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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2019

Open to Public Inspection

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.

A For the 2019 calendar year, or tax year beginning 07-01-2019 , and ending 06-30-2020

B Check if applicable:
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

% MICHAELLE CORNWELL
Doing business as
CHAMBERS MEMORIAL HOSPITAL

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
PO BOX 639

City or town, state or province, country, and ZIP or foreign postal code
DANVILLE, AR 728330639

F Name and address of principal officer:
MIKE MCCOY
PO BOX 639
DANVILLE, AR 728330639

D Employer identification number

71-6044543

E Telephone number

(479) 495-2241

G Gross receipts \$ 22,930,670

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.CHAMBERSHOSPITAL.COM

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1998

M State of legal domicile: AR

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
IT IS THE GOAL OF CHAMBERS MEMORIAL HOSPITAL TO PROVIDE QUALITY HEALTHCARE SERVICES IN A COST EFFECTIVE MANNER THAT MEETS THE NEEDS & EXPECTATIONS OF PATIENTS & COMMUNITIES.

2 Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3 Number of voting members of the governing body (Part VI, line 1a)

4 Number of independent voting members of the governing body (Part VI, line 1b)

5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

7a Total unrelated business revenue from Part VIII, column (C), line 12

7b Net unrelated business taxable income from Form 990-T, line 39

Revenue

Expenses

Net Assets or Fund Balances

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

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)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses. Subtract line 18 from line 12

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances. Subtract line 21 from line 20

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.

Signature of officer
MIKE MCCOY CEO
Type or print name and title

2021-04-12
Date

Paid Preparer Use Only

Print/Type preparer's name
Firm's name ▶ BKD LLP
Firm's address ▶ PO BOX 3667
LITTLE ROCK, AR 722033667

Preparer's signature
Date

Check ☐ if self-employed
Firm's EIN ▶
Phone no. (501) 372-1040

PTIN P00748683

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2019)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

IT IS THE GOAL OF CHAMBERS MEMORIAL HOSPITAL TO PROVIDE QUALITY HEALTHCARE SERVICES IN A COST EFFECTIVE MANNER THAT MEETS THE NEEDS AND EXPECTATIONS OF PATIENTS AND THE COMMUNITITES SERVED.

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 ☒ No

If "Yes," describe these new services on Schedule O.

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

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 18,499,391 including grants of \$ 0) (Revenue \$ 20,464,744)
See Additional Data


















4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

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

4e Total program service expenses ► 18,499,391

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)? If "Yes," complete Schedule A  | 1 Yes | |
| 2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?  | 2 Yes | |
| 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I | 3 | No |
| 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? If "Yes," complete Schedule C, Part II | 4 | No |
| 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 Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III | 5 | No |
| 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? If "Yes," complete Schedule D, Part I  | 6 | No |
| 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II  | 7 | No |
| 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III  | 8 | No |
| 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? If "Yes," complete Schedule D, Part IV  | 9 | No |
| 10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? If "Yes," complete Schedule D, Part V  | 10 | No |
| 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? If "Yes," complete Schedule D, Part VI  | 11a Yes | |
| 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? If "Yes," complete Schedule D, Part VII  | 11b | No |
| 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? If "Yes," complete Schedule D, Part VIII  | 11c | No |
| 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? If "Yes," complete Schedule D, Part IX  | 11d | No |
| e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X  | 11e | No |
| 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)? If "Yes," complete Schedule D, Part X  | 11f | No |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII  | 12a Yes | |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional  | 12b | No |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| 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? If "Yes," complete Schedule F, Parts I and IV | 14b | No |
| 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? If "Yes," complete Schedule F, Parts II and IV | 15 | No |
| 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? If "Yes," complete Schedule F, Parts III and IV | 16 | No |
| 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? If "Yes," complete Schedule G, Part I (see instructions) | 17 | No |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II | 18 Yes | |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III | 19 | No |
| 20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H  | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?  | 20b Yes | |
| 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? If "Yes," complete Schedule I, Parts I and II | 21 | No |

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? If "Yes," complete Schedule I, Parts I and III | 22 | No |
| 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? If "Yes," complete Schedule J | 23 | Yes |
| 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? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a | 24a | Yes |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | No |
| 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 | No |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | No |
| 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? If "Yes," complete Schedule L, Part I | 25a | No |
| 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? If "Yes," complete Schedule L, Part I | 25b | No |
| 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? If "Yes," complete Schedule L, Part II | 26 | Yes |
| 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? If "Yes," complete Schedule L, Part III | 27 | No |
| 28 | Was the organization a party to a business transaction with one of the following parties (see 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? If "Yes," complete Schedule L, Part IV | 28a | No |
| b | A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV | 28b | No |
| c | A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? If "Yes," complete Schedule L, Part IV | 28c | Yes |
| 29 | Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M | 29 | No |
| 30 | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M | 30 | No |
| 31 | Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I | 31 | No |
| 32 | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II | 32 | No |
| 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? If "Yes," complete Schedule R, Part I | 33 | No |
| 34 | Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 | 34 | No |
| 35a | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a | No |
| 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)? If "Yes," complete Schedule R, Part V, line 2 | 35b | |
| 36 | Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2 | 36 | No |
| 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? If "Yes," complete Schedule R, Part VI | 37 | No |
| 38 | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O. | 38 | Yes |

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck 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 | 30 |
| b | Enter the number of Forms W-2G included in 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 | Yes |

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

Form **990** (2019)

Part VI

Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

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

Section A. Governing Body and Management

| | | Yes | No |
|-----------|---|-----|-----|
| 1a | Enter the number of voting members of the governing body at the end of the tax year | 7 | |
| | If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O. | | |
| b | Enter the number of voting members included in line 1a, above, who are independent | 5 | |
| 2 | Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? | 2 | No |
| 3 | Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? | 3 | No |
| 4 | Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? | 4 | No |
| 5 | Did the organization become aware during the year of a significant diversion of the organization's assets? | 5 | No |
| 6 | Did the organization have members or stockholders? | 6 | No |
| 7a | Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? | 7a | No |
| b | Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? | 7b | No |
| 8 | Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: | | |
| a | The governing body? | 8a | Yes |
| b | Each committee with authority to act on behalf of the governing body? | 8b | Yes |
| 9 | Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O | 9 | No |

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

| | | Yes | No |
|------------|--|-----|-----|
| 10a | Did the organization have local chapters, branches, or affiliates? | 10a | No |
| b | If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? | 10b | |
| 11a | Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? | 11a | Yes |
| b | Describe in Schedule O the process, if any, used by the organization to review this Form 990. | | |
| 12a | Did the organization have a written conflict of interest policy? If "No," go to line 13 | 12a | Yes |
| b | Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | 12b | Yes |
| c | Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done | 12c | Yes |
| 13 | Did the organization have a written whistleblower policy? | 13 | No |
| 14 | Did the organization have a written document retention and destruction policy? | 14 | Yes |
| 15 | Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? | | |
| a | The organization's CEO, Executive Director, or top management official | 15a | Yes |
| b | Other officers or key employees of the organization | 15b | Yes |
| | If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions). | | |
| 16a | Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? | 16a | No |
| b | If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? | 16b | |

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed **AR**

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
►MICHAELLE CORNWELL 719 DETROIT AVENUE DANVILLE, AR 728330639 (479) 495-6219

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 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 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or 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 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 dotted 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) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (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) THOMAS TINNESZ MD PHYSICIAN | 40.0 0.0 | | | | | X | | 337,655 | 0 | 18,712 |
| (2) MIKE MCCOY CEO | 40.0 0.0 | | | X | | | | 251,897 | 0 | 15,473 |
| (3) TIMMY KAY MD PHYSICIAN | 32.0 0.0 | | | | | X | | 223,618 | 0 | 14,029 |
| (4) JOHN WESTWOOD MD PYSICIAN | 32.0 0.0 | | | | | X | | 224,159 | 0 | 9,258 |
| (5) WILLIAM BERRY MD PHYSICIAN | 32.0 0.0 | | | | | X | | 217,220 | 0 | 13,029 |
| (6) KARL SANDBERG MD PHYSICIAN | 32.0 0.0 | | | | | X | | 177,580 | 0 | 8,120 |
| (7) JOHNNY CHAMBERS CHAIRMAN | 1.0 0.0 | X | | X | | | | 0 | 0 | 0 |
| (8) DAVID FISHER VICE CHAIRMAN | 1.0 0.0 | X | | X | | | | 0 | 0 | 0 |
| (9) ROBERT REDFERN SECRETARY | 1.0 0.0 | X | | X | | | | 0 | 0 | 0 |
| (10) TODD SANDERS DIRECTOR | 1.0 0.0 | X | | | | | | 0 | 0 | 0 |
| (11) TOMMY PAPASAN DIRECTOR | 1.0 0.0 | X | | | | | | 0 | 0 | 0 |
| (12) RITCHIE TIPPIN DIRECTOR | 1.0 0.0 | X | | | | | | 0 | 0 | 0 |
| (13) PHILIP ALEXANDER DIRECTOR | 1.0 0.0 | X | | | | | | 0 | 0 | 0 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)

| (A) Name and title | (B) Average hours per week (list any hours for related organizations below dotted 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) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (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 | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |
| 1b Sub-Total | | | | | | | | | | |
| c Total from continuation sheets to Part VII, Section A | | | | | | | | | | |
| d Total (add lines 1b and 1c) | | | | | | | | 1,432,129 | 0 | 78,621 |

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 13

| | Yes | No |
|--|-----|----|
| 3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i> | | No |
| 4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i> | Yes | |
| 5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i> | | No |

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

| (A) Name and business address | (B) Description of services | (C) Compensation |
|---|--------------------------------|---------------------|
| RIVER RIDGE RX INC, PO BOX 394 DANVILLE, AR 728330394 | PHARMACY SERVICES | 324,250 |
| VESPER ANESTHESIA, PO BOX 10911 FORT SMITH, AR 72917 | ANESTHESIA SERVICES | 300,000 |
| | | |
| | | |
| | | |

