

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public.
 Go to www.irs.gov/Form990 for instructions and the latest information.

2022

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

A For the 2022 calendar year, or tax year beginning and ending

| | | |
|--|---|--|
| B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | C Name of organization REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 1901 RED ROCK DRIVE City or town, state or province, country, and ZIP or foreign postal code GALLUP, NM 87301 F Name and address of principal officer: DAVID MCGRAIL SAME AS C ABOVE | D Employer identification number 85-0313268 E Telephone number 505-863-7000 G Gross receipts \$ 63,088,820. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions H(c) Group exemption number |
| I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | |
| J Website: WWW.RMCH.ORG | | |
| K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other | | |
| L Year of formation: 1985 | | M State of legal domicile: NM |

Part I Summary

| | | |
|--|---|--|
| | 1 Briefly describe the organization's mission or most significant activities: RMCHCS STRIVES TO BE THE PREFERRED HEALTHCARE PROVIDER FOR MCKINLEY COUNTY (NM) AND THE | |
| | 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets. | |
| Activities & Governance | 3 Number of voting members of the governing body (Part VI, line 1a) | 3 7 |
| | 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 6 |
| | 5 Total number of individuals employed in calendar year 2022 (Part V, line 2a) | 5 529 |
| | 6 Total number of volunteers (estimate if necessary) | 6 0 |
| | 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a 0. |
| | 7b Net unrelated business taxable income from Form 990-T, Part I, line 11 | 7b 0. |
| | Revenue | 8 Contributions and grants (Part VIII, line 1h) |
| 9 Program service revenue (Part VIII, line 2g) | | 67,409,201. 56,089,656. |
| 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | | 56,033. 21,925. |
| 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | | -452,425. 0. |
| 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) | | 70,414,775. 63,060,572. |
| Expenses | | 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) |
| | 14 Benefits paid to or for members (Part IX, column (A), line 4) | 0. 0. |
| | 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) | 44,793,011. 28,971,950. |
| | 16a Professional fundraising fees (Part IX, column (A), line 11e) | 0. 0. |
| | b Total fundraising expenses (Part IX, column (D), line 25) | 0. |
| | 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) | 37,738,225. 55,971,772. |
| 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 82,531,236. 84,944,747. | |
| 19 Revenue less expenses. Subtract line 18 from line 12 | -12,116,461. -21,884,175. | |
| Net Assets or Fund Balances | 20 Total assets (Part X, line 16) | Beginning of Current Year 34,587,674. End of Year 53,188,952. |
| | 21 Total liabilities (Part X, line 26) | 29,239,884. 67,577,928. |
| | 22 Net assets or fund balances. Subtract line 21 from line 20 | 5,347,790. -14,388,976. |

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

| | | | | | |
|-------------------------------|--|---|-------------------------------|---|--------------------------|
| Sign Here | Signature of officer DAVID MCGRAIL, CFO | Date | | | |
| | Type or print name and title | | | | |
| Paid Preparer Use Only | Print/Type preparer's name JAMIE S. FRIDLEY, CPA | Preparer's signature JAMIE S. FRIDLEY, CP | Date 11/12/25 | Check if self-employed <input type="checkbox"/> | PTIN P00380605 |
| | Firm's name REDW, LLC | Firm's EIN 85-0203431 | Phone no. 505-998-3200 | | |
| | Firm's address 8801 HORIZON BLVD NE #401 ALBUQUERQUE, NM 87113 | | | | |

May the IRS discuss this return with the preparer shown above? See instructions Yes No

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III [X]

1 Briefly describe the organization's mission: THE MISSION OF RMCHCS IS TO SERVE GOD BY MAKING A PROFOUND AND LASTING DIFFERENCE IN THE HEALTH AND QUALITY OF LIFE FOR ALL PEOPLE IN THE COMMUNITY.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [X] Yes [] No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 61,009,077. including grants of \$ 1,025.) (Revenue \$ 52,238,119.) HOSPITAL SERVICES INCLUDE MEDICAL CARE SERVICES AND/OR SURGICAL CARE SERVICES PROVIDED TO PATIENTS IN AN INPATIENT, OUTPATIENT AND/OR EMERGENCY SETTING.

4b (Code:) (Expenses \$ 6,228,387. including grants of \$) (Revenue \$ 3,712,930.) CLINIC SERVICES INCLUDE PRIMARY CARE SERVICES AND/OR SPECIALTY CARE SERVICES PROVIDED TO PATIENTS IN A MEDICAL CLINIC SETTING.

4c (Code:) (Expenses \$ 746,601. including grants of \$) (Revenue \$ 138,607.) HOME HEALTH SERVICES INCLUDE MEDICAL CARE SERVICES TO PATIENTS WHO ARE HOMEBOUND DUE TO INJURY, ILLNESS, OR CHRONIC CONDITIONS.

4d Other program services (Describe on Schedule O.) (Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 67,984,065.

**REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES, INC.**

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Part IV Checklist of Required Schedules

| | Yes | No |
|---|----------|----------|
| 1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i> | X | |
| 2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions | X | |
| 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i> | | X |
| 4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i> | | X |
| 5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i> | | X |
| 6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i> | | X |
| 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i> | | X |
| 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i> | | X |
| 9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i> | | X |
| 10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i> | | X |
| 11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable. | | |
| a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i> | X | |
| b Did the organization report an amount for investments - other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i> | | X |
| c Did the organization report an amount for investments - program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i> | | X |
| d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i> | X | |
| e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i> | X | |
| f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i> | X | |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i> | | X |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i> | X | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i> | | X |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | | X |
| b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i> | | X |
| 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i> | | X |
| 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i> | | X |
| 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I.</i> See instructions | | X |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i> | | X |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i> | | X |
| 20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> | X | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? | X | |
| 21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> | | X |

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Part IV Checklist of Required Schedules *(continued)*

| | Yes | No |
|---|------------|----------|
| 22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> | 22 | X |
| 23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> | 23 | X |
| 24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | 24a | X |
| b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | |
| c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | |
| d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | |
| 25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> | 25a | X |
| b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> | 25b | X |
| 26 Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part II</i> | 26 | X |
| 27 Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | 27 | X |
| 28 Was the organization a party to a business transaction with one of the following parties (see the Schedule L, Part IV, instructions for applicable filing thresholds, conditions, and exceptions): | | |
| a A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | X |
| b A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV</i> | 28b | X |
| c A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? <i>If "Yes," complete Schedule L, Part IV</i> | 28c | X |
| 29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | X |
| 30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | 30 | X |
| 31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | X |
| 32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | 32 | X |
| 33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> | 33 | X |
| 34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> | 34 | X |
| 35a Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a | X |
| b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35b | X |
| 36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 36 | X |
| 37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> | 37 | X |
| 38 Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19? | 38 | X |

Note: All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V

| | Yes | No |
|---|-----------|----------|
| 1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable | 1a | 60 |
| b Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable | 1b | 0 |
| c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c | X |

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Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

| | | Yes | No |
|-----|--|-----|-----|
| 2a | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return | | |
| | 2a | | 529 |
| b | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? | X | |
| 3a | Did the organization have unrelated business gross income of \$1,000 or more during the year? | | X |
| b | If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O | | |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | | X |
| b | If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | | X |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | X |
| c | If "Yes" to line 5a or 5b, did the organization file Form 8886-T? | | |
| 6a | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | | X |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | |
| 7 | Organizations that may receive deductible contributions under section 170(c). | | |
| a | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | | X |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | X |
| d | If "Yes," indicate the number of Forms 8282 filed during the year | | |
| | 7d | | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | X |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | | X |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | | |
| 8 | Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | | |
| 9 | Sponsoring organizations maintaining donor advised funds. | | |
| a | Did the sponsoring organization make any taxable distributions under section 4966? | | |
| b | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | | |
| 10 | Section 501(c)(7) organizations. Enter: | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12 | 10a | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | 10b | |
| 11 | Section 501(c)(12) organizations. Enter: | | |
| a | Gross income from members or shareholders | 11a | |
| b | Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) | 11b | |
| 12a | Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | 12a | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year | 12b | |
| 13 | Section 501(c)(29) qualified nonprofit health insurance issuers. | | |
| a | Is the organization licensed to issue qualified health plans in more than one state? Note: See the instructions for additional information the organization must report on Schedule O. | 13a | |
| b | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans | 13b | |
| c | Enter the amount of reserves on hand | 13c | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | 14a | X |
| b | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O | 14b | |
| 15 | Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N. | 15 | X |
| 16 | Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O. | 16 | X |
| 17 | Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? If "Yes," complete Form 6069. | 17 | |

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Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
 - List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
 - List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
 - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.
- See the instructions for the order in which to list the persons above.

