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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public.

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

OMB No. 1545-0047

2020

Open to Public Inspection

A For the 2020 calendar year, or tax year beginning 07-01-2020 , and ending 06-30-2021

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

C Name of organization
JAVON BEA HOSPITAL

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
2400 N ROCKTON AVE

City or town, state or province, country, and ZIP or foreign postal code
ROCKFORD, IL 61103

D Employer identification number
36-2167847

E Telephone number
(815) 971-5000

G Gross receipts $ 455,716,077

F Name and address of principal officer:
JAVON BEA
2400 N ROCKTON AVE
ROCKFORD, IL 61103

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ WWW.MERCYHEALTHSYSTEM.ORG

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

L Year of formation: 1883

M State of legal domicile: IL

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO IMPROVE AND PROTECT THE HEALTH AND WELFARE OF THE COMMUNITY IN ACCORDANCE WITH OUR MISSION, THE MISSION OF JAVON BEA HOSPITAL IS "EXCEPTIONAL HEALTH CARE SERVICES WITH A PASSION FOR MAKING LIVES BETTER". WITH A VISION OF QUALITY - EXCELLENCE IN PATIENT CARE, SERVICE - EXCEPTIONAL PATIENT AND CUSTOMER CARE, PARTNERING - BEST PLACE TO WORK AND COST - COST-EFFECTIVE CARE AND A COMMITMENT TO THE VALUES OF: HEALING IN THE BROADEST SENSE, PATIENTS COME FIRST, TREAT EACH OTHER LIKE FAMILY AND ALWAYS SEEK EXCELLENCE.

Activities & Governance

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)	**3**	8
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	6
5	Total number of individuals employed in calendar year 2020 (Part V, line 2a)	**5**	2,924
6	Total number of volunteers (estimate if necessary)	**6**	140
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	518,913
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	0

		Prior Year	Current Year
Revenue			
8	Contributions and grants (Part VIII, line 1h)	11,802,342	21,041,187
9	Program service revenue (Part VIII, line 2g)	426,188,016	395,600,410
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	928,926	4,753,918
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,455,326	3,940,407
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	444,374,610	425,335,922
Expenses			
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	427,408	179,545
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	179,007,594	146,978,814
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	298,803,051	297,373,964
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	478,238,053	444,532,323
19	Revenue less expenses. Subtract line 18 from line 12	-33,863,443	-19,196,401
Net Assets or Fund Balances		**Beginning of Current Year**	**End of Year**
20	Total assets (Part X, line 16)	768,876,966	764,323,993
21	Total liabilities (Part X, line 26)	635,650,039	612,995,444
22	Net assets or fund balances. Subtract line 21 from line 20	133,226,927	151,328,549

Part II Signature Block

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

Sign Here

****** 2022-05-16
Signature of officer Date

JAVON BEA PRESIDENT/CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2022-05-16		P00187863

Firm's name ▶ BAKER TILLY US LLP — Firm's EIN ▶ 39-0859910

Firm's address ▶ 500 MIDLAND COURT PO BOX 8130
JANESVILLE, WI 535478130 — Phone no. (608) 752-5835

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

THE MISSION OF JAVON BEA HOSPITAL IS "EXCEPTIONAL HEALTH CARE SERVICES WITH A PASSION FOR MAKING LIVES BETTER". WITH A VISION OF QUALITY - EXCELLENCE IN PATIENT CARE, SERVICE - EXCEPTIONAL PATIENT AND CUSTOMER CARE, PARTNERING - BEST PLACE TO WORK AND COST - COST-EFFECTIVE CARE AND A COMMITMENT TO THE VALUES OF: HEALING IN THE BROADEST SENSE, PATIENTS COME FIRST, TREAT EACH OTHER LIKE FAMILY AND ALWAYS SEEK EXCELLENCE.