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 2

| | | | | | | | | | | | | | |
|--|--|------------|----------------------|----------------------|------------|--|------------|------------|--|-----------------------------|---|--|---|
| Form 990 (2019) | | | | | | | | | | Page 9 | | | |
| Part VIII Statement of Revenue | | | | | | | | | | | | | |
| Check if Schedule O contains a response or note to any line in this Part VIII <input type="checkbox"/> | | | | | | | | | | | | | |
| | | | | | | | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512 - 514 |
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns . . . | | 1a | | | | | | | | | | |
| | b Membership dues . . . | | 1b | | | | | | | | | | |
| | c Fundraising events . . . | | 1c | 25,120 | | | | | | | | | |
| | d Related organizations | | 1d | | | | | | | | | | |
| | e Government grants (contributions) | | 1e | 2,191,451 | | | | | | | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | | 1f | 41,967 | | | | | | | | | |
| | g Noncash contributions included in lines 1a - 1f:\$ | | 1g | | | | | | | | | | |
| | h Total. Add lines 1a-1f ▶ | | | | 2,258,538 | | | | | | | | |
| Program Service Revenue | | | | Business Code | | | | | | | | | |
| | 2a PATIENT SERVICES | | | 622110 | 19,276,163 | | | 19,276,163 | | | | | |
| | b 340B REVENUE | | | 622110 | 979,281 | | | 979,281 | | | | | |
| | c MANAGED CARE FEES | | | 622110 | 200,175 | | | 200,175 | | | | | |
| | d PHYSICALS REVENUE | | | 621999 | 9,125 | | | 9,125 | | | | | |
| | e | | | | | | | | | | | | |
| | f All other program service revenue. | | | | | | | | | | | | |
| g Total. Add lines 2a-2f. ▶ | | | | 20,464,744 | | | | | | | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) ▶ | | | | 55,231 | | | | | | 55,231 | | |
| | 4 Income from investment of tax-exempt bond proceeds ▶ | | | | 0 | | | | | | | | |
| | 5 Royalties ▶ | | | | 0 | | | | | | | | |
| | | | (i) Real | (ii) Personal | | | | | | | | | |
| | 6a Gross rents | | 6a | 20,305 | | | | | | | | | |
| | b Less: rental expenses | | 6b | | | | | | | | | | |
| | c Rental income or (loss) | | 6c | 20,305 | 0 | | | | | | | | |
| | d Net rental income or (loss) ▶ | | | | 20,305 | | | | | | 20,305 | | |
| | | | (i) Securities | (ii) Other | | | | | | | | | |
| | 7a Gross amount from sales of assets other than inventory | | 7a | | 269 | | | | | | | | |
| | b Less: cost or other basis and sales expenses | | 7b | | | | | | | | | | |
| | c Gain or (loss) | | 7c | | 269 | | | | | | | | |
| | d Net gain or (loss) ▶ | | | | 269 | | | | | | 269 | | |
| | 8a Gross income from fundraising events (not including \$ 25,120 of contributions reported on line 1c). See Part IV, line 18 | | 8a | 14,030 | | | | | | | | | |
| | b Less: direct expenses | | 8b | 14,668 | | | | | | | | | |
| | c Net income or (loss) from fundraising events . . . ▶ | | | | -638 | | | | | | -638 | | |
| | 9a Gross income from gaming activities. See Part IV, line 19 | | 9a | 0 | | | | | | | | | |
| | b Less: direct expenses | | 9b | 0 | | | | | | | | | |
| | c Net income or (loss) from gaming activities . . . ▶ | | | | 0 | | | | | | | | |
| | 10a Gross sales of inventory, less returns and allowances . . . | | 10a | 0 | | | | | | | | | |
| b Less: cost of goods sold . . . | | 10b | 0 | | | | | | | | | | |
| c Net income or (loss) from sales of inventory . . . ▶ | | | | 0 | | | | | | | | | |
| Miscellaneous Revenue | | | Business Code | | | | | | | | | | |
| 11a CAFETERIA REVENUE | | | 722310 | 98,630 | | | | | | 98,630 | | | |
| b VENDING MACHINE | | | 454210 | 1,587 | | | | | | 1,587 | | | |
| c All Other Misc Revenue | | | 900099 | 17,336 | | | | | | 17,336 | | | |
| d All other revenue | | | | 17,336 | | | | | | 17,336 | | | |
| e Total. Add lines 11a-11d ▶ | | | | 117,553 | | | | | | | | | |
| 12 Total revenue. See instructions ▶ | | | | 22,916,002 | | | 20,464,744 | | | 192,720 | | | |

Form 990 (2019)

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 ☒

| 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 | 0 | | | |
| 2 Grants and other assistance to domestic individuals. See Part IV, line 22 | 0 | | | |
| 3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. | 0 | | | |
| 4 Benefits paid to or for members | 0 | | | |
| 5 Compensation of current officers, directors, trustees, and key employees | 267,370 | | 267,370 | 0 |
| 6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | | | |
| 7 Other salaries and wages | 10,326,885 | 8,694,482 | 1,632,403 | |
| 8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) | 304,569 | 256,425 | 48,144 | |
| 9 Other employee benefits | 751,923 | 633,064 | 118,859 | |
| 10 Payroll taxes | 743,963 | 626,362 | 117,601 | |
| 11 Fees for services (non-employees): | | | | |
| a Management | 0 | | | |
| b Legal | 0 | | | |
| c Accounting | 47,936 | 40,359 | 7,577 | |
| d Lobbying | 0 | | | |
| e Professional fundraising services. See Part IV, line 17 | 0 | | | |
| f Investment management fees | 0 | | | |
| g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 3,462,745 | 2,915,378 | 547,367 | 0 |
| 12 Advertising and promotion | 42,120 | 35,462 | 6,658 | |
| 13 Office expenses | 272,765 | 229,648 | 43,117 | |
| 14 Information technology | 31,455 | 26,483 | 4,972 | |
| 15 Royalties | 0 | | | |
| 16 Occupancy | 277,784 | 233,874 | 43,910 | |
| 17 Travel | 144,056 | 121,285 | 22,771 | |
| 18 Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 Conferences, conventions, and meetings | 0 | | | |
| 20 Interest | 585,079 | 492,594 | 92,485 | |
| 21 Payments to affiliates | 0 | | | |
| 22 Depreciation, depletion, and amortization | 886,664 | 746,506 | 140,158 | |
| 23 Insurance | 288,495 | 242,892 | 45,603 | |
| 24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) | | | | |
| a OPERATING SUPPLIES | 1,502,727 | 1,265,186 | 237,541 | |
| b BAD DEBT EXPENSE | 1,100,019 | 1,100,019 | | |
| c EQUIPMENT EXPENSE | 322,235 | 271,298 | 50,937 | |
| d REPAIRS & MAINTENANCE | 288,115 | 242,572 | 45,543 | |
| e All other expenses | 386,615 | 325,502 | 61,113 | |
| 25 Total functional expenses. Add lines 1 through 24e | 22,033,520 | 18,499,391 | 3,534,129 | 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). | | | | |

Part X Balance SheetCheck if Schedule O contains a response or note to any line in this Part IX ☐

| | | | | (A) Beginning of year | | (B) End of year | |
|------------------------------------|--|--|------------|--------------------------|------------|--------------------|------------|
| Assets | 1 | Cash—non-interest-bearing | | 1,800 | 1 | 14,680,363 | |
| | 2 | Savings and temporary cash investments | | 6,650,486 | 2 | 6,325,906 | |
| | 3 | Pledges and grants receivable, net | | 0 | 3 | 0 | |
| | 4 | Accounts receivable, net | | 3,329,728 | 4 | 2,611,729 | |
| | 5 | 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 | | 0 | 5 | 0 | |
| | 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) | | 0 | 6 | 0 | |
| | 7 | Notes and loans receivable, net | | 0 | 7 | 0 | |
| | 8 | Inventories for sale or use | | 332,461 | 8 | 340,019 | |
| | 9 | Prepaid expenses and deferred charges | | 232,580 | 9 | 217,601 | |
| | 10a | Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D | 10a | 34,041,157 | | | |
| | b | Less: accumulated depreciation | 10b | 20,199,921 | 14,721,313 | 10c | 13,841,236 |
| | 11 | Investments—publicly traded securities | | 0 | 11 | 0 | |
| | 12 | Investments—other securities. See Part IV, line 11 | | 0 | 12 | 0 | |
| | 13 | Investments—program-related. See Part IV, line 11 | | 0 | 13 | 0 | |
| | 14 | Intangible assets | | 0 | 14 | 0 | |
| | 15 | Other assets. See Part IV, line 11 | | 452,674 | 15 | 713,366 | |
| 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 25,721,042 | 16 | 38,730,220 | | |
| Liabilities | 17 | Accounts payable and accrued expenses | | 1,211,063 | 17 | 4,738,576 | |
| | 18 | Grants payable | | 0 | 18 | 0 | |
| | 19 | Deferred revenue | | 0 | 19 | 9,437,950 | |
| | 20 | Tax-exempt bond liabilities | | 10,172,868 | 20 | 9,451,405 | |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | 0 | 21 | 0 | |
| | 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 | | 90,944 | 22 | 37,251 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | 217,407 | 23 | 153,796 | |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | 0 | 24 | 0 | |
| | 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 | | 0 | 25 | 0 | |
| | 26 | Total liabilities. Add lines 17 through 25 | | 11,692,282 | 26 | 23,818,978 | |
| 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 | | 14,028,760 | 27 | 14,911,242 | |
| | 28 | Net assets with donor restrictions | | 0 | 28 | 0 | |
| | 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 | | 14,028,760 | 32 | 14,911,242 | |
| 33 | Total liabilities and net assets/fund balances | | 25,721,042 | 33 | 38,730,220 | | |

Part XI Reconciliation of Net AssetsCheck 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 | 22,916,002 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 22,033,520 |
| 3 | Revenue less expenses. Subtract line 2 from line 1 | 3 | 882,482 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 14,028,760 |
| 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 in Schedule O) | 9 | |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 14,911,242 |

Part XII Financial Statements and ReportingCheck 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 in 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 | | No |
| 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 checked="" type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | Yes | |
| 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 in Schedule O. | Yes | |
| 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? | | No |
| 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 in Schedule O and describe any steps taken to undergo such audits. | | |

Additional Data

Software ID:

Software Version:

EIN: 71-6044543

Name: JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Form 990 (2019)

Form 990, Part III, Line 4a:

IT IS THE GOAL OF CHAMBERS MEMORIAL HOSPITAL TO PROVIDE QUALITY HEALTHCARE SERVICES IN A COST EFFECTIVE MANNER THAT MEETS THE NEEDS AND EXPECTATIONS OF PATIENTS AND THE COMMUNITITES SERVED.