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC) | (E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|---|---|-----------------------|---------|--------------|------------------------------|----------|---|--|---|
| | | Individual trustee or director | Institutional trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) LETITIA BRADFORD, MD PHYSICIAN | 40.00 | | | | X | | 594,563. | 0. | 0. | |
| (2) JOHN YORK PHYSICIAN | 40.00 | | | | X | | 548,840. | 0. | 22,397. | |
| (3) CHARLES J S GUIMARAES PHYSICIAN | 40.00 | | | | X | | 466,432. | 0. | 42,336. | |
| (4) KIMBERLY COLLINS, MD, PHYSICIAN | 40.00 | | | | X | | 454,853. | 0. | 0. | |
| (5) BRANDON MURGUIA PHYSICIAN | 40.00 | | | | X | | 359,038. | 0. | 0. | |
| (6) DON SMITHBURG INTERIM CEO TO MARCH 2022 | 40.00 | | | X | | | 0. | 0. | 0. | |
| (7) ROBERT WHITAKER CEO FROM APRIL 2022 | 40.00 | | | X | | | 0. | 0. | 0. | |
| (8) CHANTELE VENTER CFO TO APRIL 2022 | 40.00 | | | X | | | 0. | 0. | 0. | |
| (9) BLAISE BONDI, INTERIM CFO FROM MAY 2022 | 40.00 | | | X | | | 0. | 0. | 0. | |
| (10) WARNER ANDERSON MD TRUSTEE | 1.00 | X | | | | | 0. | 0. | 0. | |
| (11) MIKE HYATT TRUSTEE | 1.00 | X | | | | | 0. | 0. | 0. | |
| (12) STEVE MCKERNAN TRUSTEE | 1.00 | X | | | | | 0. | 0. | 0. | |
| (13) DEBBIE GORENZ TRUSTEE | 1.00 | X | | | | | 0. | 0. | 0. | |
| (14) GENEVIEVE ROBRAN TRUSTEE | 1.00 | X | | | | | 0. | 0. | 0. | |
| (15) BILL LEE TRUSTEE | 1.00 | X | | | | | 0. | 0. | 0. | |
| (16) JEREMY GAY TRUSTEE TO AUG 2022 | 1.00 | X | | | | | 0. | 0. | 0. | |
| (17) AYODELE ERINELE MD TRUSTEE TO AUG 2022 | 1.00 | X | | | | | 0. | 0. | 0. | |

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Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII

| | | | (A) | (B) | (C) | (D) | |
|--|--|--|----------------------|------------------------------------|----------------------------|--|--|
| | | | Total revenue | Related or exempt function revenue | Unrelated business revenue | Revenue excluded from tax under sections 512 - 514 | |
| Contributions, Gifts, Grants and Other Similar Amounts | 1 a | Federated campaigns | 1a | | | | |
| | b | Membership dues | 1b | | | | |
| | c | Fundraising events | 1c | | | | |
| | d | Related organizations | 1d | 125,845. | | | |
| | e | Government grants (contributions) | 1e | 3,574,651. | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 3,248,495. | | | |
| | g | Noncash contributions included in lines 1a-1f | 1g | \$ | | | |
| | h Total. Add lines 1a-1f | | | 6,948,991. | | | |
| Program Service Revenue | | | Business Code | | | | |
| | 2 a | NET PATIENT SERVICE REVENUE | 621110 | 47,985,359. | 47985359. | | |
| | b | OTHER OPERATING REVENUE | 621110 | 7,802,634. | 7,802,634. | | |
| | c | MEDICAL OFFICE RENTAL REVENUE | 531120 | 301,663. | 301,663. | | |
| | d | | | | | | |
| | e | | | | | | |
| | f | All other program service revenue | | | | | |
| g Total. Add lines 2a-2f | | | 56,089,656. | | | | |
| Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | | 50,173. | | 50,173. | |
| | 4 | Income from investment of tax-exempt bond proceeds | | | | | |
| | 5 | Royalties | | | | | |
| | 6 a | Gross rents | 6a | (i) Real | | | |
| | | | | (ii) Personal | | | |
| | | | | | | | |
| | b | Less: rental expenses | 6b | | | | |
| | c | Rental income or (loss) | 6c | | | | |
| | d | Net rental income or (loss) | | | | | |
| | 7 a | Gross amount from sales of assets other than inventory | 7a | (i) Securities | | | |
| | | | | (ii) Other | | | |
| | | | | | | | |
| | b | Less: cost or other basis and sales expenses | 7b | | 28,248. | | |
| | c | Gain or (loss) | 7c | | -28,248. | | |
| d | Net gain or (loss) | | -28,248. | | -28,248. | | |
| 8 a | Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 | 8a | | | | | |
| b | Less: direct expenses | 8b | | | | | |
| c | Net income or (loss) from fundraising events | | | | | | |
| 9 a | Gross income from gaming activities. See Part IV, line 19 | 9a | | | | | |
| b | Less: direct expenses | 9b | | | | | |
| c | Net income or (loss) from gaming activities | | | | | | |
| 10 a | Gross sales of inventory, less returns and allowances | 10a | | | | | |
| b | Less: cost of goods sold | 10b | | | | | |
| c | Net income or (loss) from sales of inventory | | | | | | |
| Miscellaneous Revenue | | | Business Code | | | | |
| | 11 a | | | | | | |
| | b | | | | | | |
| | c | | | | | | |
| | d | All other revenue | | | | | |
| e Total. Add lines 11a-11d | | | | | | | |
| 12 Total revenue. See instructions | | | 63,060,572. | 56089656. | 0. | 21,925. | |

**REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
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Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX **X**

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|---|------------------------------|--|---|------------------------------------|
| 1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ... | 1,025. | 1,025. | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | | | | |
| 4 Benefits paid to or for members | | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | | | | |
| 6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 Other salaries and wages | 24,224,902. | 19,204,538. | 5,020,364. | |
| 8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | | | | |
| 9 Other employee benefits | 2,459,855. | 1,950,075. | 509,780. | |
| 10 Payroll taxes | 2,287,193. | 1,813,196. | 473,997. | |
| 11 Fees for services (nonemployees): | | | | |
| a Management | | | | |
| b Legal | 599,295. | 111,815. | 487,480. | |
| c Accounting | 251,343. | 46,895. | 204,448. | |
| d Lobbying | | | | |
| e Professional fundraising services. See Part IV, line 17 | | | | |
| f Investment management fees | | | | |
| g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.) | 33,584,089. | 26,854,661. | 6,729,428. | |
| 12 Advertising and promotion | 55,250. | 55,006. | 244. | |
| 13 Office expenses | 202,319. | 198,118. | 4,201. | |
| 14 Information technology | 322,860. | 321,437. | 1,423. | |
| 15 Royalties | | | | |
| 16 Occupancy | 3,763,251. | 3,746,660. | 16,591. | |
| 17 Travel | 703,155. | 700,056. | 3,099. | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials ... | | | | |
| 19 Conferences, conventions, and meetings | | | | |
| 20 Interest | 650,696. | 95,007. | 555,689. | |
| 21 Payments to affiliates | | | | |
| 22 Depreciation, depletion, and amortization | 1,827,647. | 1,088,812. | 738,835. | |
| 23 Insurance | 1,301,689. | | 1,301,689. | |
| 24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.) | | | | |
| a SUPPLIES & PHARMACEUTIC | 9,082,092. | 8,191,826. | 890,266. | |
| b EQUIPMENT RENTAL | 1,151,367. | 1,146,292. | 5,075. | |
| c OTHER TAXES | 929,305. | 925,209. | 4,096. | |
| d REPAIRS & MAINTENANCE | 841,244. | 837,536. | 3,708. | |
| e All other expenses | 706,170. | 695,901. | 10,269. | |
| 25 Total functional expenses. Add lines 1 through 24e | 84,944,747. | 67,984,065. | 16,960,682. | 0. |
| 26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | | | | |

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC.

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Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X

| | | (A) | | (B) |
|---|--|------------------------|-------------|--------------|
| | | Beginning of year | | End of year |
| Assets | 1 Cash - non-interest-bearing | 1,062,907. | 1 | 3,104,519. |
| | 2 Savings and temporary cash investments | 5,731,871. | 2 | 1,100,600. |
| | 3 Pledges and grants receivable, net | | 3 | |
| | 4 Accounts receivable, net | 9,645,225. | 4 | 9,596,596. |
| | 5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | 5 | |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) | | 6 | |
| | 7 Notes and loans receivable, net | 1,121,106. | 7 | |
| | 8 Inventories for sale or use | 1,347,137. | 8 | 1,481,839. |
| | 9 Prepaid expenses and deferred charges | 657,743. | 9 | 511,438. |
| | 10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a 68,623,828. | | |
| | b Less: accumulated depreciation | 10b 57,818,484. | 10c | 10,805,344. |
| | 11 Investments - publicly traded securities | | 11 | |
| | 12 Investments - other securities. See Part IV, line 11 | 1,265,974. | 12 | 1,237,726. |
| | 13 Investments - program-related. See Part IV, line 11 | | 13 | |
| | 14 Intangible assets | 50,000. | 14 | 50,000. |
| | 15 Other assets. See Part IV, line 11 | 1,018,548. | 15 | 25,300,890. |
| 16 Total assets. Add lines 1 through 15 (must equal line 33) | 34,587,674. | 16 | 53,188,952. | |
| Liabilities | 17 Accounts payable and accrued expenses | 12,474,006. | 17 | 28,274,669. |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | 3,289,642. | 19 | 21,087. |
| | 20 Tax-exempt bond liabilities | | 20 | |
| | 21 Escrow or custodial account liability. Complete Part IV of Schedule D | | 21 | |
| | 22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons | | 22 | |
| | 23 Secured mortgages and notes payable to unrelated third parties | 8,699,176. | 23 | 10,389,398. |
| | 24 Unsecured notes and loans payable to unrelated third parties | | 24 | |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D | 4,777,060. | 25 | 28,892,774. |
| | 26 Total liabilities. Add lines 17 through 25 | 29,239,884. | 26 | 67,577,928. |
| Net Assets or Fund Balances | Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33. | | | |
| | 27 Net assets without donor restrictions | 4,679,331. | 27 | -14,926,274. |
| | 28 Net assets with donor restrictions | 668,459. | 28 | 537,298. |
| | Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33. | | | |
| | 29 Capital stock or trust principal, or current funds | | 29 | |
| | 30 Paid-in or capital surplus, or land, building, or equipment fund | | 30 | |
| | 31 Retained earnings, endowment, accumulated income, or other funds | | 31 | |
| | 32 Total net assets or fund balances | 5,347,790. | 32 | -14,388,976. |
| | 33 Total liabilities and net assets/fund balances | 34,587,674. | 33 | 53,188,952. |

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**REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
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Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI

| | | | |
|-----------|--|-----------|--------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 63,060,572. |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 84,944,747. |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | -21,884,175. |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A)) | 4 | 5,347,790. |
| 5 | Net unrealized gains (losses) on investments | 5 | |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain on Schedule O) | 9 | 2,147,409. |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B)) | 10 | -14,388,976. |