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: See Additional Data)	(Expenses $	208,380,147	including grants of $	) (Revenue $	299,377,246)
4b	(Code: See Additional Data)	(Expenses $	155,586,385	including grants of $	) (Revenue $	94,222,215)
4c	(Code: See Additional Data)	(Expenses $	5,157,526	including grants of $	150,267) (Revenue $	1,379,062)
	(Code:)	(Expenses $	124,675	including grants of $	29,278) (Revenue $	103,207)

THROUGH JAVON BEA HOSPITAL AUXILIARY, JBH IS ABLE TO PROVIDE EXTRA FUNDS AND SERVICES TO SUPPORT ITS MISSION.THE AUXILIARY HAS 445 VOLUNTEERS WHO LOGGED APPROXIMATELY 33,029 HOURS WHILE ASSISTING WITH GREETING VISITORS, TRANSPORTING PATIENTS, FLORAL OR GIFT DELIVERIES, THRIFT SHOP AND GIFT SHOP ACTIVITIES, AND OTHER SERVICES AS REQUESTED.THE VOLUNTEERS' EFFORTS PROVIDE EXTRA FUNDS AND ENHANCE THE OVERALL HOSPITAL EXPERIENCE FOR PATIENTS, VISITORS, AND STAFF.

4d	Other program services (Describe in Schedule O.) (Expenses $	124,675	including grants of $	29,278) (Revenue $	103,207)	
4e	**Total program service expenses ▶**	369,248,733				

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	Yes	
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	Yes	
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	Yes	
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		No
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	Yes	
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	Yes	
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		No
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	Yes	

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		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *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		No
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		No
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	Yes	
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	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
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	Yes	
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 Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	183		
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)*

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	2,924		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	Yes
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	Yes
b	If "Yes," enter the name of the foreign country: ▶BD See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.			**16**	No

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	1a	8		
	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	1b	6		
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		Yes	
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		Yes	
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		Yes	
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		No
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	Yes	
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		No
b	Other officers or key employees of the organization	15b		No
	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	Yes	
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	Yes	

Section C. Disclosure

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

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:
▶TODD ANDERSON 2400 N ROCKTON AVE ROCKFORD, IL 61103 (815) 971-6738

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) JAVON R BEA PRESIDENT & CEO (SEE PAGES 74-77)	1.00 66.00	X		X				0	5,057,986	7,074,160
(2) JOHN DORSEY VP CLINICAL INTERGRATION	40.00 0.00					X		614,588	0	51,816
(3) TODD ANDERSON VP & CFO (AS OF 05/2020)	1.00 56.00			X				0	542,858	18,158
(4) MARK L GOELZER MD DIRECTOR/PHYSICIAN	1.00 45.00	X						0	501,965	29,148
(5) ROBERT WALTERS VP HOME CARE	40.00 0.00					X		295,804	0	42,785
(6) SHANNON DUNPHY-ALEXANDER SR EXECUTIVE DIRECTOR	1.00 56.00			X				0	313,241	15,917
(7) WENDI AUBRY REGIONAL PHARMACY MANAGER	40.00 0.00					X		200,227	0	88,091
(8) PAUL VAN DEN HEUVEL FORMER VICE PRESIDENT (THROUGH 04/2020)	0.00 55.00						X	0	240,858	27,557
(9) MATTHEW PYCIOR PERFUSIONIST	40.00 0.00					X		220,528	0	36,495
(10) SUE SCHRIEBER VP BUSINESS INTELLIGENCE	40.00 0.00					X		220,895	0	21,272
(11) ROWLAND J MCCLELLAN CHAIR & DIRECTOR	1.00 6.00	X		X				0	15,634	0
(12) WESLEY M JOST DIRECTOR	1.00 6.00	X						0	15,557	0
(13) THOMAS D BUDD SECRETARY & TREASURER	1.00 6.00	X		X				0	15,308	0
(14) DAVE L SYVERSON DIRECTOR	1.00 6.00	X						0	15,110	0
(15) KATHERINE A SCHACK DIRECTOR	1.00 6.00	X						0	15,000	0
(16) THOMAS R POOL VICE CHAIR & DIRECTOR	1.00 6.00	X		X				0	15,000	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			
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								1,552,042	6,748,517	7,405,399