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Employer identification number
71-6044543

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
- 3☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations
- g Provide the following information about the supported organization(s).

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1- 10 above (see instructions)) | (iv) Is the organization listed in your governing document? | | (v) Amount of monetary support (see instructions) | (vi) Amount of other support (see instructions) |
|------------------------------------|----------|--|---|----|---|---|
| | | | Yes | No | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total | | | | | | |

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 failed to qualify under the tests listed below, please complete Part III.)

| | | | | | | | |
|---|---|----------|----------|----------|----------|----------|-----------|
| Section A. Public Support | | | | | | | |
| | Calendar year (or fiscal year beginning in) ▶ | (a) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (f) Total |
| 1 | Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . . | | | | | | |
| 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) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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 five 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 2019 (line 6, column (f) divided by line 11, column (f)) | | | | | 14 | |
| 15 | Public support percentage for 2018 Schedule A, Part II, line 14 | | | | | 15 | |
| 16a | 33 1/3% support test—2019. 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—2018. 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—2019. 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—2018. 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) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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) 2015 | (b) 2016 | (c) 2017 | (d) 2018 | (e) 2019 | (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 in 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 five 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

| | | |
|--|-----------|--|
| 15 Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2018 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2019 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2018 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2019. 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—2018. 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 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of 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> | | |
| 1 | | |
| 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> | | |
| 2 | | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i> | | |
| 3a | | |
| 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> | | |
| 3b | | |
| 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> | | |
| 3c | | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i> | | |
| 4a | | |
| 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> | | |
| 4b | | |
| 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> | | |
| 4c | | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) 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> | | |
| 5a | | |
| 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? | | |
| 5b | | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | | |
| 5c | | |
| 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> | | |
| 6 | | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (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 or 990-EZ) .</i> | | |
| 7 | | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i> | | |
| 8 | | |
| 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> | | |
| 9a | | |
| b Did one or more disqualified persons (as defined in 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> | | |
| 9b | | |
| c Did a disqualified person (as defined in 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> | | |
| 9c | | |
| 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> | | |
| 10a | | |
| 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> | | |
| 10b | | |

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 in (b) and (c) below, the governing body of a supported organization? | | |
| b A family member of a person described in (a) above? | | |
| c A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI.</i> | | |

Section B. Type I Supporting Organizations

| | Yes | No |
|--|-----|----|
| 1 Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's 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 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> | | |

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> | | |

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 in (2), 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> | | |

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 government entity (see instructions) | | |
| 2 Activities Test. Answer (a) and (b) 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> | | |
| b Did the activities described in (a) 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 (a) and (b) 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>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> | | |

Part V

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

| | | | |
|----------------------------------|--|--|-----------------------------|
| 1 | | <input type="checkbox"/> 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): | 1 | |
| 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 (explain in detail in Part VI): | | |
| 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 1-1/2% 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 .035 | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | Minimum Asset Amount (add line 7 to line 6) | 8 | |
| Section C - Distributable Amount | | | Current Year |
| 1 | Adjusted net income for prior year (from Section A, line 8, Column A) | 1 | |
| 2 | Enter 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) | | |

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 | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI). See instructions | |
| 7 Total annual distributions. Add lines 1 through 6. | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions | |
| 9 Distributable amount for 2019 from Section C, line 6 | |
| 10 Line 8 amount divided by Line 9 amount | |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2019 | (iii) Distributable Amount for 2019 |
|---|-----------------------------|--|---|
| 1 Distributable amount for 2019 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions. | | | |
| 3 Excess distributions carryover, if any, to 2019: | | | |
| a From 2014. | | | |
| b From 2015. | | | |
| c From 2016. | | | |
| d From 2017. | | | |
| e From 2018. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2019 distributable amount | | | |
| i Carryover from 2014 not applied (see instructions) | | | |
| j Remainder. Subtract lines 3g, 3h, and 3i from 3f. | | | |
| 4 Distributions for 2019 from Section D, line 7: | | | |
| \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2019 distributable amount | | | |
| c Remainder. Subtract lines 4a and 4b from 4. | | | |
| 5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI. See instructions. | | | |
| 6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI. See instructions. | | | |
| 7 Excess distributions carryover to 2020. Add lines 3j and 4c. | | | |
| 8 Breakdown of line 7: | | | |
| a Excess from 2015. | | | |
| b Excess from 2016. | | | |
| c Excess from 2017. | | | |
| d Excess from 2018. | | | |
| e Excess from 2019. | | | |

Additional Data

Software ID:
Software Version:
EIN: 71-6044543
Name: JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

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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

2019

Open to Public Inspection

Name of the organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Employer identification number
71-6044543

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.

| | (a) Donor advised funds | (b) Funds and other accounts |
|---|-------------------------|------------------------------|
| 1 Total number at end of year | | |
| 2 Aggregate value of contributions to (during year) | | |
| 3 Aggregate value of grants from (during year) | | |
| 4 Aggregate value at end of year | | |

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

| | Held at the End of the Year |
|--|-----------------------------|
| a Total number of conservation easements | 2a |
| b Total acreage restricted by conservation easements | 2b |
| c Number of conservation easements on a certified historic structure included in (a) | 2c |
| d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register | 2d |

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►

4 Number of states where property subject to conservation easement is located ►

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 ► \$

(ii) Assets included in Form 990, Part X ► \$

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ► \$

b Assets included in Form 990, Part X ► \$

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

Cat. No. 52283D Schedule D (Form 990) 2019

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 are a 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 programs

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 |
|----|--------|
| 1c | |
| 1d | |
| 1e | |
| 1f | |

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

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 in 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

Temporarily restricted 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:

(i) unrelated organizations

(ii) related organizations

| | Yes | No |
|--------|-----|----|
| 3a(i) | | |
| 3a(ii) | | |
| 3b | | |

b

If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?

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 | 1,229,124 | | 1,229,124 |
| b | Buildings | 21,470,299 | 12,456,657 | 9,013,642 |
| c | Leasehold improvements | | | |
| d | Equipment | 10,852,933 | 7,514,967 | 3,337,966 |
| e | Other | 488,801 | 228,297 | 260,504 |
| Total. | Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶ | | | 13,841,236 |

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. (Column (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. (Column (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) | |
| (2) | |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) ▶ | |

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) | |
| (3) | |
| (4) | |
| (5) | |
| (6) | |
| (7) | |
| (8) | |
| (9) | |
| (10) | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶ | |

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 FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☐

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 | 21,844,908 |
| 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 | 29,194 |
| e | Add lines 2a through 2d | 2e | 29,194 |
| 3 | Subtract line 2e from line 1 | 3 | 21,815,714 |
| 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 | 1,100,288 |
| c | Add lines 4a and 4b | 4c | 1,100,288 |
| 5 | Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.) | 5 | 22,916,002 |

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 | 20,962,426 |
| 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 | 29,194 |
| e | Add lines 2a through 2d | 2e | 29,194 |
| 3 | Subtract line 2e from line 1 | 3 | 20,933,232 |
| 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 | 1,100,288 |
| c | Add lines 4a and 4b | 4c | 1,100,288 |
| 5 | Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.) | 5 | 22,033,520 |

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.

| Return Reference | Explanation |
|---------------------------|-------------|
| See Additional Data Table | |
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Part XIII Supplemental Information *(continued)*

| Return Reference | Explanation |
|------------------|-------------|
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Additional Data

Software ID:
Software Version:
EIN: 71-6044543
Name: JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Supplemental Information

| Return Reference | Explanation |
|--------------------------------------|---|
| FORM 990, SCHEDULE D, PART X, LINE 2 | MANAGEMENT HAS EVALUATED THEIR INCOME TAX POSITIONS UNDER THE GUIDANCE INCLUDED IN ASC 740 . BASED ON THEIR REVIEW, MANAGEMENT HAS NOT IDENTIFIED ANY MATERIAL INCOME TAX POSITIONS T O BE RECORDED OR DISCLOSED IN THE FINANCIAL STATEMENTS. |

| Supplemental Information | |
|--|--|
| Return Reference | Explanation |
| FORM 990, SCHEDULE D, PART XI, LINE 2D | FUNDRAISING EXPENSE \$14,668 EXPENSES INCLUDED IN REVENUE PER AUDIT \$14,526 ----- ----- TOTAL \$29,194 |

| Supplemental Information | |
|--|---|
| Return Reference | Explanation |
| FORM 990, SCHEDULE D, PART XI, LINE 4B | BAD DEBT EXPENSE \$1,100,019 GAIN ON SALE \$269 ----- TOTAL \$1,100,288 |

| Supplemental Information | |
|---|--|
| Return Reference | Explanation |
| FORM 990, SCHEDULE D, PART XII, LINE 2D | FUNDRAISING EXPENSE \$14,668 EXPENSES INCLUDED IN REVENUE PER AUDIT \$14,526 ----- ----- TOTAL \$29,194 |

| Supplemental Information | |
|---|---|
| Return Reference | Explanation |
| FORM 990, SCHEDULE D, PART XII, LINE 4B | BAD DEBT EXPENSE \$1,100,019 GAIN ON SALE \$269 ----- TOTAL \$1,100,288 |

| | | |
|------------------------------------|--|---------------------------|
| SCHEDULE G (Form 990 or 990-EZ) | <div>Supplemental Information Regarding Fundraising or Gaming Activities</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a. ▶ Attach to Form 990 or Form 990-EZ. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.</div> | OMB No. 1545-0047 |
| | | 2019 |
| | | Open to Public Inspection |

| | |
|--|--|
| Name of the organization JOHN ED CHAMBERS MEMORIAL HOSPITAL INC | Employer identification number 71-6044543 |
|--|--|