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII

| | Yes | No |
|---|----------|----|
| 1 Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O. | | |
| 2a Were the organization's financial statements compiled or reviewed by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | X | |
| b Were the organization's financial statements audited by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | X | |
| c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? _____ If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O. | X | |
| 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F? _____ | X | |
| b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits _____ | X | |

Form **990** (2022)

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

| Calendar year (or fiscal year beginning in) | (a) 2018 | (b) 2019 | (c) 2020 | (d) 2021 | (e) 2022 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 Public support. Subtract line 5 from line 4. | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) | (a) 2018 | (b) 2019 | (c) 2020 | (d) 2021 | (e) 2022 | (f) Total |
|---|----------|----------|----------|----------|----------|--------------------------|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc. (see instructions) | | | | | 12 | |
| 13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here | | | | | | <input type="checkbox"/> |

Section C. Computation of Public Support Percentage

| | | |
|---|----|--------------------------|
| 14 Public support percentage for 2022 (line 6, column (f), divided by line 11, column (f)) | 14 | % |
| 15 Public support percentage from 2021 Schedule A, Part II, line 14 | 15 | % |
| 16a 33 1/3% support test - 2022. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| b 33 1/3% support test - 2021. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| 17a 10% -facts-and-circumstances test - 2022. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| b 10% -facts-and-circumstances test - 2021. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization | | <input type="checkbox"/> |
| 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions | | <input type="checkbox"/> |

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

| Calendar year (or fiscal year beginning in) | (a) 2018 | (b) 2019 | (c) 2020 | (d) 2021 | (e) 2022 | (f) Total |
|---|----------|----------|----------|----------|----------|-----------|
| 1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") | | | | | | |
| 2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose | | | | | | |
| 3 Gross receipts from activities that are not an unrelated trade or business under section 513 | | | | | | |
| 4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 5 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 6 Total. Add lines 1 through 5 | | | | | | |
| 7a Amounts included on lines 1, 2, and 3 received from disqualified persons | | | | | | |
| b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year | | | | | | |
| c Add lines 7a and 7b | | | | | | |
| 8 Public support. (Subtract line 7c from line 6.) | | | | | | |

Section B. Total Support

| Calendar year (or fiscal year beginning in) | (a) 2018 | (b) 2019 | (c) 2020 | (d) 2021 | (e) 2022 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |

14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

Section C. Computation of Public Support Percentage

| | | |
|---|-----------|---|
| 15 Public support percentage for 2022 (line 8, column (f), divided by line 13, column (f)) | 15 | % |
| 16 Public support percentage from 2021 Schedule A, Part III, line 15 | 16 | % |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|---|
| 17 Investment income percentage for 2022 (line 10c, column (f), divided by line 13, column (f)) | 17 | % |
| 18 Investment income percentage from 2021 Schedule A, Part III, line 17 | 18 | % |

19a 33 1/3% support tests - 2022. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2021. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i> | | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i> | | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i> | | |
| b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i> | | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i> | | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i> | | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i> | | |
| c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i> | | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i> | | |
| b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i> | | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i> | | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i> | | |
| 9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i> | | |
| b Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| c Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i> | | |
| 10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i> | | |
| b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i> | | |

Part IV Supporting Organizations (continued)

| | Yes | No |
|--|-----|----|
| 11 Has the organization accepted a gift or contribution from any of the following persons? | | |
| a A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization? | | |
| b A family member of a person described on line 11a above? | | |
| c A 35% controlled entity of a person described on line 11a or 11b above? <i>If "Yes" to line 11a, 11b, or 11c, provide detail in Part VI.</i> | | |
| 11a | | |
| 11b | | |
| 11c | | |

Section B. Type I Supporting Organizations

| | Yes | No |
|---|-----|----|
| 1 Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove officers, directors, or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i> | | |
| 2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.</i> | | |
| 1 | | |
| 2 | | |

Section C. Type II Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i> | | |
| 1 | | |

Section D. All Type III Supporting Organizations

| | Yes | No |
|---|-----|----|
| 1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided? | | |
| 2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i> | | |
| 3 By reason of the relationship described on line 2, above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i> | | |
| 1 | | |
| 2 | | |
| 3 | | |

Section E. Type III Functionally Integrated Supporting Organizations

| | | |
|---|-----|----|
| 1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions). | | |
| a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below. | | |
| b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below. | | |
| c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions). | | |
| 2 Activities Test. Answer lines 2a and 2b below. | | |
| a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i> | Yes | No |
| b Did the activities described on line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i> | | |
| 3 Parent of Supported Organizations. Answer lines 3a and 3b below. | | |
| a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>If "Yes" or "No" provide details in Part VI.</i> | | |
| b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i> | | |
| 2a | | |
| 2b | | |
| 3a | | |
| 3b | | |

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES, INC.

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (*explain in Part VI*). **See instructions.**
All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

| Section A - Adjusted Net Income | (A) Prior Year | (B) Current Year (optional) |
|--|----------------|--------------------------------|
| 1 Net short-term capital gain | 1 | |
| 2 Recoveries of prior-year distributions | 2 | |
| 3 Other gross income (see instructions) | 3 | |
| 4 Add lines 1 through 3. | 4 | |
| 5 Depreciation and depletion | 5 | |
| 6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | |
| 7 Other expenses (see instructions) | 7 | |
| 8 Adjusted Net Income (subtract lines 5, 6, and 7 from line 4) | 8 | |

| Section B - Minimum Asset Amount | (A) Prior Year | (B) Current Year (optional) |
|---|----------------|--------------------------------|
| 1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year): | | |
| a Average monthly value of securities | 1a | |
| b Average monthly cash balances | 1b | |
| c Fair market value of other non-exempt-use assets | 1c | |
| d Total (add lines 1a, 1b, and 1c) | 1d | |
| e Discount claimed for blockage or other factors (<i>explain in detail in Part VI</i>): | | |
| 2 Acquisition indebtedness applicable to non-exempt-use assets | 2 | |
| 3 Subtract line 2 from line 1d. | 3 | |
| 4 Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions). | 4 | |
| 5 Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 Multiply line 5 by 0.035. | 6 | |
| 7 Recoveries of prior-year distributions | 7 | |
| 8 Minimum Asset Amount (add line 7 to line 6) | 8 | |

| Section C - Distributable Amount | (A) Prior Year | (B) Current Year (optional) |
|---|----------------|--------------------------------|
| 1 Adjusted net income for prior year (from Section A, line 8, column A) | 1 | Current Year |
| 2 Enter 0.85 of line 1. | 2 | |
| 3 Minimum asset amount for prior year (from Section B, line 8, column A) | 3 | |
| 4 Enter greater of line 2 or line 3. | 4 | |
| 5 Income tax imposed in prior year | 5 | |
| 6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions). | 6 | |
| 7 <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions). | | |

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES, INC.

Schedule A (Form 990) 2022

85-0313268 Page 7

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

| Section D - Distributions | Current Year |
|--|--------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | 1 |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | 2 |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | 3 |
| 4 Amounts paid to acquire exempt-use assets | 4 |
| 5 Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>) | 5 |
| 6 Other distributions (<i>describe in Part VI</i>). See instructions. | 6 |
| 7 Total annual distributions. Add lines 1 through 6. | 7 |
| 8 Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions. | 8 |
| 9 Distributable amount for 2022 from Section C, line 6 | 9 |
| 10 Line 8 amount divided by line 9 amount | 10 |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2022 | (iii) Distributable Amount for 2022 |
|--|-----------------------------|--|---|
| 1 Distributable amount for 2022 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2022 (reasonable cause required - <i>explain in Part VI</i>). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2022 | | | |
| a From 2017 | | | |
| b From 2018 | | | |
| c From 2019 | | | |
| d From 2020 | | | |
| e From 2021 | | | |
| f Total of lines 3a through 3e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2022 distributable amount | | | |
| i Carryover from 2017 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from line 3f. | | | |
| 4 Distributions for 2022 from Section D, line 7: \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2022 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from line 4. | | | |
| 5 Remaining underdistributions for years prior to 2022, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions. | | | |
| 6 Remaining underdistributions for 2022. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions. | | | |
| 7 Excess distributions carryover to 2023. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a Excess from 2018 | | | |
| b Excess from 2019 | | | |
| c Excess from 2020 | | | |
| d Excess from 2021 | | | |
| e Excess from 2022 | | | |

Schedule A (Form 990) 2022

Schedule B
(Form 990)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

Attach to Form 990 or Form 990-PF.
Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2022

Name of the organization

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES, INC.

Employer identification number

85-0313268

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(3) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990).

LHA For Paperwork Reduction Act Notice, see the instructions for Form 990, 990-EZ, or 990-PF.