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 ▶ 127

			Yes	No
3	Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	**3**	Yes	
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? *If "Yes," complete Schedule J for such individual*	**4**	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? *If "Yes," complete Schedule J for such person*	**5**		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
BAKER TILLY US LLP PO BOX 78975 MILWAUKEE, WI 532788975	TAX AND CONSULTING	1,384,786
RED DOT MANAGEMENT LLC 1401 SOUTH VIRGINIA ST SUITE 225 RENO, NV 89502	ACCOUNTS RECEIVABLE MANAGEMENT	1,283,841
ACCELERATED SOLUTIONS LLC 725 COOL SPRINGS BOULEVARD SUITE 3 FRANKLIN, TN 37067	ACCOUNTS RECEIVABLE MANAGEMENT	1,281,115
MED ONE CAPITAL FUNDING LLC PO BOX 35145 SEATTLE, WA 981245145	CLAIMS PROCESSING	1,222,302
ROCK VALLEY INDUSTRIES LLC 5549 INTERNATIONAL DRIVE ROCKFORD, IL 61109	JANITORIAL SERVICE	639,470

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 ▶ 16

Part VIII Statement of Revenue

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

		(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				
d Related organizations	1d	330,421			
e Government grants (contributions)	1e	20,710,766			
f All other contributions, gifts, grants, and similar amounts not included above	1f				
g Noncash contributions included in lines 1a - 1f:$	1g				
h **Total.** Add lines 1a-1f		21,041,187			
Program Service Revenue	Business Code				
2a MEDICARE/MEDICAID	621110	178,981,673	178,981,673		
b OUTPATIENT & EMERGENCY	621400	107,859,637	107,340,957	518,680	
c INPATIENT ROUTINE & ANCILLARY	621110	79,017,441	79,017,441		
d ALL OTHER PROGRAM REVENUE	900099	26,730,126	26,730,126		
e DIAGNOSTIC & MEDICAL LABORATORY	621500	3,011,533	3,011,533		
f All other program service revenue.					
g **Total.** Add lines 2a–2f.	395,600,410				
Other Revenue					
3 Investment income (including dividends, interest, and other similar amounts)		442,297			442,297
4 Income from investment of tax-exempt bond proceeds					
5 Royalties					

		(i) Real	(ii) Personal			
6a Gross rents	6a	402,090				
b Less: rental expenses	6b	219,392				
c Rental income or (loss)	6c	182,698				
d Net rental income or (loss)				182,698		182,698

		(i) Securities	(ii) Other			
7a Gross amount from sales of assets other than inventory	7a	31,112,501	3,359,883			
b Less: cost or other basis and sales expenses	7b	27,668,631	2,492,132			
c Gain or (loss)	7c	3,443,870	867,751			
d Net gain or (loss)				4,311,621		4,311,621

8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	8a				
b Less: direct expenses	8b				
c Net income or (loss) from fundraising events					
9a Gross income from gaming activities. See Part IV, line 19	9a				
b Less: direct expenses	9b				
c Net income or (loss) from gaming activities					
10a Gross sales of inventory, less returns and allowances	10a				
b Less: cost of goods sold	10b				
c Net income or (loss) from sales of inventory					

Miscellaneous Revenue	Business Code				
11a INTEREST ON IL MEDICAID PAYMENTS	621110	1,344,936			1,344,936
b CAFETERIA/FOOD SERVICE/CATERING	722210	1,222,410		233	1,222,177
c CLINICAL FLIGHT CREW AND MARKETIN	621990	1,014,798			1,014,798
d All other revenue		175,565			175,565
e **Total.** Add lines 11a–11d		3,757,709			
12 **Total revenue.** See instructions		425,335,922	395,081,730	518,913	8,694,092