Part I Fundraising Activities. Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

- 1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.
- a☐ Mail solicitations

b☐ Internet and email solicitations

c☐ Phone solicitations

d☐ In-person solicitations

e☐ Solicitation of non-government grants

f☐ Solicitation of government grants

g☐ Special fundraising events
- 2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No
- b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

| (i) Name and address of individual or entity (fundraiser) | (ii) Activity | (iii) Did fundraiser have custody or control of contributions? | | (iv) Gross receipts from activity | (v) Amount paid to (or retained by) fundraiser listed in col. (i) | (vi) Amount paid to (or retained by) organization |
|---|---------------|--|----|-----------------------------------|---|---|
| | | Yes | No | | | |
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| Total ▶ | | | | | | |

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

Part II Fundraising Events. Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

| | | (a) Event #1 | (b) Event #2 | (c) Other events | (d) Total events |
|--|---|--|--------------|----------------------------|---------------------------------|
| | | GOLF TOURNAMENT (event type) | (event type) | 0 (total number) | (add col. (a) through col. (c)) |
| Revenue | 1 Gross receipts | 39,150 | | | 39,150 |
| | 2 Less: Contributions | 25,120 | | | 25,120 |
| | 3 Gross income (line 1 minus line 2) | 14,030 | | | 14,030 |
| | | | | | |
| Direct Expenses | 4 Cash prizes | | | | |
| | 5 Noncash prizes | 11,960 | | | 11,960 |
| | 6 Rent/facility costs | 1,910 | | | 1,910 |
| | 7 Food and beverages | 598 | | | 598 |
| | 8 Entertainment | | | | |
| | 9 Other direct expenses | 200 | | | 200 |
| | 10 Direct expense summary. Add lines 4 through 9 in column (d) ▶ | | | | 14,668 |
| 11 Net income summary. Subtract line 10 from line 3, column (d) ▶ | | | | -638 | |

Part III Gaming. Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

| | | (a) Bingo | (b) Pull tabs/Instant bingo/progressive bingo | (c) Other gaming | (d) Total gaming (add col.(a) through col.(c)) |
|-----------------|---|---|---|---|--|
| Revenue | 1 Gross revenue | | | | |
| | 2 Cash prizes | | | | |
| | 3 Noncash prizes | | | | |
| | 4 Rent/facility costs | | | | |
| | 5 Other direct expenses | | | | |
| Direct Expenses | 6 Volunteer labor | <input type="checkbox"/> Yes _____ % <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ % <input type="checkbox"/> No | <input type="checkbox"/> Yes _____ % <input type="checkbox"/> No | |
| | 7 Direct expense summary. Add lines 2 through 5 in column (d) ▶ | | | | |
| | 8 Net gaming income summary. Subtract line 7 from line 1, column (d) ▶ | | | | |

9 Enter the state(s) in which the organization conducts gaming activities: _____

a Is the organization licensed to conduct gaming activities in each of these states? ☐ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☐ No

b If "Yes," explain: _____

| | | | |
|------------|---|------------------------------|-----------------------------|
| 11 | Does the organization conduct gaming activities with nonmembers? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12 | Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13 | Indicate the percentage of gaming activity conducted in: | | |
| a | The organization's facility | 13a | % |
| b | An outside facility | 13b | % |
| 14 | Enter the name and address of the person who prepares the organization's gaming/special events books and records: | | |
| | Name ► | | |
| | Address ► | | |
| 15a | Does the organization have a contract with a third party from whom the organization receives gaming revenue? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b | If "Yes," enter the amount of gaming revenue received by the organization ► \$ and the amount of gaming revenue retained by the third party ► \$ | | |
| c | If "Yes," enter name and address of the third party: | | |
| | Name ► | | |
| | Address ► | | |
| 16 | Gaming manager information: | | |
| | Name ► | | |
| | Gaming manager compensation ► \$ | | |
| | Description of services provided ► | | |
| | <input type="checkbox"/> Director/officer <input type="checkbox"/> Employee <input type="checkbox"/> Independent contractor | | |
| 17 | Mandatory distributions: | | |
| a | Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| b | Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ► \$ | | |

Part IV Supplemental Information. Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions.

| Return Reference | Explanation |
|------------------|-------------|
|------------------|-------------|

SCHEDULE H
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Go to www.irs.gov/Form990EZ for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Employer identification number
71-6044543

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 | 1a | Yes |
| b | If "Yes," was it a written policy? | 1b | Yes |
| 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 free 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 110 % b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other % 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. | 3a | Yes |
| | | 3b | Yes |
| 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"? | 4 | Yes |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | Yes |
| 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? | 5c | No |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes |
| 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

| Financial Assistance and Means-Tested Government Programs | (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 |
|--|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| a Financial Assistance at cost (from Worksheet 1) | | | 460,164 | | 460,164 | 2.090 % |
| b Medicaid (from Worksheet 3, column a) | | | 2,196,933 | 1,499,787 | 697,146 | 3.160 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | | | 2,657,097 | 1,499,787 | 1,157,310 | 5.250 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4). | | | | | | |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | 4,356,517 | 3,429,566 | 926,951 | 4.210 % |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | | | | | |
| j Total. Other Benefits | | | 4,356,517 | 3,429,566 | 926,951 | 4.210 % |
| k Total. Add lines 7d and 7j | | | 7,013,614 | 4,929,353 | 2,084,261 | 9.460 % |

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | | | | | | |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | | | | | | |
| 9 Other | | | | | | |
| 10 Total | | | | | | |

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

| | | Yes | No |
|--|----------|-----------|----|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | 1 | Yes | |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | 1,100,019 | |
| 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. | 3 | 605,010 | |
| 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | |

Section B. Medicare

| | | | |
|---|--|--------------------------------|--|
| 5 Enter total revenue received from Medicare (including DSH and IME) | 5 | 6,685,466 | |
| 6 Enter Medicare allowable costs of care relating to payments on line 5 | 6 | 4,202,701 | |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall) | 7 | 2,482,765 | |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: | | | |
| <input type="checkbox"/> Cost accounting system | <input checked="" type="checkbox"/> Cost to charge ratio | <input type="checkbox"/> Other | |

Section C. Collection Practices

| | | | |
|--|-----------|-----|--|
| 9a Did the organization have a written debt collection policy during the tax year? | 9a | Yes | |
| b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI | 9b | Yes | |

Part IV Management Companies and Joint Ventures

| (a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions) | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|---|---|--|--|---|
| 1 | | | | |
| 2 | | | | |
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| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

Part V Facility Information**Section A. Hospital Facilities**

(list in order of size from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year?
1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

| | Other (describe) | ER-other | ER-24 hours | Research facility | Critical access hospital | Teaching hospital | Children's hospital | General medical & surgical | Licensed hospital | Facility reporting group |
|---------------------------|------------------|----------|-------------|-------------------|--------------------------|-------------------|---------------------|----------------------------|-------------------|--------------------------|
| | | | | | | | | | | |
| See Additional Data Table | | | | | | | | | | |
| | | | | | | | | | | |
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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)
CHAMBERS MEMORIAL HOSPITAL**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

| | 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? | 1 | No |
| 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. | 2 | No |
| 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. If "Yes," indicate what the CHNA report describes (check all that apply): | 3 | Yes |
| 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>18</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 | 5 | Yes |
| 6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | No |
| 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 | 6b | No |
| 7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply): | 7 | Yes |
| a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.CHAMBERSHOSPITAL.COM</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. | 8 | Yes |
| 9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u> | | |
| 10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>WWW.CHAMBERSHOSPITAL.COM</u> | 10 | Yes |
| a | | |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | |
| 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)? | 12a | No |
| b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c If "Yes" on 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)**

CHAMBERS MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

| | | 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? If "Yes," indicate the eligibility criteria explained in the FAP: | 13 Yes | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>110.</u> % and FPG family income limit for eligibility for discounted care of <u>200.</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 checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 Yes | |
| 15 | Explained the method for applying for financial assistance? 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): | 15 Yes | |
| 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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply): | 16 Yes | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.CHAMBERSHOSPITAL.COM</u> | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>WWW.CHAMBERSHOSPITAL.COM</u> | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>WWW.CHAMBERSHOSPITAL.COM</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 LEP populations | | |
| j | <input checked="" type="checkbox"/> Other (describe in Section C) | | |

Part V Facility Information (continued)**Billing and Collections**

CHAMBERS MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

| | 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? | 17 Yes | |
| 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? | 19 | No |
| 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 checked="" 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 checked="" 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? | 21 Yes | |
| 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)

CHAMBERS MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ 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** ☐ 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** ☐ 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?

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?

If "Yes," explain in Section C.

| | Yes | No |
|-----------|-----|----|
| 22 | | |
| 23 | | No |
| 24 | | No |

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.

[illegible]

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 CHAMBERS MEMORIAL CLINIC 719 DETROIT AVENUE DANVILLE, AR 72833 | FAMILY CLINIC |
| 2 SCENIC 7 MEDICAL CLINIC 402 SOUTH SCENIC 7 DRIVE OLA, AR 72853 | FAMILY CLINIC |
| 3 WESTERN YELL COUNTY MEDICAL CLINIC 301 WEST BROADWAY HAVANA, AR 72842 | FAMILY CLINIC |
| 4 PLAINVIEW MEDICAL CLINIC 102 NORTH GARFIELD AVENUE PLAINVIEW, AR 72857 | FAMILY CLINIC |
| 5 CHAMBERS MEMORIAL HOME HEALTH AGENCY 719 DETROIT AVENUE DANVILLE, AR 72833 | HOME HEALTH |
| 6 OUTPATIENT INFUSION CENTER 719 DETROIT AVE DANVILLE, AR 72833 | INFUSION CENTER |
| 7 | |
| 8 | |
| 9 | |
| 10 | |

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 (e.g., 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.