Schedule B (Form 990) (2022)

| | |
|---|--|
| Name of organization REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number 85-0313268 |
|---|--|

Part I Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

| (a) No. | (b) Name, address, and ZIP + 4 | (c) Total contributions | (d) Type of contribution |
|------------|-----------------------------------|----------------------------|---|
| 1 | <hr/> <hr/> <hr/> | \$ 125,845. | Person <input checked="" type="checkbox"/> Payroll Noncash (Complete Part II for noncash contributions.) |
| 2 | <hr/> <hr/> <hr/> | \$ 612,375. | Person <input checked="" type="checkbox"/> Payroll Noncash (Complete Part II for noncash contributions.) |
| 3 | <hr/> <hr/> <hr/> | \$ 17,000. | Person <input checked="" type="checkbox"/> Payroll Noncash (Complete Part II for noncash contributions.) |
| 4 | <hr/> <hr/> <hr/> | \$ 568,054. | Person <input checked="" type="checkbox"/> Payroll Noncash (Complete Part II for noncash contributions.) |
| 5 | <hr/> <hr/> <hr/> | \$ 2,377,222. | Person <input checked="" type="checkbox"/> Payroll Noncash (Complete Part II for noncash contributions.) |
| | <hr/> <hr/> <hr/> | \$ _____ | Person <input type="checkbox"/> Payroll Noncash (Complete Part II for noncash contributions.) |

| | |
|---|---|
| Name of organization REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number 85-0313268 |
|---|---|

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

| (a) No. from Part I | (b) Description of noncash property given | (c) FMV (or estimate) (See instructions.) | (d) Date received |
|------------------------------|--|---|----------------------|
| | | \$ _____ | _____ |
| | | \$ _____ | _____ |
| | | \$ _____ | _____ |
| | | \$ _____ | _____ |
| | | \$ _____ | _____ |
| | | \$ _____ | _____ |
| | | \$ _____ | _____ |

| | |
|---|---|
| Name of organization REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number 85-0313268 |
|---|---|

Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) \$ _____
Use duplicate copies of Part III if additional space is needed.

| (a) No. from Part I | (b) Purpose of gift | (c) Use of gift | (d) Description of how gift is held |
|---|---------------------|--|-------------------------------------|
| | | | |
| (e) Transfer of gift | | | |
| Transferee's name, address, and ZIP + 4 | | Relationship of transferor to transferee | |
| | | | |
| (a) No. from Part I | (b) Purpose of gift | (c) Use of gift | (d) Description of how gift is held |
| | | | |
| (e) Transfer of gift | | | |
| Transferee's name, address, and ZIP + 4 | | Relationship of transferor to transferee | |
| | | | |
| (a) No. from Part I | (b) Purpose of gift | (c) Use of gift | (d) Description of how gift is held |
| | | | |
| (e) Transfer of gift | | | |
| Transferee's name, address, and ZIP + 4 | | Relationship of transferor to transferee | |
| | | | |
| (a) No. from Part I | (b) Purpose of gift | (c) Use of gift | (d) Description of how gift is held |
| | | | |
| (e) Transfer of gift | | | |
| Transferee's name, address, and ZIP + 4 | | Relationship of transferor to transferee | |
| | | | |

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. Attach to Form 990.

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2022

Open to Public Inspection

Name of the organization REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. Employer identification number 85-0313268

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two Yes/No questions regarding donor property and grant fund usage.

Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include purpose of easements, a table for lines 2a-2d (Total number, acreage, certified historic structures, acquired after 2006), and questions about monitoring, expenses, and reporting requirements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include questions about reporting requirements for art and historical treasures, including revenue and asset amounts.

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule D (Form 990) 2022

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

- 3 Using the organization's acquisition, accession, and other records, check any of the following that make significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange program
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

- 1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|---------------------------------|--------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds. Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

| | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|--|------------------|----------------|--------------------|----------------------|---------------------|
| 1a Beginning of year balance | | | | | |
| b Contributions | | | | | |
| c Net investment earnings, gains, and losses | | | | | |
| d Grants or scholarships | | | | | |
| e Other expenditures for facilities and programs | | | | | |
| f Administrative expenses | | | | | |
| g End of year balance | | | | | |

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment _____%
 - b Permanent endowment _____%
 - c Term endowment _____%
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|--------|----|
| (i) Unrelated organizations | 3a(i) | |
| (ii) Related organizations | 3a(ii) | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <input type="checkbox"/> | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

| Description of property | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|--------------------|
| 1a Land | | 788,219. | | 788,219. |
| b Buildings | | 32,424,983. | 27,921,888. | 4,503,095. |
| c Leasehold improvements | | 1,989,226. | 1,899,106. | 90,120. |
| d Equipment | | 33,031,650. | 27,997,490. | 5,034,160. |
| e Other | | 389,750. | | 389,750. |
| Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) | | | | 10,805,344. |

**REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES, INC.**

Schedule D (Form 990) 2022

85-0313268 Page **3**

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

| (a) Description of security or category (including name of security) | (b) Book value | (c) Method of valuation: Cost or end-of-year market value |
|---|----------------|---|
| (1) Financial derivatives | | |
| (2) Closely held equity interests | | |
| (3) Other | | |
| (A) | | |
| (B) | | |
| (C) | | |
| (D) | | |
| (E) | | |
| (F) | | |
| (G) | | |
| (H) | | |
| Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) | | |

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

| (a) Description of investment | (b) Book value | (c) Method of valuation: Cost or end-of-year market value |
|---|----------------|---|
| (1) | | |
| (2) | | |
| (3) | | |
| (4) | | |
| (5) | | |
| (6) | | |
| (7) | | |
| (8) | | |
| (9) | | |
| Total. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) | | |

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

| (a) Description | (b) Book value |
|---|----------------|
| (1) OPERATING LEASE RIGHT OF USE ASSET | 24,406,407. |
| (2) FINANCE LEASE RIGHT OF USE ASSETS | 894,483. |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) | 25,300,890. |

Part X Other Liabilities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

| 1. (a) Description of liability | (b) Book value |
|---|----------------|
| (1) Federal income taxes | |
| (2) ESTIMATED AMOUNT DUE TO THIRD | |
| (3) PARTY | 356,697. |
| (4) DEFERRED COMP LIABILITY | 387,167. |
| (5) PATIENT REFUNDS | 2,515,702. |
| (6) OPERATING FINANCE LEASE | |
| (7) LIABILITIES | 24,724,968. |
| (8) FINANCE LEASE LIABILITIES | 908,240. |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) | 28,892,774. |

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII ...

Schedule D (Form 990) 2022

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

| | | | |
|----------|--|-----------|-----------|
| 1 | Total revenue, gains, and other support per audited financial statements | | 1 |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12: | | |
| a | Net unrealized gains (losses) on investments | 2a | |
| b | Donated services and use of facilities | 2b | |
| c | Recoveries of prior year grants | 2c | |
| d | Other (Describe in Part XIII.) | 2d | |
| e | Add lines 2a through 2d | | 2e |
| 3 | Subtract line 2e from line 1 | | 3 |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line 1: | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | |
| b | Other (Describe in Part XIII.) | 4b | |
| c | Add lines 4a and 4b | | 4c |
| 5 | Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.) | | 5 |

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

| | | | |
|----------|---|-----------|-----------|
| 1 | Total expenses and losses per audited financial statements | | 1 |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25: | | |
| a | Donated services and use of facilities | 2a | |
| b | Prior year adjustments | 2b | |
| c | Other losses | 2c | |
| d | Other (Describe in Part XIII.) | 2d | |
| e | Add lines 2a through 2d | | 2e |
| 3 | Subtract line 2e from line 1 | | 3 |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line 1: | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | |
| b | Other (Describe in Part XIII.) | 4b | |
| c | Add lines 4a and 4b | | 4c |
| 5 | Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.) | | 5 |

Part XIII Supplemental Information.

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

PART X, LINE 2:

THE HOSPITAL IS EXEMPT FROM FEDERAL AND STATE INCOME TAXES UNDER SECTION 501(A) OF THE INTERNAL REVENUE CODE AND A SIMILAR PROVISION OF STATE LAW. HOWEVER, THE ENTITY IS SUBJECT TO FEDERAL INCOME TAX ON ANY UNRELATED BUSINESS TAXABLE INCOME.

THE HOSPITAL FILES AN EXEMPT ORGANIZATION RETURN, AND IF APPLICABLE, UNRELATED BUSINESS INCOME TAX OR OTHER RETURNS WITH INTERNAL REVENUE SERVICE, NEW MEXICO ATTORNEY GENERAL, AND NEW MEXICO DEPARTMENT OF TAXATION AND REVENUE. THE HOSPITAL IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS BY TAXING AUTHORITIES FOR YEARS BEFORE FISCAL YEAR 2019 FOR

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.
Attach to Form 990.

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2022

Open to Public Inspection

| | | | |
|---------------------------------|---|---------------------------------------|-------------------|
| Name of the organization | REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number | 85-0313268 |
|---------------------------------|---|---------------------------------------|-------------------|

Part I Financial Assistance and Certain Other Community Benefits at Cost

| | Yes | No |
|--|-----|----|
| 1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a | X | |
| b If "Yes," was it a written policy? | X | |
| 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year: <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities | | |
| 3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. | | |
| a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300</u> % | X | |
| b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500</u> % | X | |
| c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care. | | |
| 4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"? | X | |
| 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | X | |
| b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | | X |
| c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | | |
| 6a Did the organization prepare a community benefit report during the tax year? | | X |
| b If "Yes," did the organization make it available to the public? | | |

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs | | | | | | |
| a Financial Assistance at cost (from Worksheet 1) | | | 254,649. | | 254,649. | .30% |
| b Medicaid (from Worksheet 3, column a) | | | 28028150. | 16471845. | 11556305. | 13.60% |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total. Financial Assistance and Means-Tested Government Programs | | | 28282799. | 16471845. | 11810954. | 13.90% |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | | | | |
| f Health professions education (from Worksheet 5) | | | 374,236. | 497,523. | 0. | .00% |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j Total. Other Benefits | | | 374,236. | 497,523. | 0. | .00% |
| k Total. Add lines 7d and 7j | | | 28657035. | 16969368. | 11810954. | 13.90% |

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group: RMCHCS HOSPITAL

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

| | Yes | No |
|--|-----|----|
| Community Health Needs Assessment | | |
| 1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? | | X |
| 2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | | X |
| 3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 | X | |
| If "Yes," indicate what the CHNA report describes (check all that apply): | | |
| a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b <input checked="" type="checkbox"/> Demographics of the community | | |
| c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d <input checked="" type="checkbox"/> How data was obtained | | |
| e <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | | |
| j <input type="checkbox"/> Other (describe in Section C) | | |
| 4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>22</u> | | |
| 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | X | |
| 6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | | X |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | | X |
| 7 Did the hospital facility make its CHNA report widely available to the public? | X | |
| If "Yes," indicate how the CHNA report was made widely available (check all that apply): | | |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.RMCHCS.ORG</u> | | |
| b <input type="checkbox"/> Other website (list url): _____ | | |
| c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |
| 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | X | |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>22</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? | X | |
| a If "Yes," (list url): <u>WWW.RMCHCS.ORG</u> | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | | |
| 11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed. | | |
| 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | X |
| b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ | | |

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group: RMCHCS HOSPITAL

| | Yes | No |
|--|----------|----|
| Did the hospital facility have in place during the tax year a written financial assistance policy that: | | |
| 13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? | X | |
| If "Yes," indicate the eligibility criteria explained in the FAP: | | |
| a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300</u> % and FPG family income limit for eligibility for discounted care of <u>500</u> % | | |
| b <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c <input checked="" type="checkbox"/> Asset level | | |
| d <input checked="" type="checkbox"/> Medical indigency | | |
| e <input checked="" type="checkbox"/> Insurance status | | |
| f <input type="checkbox"/> Underinsurance status | | |
| g <input type="checkbox"/> Residency | | |
| h <input type="checkbox"/> Other (describe in Section C) | | |
| 14 Explained the basis for calculating amounts charged to patients? | X | |
| 15 Explained the method for applying for financial assistance? | X | |
| If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply): | | |
| a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| 16 Was widely publicized within the community served by the hospital facility? | X | |
| If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | | |
| a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.RMCHCS.ORG</u> | | |
| b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.RMCHCS.ORG</u> | | |
| c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.RMCHCS.ORG</u> | | |
| d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention | | |
| h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations | | |
| j <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Schedule H (Form 990) 2022

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group: RMCHCS HOSPITAL

| | Yes | No |
|---|-----|----|
| 17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? | X | |
| 18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP: | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP | | |
| d <input type="checkbox"/> Actions that require a legal or judicial process | | |
| e <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |
| 19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? | | X |
| If "Yes," check all actions in which the hospital facility or a third party engaged: | | |
| a <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b <input type="checkbox"/> Selling an individual's debt to another party | | |
| c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP | | |
| d <input type="checkbox"/> Actions that require a legal or judicial process | | |
| e <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| 20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply): | | |
| a <input type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C) | | |
| b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) | | |
| c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) | | |
| d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) | | |
| e <input type="checkbox"/> Other (describe in Section C) | | |
| f <input type="checkbox"/> None of these efforts were made | | |

Policy Relating to Emergency Medical Care

| | | |
|---|---|--|
| 21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? | X | |
| If "No," indicate why: | | |
| a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions | | |
| b <input type="checkbox"/> The hospital facility's policy was not in writing | | |
| c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) | | |
| d <input type="checkbox"/> Other (describe in Section C) | | |

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group: RMCHCS HOSPITAL

| | Yes | No |
|---|-----|----|
| 22 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care: | | |
| a <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period | | |
| b <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | |
| c <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period | | |
| d <input checked="" type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method | | |
| 23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? | 23 | X |
| If "Yes," explain in Section C. | | |
| 24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? | 24 | X |
| If "Yes," explain in Section C. | | |

Schedule H (Form 990) 2022

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

RMCHCS HOSPITAL:

PART V, SECTION B, LINE 5: REPRESENTATIVES OF THE COMMUNITY:

OVER ONE HUNDRED PRIMARY SOURCES WERE INTERVIEWED AND EIGHT FOCUS GROUPS SESSIONS WERE CONDUCTED WITH A RANGE OF COMMUNITY STAKEHOLDERS FOR THIS REPORT. THESE INCLUDED; HEALTHCARE PROVIDERS, SOCIAL SERVICE PROVIDERS, GOVERNMENTAL AGENCY REPRESENTATIVES, EDUCATORS, COUNSELORS, COMMUNITY ACTIVISTS, ADVOCACY GROUPS, COALITIONS, CLIENTS AND PATIENTS. MANY NATIVE AMERICANS AS WELL AS OTHER ETHNIC GROUPS WERE INCLUDED, WITH PRIMARY PARTICIPATION FROM THE NAVAJO NATION AND PUEBLO OF ZUNI, THE TWO TRIBAL ENTITIES WHO MAKE UP THE MAJORITY OF THIS NATIVE AMERICAN POPULATION IN MCKINLEY COUNTY.

PERSONS THE HOSPITAL CONSULTED FOR THE 2022 CHNA:

1. WORK FOR A STATE, LOCAL, TRIBAL, OR REGIONAL GOVERNMENTAL PUBLIC HEALTH DEPARTMENT (OR EQUIVALENT DEPARTMENT OR AGENCY) WITH KNOWLEDGE, INFORMATION, OR EXPERTISE RELEVANT TO THE HEALTH NEEDS OF THE COMMUNITY:

-MCKINLEY COUNTY EMERGENCY MANAGEMENT; POPULATION SERVED: GENERAL PUBLIC

-NAVAJO NATION DEPARTMENT OF HEALTH; POPULATION SERVED: TRIBAL GROUP

-GALLUP MCKINLEY COUNTY CHAMBER OF COMMERCE; POPULATION SERVED:

UNDERSERVED, LOW INCOME, UN/UNDERINSURED

- NAVAJO NATION; POPULATION SERVED: TRIBAL GROUP

- NEW MEXICO DEPARTMENT OF HEALTH; POPULATION GROUP: GENERAL PUBLIC

- CITY OF GALLUP COVID19 HOTEL SHELTER; POPULATION SERVED: GENERAL PUBLIC

- STATE SENATOR DISTRICT 4; POPULATION SERVED: GENERAL PUBLIC

-CITY OF GALLUP SENIOR CITIZENS CENTER; POPULATION SERVED: SENIORS,

ELDERLY

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

-CATHOLIC CHARITIES; POPULATION SERVED: LOW INCOME, UN/UNDERINSURED, GENERAL PUBLIC

2. MEMBERS OF A MEDICALLY UNDERSERVED, LOW-INCOME OR MINORITY POPULATIONS IN THE COMMUNITY, OR INDIVIDUALS OR ORGANIZATIONS SERVING OR REPRESENTING THE INTERESTS OF SUCH POPULATIONS:

- GALLUP VETERANS CLINIC; POPULATION SERVED: VETERANS
-RESIDENTS GALLUP, NEW MEXICO; POPULATION SERVED: GENERAL PUBLIC
- MANUELITO CHILDREN'S HOME; POPULATION SERVED: PEDIATRICS
- BATTERED FAMILY SHELTER; POPULATION SERVED: HOMELESS UN/UNDERINSURED
- NA NIHZHOOZHI CENTER INC. DETOX AND INPATIENT SUBSTANCE USE REHAB; POPULATION SERVED: BEHAVIORAL HEALTH
- MCKINLEY COUNTY HEALTH ALLIANCE; POPULATION SERVED: MEDICAID
- GALLUP MCKINLEY COUNTY SCHOOLS; POPULATION SERVED: YOUTH/ADOLESCENT
- GALLUP WOMEN, INFANTS AND CHILDREN OFFICE; POPULATION SERVED: OBSTETRICS

COMMUNITY LEADERS:

- ZUNI COMPREHENSIVE HEALTH CENTER; POPULATION SERVED: GENERAL PUBLIC
- SOUTHWEST INDIAN FOUNDATION PROJECT OFFICE; POPULATION SERVED: TRIBAL GROUP
- LEXINGTON HOTEL; POPULATION SERVED: HOMELESS
- PRESBYTERIAN MEDICAL SERVICES; POPULATION SERVED: BEHAVIORAL HEALTH
- HOZHO CENTER FOR PERSONAL ENHANCEMENT; POPULATION SERVED: SENIORS/ELDERLY, MEDICALLY COMPLEX
- REHOBOTH CHRISTIAN SCHOOL; POPULATION SERVED: YOUTH/ADOLESCENT
- FOUR CORNERS RECOVERY CENTER; POPULATION SERVED: BEHAVIORAL HEALTH
- GALLUP MCKINLEY COUNTY SCHOOLS (SUPPORT SERVICES); POPULATION SERVED:

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

YOUTH/ADOLESCENT

- BIG BROTHERS BIG SISTERS MOUNTAIN REGION CITY OF GALLUP; POPULATION

SERVED: YOUTH, GENERAL PUBLIC

- CHILDREN YOUTH & FAMILIES DEPARTMENT GALLUP OFFICE; POPULATION SERVED:

YOUTH/FAMILIES

- BETHANY DAY CARE; POPULATION SERVED: PEDIATRIC

- FOUR CORNERS RECOVERY CENTER; POPULATION SERVED: BEHAVIORAL HEALTH

RMCHCS HOSPITAL:

PART V, SECTION B, LINE 11: NEEDS ADDRESSED AND NOT ADDRESSED:

HOSPITAL LEADERSHIP DECIDED TO ADDRESS FOUR OF THE FIVE OF THE RANKED HEALTH NEEDS. THE FINAL HEALTH PRIORITIES THAT RMCHCS WILL ADDRESS THROUGH ITS IMPLEMENTATION PLAN ARE LISTED BELOW:

1. CONTINUED RECRUITMENT & RETENTION OF HEALTHCARE WORKFORCE:

- LAUNCHING FAMILY MEDICINE RESIDENCY PROGRAM TO INCREASE PRIMARY CARE PROVIDERS.

- FIRST-YEAR RESIDENTS BEGAN IN JULY 2021. GOAL: 12 RESIDENTS IN THE 3-YEAR PROGRAM BY 2022.

- RESIDENCY INCLUDES PALLIATIVE CARE ROTATION, RESPONDING TO COMMUNITY NEEDS ASSESSMENT.

- EXPANDING WOMEN'S HEALTH, PODIATRY, AND WOUND CARE SERVICES FOR BROADER COMMUNITY ACCESS.

- COMMITMENTS TO BROADENING PRIMARY AND SOME SPECIALTY CARE, REDUCING PATIENT NEED TO TRAVEL LONG DISTANCES FOR SERVICES.