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	179,545	179,545		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	119,790,609	94,291,085	25,499,524	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	5,840,928	4,675,092	1,165,836	
9 Other employee benefits	12,954,852	10,440,710	2,514,142	
10 Payroll taxes	8,392,425	6,849,374	1,543,051	
11 Fees for services (non-employees):				
a Management				
b Legal	978,355		978,355	
c Accounting	171,294		171,294	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	150,874		150,874	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	1,664,980	34,067	1,630,913	
12 Advertising and promotion	1,968,949	413,922	1,555,027	
13 Office expenses	6,935,173	2,575,214	4,359,959	
14 Information technology	13,288,716	2,291,842	10,996,874	
15 Royalties				
16 Occupancy	14,706,658	10,549,774	4,156,884	
17 Travel	144,858	79,843	65,015	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	282,409	135,228	147,181	
20 Interest	19,506,441	15,605,153	3,901,288	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	36,078,691	24,986,892	11,091,799	
23 Insurance	16,655,530	14,757,904	1,897,626	
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 SUPPLIES/DRUGS	63,332,601	62,992,817	339,784	
b HEALTHCARE SERVICES	57,980,617	57,654,408	326,209	
c BAD DEBT EXPENSE	36,528,032	36,528,032		
d MEDICAID ASSESSMENT TAX	14,790,065	14,790,065		
e All other expenses	12,209,721	9,417,766	2,791,955	
25 **Total functional expenses.** Add lines 1 through 24e	444,532,323	369,248,733	75,283,590	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 ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

Check 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	15,347,351	1	23,379,433
	2	Savings and temporary cash investments	4,498,940	2	24,493,806
	3	Pledges and grants receivable, net	568,104	3	2,895,787
	4	Accounts receivable, net	76,475,679	4	26,824,907
	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		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7	Notes and loans receivable, net	1,736,431	7	2,733,516
	8	Inventories for sale or use	11,892,356	8	11,580,220
	9	Prepaid expenses and deferred charges	3,168,478	9	2,349,269
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 855,405,999			
	b	Less: accumulated depreciation — 10b: 380,917,752	503,096,143	10c	474,488,247
	11	Investments—publicly traded securities	136,134,533	11	172,459,455
	12	Investments—other securities. See Part IV, line 11		12	
	13	Investments—program-related. See Part IV, line 11	9,247,880	13	12,844,829
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11	6,711,071	15	10,274,524
	16	**Total assets.** Add lines 1 through 15 (must equal line 33)	768,876,966	16	764,323,993
Liabilities	17	Accounts payable and accrued expenses	52,557,459	17	43,784,637
	18	Grants payable		18	
	19	Deferred revenue	11,084,577	19	655,440
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	572,008,003	25	568,555,367
	26	**Total liabilities.** Add lines 17 through 25	635,650,039	26	612,995,444
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**			
	27	Net assets without donor restrictions	121,039,715	27	138,466,567
	28	Net assets with donor restrictions	12,187,212	28	12,861,982
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ 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	133,226,927	32	151,328,549
	33	Total liabilities and net assets/fund balances	768,876,966	33	764,323,993

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	425,335,922
2	Total expenses (must equal Part IX, column (A), line 25)	2	444,532,323
3	Revenue less expenses. Subtract line 2 from line 1	3	-19,196,401
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	133,226,927
5	Net unrealized gains (losses) on investments	5	32,099,310
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	5,198,713
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	151,328,549

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ Cash ☑ Accrual ☐ 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?	2a		No
	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: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis			
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
	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: ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separate basis			
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?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.			
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?	3a	Yes	
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.	3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 36-2167847

Name: JAVON BEA HOSPITAL

Form 990 (2020)

Form 990, Part III, Line 4a:

JAVON BEA HOSPITAL (JBH) IS A NOT-FOR-PROFIT CHARITABLE HEALTHCARE INSTITUTION THAT FUNCTIONS IN ACCORDANCE WITH ALL APPLICABLE LAWS AND REGULATIONS. IN THE COURSE OF OPERATIONS, JBH IS COMMITTED TO PROVIDING SUPERIOR CARE EVERY DAY FOR ALL ITS PATIENTS. JBH IS A 285 LICENSED BED, REGIONAL REFERRAL HOSPITAL WHICH INCLUDES A LEVEL 1 TRAUMA CENTER, LEVEL III NEONATAL INTENSIVE CARE UNIT AND LEVEL III REGIONAL PERINATAL CENTER. IN FISCAL YEAR 2021, PATIENT CARE WAS RENDERED TO 8,456 INDIVIDUALS WHO PRESENTED THEMSELVES FOR SERVICE INCLUDING 1,083 DELIVERIES AND 1,728 INPATIENT SURGERIES ALONG WITH SUPPORTING 32,717 EMERGENCY ROOM VISITS. IN ADDITION, A SUBACUTE LONG-TERM CARE INPATIENT DEPARTMENT BEGAN TO CARE FOR PATIENTS IN MAY 2021. THE SUBACUTE CARE UNIT PROVIDES LONG-TERM CARE TO PATIENTS RELEASED FROM BASIC HOSPITAL CARE BUT NOT READY TO GO HOME OR TO MOVE ON TO A REHAB OR NURSING FACILITY.

Form 990, Part III, Line 4b:

JAVON BEA HOSPITAL (JBH) IS DESIGNATED BY THE IL DEPT OF PUBLIC HEALTH AS THE DISASTER POD HOSPITAL FOR THE NORTHERN IL EMS REGION. AS A LEVEL I TRAUMA CENTER, JBH PROVIDES PATIENT CARE AND DIAGNOSTIC SERVICES 24/7 TO ALL WHO PRESENT THEMSELVES FOR SERVICE. IN FISCAL YEAR 2021, THAT INCLUDED 1,428 VISITS TO THE SLEEP LAB; 86,075 DIAGNOSTIC RADIOLOGY PROCEDURES; 6,797 RADIATION ONCOLOGY TREATMENTS; 37,744 CARDIAC PROCEDURES OR TESTS; 6,449 VISITS TO THE PAIN CLINIC; AND 125,866 RESPIRATORY THERAPY TREATMENTS.JBH HAS AN IN-HOUSE LABORATORY THAT PROVIDES TESTING FOR ALL WHO PRESENT THEMSELVES AT THE HOSPITAL FOR TREATMENT. IN FISCAL YEAR 2021, JBH PERFORMED 925,698 TESTS.

Form 990, Part III, Line 4c:

JBH HAS PROVIDED HEALTH EDUCATION AND OUTREACH IN A VARIETY OF FORMS WITHIN THE ELEVEN COUNTY AREA THAT INCLUDES SEVERAL SCHOOL PARTNERSHIPS, MENTORING, HEALTH PROGRAMS, TEACHING, JOB SHADOWING AND VOLUNTEERING. JBH HOSTS SUPPORT GROUPS, TRAINING CLASSES AND LECTURES SERIES FOR HEALTH AND SAFETY RELATED TOPICS. EMPLOYEES STAFF COMMUNITY HEALTH FAIRS AND OPEN HEALTH SCREENINGS. IN A PROGRAM JOINTLY SPONSORED WITH RONALD MCDONALD CHARITIES, JBH STAFFS THE CAREMOBILE WHICH PROVIDED 28 HEALTH CHECKUPS, 35 IMMUNIZATIONS AND BASIC HEALTH SERVICES TO 16 UNDERINSURED AND UNINSURED CHILDREN. JBH ALSO PROVIDES LANGUAGE ASSISTANCE TO PATIENTS AND THEIR FAMILIES WHO NEED TO COMMUNICATE WITH MEDICAL PERSONNEL FOR TREATMENT AND MEETING SPACE FOR VARIOUS MEDICAL AND SOCIAL SERVICE SUPPORT GROUPS. FUNDS WERE ALSO USED TO SUPPORT HEALTHCARE CONDITIONS THROUGHOUT THE STATE OF ILLINOIS.