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|--|---|
| FORM 990, SCHEDULE H, PART I, LINE 3C | PLEASE REFER TO THE FINANCIAL ASSISTANCE POLICY OR SCHEDULE H, PART V, LINES 13 THROUGH 16 FOR ADDITIONAL INFORMATION ON THE FAP. |
| FORM 990, SCHEDULE H, PART I, LINE 7, COLUMN F | BAD DEBT EXPENSE IN THE AMOUNT OF \$1,100,019 IS INCLUDED ON FORM 990 PART IX, LINE 25, COLUMN (A) ("TOTAL FUNCTIONAL EXPENSES"), BUT IS SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES IN THIS COLUMN. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|---|
| FORM 990, SCHEDULE H, PART I, LINE 7 | CHAMBERS MEMORIAL HOSPITAL USES THE MEDICARE COST REPORT COST TO CHARGE RATIO METHODOLOGY. |
| FORM 990, SCHEDULE H, PART III, LINES 2 & 3 | <p>ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. IN EVALUATING THE COLLECTIBILITY OF ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND PROVISION FOR UNCOLLECTIBLE ACCOUNTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR UNCOLLECTIBLE ACCOUNTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND CO-PAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY PAYOR HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDE BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND CO-PAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), THE HOSPITAL RECORDS A SIGNIFICANT PROVISION FOR UNCOLLECTIBLE ACCOUNTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES (OR THE DISCOUNTED RATES IF NEGOTIATED OR PROVIDED BY POLICY) AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS.</p> |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---|--|
| FORM 990, SCHEDULE H, PART III, LINE 4 | PLEASE SEE ATTACHED AUDIT REPORT NOTE 1. |
| FORM 990, SCHEDULE H, PART III, LINE 9B | PATIENTS ARE INFORMED OF CHARITY CARE PROGRAM UPON ADMISSION AND DISCHARGE. THE PLAIN LANGUAGE SUMMARY OF THE FAP IS INCLUDED IN THE REGISTRATION PACKET. ALL PATIENTS IDENTIFIED AS POTENTIAL FINANCIAL ASSISTANCE RECIPIENTS OR ANYONE REQUESTING FINANCIAL ASSISTANCE WILL BE OFFERED THE OPPORTUNITY TO APPLY FOR FINANCIAL ASSISTANCE. THE FINANCIAL COUNSELOR WILL MAIL A FINANCIAL ASSISTANCE APPLICATION TO THE PATIENT AND INFORMATION REGARDING THE FAP WILL BE MADE AVAILABLE WITH ALL BILLING STATEMENTS AND COMMUNICATIONS WITHIN THE FIRST 120 DAYS FOLLOWING THE FIRST BILLING STATEMENT. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---------------------------------------|---|
| FORM 990, SCHEDULE H, PART VI, LINE 2 | IN ADDITION TO ANY HEALTH NEEDS REPORTED ON PART V, SECTION B, THE HOSPITAL UTILIZES THE 'COUNTY HEALTH RANKINGS' MODEL TO WEIGH THE HEALTH FACTORS NEEDS TO THE COMMUNITIES IT SERVES. THE MODEL PROVIDES A RANKING METHOD THAT RANKS ALL 50 STATES AND THE COUNTIES WITHIN EACH STATE BASED ON TWO TYPES OF HEALTH OUTCOMES FOR EACH COUNTY: MORTALITY AND MORBIDITY. COUNTIES ARE RANKED RELATIVE TO THE HEALTH OF OTHER COUNTIES IN THE STATES. AS PART OF THE ANALYSIS OF THE CHNA FOR THE COMMUNITY, THE RELATIVE HEALTH STATUS FOR YELL COUNTY WILL BE COMPARED TO THE STATE OF ARKANSAS AS WELL AS TO THE NATIONAL BENCHMARK. A BETTER UNDERSTANDING OF THE FACTORS THAT AFFECT THE HEALTH OF THE COMMUNITY WILL ASSIST WITH HOW TO IMPROVE THE COMMUNITY'S HABITS, CULTURE, AND ENVIRONMENT. YELL COUNTY FELL WITHIN THE LOWER 50TH PERCENTILE OF THE 75 COUNTIES IN ARKANSAS. THE HEALTH NEEDS ARE SIMILAR TO THE NEEDS ADDRESSED IN THE CHNA AND VOICED BY THE INTERVIEWS CONDUCTED. |
| FORM 990, SCHEDULE H, PART VI, LINE 3 | ALL PATIENTS WILL BE OFFERED, AS PART OF THE REGISTRATION AND/OR DISCHARGE PROCESS, A COPY OF THE PLAIN LANGUAGE SUMMARY OF THIS POLICY. ADDITIONALLY, ALL PATIENTS IDENTIFIED AS POTENTIAL FINANCIAL ASSISTANCE RECIPIENTS OR ANYONE REQUESTING FINANCIAL ASSISTANCE WILL BE OFFERED THE OPPORTUNITY TO APPLY FOR FINANCIAL ASSISTANCE. IF THIS EVALUATION IS NOT CONDUCTED UNTIL AFTER THE PATIENT LEAVES THE FACILITY, OR IN CASE OF OUTPATIENTS OR EMERGENCY PATIENTS, THE FINANCIAL COUNSELOR WILL MAIL A FINANCIAL ASSISTANCE APPLICATION TO THE PATIENT FOR COMPLETION. IN ADDITION, THE HOSPITAL WILL PROVIDE A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY TO THE PATIENT WITH ALL BILLING STATEMENTS AND COMMUNICATIONS WITHIN THE FIRST 120 DAYS FOLLOWING THE FIRST BILLING STATEMENT. IN ADDITION, PATIENTS WILL BE CONTACTED VIA TELEPHONE. |

990 Schedule H, Supplemental Information

| Form and Line Reference | Explanation |
|---------------------------------------|--|
| FORM 990, SCHEDULE H, PART VI, LINE 4 | <p>THE COMMUNITY SERVED BY THE HOSPITAL IS A RURAL AREA IN CENTRAL WESTERN ARKANSAS. THE HOSPITAL IS LOCATED IN DANVILLE, ARKANSAS, WHICH IS THE SECOND LARGEST TOWN IN THE COMMUNITY WITH A POPULATION OF AROUND 2,350 PEOPLE. THE POPULATION IS ABOUT 75% CAUCASIAN, MAKING IT MUCH MORE RACIALLY HOMOGENOUS THAN EITHER THE STATE OF ARKANSAS OR THE UNITED STATES AS A WHOLE. MOST OF THE REMAINING POPULATION IS HISPANIC OR LATINO. ACCORDING TO THE U.S. CENSUS BUREAU, ABOUT 16% OF THE COMMUNITY'S POPULATION IS OVER AGE 65, WHICH IS HIGHER THAN ARKANSAS (15%). THIS AGE GROUP USES MORE HEALTH SERVICES THAN ANY OTHER SO THE HOSPITAL SHOULD BE PREPARED FOR AN INCREASE IN PATIENT VOLUME IN THE FUTURE. ADDITIONALLY, THE PERCENTAGE OF THE COMMUNITY POPULATION AGED 15 TO 44 IS EXPECTED TO DECREASE OVER THE NEXT TWO YEARS, WHICH COULD CONTRIBUTE TO DIFFICULTIES IN RECRUITING PHYSICIANS TO CARE FOR THE AGING POPULATION. FACTORS SUCH AS EDUCATIONAL, ATTAINMENT, POVERTY LEVELS, UNEMPLOYMENT RATES AND INSURANCE COVERAGE LEVELS CONTRIBUTE SIGNIFICANTLY TO THE HEALTH STATUS OF A COMMUNITY. APPROXIMATELY 14% OF THE COMMUNITY'S POPULATION AGE 25 YEARS OR OLDER HAS OBTAINED AN BACHELOR'S DEGREE OR HIGHER, COMPARED TO ABOUT 31% OF THE UNITED STATES. ABOUT 21% OF THE POPULATION DOES NOT HAVE A HIGH SCHOOL DIPOLMA COMPARED TO ABOUT 13% OF THE COUNTRY AS A WHOLE. LOWER LEVELS OF EDUCATIONAL ATTAINMENT HAVE BEEN LINKED TO NEGATIVE HEALTH OUTCOMES, SO THIS IS RELEVANT TO THE CONSIDERATION OF THE HEALTH NEEDS OF THE COMMUNITY. THE INCOME LEVELS OF INDIVIDUALS WITHIN THE COMMUNITY ALSO HAVE A SIGNIFICANT EFFECT ON THEIR ABILITY TO ACCESS HEALTH SERVICES. THE MEDIAN HOUSEHOLD INCOME IN YELL COUNTY IS \$39,696, COMPARED TO \$43,813 FOR THE STATE OF ARKANSAS AND \$57,652 FOR THE UNITED STATES. LOWER THAN MEDIAN HOUSEHOLD INCOME SUGGESTS THAT MANY MEMBERS OF THE COMMUNITY MAY HAVE DIFFICULTY OBTAINING HEALTH CARE, ESPECIALLY PREVENTATIVE CARE. ADDITIONALLY, WHILE SIMILAR TO THE STATE OF ARKANSAS, THE LEVELS OF POVERTY IN YELL COUNTY ARE SIGNIFICANTLY HIGHER THAN THE RATES IN THE UNITED STATES.</p> |
| FORM 990, SCHEDULE H, PART VI, LINE 5 | <p>THE HOSPITAL AND OTHER HEALTH CARE FACILITIES FURTHER THEIR EXEMPT PURPOSE BY PROMOTING HEALTH CARE INITIATIVES IN THE COMMUNITIES SERVED. THE HOSPITAL IS INVOLVED WITH LOCAL SCHOOL DISTRICTS, HEALTH DEPARTMENTS, CHURCHES AND FAITH-BASED ORGANIZATIONS, SENIOR CITIZEN CENTERS, AND OTHER ORGANIZATIONS TO HELP PROMOTE HEALTH EDUCATION. A FEW EVENTS IN WHICH THE HOSPITAL IS INVOLVED IN INCLUDES CAR SEAT SAFETY, HEALTH FAIRS, YELL COUNTY FAIR, FARM SAFETY, AND OTHER LOCAL EVENTS THAT WILL HELP THE HOSPITAL DISTRIBUTE HEALTH KNOWLEDGE.</p> |