- TELEMEDICINE PROGRAM GROWTH CONTINUES AFTER PANDEMIC; TELEHEALTH IS AN

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

IMPORTANT PART OF CARE DELIVERY.

2. ACCESS TO MENTAL AND BEHAVIORAL HEALTH CARE SERVICES AND PROVIDERS:

- INCREASED COMMUNITY ACCESS VIA OPENING URGENT CARE CENTER AND ESTABLISHING MOBILE HEALTH CLINIC PROGRAM.
- MOBILE HEALTH UNIT BEGAN OFFERING WOMEN'S HEALTH SERVICES TO WOMEN AGED 15+ IN RURAL AREAS LIKE RAMAH-NAVAJO CHAPTER, ADDRESSING GAPS IN UNDERSERVED REGIONS.
- SERVICE EXPANSION PLANNED FOR ADDITIONAL NEEDS, INCLUDING PODIATRY AND EYE EXAMS, WHICH ARE CRUCIAL FOR DIABETIC PATIENTS.
- PLANS TO EXTEND MOBILE HEALTHCARE SERVICES TO MORE RURAL POPULATIONS THROUGHOUT MCKINLEY COUNTY IN THE NEXT THREE YEARS.

3. ACCESS TO AFFORDABLE CARE AND REDUCING HEALTH DISPARITIES:

- RMCHCS, AS A MAJOR REGIONAL EMPLOYER, IS FOCUSED ON CREATING JOBS AND SUPPORTING FAIR WAGES FOR STAFF.
- MEDICAL TRANSPORT IS AVAILABLE THROUGH HOSPITAL SOCIAL WORKERS AND THE MOBILE HEALTH UNIT, HELPING OVERCOME TRANSPORTATION BARRIERS TO HEALTHCARE.
- ONGOING MARKET ANALYSIS AND COMMITMENT TO INTERNAL PAY EQUITY FOR ALL POSITIONS AND EMPLOYEES.

4. PREVENTION, EDUCATION, AND SERVICES TO ADDRESS HIGH MORTALITY RATES, CHRONIC DISEASES, AND UNHEALTHY LIFESTYLES:

- PARTNERSHIP WITH UNIVERSITY OF NEW MEXICO (UNM) GALLUP TO SUPPORT LOCAL NURSING PROGRAM AND CLINICAL EDUCATION FOR STUDENTS INCLUDING: JOINT EFFORTS WITH RMCHCS LEADERSHIP AND NURSING DIRECTOR TO STRENGTHEN NURSING

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

WORKFORCE PIPELINE, RN SCHOLARSHIPS INITIATED IN MAY 2022, WITH THE INTENTION TO ESTABLISH A NURSE INTERN PROGRAM BY FALL 2022, PRIORITIZING SCHOLARSHIP RECIPIENTS AND PLANS UNDERWAY TO EXPAND ALLIED HEALTH OFFERINGS (E.G., MEDICAL ASSISTANT PROGRAM) AT LOCAL CAMPUSES.

- BUILDING STRONG TIES WITH UNM MEDICAL SCHOOL, UNM COLLEGE OF NURSING, UNM GALLUP'S NURSING & ALLIED HEALTH, AND OTHER HEALTH EDUCATION ENTITIES STATEWIDE AND NATIONALLY. RMCHCS SERVES AS PRIMARY "HUB" FOR BURRELL COLLEGE OF MEDICINE STUDENTS IN LAS CRUCES, SUPPORTING ROBUST MEDICAL STUDENT ENGAGEMENT AND COMMUNITY LEARNING.

- EXPANDED WOMEN'S HEALTH SERVICES: ADDED TWO FEMALE OB-GYN PHYSICIANS AND TWO VISITING FELLOWSHIP DOCTORS SET TO WORK SIX MONTHS IN MCKINLEY COUNTY. WOMEN'S HEALTH TO BE A MAJOR FOCUS WITHIN FAMILY MEDICINE RESIDENCY. MOBILE CLINIC IS GROWING WOMEN'S HEALTH OFFERINGS AND AIMS TO SERVE MORE COUNTY LOCATIONS.

- RMCHCS BECAME NEW MEXICO'S NEWEST HUMAN MILK REPOSITORY STATION (HMRNM), ENABLING BREASTMILK DONATIONS FOR INFANT HEALTH.

- CONTINUED INVESTMENT IN OB/GYN SERVICE LINE: RENOVATION OF WOMEN'S HEALTH UNIT (COMPLETION JUNE 2022) TO PROVIDE ADVANCED EQUIPMENT AND A MODERN, WELCOMING HEALTHCARE ENVIRONMENT.

NEEDS NOT ADDRESSED:

RMCHCS DECIDED NOT TO SPECIFICALLY ADDRESS "ACCESS TO DENTAL CARE SERVICES AND PROVIDERS." WHILE RMCHCS ACKNOWLEDGES THAT THIS IS A SIGNIFICANT NEED IN THE COMMUNITY, "ACCESS TO DENTAL CARE SERVICES AND PROVIDERS" IS NOT ADDRESSED LARGELY DUE TO THE FACT THAT IT IS NOT CORE BUSINESS FUNCTION OF THE HOSPITAL AND THE LIMITED CAPACITY OF THE HOSPITAL TO ADDRESS THIS NEED. RMCHCS WILL CONTINUE TO SUPPORT LOCAL ORGANIZATIONS AND EFFORTS TO

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

ADDRESS THIS NEED IN THE COMMUNITY.

RMCHCS HOSPITAL:

PART V, SECTION B, LINE 16J: OTHER METHOD FOR PUBLICIZING FINANCIAL

ASSISTANCE POLICY:

ALL SELF-PAY PATIENTS WILL BE INFORMED AT, OR BEFORE, THE TIME OF
ADMISSION OF THE AVAILABILITY OF ALTERNATIVE RESOURCES BASED ON FINANCIAL
MEANS.

Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 6

| Name and address | Type of facility (describe) |
|---|--------------------------------------|
| 1 RMCHCS COLLEGE CLINIC 211 COLLEGE DRIVE GALLUP, NM 87301 | PEDIATRICS, INTERNAL AND FAMILY CARE |
| 2 RMCHCS RED ROCK CLINIC 1900 RED ROCK DRIVE GALLUP, NM 87301 | OB/GYN ORTHOPEDICS |
| 3 RMCH BEHAVIORAL HEALTH SVC 650 VANDEN BOSCH PKWY GALLUP, NM 87301 | ADDICTION AND PSYCHIATRIC SERVICES |
| 4 RMCH HOME HEALTH/HOSPICE 211 E. AZTEC DRIVE GALLUP, NM 87301 | HOME HEALTH/HOSPICE |
| 5 RMCHCS URGENT CARE, LLC 520 HWY 564 GALLUP, NM 87301 | URGENT CARE |
| 6 RMCH CARE SERVICES 1910 RED ROCK DR. GALLUP, NM 87301 | WELLNESS CENTER |
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Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8, and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (for example, open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7:

THE COST TO CHARGE RATIO CALCULATED ON IRS WORKSHEET 2 WAS USED IN THE CALCULATION OF COST ON IRS WORKSHEETS 1 AND 3. COST COMPUTED ON IRS WORKSHEETS 4 AND 5 WAS COMPUTED FROM THE MEDICARE COST REPORT, INCLUDING DIRECT COSTS PLUS OVERHEAD ALLOCATIONS COMPUTED IN THE COST REPORT.

PART III, LINE 2:

THIS IS BASED ON ACTUAL WRITE-OFFS AFTER ALL COLLECTION EFFORTS ARE EXHAUSTED AND ESTIMATED BASED ON AGE OF THE ACCOUNT PER POLICY.

PART III, LINE 3:

MANY PATIENTS THAT WOULD OTHERWISE QUALIFY FOR CHARITY CARE, FAIL TO COMPLETE THE REQUIRED DOCUMENTATION AND INSTEAD LET THE ACCOUNTS GO TO COLLECTIONS AND ULTIMATELY TO BAD DEBT. THE BAD DEBT RELATED TO PATIENTS WHO MAY MEET CERTAIN CRITERIA UNDER THE HOSPITAL'S CHARITY CARE POLICY ARE ESTIMATED AT 40% OF TOTAL BAD DEBT.

PART III, LINE 4:

232100 11-18-22

Part VI Supplemental Information (Continuation)

NOT APPLICABLE DUE TO ADOPTION OF ASU 606 REVENUE FROM CONTRACTS WITH CUSTOMERS.

PART III, LINE 8:

THE HOSPITAL USES COST REPORT METHODOLOGY, WHICH APPORTIONS ROUTINE COSTS BASED ON MEDICARE OR MEDICAID DAYS TO TOTAL DAYS AND APPORTIONS ANCILLARY COSTS BASED ON PROGRAM CHARGES TO TOTAL CHARGES.

