOR, NURSE, OR ANYONE ELSE, TO JOIN US FOR SOME GOOD FOOD AND TO LEARN ABOUT WHAT CLUBHOUSE IS, WHAT WE DO AS STAFF/MEMBERS, AND WHY WE DO WHAT WE DO!



MAY 27TH
12:00-1:00 PM

RSVP to affinityhouse2020@gmail.com or call (269) 467-1923

FULL MEAL
$7.00

Homemade Lunch Includes:

- **Sloppy Joes**
- **Pasta Salad**
- **No Bake Cookies**

WEDNESDAY
MAY 20TH
PICKUP @12:00PM

To order: Email or call Affinity Clubhouse
Affinityclubhouse2020@gmail.com or
(269) 467-1923
Please RSVP your meal as soon as possible!

MONEY EARNED WILL BE USED FOR FOOD COSTS AND SOCIAL OUTTINGS