Additional Data

Software ID:

Software Version:

EIN: 71-6044543

Name: JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Form 990 Schedule H, Part V Section A. Hospital Facilities

| Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1 | | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER—24 hours | ER—other | Other (Describe) | Facility reporting group |
|--|--|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------|--------------------------|
| 1 | CHAMBERS MEMORIAL HOSPITAL 719 DETROIT STREET DANVILLE, AR 728330639 WWW.CHAMBERSHOSPITAL.COM AR4825 | X | X | | | | | X | | | |

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|---|---|
| FORM 990, SCHEDULE H, PART V, SECTION B, LINE 5 | THE HOSPITAL CALCULATED THE COMMUNITY HEALTH INPUT QUESTIONNAIRES IN ORDER TO GATHER BROAD COMMUNITY INPUT REGARDING HEALTH ISSUES. THE HOSPITAL ENGAGED BKD, LLP TO ASSIST IN CONDUCTING A FORMAL COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). KEY INTERVIEWEES INCLUDED COMMUNITY STAKEHOLDERS THAT REPRESENT THE BROAD INTEREST OF THE COMMUNITY WITH KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH. DIAGLOGUES WITH FIVE KEY INTERVIEWEES WERE CONDUCTED. INTERVIEWEES WERE DETERMINED BASED ON THEIR SPECIALIZED KNOWLEDGE OR EXPERTISE IN PUBLIC HEALTH OR THEIR INVOLVEMENT WITH UNDERSERVED AND MINORITY POPULATIONS. ALL INTERVIEWS WERE CONDUCTED BY HOSPITAL PERSONNEL USING A STANDARD QUESTIONNAIRE. A SUMMARY OF THEIR OPINIONS IS REPORTED WITHOUT JUDGING THE TRUTHFULNESS OR ACCURACY OF THEIR REMARKS. INTERVIEW DATA WAS INITIALLY RECORDED IN NARRATIVE FORM. INTERVIEWEES WERE ASSURED THAT PERSONAL IDENTIFIERS SUCH AS NAME OR ORGANIZATIONAL AFFILIATIONS WOULD NOT BE CONNECTED IN ANY WAY TO THE INFORMATION PRESENTED IN THE CHNA. |

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|--|--|
| FORM 990, SCHEDULE H, PART V, SECTION B, LINE 11 | THE NEEDS THAT WILL BE ADDRESSED IN THE MOST CURRENTLY ADOPTED CHNA INCLUDE THE FOLLOWING ISSUES CONSISTENTLY RAISED DURING INTERVIEWS: 1. OBESITY OBESITY INCREASES RISKS FOR MORBIDITY AND MORTALITY OF NUMEROUS MEDICAL CONDITIONS. YELL COUNTY HAS A 14% HIGHER INCIDENT OF OBESITY THAN THE NATIONAL BENCHMARK AND 5% HIGHER THAN THE STATE OF ARKANSAS AS A WHOLE. WE FEEL IT IS VERY IMPORTANT TO BRING THIS KNOWLEDGE TO THE COMMUNITY WHEN PERFORMING SURVEYS AND ASKING ABOUT OBESITY IN YELL COUNTY AS A LARGE PERCENTAGE OF YELL COUNTY PARTICIPANTS DID NOT THINK YELL COUNTY HAD AN OBESITY PROBLEM. WE WILL CONTINUE TO PARTNER WITH AND HELP SPONSOR HEALTHY ACTIVE YELL WHICH MEETS WITH MEMBERS OF THE COMMUNITY MONTHLY TO CONTINUE TO INCREASE AWARENESS OF THIS GROWING PROBLEM AND WORK TOGETHER TO CONTINUE TO EDUCATE AND HELP YELL COUNTY TO BECOME HEALTHIER AND MORE ACTIVE. WE HAVE REPRESENTATION FROM ALL SCHOOLS (STUDENTS, TEACHER AND NURSES) IN YELL COUNTY ALONG WITH THE ARKANSAS DEPT. OF HEALTH AND COUNTY EXTENSION SERVICES. OUR GROUP CONTINUES TO BE PART OF ARCOPS WHICH IS THE ARKANSAS COALITION FOR OBESITY PREVENTION. THIS PARTNERSHIP WITH ARCOPS HELPS US TO ASSIST RESIDENTS OF YELL COUNTY. WE WILL ALSO CONTINUE TO PARTNER WITH OUR SCHOOLS, ADHS, ARCOPS, COUNTY EXTENSION AND THE SENIOR CITIZEN CENTER TO CONTINUE TO BUILD A HEALTHIER AND MORE ACTIVE COMMUNITY. 2. HEALTH KNOWLEDGE AND EDUCATION KNOWLEDGE IS CRUCIAL TO CREATING A HEALTHIER COMMUNITY. WE HAVE DISCOVERED THROUGH INTERVIEWS AND SURVEYS THAT WE HAVE NOT BEEN COMPLETELY SUCCESSFUL IN GETTING THE INFORMATION TO THE CITIZENS OF YELL COUNTY. WE FEEL IT IS NECESSARY TO DIRECT THE COMMUNITIES' ATTENTION TO IMPORTANT HEALTHCARE TOPICS IN ORDER TO BRING AWARENESS OF CHRONIC ILLNESSES THAT AFFECT OUR HEALTH AND THE HEALTH OF OUR LOVED ONES. WE PLAN TO CONTINUE TO GET KNOWLEDGE AND EDUCATION OUT BY UTILIZING OUR LOCAL NEWSPAPER, BY ASSIGNING NURSE EDUCATOR TO UPDATE AND KEEP EDUCATIONAL MATERIAL CURRENT ON OUR FACILITY WEBSITE, THROUGH HEALTH FAIRS, THE SENIOR CITIZEN CENTER, AND THROUGH OUR SCHOOLS AND OUR LOCAL FAITH-BASED ORGANIZATIONS. WE PLAN TO PROVIDE EDUCATION AND MATERIAL ON TOPICS SUCH AS FAMILY HEALTH, CHRONIC DISEASES, PREVENTATIVE HEALTH, HEALTHY EATING THROUGH NUTRITION EDUCATION, PROMOTION OF INCREASED ACTIVITY, AND SMOKING CESSATION. WE ALSO PLAN TO PROVIDE EDUCATION AND INFORMATION ON DRUG AND ALCOHOL ABUSE AND TREATMENT OPTIONS. INFORMATION AND EDUCATION WILL BE PROVIDED BY NURSING EDUCATOR, DON, HOSPITAL NURSING STAFF, HOME HEALTH NURSING STAFF AND OUR STAFF PHYSICIANS. OUR NURSE PRACTITIONERS WILL ALSO BE PART OF GETTING THIS KNOWLEDGE AND EDUCATION TO OUR COMMUNITY. 3. MENTAL HEALTH SERVICES CHAMBERS MEMORIAL HOSPITAL RECOGNIZED THE NEED FOR MENTAL HEALTH SERVICES THROUGH OUR INPATIENT AND CLINICS. AS A RESULT, CHAMBERS OPENED A 12 BED ADULT BEHAVIOR UNIT, RESTORATIONS, IN JULY 2018. WHEN THE UNIT OPENED IT WAS FOCUSED ON ADULTS 60 AND GREATER BUT DUE TO THE NEED NOTED, THE AGE LIMITED |