THE ORGANIZATION HAD A MEDICARE SHORTFALL IN THE AMOUNT OF \$9,043,255. THE HOSPITAL TREATS MEDICARE SHORTFALL AS COMMUNITY BENEFIT FOR MEETING CHARITY CARE AND COMMUNITY BENEFITS

PART III, LINE 9B:

A. IN COMPLIANCE WITH RELEVANT STATE AND FEDERAL LAWS, AND IN ACCORDANCE WITH THE PROVISIONS OUTLINED IN THIS BILLING AND COLLECTIONS POLICY, RMCHCS MAY ENGAGE IN COLLECTION ACTIVITIES-INCLUDING EXTRAORDINARY COLLECTION ACTIONS (ECAS)-TO COLLECT OUTSTANDING PATIENT BALANCES. GENERAL COLLECTION ACTIVITIES MAY INCLUDE [FOLLOW-UP CALLS ON STATEMENTS] PATIENT BALANCES MAY BE REFERRED TO A THIRD PARTY FOR COLLECTION AT THE DISCRETION OF RMCHCS. ACCOUNTS WILL BE REFERRED FOR COLLECTIONS ONLY WITH THE FOLLOWING CAVEATS:

THERE IS A REASONABLE BASIS TO BELIEVE THE PATIENT OWES THE DEBT. ALL THIRD-PARTY PAYERS HAVE BEEN PROPERLY BILLED, AND THE REMAINING DEBT IS THE FINANCIAL RESPONSIBILITY OF THE PATIENT. RMCHCS SHALL NOT BILL A PATIENT FOR ANY AMOUNT THAT AN INSURANCE COMPANY IS OBLIGATED TO PAY. RMCHCS WILL NOT REFER ACCOUNTS FOR COLLECTION WHILE A CLAIM ON THE ACCOUNT IS STILL PENDING PAYER PAYMENT. HOWEVER RMCHCS MAY CLASSIFY CERTAIN CLAIMS

Part VI Supplemental Information (Continuation)

AS "DENIED" IF SUCH CLAIMS ARE STUCK IN "PENDING" MODE FOR AN UNREASONABLE LENGTH OF TIME DESPITE EFFORTS TO FACILITATE RESOLUTION. RMCHCS WILL NOT REFER ACCOUNTS FOR COLLECTION WHERE THE CLAIM WAS DENIED DUE TO A RMCHCS ERROR. HOWEVER, RMCHCS MAY STILL REFER THE PATIENT LIABILITY PORTION OF SUCH CLAIMS FOR COLLECTION IF UNPAID. RMCHCS WILL NOT REFER ACCOUNTS FOR COLLECTION WHERE THE PATIENT HAS INITIALLY APPLIED FOR FINANCIAL ASSISTANCE OR OTHER RMCHCS SPONSORED PROGRAM AND RMCHCS HAS NOT YET NOTIFIED THE PATIENT OF ITS DETERMINATION (PROVIDED THE PATIENT HAS COMPLIED WITH THE TIMELINE AND INFORMATION REQUESTS DELINEATED DURING THE APPLICATION PROCESS).

B. REASONABLE EFFORTS AND EXTRAORDINARY COLLECTION ACTIONS (ECAS). BEFORE ENGAGING IN ECAS TO OBTAIN PAYMENT FOR CARE RMCHCS MUST MAKE CERTAIN REASONABLE EFFORTS TO DETERMINE WHETHER AN INDIVIDUAL IS ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER OUR FINANCIAL ASSISTANCE POLICY:

ECAS MAY BEGIN ONLY WHEN 90 DAYS HAVE PASSED SINCE THE FIRST POST-DISCHARGE STATEMENT WAS PROVIDED. HOWEVER, AT LEAST 30 DAYS BEFORE INITIATING ECAS TO OBTAIN PAYMENT, RMCHCS SHALL DO THE FOLLOWING:

-PROVIDE THE INDIVIDUAL WITH A WRITTEN NOTICE THAT INDICATES THE AVAILABILITY OF FINANCIAL ASSISTANCE, LISTS POTENTIAL ECAS THAT MAY BE TAKEN TO OBTAIN PAYMENT FOR CARE, AND GIVES A DEADLINE AFTER WHICH ECAS MAY BE INITIATED (NO SOONER THAN 90 DAYS AFTER THE FIRST POST-DISCHARGE BILLING STATEMENT AND 30 DAYS AFTER THE WRITTEN NOTICE)

-PROVIDE A PLAIN-LANGUAGE SUMMARY OF THE FAP ALONG WITH THE NOTICE DESCRIBED ABOVE

-ATTEMPT TO NOTIFY THE INDIVIDUAL ORALLY ABOUT THE FAP AND HOW HE OR SHE MAY GET ASSISTANCE WITH THE APPLICATION PROCESS AFTER MAKING REASONABLE

Part VI Supplemental Information (Continuation)

EFFORTS TO DETERMINE FINANCIAL ASSISTANCE ELIGIBILITY AS OUTLINED ABOVE
RMCHCS (OR ITS AUTHORIZED BUSINESS PARTNERS) MAY TAKE THE FOLLOWING ECA

TO OBTAIN PAYMENT FOR CARE:

REPORT ADVERSE INFORMATION TO CREDIT REPORTING AGENCIES AND/OR CREDIT
BUREAUS IF A PATIENT HAS AN OUTSTANDING BALANCE FOR PREVIOUSLY PROVIDED
CARE, RMCHCS MAY ENGAGE IN THE ECA OF DEFERRING, DENYING, OR REQUIRING
PAYMENT BEFORE PROVIDING ADDITIONAL MEDICALLY NECESSARY (BUT NON-EMERGENT)
CARE ONLY WHEN THE FOLLOWING STEPS ARE TAKEN:

-RMCHCS PROVIDES THE PATIENT WITH AN FAP APPLICATION AND A PLAIN LANGUAGE
SUMMARY OF THE FAP RMCHCS PROVIDES A WRITTEN NOTICE INDICATING THE
AVAILABILITY OF FINANCIAL ASSISTANCE AND SPECIFYING ANY DEADLINE AFTER
WHICH A COMPLETED APPLICATION FOR ASSISTANCE FOR THE PREVIOUS CARE EPISODE
WILL NO LONGER BE ACCEPTED. THIS DEADLINE MUST BE AT LEAST 30 DAYS AFTER
THE NOTICE DATE OR 211 DAYS AFTER THE FIRST POST-DISCHARGE BILLING
STATEMENT FOR PRIOR
CARE, WHICHEVER IS LATER.

-RMCHCS MAKES A REASONABLE EFFORT TO ORALLY NOTIFY THE INDIVIDUAL ABOUT
THE FINANCIAL ASSISTANCE POLICY AND EXPLAIN HOW TO RECEIVE ASSISTANCE
WITH THE APPLICATION PROCESS.

-RMCHCS PROCESSES ON AN EXPEDITED BASIS ANY FAP APPLICATIONS FOR PREVIOUS
CARE RECEIVED WITHIN THE STATED DEADLINE PATIENT FINANCIAL SERVICES IS
ULTIMATELY RESPONSIBLE FOR DETERMINING IF
AN INDIVIDUAL IS ELIGIBLE FOR FINANCIAL ASSISTANCE. THIS BODY ALSO HAS
FINAL AUTHORITY FOR DECIDING WHETHER THE ORGANIZATION MAY PROCEED WITH ANY
OF THE ECAS OUTLINED IN THIS POLICY.

Part VI Supplemental Information (Continuation)

PART VI, LINE 3:

THE FINANCIAL ADVISOR GIVES ASSISTANCE TO THE PATIENT AT REGISTRATION, AT
BEDSIDE OR AFTER DISCHARGE AS NEEDED FOR FINANCIAL COUNSELING, CHARITY
APPLICATIONS, MEDICAID ELIGIBILITY AND ENROLLMENT AS WELL AS ANY OTHER
PROGRAMS AVAILABLE. THIS IS ALSO AVAILABLE ON OUR WEBSITE AT
WWW.RMCHCS.ORG.

PART VI, LINE 4:

GALLUP, WHICH IS THE COUNTY SEAT OF MCKINLEY COUNTY, IS THE HEART OF THE
INDIAN SOUTHWEST. SEVENTY-THREE PERCENT OF THE RESIDENTS ARE OF AMERICAN
INDIAN DESCENT. GALLUP IS THE ECONOMIC CENTER OF THREE MAJOR INDIAN
TRIBES, ZUNI, HOPI, AND NAVAJO AND SERVES THE SURROUNDING AREAS OF NEW
MEXICO AND ARIZONA. THE PRIMARY SERVICE AREA (GALLUP) HAS A POPULATION OF
22,000 WITH A SECONDARY SERVICE AREA OF APPROXIMATELY 90,000 PEOPLE.
GALLUP IS SITUATED AT 6,515 FEET AND HAS A MILD AND COMFORTABLE
FOUR-SEASON CLIMATE. THE LANDSCAPE IS BEAUTIFUL, WITH RED MESAS
SURROUNDING THE CITY. GALLUP HAS A UNIQUE BLEND OF INDIGENOUS CULTURE,
WITH GENUINE AMERICAN INDIAN AND SOUTHWEST-HISPANIC ARTS AND CRAFTS IN
RICH ABUNDANCE.

THE MEDIAN AGE IN MCKINLEY COUNTRY IS 30.7 YEARS. THAT IS SIX YEARS
YOUNGER THAN THE MEDIAN AGE IN THE UNITED STATES. HOWEVER, THE LIFE SPAN
OF THE POPULATION IN MCKINLEY COUNTY IS FOUR YEARS LESS THAN THE AVERAGE
AMERICAN. THE AVERAGE LIFE SPAN IN MCKINLEY COUNTY IS 74.4 YEARS VERSUS
THE NATIONAL AVERAGE OF 78.8 YEARS.

PART VI, LINE 5:

PROMOTION OF COMMUNITY HEALTH:

Part VI Supplemental Information (Continuation)

REHOBOTH MCKINLEY CHRISTIAN HOSPITAL IS THE MAIN CAMPUS. THIS 60-BED
GENERAL ACUTE INPATIENT FACILITY OFFERS A WIDE RANGE OF MEDICAL AND
DIAGNOSTIC SERVICES. HOSPITAL INPATIENT SERVICES INCLUDE A MEDICAL
SURGICAL UNIT, INTENSIVE AND CRITICAL CARE UNITS. HOSPITAL ANCILLARY
SERVICES INCLUDE A CARDIOPULMONARY REHABILITATION UNIT, DIAGNOSTIC IMAGING
AND LABORATORY SERVICES, AS WELL AS PHYSICAL REHABILITATION SERVICES. THE
MAIN CAMPUS IS ALSO HOME TO THE SURGICAL SERVICES UNIT AND THE EMERGENCY
DEPARTMENT.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

NM

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest
Compensated Employees
Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2022

Open to Public
Inspection

Name of the organization **REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC.** Employer identification number **85-0313268**

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|---|---|
| <input type="checkbox"/> First-class or charter travel | <input checked="" type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input checked="" type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|--|---|
| <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in or receive payment from a supplemental nonqualified retirement plan?
- c** Participate in or receive payment from an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

| | Yes | No |
|-----------|-----|----|
| 1b | | X |
| 2 | | X |
| 4a | | X |
| 4b | | X |
| 4c | | X |
| 5a | | X |
| 5b | | X |
| 6a | | X |
| 6b | | X |
| 7 | X | |
| 8 | | X |
| 9 | | |

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2022

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

PART I, LINE 7:

THE BONUSES OF THE PHYSICIANS LISTED ARE DETERMINED BY A JOINT CONSULTATION BETWEEN THE CEO, CMO, CFO AND THE HR DIRECTOR. THIS IS INCORPORATED WITH MGMA DATA AND OTHER DATA SOURCES.