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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

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

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 331/3% 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 331/3% 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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
7 Amounts from line 4. .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). .						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2020 (line 6, column (f) divided by line 11, column (f)) 14

15 Public support percentage for 2019 Schedule A, Part II, line 14 15

16a **33 1/3% support test—2020.** 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 . . . . . ▶ ☐

b **33 1/3% support test—2019.** 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 . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2020.** 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 . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2019.** 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 . . . . . ▶ ☐

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 . . . . . ▶ ☐

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) ▶	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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) ▶	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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 5 years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**. . . . . ▶ ☐

Section C. Computation of Public Support Percentage

15	Public support percentage for 2020 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2019 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2020** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2019** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2020.** 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—2019.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . ▶ ☐

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 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? *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.*	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)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2).*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer lines 3b and 3c below.*	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)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination.*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use.*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *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.*	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)? *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.*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in* ***Part VI,*** *including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).*	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? *If "Yes," provide detail in* ***Part VI.***	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? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).*	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))? *If "Yes," provide detail in* ***Part VI.***	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? *If "Yes," provide detail in* ***Part VI.***	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? *If "Yes," provide detail in* ***Part VI.***	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)? *If "Yes," answer line 10b below.*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).*	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 lines 11b and 11c below, the governing body of a supported organization?	**11a**		
b	A family member of a person described in 11a above?	**11b**		
c	A 35% controlled entity of a person described in line 11a or 11b above? *If "Yes" to 11a, 11b, or 11c, provide detail in* ***Part VI.***	**11c**		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the officers, 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? *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.*	**1**		
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? *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.*	**2**		

Section C. Type II Supporting Organizations

			Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? *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).*	**1**		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**:

- **a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- **b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- **c** ☐ The organization supported a governmental entity. Describe in **Part VI** how you supported a government entity (see instructions)

2 Activities Test. **Answer lines 2a and 2b below.**

			Yes	No
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? *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.*	**2a**		
b	Did the activities described in line 2a constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *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.*	**2b**		
3	Parent of Supported Organizations. **Answer lines 3a and 3b below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *If "Yes" or "No" provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

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

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

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

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	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 0.015 of line 3 (for greater amount, see instructions).	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by 0.035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

	Section C - Distributable Amount			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 ☐ 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	**1**	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	**2**	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	**3**	
4 Amounts paid to acquire exempt-use assets	**4**	
5 Qualified set-aside amounts (*prior IRS approval required - provide details in* ***Part VI***)	**5**	
6 Other distributions (*describe in* ***Part VI***). See instructions	**6**	
7 **Total annual distributions.** Add lines 1 through 6.	**7**	
8 Distributions to attentive supported organizations to which the organization is responsive (*provide details in* ***Part VI***). See instructions	**8**	
9 Distributable amount for 2020 from Section C, line 6	**9**	
10 Line 8 amount divided by Line 9 amount	**10**	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2020**	**(iii) Distributable Amount for 2020**
1 Distributable amount for 2020 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2020 (reasonable cause required-- *explain in* ***Part VI***). See instructions.			
3 Excess distributions carryover, if any, to 2020:			
a From 2015.			
b From 2016.			
c From 2017.			
d From 2018.			
e From 2019.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2020 distributable amount			
i Carryover from 2015 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4 Distributions for 2020 from Section D, line 7: $			
a Applied to underdistributions of prior years			
b Applied to 2020 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4.			
5 Remaining underdistributions for years prior to 2020, 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 2020. 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 2021.** Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2016.			
b Excess from 2017.			
c Excess from 2018.			
d Excess from 2019.			
e Excess from 2020.			