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|--|---|
| FORM 990, SCHEDULE H, PART V, SECTION B, LINE 11 | <p>WAS LOWERED IN RECENT MONTHS. RESTORATIONS HAS ADDED A SOCIAL WORKER ON STAFF FOR THE UNIT AS WELL AS A PSYCHIATRIST VIA TELE MED. RESTORATIONS IS IN THE PROCESS OF HIRING A FULL T IME APRN WITH A SPECIALTY IN PSYCH. THIS APRN WILL BE IN HOUSE TO ROUND ON PATIENTS AND ME ET WITH THE ADMITTING PHYSICIANS AND THE PSYCHIATRIST. THIS SHOULD BE A GREAT ADDITION TO THE UNIT FOR OUR PATIENTS AND EMPLOYEES. THE UNIT HAS ADDED A COMMUNITY EDUCATION EMPLOYEE THAT VISITS NURSING HOMES, HOSPITALS, CLINICS AND SCHOOLS TO GET INFORMATION AND EDUCATIO N OUT REGARDING MENTAL HEALTH AS WELL AS TO TELL THESE AGENCIES ABOUT OUR FACILITY. THE AD DITION OF THE APRN WILL ALLOW US TO EXPLORE OPPORTUNITIES TO IMPROVE OUTPATIENT PSYCHIATRI C SERVICES. 4. SERVICES TO TREAT DRUG AND ALCOHOL ABUSE SOME OF THE ISSUES FOR PATIENTS WI TH DRUG AND ALCOHOL ABUSE MAY BE HANDLED BY BEHAVIORAL HEALTH AS DRUG AND ALCOHOL ABUSE GO HAND IN HAND WITH MENTAL HEALTH ISSUES. WE REALIZE THAT IT IS IMPORTANT TO EDUCATE THE PU BLIC AS WELL AS EMPLOYEES REGARDING SIGNS AND SYMPTOMS OF DRUG AND/OR ALCOHOL ABUSE. WE FE EL IT IS ALSO IMPORTANT TO EDUCATE THE COMMUNITY REGARDING PRESCRIPTION DRUGS AND HOW THEY CAN BECOME ADDICTED TO THEM. WE ARE ALWAYS TAUGHT TO FINISH TAKING OUR PRESCRIPTIONS AS P RESCIBED BUT WE FEEL EDUCATION NEEDS TO BE IMPROVED CONCERNING PRESCRIPTION NARCOTICS. WE INTEND TO USE THE LOCAL DRUG STORES TO HELP GET THIS INFORMATION OUT TO THE PUBLIC AND TO BE SURE AND HAND OUT INFORMATION REGARDING THESE TYPES OF PRESCRIPTIONS WITH THE PRESCRIP TION DURING OFFICE VISITS OR WHEN BEING DISCHARGED FORM HOSPITAL OR EMERGENCY ROOM. WE ALS O DISCUSSED LOOKING AT THE FREQUENCY OF CERTAIN DRUGS BEING PRESCRIBED AS THE GOVERNMENT I S LOOKING INTO THIS TO SOME DEGREE DUE TO THE OPIOID CRISIS. WE FEEL IT IS IMPORTANT TO LO OK AT ALTERNATIVES TO DRUG USE. YELL COUNTY HAS A DRUG COURT WHICH HAS HELPED SOME STAY OF F OF DRUGS. PLANS TO UTILIZE LOCAL POLICE FOR TRAINING AS WELL AS DRUG COURT FOR TRAINING ON WHAT HAPPENS WHEN YOU ARE ASSIGNED TO DRUG COURT. YELL COUNTY ALSO HAS AT LEAST ONE AA MEETING PLACE. WE BELIEVE INCREASING AWARENESS TO DRUG AND ALCOHOL ABUSE AND BEING AWARE O F WHAT AGENCY OR FACILITY TO REFER PATIENTS TOO AS WELL AS STAYING ON TOP OF WHAT WE AND T HE STATE AND GOVERNMENT ARE DOING TO HELP CONTROL THE OPIOID CRISIS WILL HELP TO HAVE A HE ALTHIER COMMUNITY WITH REGARDS TO SERVICES FOR DRUG AND ALCOHOL ABUSE. 5. CHILDREN'S HEALT H SERVICES CHILDREN ARE THE FUTURE OF OUR COMMUNITY AND IT IS IMPORTANT THAT OUR FACILITY PLAYS AN ACTIVE ROLE IN CHILDREN'S HEALTH SERVICES. CHILDREN'S HEALTH SERVICES IS VERY IMP ORTANT TO THE HEALTH OF THE CHILDREN OF OUR COMMUNITY. WE HAVE WORKED ON THIS FOR THE PAST 3 YEARS AND PLAN TO CONTINUE AND INCREASE OUR EFFORTS IN THIS. OUR FACILITY CONTINUES TO PROVIDE FREE PHYSICALS TO ALL CHILDREN INVOLVED IN ANY TYPE OF SPORTS FOR ALL SCHOOLS ON T HE WEST SIDE OF YELL COUNTY WHICH ENCOMPASSES THREE SCHOOLS. WE STILL HAVE ONE CAR SEAT IN STRUCTOR WORKING FOR OUR FACIL</p> |

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|--|---|
| FORM 990, SCHEDULE H, PART V, SECTION B, LINE 11 | <p>ITY AND PLAN TO SCHEDULE A CLASS TO EDUCATE FAMILIES ON CAR SEAT SAFETY AND WILL LOOK INTO GETTING AT LEAST ONE MORE INSTRUCTOR ON BOARD. WE WILL ALSO LOOK INTO FINDING WAYS OF REC EIVING CAR SEATS TO GIVE TO FAMILIES IN NEED UPON COMPLETION OF THE CAR SEAT SAFETY COURSE . THE FACILITY CONTINUES TO BE INVOLVED IN FARM SAFETY PROGRAM THAT IS HELD IN MAY OF EACH YEAR AND PLAN TO CONTINUE TO DO THIS. THIS IS AIMED AT 5TH GRADE STUDENTS FROM SCHOOLS AL L OVER THE COUNTY AND HOSPITAL EMPLOYEES SPEAK ON FIRST AIDE AND PROVIDE EACH 5TH GRADER W ITH A FIRST AID PACKAGE AS WELL AS TEACHING MATERIAL ON SAFETY. WE REALIZE THAT WE HAVE NO T MET OUR GOALS ON CHILDREN'S HEALTH SERVICES AND PLAN TO STEP UP OUR EDUCATION TO FAMILIE S ON THE IMPORTANCE OF PREVENTATIVE MEDICINE. THIS WILL BE DONE THROUGH THE SCHOOLS AS WEL L AS ON AN INPATIENT AND OUTPATIENT LEVEL. OUR PARTNERSHIP WITH HEALTHY ACTIVE YELL BRINGS US TOGETHER WITH MEMBERS FROM EVERY SCHOOL IN YELL COUNTY AND GIVES US OPPORTUNITY TO REA CH STUDENTS OF ALL AGES AS WELL AS PARENTS THROUGH THIS EFFORT. WE CONTINUE TO BELIEVE THA T BY HELPING TO INCREASE CHILDREN'S HEALTH SERVICES AND EDUCATING FAMILIES IN THIS REGARD WE WILL HAVE A HEALTHIER COMMUNITY OF TOMORROW.</p> |

Form 990 Part V Section C Supplemental Information for Part V, Section B.

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

| Form and Line Reference | Explanation |
|--|--|
| FORM 990, SCHEDULE H, PART V, LINE 16J | ALL PATIENTS WILL BE OFFERED, AS PART OF THE REGISTRATION AND/OR DISCHARGE PROCESS, A COPY OF THE PLAIN LANGUAGE SUMMARY OF THIS POLICY. ADDITIONALLY, ALL PATIENTS IDENTIFIED AS POTENTIAL FINANCIAL ASSISTANCE RECIPIENTS OR ANYONE REQUESTING FINANCIAL ASSISTANCE WILL BE OFFERED THE OPPORTUNITY TO APPLY FOR FINANCIAL ASSISTANCE. IF THIS EVALUATION IS NOT CONDUCTED UNTIL AFTER THE PATIENT LEAVES THE FACILITY, OR IN CASE OF OUTPATIENTS OR EMERGENCY PATIENTS, THE FINANCIAL COUNSELOR WILL MAIL A FINANCIAL ASSISTANCE APPLICATION TO THE PATIENT FOR COMPLETION. IN ADDITION, THE HOSPITAL WILL PROVIDE A PLAIN LANGUAGE SUMMARY OF THE FINANCIAL ASSISTANCE POLICY TO THE PATIENT WITH ALL BILLING STATEMENTS AND COMMUNICATIONS WITHIN THE FIRST 120 DAYS FOLLOWING THE FIRST BILLING STATEMENT. |

| Form 990 Part V Section C Supplemental Information for Part V, Section B. | |
|--|---|
| Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc. | |
| Form and Line Reference | Explanation |
| FORM 990, SCHEDULE H, PART V, LINE 20E | INFORMATION REGARDING THE FINANCIAL ASSISTANCE POLICY WILL BE PROVIDED ON MONTHLY BILLING STATEMENTS AS WELL AS EFFORTS TO CONTACT THE PATIENT OR RESPONSIBLE PARTY VIA TELEPHONE. CHAMBERS MEMORIAL HOSPITAL WILL PROVIDE PATIENTS OR OTHER PARTIES RESPONSIBLE FOR PAYMENT OF THE ACCOUNT WITH A NOTICE, A MINIMUM OF 30 DAYS IN ADVANCE OF INITIATING ANY EXTRAORDINARY COLLECTION ACTIVITIES. |

| | | |
|--|---|--|
| Schedule J (Form 990) | Compensation Information | OMB No. 1545-0047 |
| | | 2019 |
| | | Open to Public Inspection |
| Department of the Treasury Internal Revenue Service | 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. | |
| Name of the organization JOHN ED CHAMBERS MEMORIAL HOSPITAL INC | | Employer identification number 71-6044543 |

| Part I Questions Regarding Compensation | | Yes | No |
|--|---|-----------|-----|
| 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 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 type="checkbox"/> Tax idemnification and gross-up payments | <input checked="" type="checkbox"/> Health or social club dues or initiation fees | | |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., 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 | | 1b | No |
| 2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a? | | 2 | Yes |
| 3 Indicate which, if any, of the following the filing 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 checked="" type="checkbox"/> Written employment contract | | |
| <input type="checkbox"/> Independent compensation consultant | <input 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? | | 4a | No |
| b Participate in, or receive payment from, a supplemental nonqualified retirement plan? | | 4b | No |
| c Participate in, or receive payment from, an equity-based compensation arrangement? | | 4c | No |
| If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III. | | | |
| Only 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? | | 5a | No |
| b Any related organization? | | 5b | No |
| 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? | | 6a | No |
| b Any related organization? | | 6b | No |
| 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 in lines 5 and 6? If "Yes," describe in Part III. | | 7 | No |
| 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. | | 8 | No |
| 9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? | | 9 | |

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.