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE
SERVICES, INC.

85-0313268

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred on prior Form 990 |
|--|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| (1) LETITIA BRADFORD, MD PHYSICIAN | (i) | 594,563. | 0. | 0. | 0. | 0. | 594,563. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (2) JOHN YORK PHYSICIAN | (i) | 548,840. | 0. | 0. | 0. | 22,397. | 571,237. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (3) CHARLES J S GUIMARAES PHYSICIAN | (i) | 466,432. | 0. | 0. | 0. | 42,336. | 508,768. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (4) KIMBERLY COLLINS, MD, PHYSICIAN | (i) | 454,853. | 0. | 0. | 0. | 0. | 454,853. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| (5) BRANDON MURGUIA PHYSICIAN | (i) | 359,038. | 0. | 0. | 0. | 0. | 359,038. | 0. |
| | (ii) | 0. | 0. | 0. | 0. | 0. | 0. | 0. |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
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| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |
| | (i) | | | | | | | |
| | (ii) | | | | | | | |

**SCHEDULE O
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.
Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2022

Open to Public
Inspection

| | | | |
|--------------------------|--|--------------------------------|------------|
| Name of the organization | REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number | 85-0313268 |
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FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:
 SURROUNDING AREAS BY RESPONDING TO THE DIVERSE HEALTHCARE NEEDS OF THE
 ENTIRE COMMUNITY WITH A BROAD ARRAY OF HEALTHCARE SERVICES DELIVERED IN
 A VARIETY OF SETTINGS.

FORM 990, PART III, LINE 3, CHANGES IN PROGRAM SERVICES:
 THE BEHAVIORAL HEALTH SERVICES PROGRAM WAS ENDED IN 2021.

FORM 990, PART VI, SECTION A, LINE 7A:
 ONE (1) TRUSTEE SHALL BE A MEMBER OF THE MEDICAL EXECUTIVE COMMITTEE (MEC),
 SELECTED BY THE MEC. THE REMAINING SIX (6) POSITIONS ON THE BOARD OF
 TRUSTEES ARE ELECTED ON A ROTATING SCHEDULE BY ALL OF THE VOTING MEMBERS OF
 THE BOARD OF TRUSTEES. IN ADDITION, THE COMMISSIONERS OF MCKINLEY COUNTY
 HAVE THE RIGHT TO APPOINT ONE (1) NON-VOTING, EX-OFFICIO MEMBER OF THE
 RMCHCS BOARD OF TRUSTEES

FORM 990, PART VI, SECTION B, LINE 11B:
 THE CFO REVIEWS THE FORM 990 PREPARED BY THE INDEPENDENT ACCOUNTING FIRM
 WHICH ALSO PERFORMED THE ANNUAL AUDIT IN COMPLIANCE WITH GAAP. THE CFO
 PRESENTS THE FORM 990 TO THE CEO FOR REVIEW AND APPROVAL FOR SUBMISSION.

FORM 990, PART VI, SECTION B, LINE 12C:
 PROCESS TO MONITOR COMPLIANCE WITH CONFLICT OF INTEREST POLICY:

RMCHCS FOLLOWS ITS ADOPTED CONFLICT OF INTEREST POLICY, WHICH MANDATES THAT
 ALL OFFICERS AND BOARD MEMBERS MUST DISCLOSE POTENTIAL CONFLICTS OF

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|--------------------------|--|--------------------------------|------------|
| Name of the organization | REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number | 85-0313268 |
|--------------------------|--|--------------------------------|------------|

INTEREST WHEN APPOINTED, AND THEN SUBSEQUENTLY IF NEW CONFLICTS ARISE, THROUGH A DISCLOSURE QUESTIONNAIRE. THE COMPLIANCE OFFICER REVIEWS AND ANALYZES ALL POTENTIAL CONFLICTS OF INTEREST AND REPORTS THEM TO THE COMPLIANCE COMMITTEE. THE COMPLIANCE COMMITTEE REVIEWS POTENTIAL CONFLICTS OF INTEREST AND REPORTS THEM TO THE BOARD OF TRUSTEES. THE BOARD RECORDS NOTICE OF ALL CONFLICTS OF INTEREST IN THE BOARD MINUTES. THE BOARD ENFORCES THE RECUSAL OF ANY BOARD MEMBER OR OFFICER FROM ANY DELIBERATIONS WHERE THEY HAVE A POTENTIAL CONFLICT OF INTEREST.

FORM 990, PART VI, SECTION B, LINE 15:

ON SEPTEMBER 1, 2020, RMCHCS ENTERED INTO A MANAGEMENT SERVICES AGREEMENT (MSA) WITH COMMUNITY HOSPITAL CONSULTING, INC. (CHC) TO PROVIDE MANAGEMENT AND ADMINISTRATIVE PERSONNEL. WHILE CHC SUPPLIES QUALIFIED STAFF FOR KEY LEADERSHIP ROLES WITH APPOINTMENTS SUBJECT TO APPROVAL BY THE RMCHCS BOARD OF TRUSTEES RMCHCS RETAINS FULL RESPONSIBILITY FOR THE OPERATION AND MAINTENANCE OF THE HOSPITAL. NO POWERS, DUTIES, OR RESPONSIBILITIES VESTED IN THE RMCHCS BOARD ARE DELEGATED TO CHC. UNDER THE TERMS OF THE MSA, THE MARKET-SPECIFIC COMPENSATION OF SAID PERSONNEL MAY BE ADJUSTED ANNUALLY BY CHC IN ACCORDANCE WITH REASONABLE INCREASES OR MERIT INCREASES OR COST-OF-LIVING INCREASES.

FORM 990, PART VI, SECTION C, LINE 19:

THE ARTICLES OF INCORPORATION, FINANCIAL STATEMENTS AND 990 ARE AVAILABLE TO THE PUBLIC ON THE WEBSITE OF THE NEW MEXICO DEPARTMENT OF JUSTICE.

FORM 990, PART IX, LINE 11G, OTHER FEES:

OTHER PROFESSIONAL SERVICES:

| | |
|--------------------------|-------------|
| PROGRAM SERVICE EXPENSES | 15,489,771. |
|--------------------------|-------------|

| | | | |
|--------------------------|--|--------------------------------|------------|
| Name of the organization | REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number | 85-0313268 |
|--------------------------|--|--------------------------------|------------|

MANAGEMENT AND GENERAL EXPENSES 3,758,469.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 19,248,240.

CONTRACT LABOR:

PROGRAM SERVICE EXPENSES 11,364,890.

MANAGEMENT AND GENERAL EXPENSES 2,970,959.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 14,335,849.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A 33,584,089.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

PRIOR PERIOD AUDIT ADJUSTMENT - SEE AUDITED FINANCIAL

STATEMENTS 2,147,409.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships
Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
Attach to Form 990.

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2022

Open to Public Inspection

| | |
|---|---|
| Name of the organization REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC. | Employer identification number 85-0313268 |
|---|---|

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
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Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related tax-exempt organizations during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| WESTERN HEALTH FOUNDATION - 85-0349559 1901 RED ROCK DRIVE GALLUP, NM 87301 | SUPPORT | NEW MEXICO | 501(C)(3) | LINE 7 | RMCHCS | <input checked="" type="checkbox"/> | |
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For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2022

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC.

Part III Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|--|-------------------------|--|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
| | | | | | | | Yes | No | | Yes | No | |
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Part IV Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Direct controlling entity | (e) Type of entity (C corp, S corp, or trust) | (f) Share of total income | (g) Share of end-of-year assets | (h) Percentage ownership | (i) Section 512(b)(13) controlled entity? | |
|--|-------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|---|----|
| | | | | | | | | Yes | No |
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REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES, INC.

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

| | Yes | No |
|--|-----|----|
| a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity | | X |
| b Gift, grant, or capital contribution to related organization(s) | | X |
| c Gift, grant, or capital contribution from related organization(s) | X | |
| d Loans or loan guarantees to or for related organization(s) | | X |
| e Loans or loan guarantees by related organization(s) | | X |
| f Dividends from related organization(s) | | X |
| g Sale of assets to related organization(s) | | X |
| h Purchase of assets from related organization(s) | | X |
| i Exchange of assets with related organization(s) | | X |
| j Lease of facilities, equipment, or other assets to related organization(s) | | X |
| k Lease of facilities, equipment, or other assets from related organization(s) | | X |
| l Performance of services or membership or fundraising solicitations for related organization(s) | | X |
| m Performance of services or membership or fundraising solicitations by related organization(s) | X | |
| n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) | X | |
| o Sharing of paid employees with related organization(s) | X | |
| p Reimbursement paid to related organization(s) for expenses | X | |
| q Reimbursement paid by related organization(s) for expenses | X | |
| r Other transfer of cash or property to related organization(s) | | X |
| s Other transfer of cash or property from related organization(s) | | X |

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|--------------------------------------|-------------------------------|------------------------|--|
| (1) WESTERN HEALTH FOUNDATION | C | 125,845. | FMV |
| (2) | | | |
| (3) | | | |
| (4) | | | |
| (5) | | | |
| (6) | | | |