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

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493136127692

SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2020

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of the organization	Employer identification number
JAVON BEA HOSPITAL	36-2167847

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $ 0

3 Volunteer hours for political campaign activities (see instructions) 0

Part I-B Complete if the organization is exempt under section 501(c)(3).

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $ 0

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $ 0

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

	(a) Name	**(b)** Address	**(c)** EIN	**(d)** Amount paid from filing organization's funds. If none, enter -0-.	**(e)** Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
1					
2					
3					
4					
5					
6					

Part II-A **Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).**

A Check ▶ ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check ▶ ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-.		
i Subtract line 1f from line 1c. If zero or less, enter -0-.		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2017	**(b)** 2018	**(c)** 2019	**(d)** 2020	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		105,848
j	Total. Add lines 1c through 1i			105,848
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3		

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
PART II-B, LINE 1:	A PERCENTAGE OF THE 2021 ILLINOIS HOSPITAL ASSOCIATION AND AMERICAN HOSPITAL ASSOCIATION DUES WERE USED FOR LOBBYING. TWO CONSULTING FIRMS WERE ENGAGED TO REVIEW LEGISLATION AFFECTING HOSPITALS. APPROXIMATELY 50% OF TOTAL PAYMENTS TO THE CONSULTANTS WERE ALLOCABLE TO LOBBYING ACTIVITIES.

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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

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

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 FASB 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 FASB 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 FASB ASC 958 relating to these items:

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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
c	Beginning balance	1c
d	Additions during the year	1d
e	Distributions during the year	1e
f	Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided 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	11,197,286	10,816,953	10,051,014	9,434,350	8,795,769
b Contributions	200	37,162	3,382	2,045	11,630
c Net investment earnings, gains, and losses	1,182,560	359,599	1,190,683	861,213	773,001
d Grants or scholarships					
e Other expenditures for facilities and programs	107,994	15,545	423,923	232,378	132,571
f Administrative expenses	708	883	4,203	14,217	13,479
g End of year balance	12,271,344	11,197,286	10,816,953	10,051,014	9,434,350

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ 4.400 %

b Permanent endowment ▶ 42.300 %

c Term endowment ▶ 53.300 %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
3a(i) (i) Unrelated organizations		No
3a(ii) (ii) Related organizations	Yes	
3b b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	Yes	

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	65,484	8,103,281		8,168,765
b Buildings		401,570,198	66,084,976	335,485,222
c Leasehold improvements		13,925,003	8,844,522	5,080,481
d Equipment		431,126,058	305,988,254	125,137,804
e Other		615,975		615,975
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				474,488,247

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		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
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)		
(10)		
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)	
(10)	
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) ACCRUED PENSION	-32,620
(3) ACCRUED POST RETIREMENT MEDICAL BENEFITS	4,057,684
(4) DUE TO THIRD PARTY PAYORS	18,590,164
(5) DUE TO MERCY HEALTH CORPORATION	513,936,903
(6) ACCRUED LIABILITY, SELF INSURANCE LESS CURRENT	23,809,221
(7) OTHER LIABILITIES	8,194,015
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	568,555,367

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII **Supplemental Information *(continued)***

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 36-2167847
Name: JAVON BEA HOSPITAL

Supplemental Information

Return Reference	Explanation
PART V, LINE 4:	FUNDS WERE USED TO PROVIDE A LECTURE SERIES, FOR CONTINUING EDUCATION FOR EMPLOYEES WANTIN G TO IMPROVE THEIR CREDENTIALS OR TO FOCUS ON A NEW SKILL OR SOME TECHNOLOGY NOT CURRENTLY AVAILABLE IN THE ROCKFORD COMMUNITY. THERE WERE ALSO MISCELLANEOUS PROJECTS DESIGNATED BY THE FOUNDATION BOARD IN ACCORDANCE WITH THE SPECIFIC ENDOWMENT. ALL FUNDS WERE EXPENDED P ER THE SPECIFIC DIRECTION OF EACH ENDOWMENT.