[illegible]

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.

| Return Reference | Explanation |
|-----------------------------|--|
| SCHEDULE J, PART I, LINE 1A | ALL MONTHLY DUES FOR CHAMBERLYNE COUNTRY CLUB ARE PAID FOR MIKE MCCOY. FOR WILLIAM BERRY, THOMAS TINNESZ, TIMMY KAY WE PAY HALF AND THEY PAYROLL DEDUCT THE OTHER HALF BASED ON THE TYPE OF MEMBERSHIP THEY HAVE. THE AMOUNTS ARE NOT INCLUDED IN W-2 WAGES AS THE MEMBERSHIP IS ONLY USED FOR BUSINESS PURPOSES AND ANY INCIDENTAL EXPENSES ARE PAID OUT OF POCKET BY THE INDIVIDUAL. |

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Supplemental Information on Tax-Exempt Bonds

► Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number

71-6044543

| Part I Bond Issues | | | | | | | | | | | |
|------------------------|----------------|-------------|-----------------|-----------------|----------------------------------|--------------|----|-------------------------|----|--------------------|----|
| (a) Issuer name | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price | (f) Description of purpose | (g) Defeased | | (h) On behalf of issuer | | (i) Pool financing | |
| | | | | | | Yes | No | Yes | No | Yes | No |
| A YELL COUNTY ARKANSAS | 71-0420105 | 98544NAA4 | 11-14-2006 | 8,100,000 | CONSTRUCTION & IMPROVEMENT BONDS | | X | | X | | X |
| B YELL COUNTY ARKANSAS | 71-0420105 | 98544NAB2 | 01-02-2007 | 1,800,000 | CONSTRUCTION & IMPROVEMENT BONDS | | X | | X | | X |

| Part II | | Proceeds | | | | | | | |
|---------|--|-----------|----|-----------|----|-----|----|-----|----|
| | | A | | B | | C | | D | |
| 1 | Amount of bonds retired | 2,613,722 | | 580,827 | | | | | |
| 2 | Amount of bonds legally defeased | 0 | | 0 | | | | | |
| 3 | Total proceeds of issue | 8,100,000 | | 1,800,000 | | | | | |
| 4 | Gross proceeds in reserve funds | 0 | | 0 | | | | | |
| 5 | Capitalized interest from proceeds | 0 | | 0 | | | | | |
| 6 | Proceeds in refunding escrows | 0 | | 0 | | | | | |
| 7 | Issuance costs from proceeds | 55,514 | | 12,336 | | | | | |
| 8 | Credit enhancement from proceeds | 0 | | 0 | | | | | |
| 9 | Working capital expenditures from proceeds | 0 | | 0 | | | | | |
| 10 | Capital expenditures from proceeds | 0 | | 0 | | | | | |
| 11 | Other spent proceeds | 8,100,000 | | 1,800,000 | | | | | |
| 12 | Other unspent proceeds | 0 | | 0 | | | | | |
| 13 | Year of substantial completion | 2009 | | 2009 | | | | | |
| | | Yes | No | Yes | No | Yes | No | Yes | No |
| 14 | Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)? | | X | | X | | | | |
| 15 | Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)? | | X | | X | | | | |
| 16 | Has the final allocation of proceeds been made? | X | | X | | | | | |
| 17 | Does the organization maintain adequate books and records to support the final allocation of proceeds? | X | | X | | | | | |

| Part III Private Business Use | | | | | | | | | | | | |
|-------------------------------|--|--|--|--|-----|----|-----|----|-----|----|-----|----|
| | | | | | A | | B | | C | | D | |
| | | | | | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 | Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? | | | | | X | | X | | | | |
| 2 | Are there any lease arrangements that may result in private business use of bond-financed property? | | | | | X | | X | | | | |

Part III Private Business Use (Continued)

| | A | | B | | C | | D | |
|---|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 3a Are there any management or service contracts that may result in private business use of bond-financed property? | | X | | X | | | | |
| b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property? | | | | | | | | |
| c Are there any research agreements that may result in private business use of bond-financed property? | | X | | X | | | | |
| d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? | | | | | | | | |
| 4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government | 0 % | | 0 % | | | | | |
| 5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government | | | | | | | | |
| 6 Total of lines 4 and 5 | | | | | | | | |
| 7 Does the bond issue meet the private security or payment test? | | X | | X | | | | |
| 8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? | | X | | X | | | | |
| b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of. . . | | | | | | | | |
| c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? | | X | | X | | | | |
| 9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? | | X | | X | | | | |

Part IV Arbitrage

| | A | | B | | C | | D | |
|---|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? | | X | | X | | | | |
| 2 If "No" to line 1, did the following apply? | | | | | | | | |
| a Rebate not due yet? | | X | | X | | | | |
| b Exception to rebate? | | X | | X | | | | |
| c No rebate due? | X | | X | | | | | |
| If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed | | | | | | | | |
| 3 Is the bond issue a variable rate issue? | | X | | X | | | | |
| 4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? | | X | | X | | | | |
| b Name of provider | 0 | | 0 | | | | | |
| c Term of hedge | | | | | | | | |
| d Was the hedge superintegrated? | | | | | | | | |
| e Was the hedge terminated? | | | | | | | | |

Part IV Arbitrage (Continued)

| | A | | B | | C | | D | |
|--|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 5a Were gross proceeds invested in a guaranteed investment contract (GIC)? | | X | | X | | | | |
| b Name of provider | 0 | | 0 | | | | | |
| c Term of GIC | | | | | | | | |
| d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied? | | | | | | | | |
| 6 Were any gross proceeds invested beyond an available temporary period? | | X | | X | | | | |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | | X | | X | | | | |

Part V Procedures To Undertake Corrective Action

| | A | | B | | C | | D | |
|--|------------|-----------|------------|-----------|------------|-----------|------------|-----------|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations? | | X | | X | | | | |

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. (See instructions).

| Return Reference | Explanation |
|--|---|
| FORM 990, SCHEDULE K, PART IV, LINE 2C | FOR BOND SERIES 2006A, THE LAST REBATE COMPUTATION DATE WAS 10/31/2016. FOR BOND SERIES 2006B, THE LAST REBATE COMPUTATION DATE WAS 10/31/2016. |

| Return Reference | Explanation |
|---|---|
| FORM 990, SCHEDULE K, PART IV, LINE 2C | A - COMPLETED ON BOND YEAR OF 10/31/2019 B - COMPLETED ON BOND YEAR OF 10/31/2019 |

| Return Reference | Explanation |
|---|--|
| FORM 990, SCHEDULE K, PART III, LINE 9 & PART IV, LINE 7 & PART V | THE ORGANIZATION IS IN THE PROCESS OF DRAFTING THESE POLICIES. |

Schedule L

(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC

Employer identification number
71-6044543

Part I

Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

| 1 | (a) Name of disqualified person | (b) Relationship between disqualified person and organization | (c) Description of transaction | (d) Corrected? | |
|--|---------------------------------|---|--------------------------------|----------------|----|
| | | | | Yes | No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958. ▶ \$ | | | | | |
| 3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization. ▶ \$ | | | | | |

Part II

Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

| (a) Name of interested person | (b) Relationship with organization | (c) Purpose of loan | (d) Loan to or from the organization? | | (e) Original principal amount | (f) Balance due | (g) In default? | | (h) Approved by board or committee? | | (i) Written agreement? | |
|-------------------------------|------------------------------------|---------------------|---------------------------------------|------|-------------------------------|-----------------|-----------------|----|-------------------------------------|----|------------------------|----|
| | | | To | From | | | Yes | No | Yes | No | Yes | No |
| (1) CHAMBERS BANK | JOHNNY CHAMBERS - BOD | EQUIPMENT | | X | 153,586 | 37,251 | | No | Yes | | Yes | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Total | | | | | | 37,251 | | | | | | |

Part III

Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of assistance | (d) Type of assistance | (e) Purpose of assistance |
|-------------------------------|---|--------------------------|------------------------|---------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|-------------------------------|---|---------------------------|--------------------------------|---|----|
| | | | | Yes | No |
| (1) CHAMBERS BANK | JOHNNY CHAMBERS - BOD | 631,120 | INVESTMENT INTEREST INC & EXP | | No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions).

| Return Reference | Explanation |
|---|---|
| FORM 990, SCHEDULE L, PART IV, LINE (1), COLUMN B | JOHNNY CHAMBERS, WHO IS A BOARD MEMBER OF CHAMBERS MEMORIAL HOSPITAL, HAS MORE THAN 35% OWNERSHIP IN CHAMBERS BANK WHICH THE HOSPITAL DOES BUSINESS WITH. |

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Name of the organization
JOHN ED CHAMBERS MEMORIAL HOSPITAL INC**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 990-EZ.

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

OMB No. 1545-0047

2019**Open to Public
Inspection****Employer identification number**

71-6044543

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 11B | THE CEO REVIEWS AND ALSO PRESENTS TO THE BOARD OF DIRECTORS FOR APPROVAL. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|--|
| FORM 990, PART VI, SECTION B, LINE 12C | THE HOSPITAL HAS A COMPLIANCE COMMITTEE THAT MONITORS FOR POLICY COMPLIANCE AND RECOMMENDS CHANGES OR NEW POLICIES TO THE CEO FOR APPROVAL. THE HOSPITAL HAS INSTITUTED A NEW POLICY FOR EMPLOYEES THAT WILL BE USED FOR BOARD MEMBERS GOING FORWARD. THE BOARD MEMBERS WILL SIGN THE AGREEMENT AND BE WITHDRAWN FROM VOTING DECISIONS AS CONFLICTS ARISE. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 15A | THIS REVIEW IS DONE ANNUALLY AT THE CEO'S ANNIVERSARY DATE BY THE BOARD OF DIRECTORS. THIS WOULD HAVE BEEN DONE IN MAY OF 2019. THE CEO PERFORMS EVALUATIONS AND COMPENSATION REVIEWS AT THE ANNIVERSARY DATE OF EACH DEPARTMENT HEAD. THEY ARE PERFORMED YEARLY. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION C, LINE 19 | NO DOCUMENTS ARE AVAILABLE TO THE PUBLIC. |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990 PART IX LINE 11G | DESCRIPTION:EMERGENCY ROOM SERVICES TOTAL FEES:1479500 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|-------------------------------------|
| FORM 990 PART IX LINE 11G | DESCRIPTION:PSYCH TOTAL FEES:532014 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:PHARMACY SERVICES TOTAL FEES:306000 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:ANESTHESIOLOGY SERVICES TOTAL FEES:300000 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:ADMIN & OFFICE SERVICES TOTAL FEES:193338 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990 PART IX LINE 11G | DESCRIPTION:OTHER PURCHASED SERVICES TOTAL FEES:156267 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:SPEECH THERAPY SERVICES TOTAL FEES:126443 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990 PART IX LINE 11G | DESCRIPTION:OCCUPATIONAL THERAPY TOTAL FEES:118170 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990 PART IX LINE 11G | DESCRIPTION:PHYSICAL THERAPY TOTAL FEES:108293 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|--|
| FORM 990 PART IX LINE 11G | DESCRIPTION:LAB & X-RAY TOTAL FEES:92995 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|---|
| FORM 990 PART IX LINE 11G | DESCRIPTION:RESPIRATORY CARE TOTAL FEES:48900 |

990 Schedule O, Supplemental Information

| Return Reference | Explanation |
|---------------------------------|------------------------------------|
| FORM 990 PART IX LINE 11G | DESCRIPTION:NURSING TOTAL FEES:825 |