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SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
► Attach to Form 990.
► Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☐ Yes ☐ No

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activites per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
CENTRAL AMERICA AND THE CARIBBEAN - ANTIGUA & BARBUDA, ARUBA, BAHAMAS,	0	0	INVESTMENTS		4,230,266
3a Sub-total	0	0			4,230,266
b Total from continuation sheets to Part I . . .	0	0			0
c Totals (add lines 3a and 3b)	0	0			4,230,266

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . . . ▶ _____

3 Enter total number of other organizations or entities . . . . . ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☐ Yes	☑ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)*	☐ Yes	☑ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with Respect to Certain Foreign Corporations. (see Instructions for Form 5471)*	☑ Yes	☐ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)* .	☐ Yes	☑ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☐ Yes	☑ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990).*	☐ Yes	☑ No

Part V Supplemental Information

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

990 Schedule F, Supplemental Information

Return Reference	Explanation
PART III ACCOUNTING METHOD:	

990 Schedule F, Supplemental Information

Return Reference	Explanation
SCHEDULE F, PART I:	METHOD USED TO REPORT ENDING BALANCE: EQUITY METHOD

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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

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

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.			
	☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities			
	☑ 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:	3a	Yes	
	☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %			
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:	3b	Yes	
	☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☑ Other 60000.0000000000 %			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	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		No
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 eligibile for free or discounted care?	5c		
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)			1,901,658		1,901,658	0.430 %
b Medicaid (from Worksheet 3, column a)			73,519,583	71,035,651	2,483,932	0.560 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			75,421,241	71,035,651	4,385,590	0.990 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			1,270,706	146,270	1,124,436	0.250 %
f Health professions education (from Worksheet 5)			9,768,569	972,414	8,796,155	1.980 %
g Subsidized health services (from Worksheet 6)			25,591,916	18,954,944	6,636,972	1.490 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			166,851		166,851	0.040 %
j **Total.** Other Benefits			36,798,042	20,073,628	16,724,414	3.760 %
k **Total.** Add lines 7d and 7j			112,219,283	91,109,279	21,110,004	4.750 %

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	36,231,669		
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			
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	64,378,965		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	71,045,849		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-6,666,884		
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:				

☐ Cost accounting system ☑ Cost to charge ratio ☐ 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

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(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					
3					
4					
5					
6					
7					
8					
9					
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?

2

	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)	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
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group JAVON BEA HOSPITAL

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	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.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 19			
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	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): MERCYHEALTHSYSTEM.ORG/COMMUNITY-NEEDS/			
b	☑ Other website (list url): WCHD.ORG			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ 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 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): MERCYHEALTHSYSTEM.ORG/COMMUNITY-NEEDS/			
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)

JAVON BEA 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?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 600.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ 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?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES			
b	☑ The FAP application form was widely available on a website (list url): MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES			
c	☑ A plain language summary of the FAP was widely available on a website (list url): MERCYHEALTHSYSTEM.ORG/FINANCIAL-POLICIES			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☑ 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	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

JAVON BEA 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 ☑ Reporting to credit agency(ies)			
b ☑ Selling an individual's debt to another party			
c ☑ 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 ☑ Actions that require a legal or judicial process			
e ☑ Other similar actions (describe in Section C)			
f ☐ 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 ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☐ Actions that require a legal or judicial process			
e ☐ 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 ☑ 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 ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
e ☐ Other (describe in Section C)			
f ☐ 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 ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility's policy was not in writing			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

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

JAVON BEA HOSPITAL

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	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? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group VANMATRE HEALTH SOUTH

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

			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.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 19			
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	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): MERCYHEALTHSYSTEM.ORG/COMMUNITY-NEEDS/			
b	☑ Other website (list url): WCHD.ORG			
c	☐ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ 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 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): MERCYHEALTHSYSTEM.ORG/COMMUNITY-NEEDS/			
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)

VANMATRE HEALTH SOUTH

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?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.000000000000 % and FPG family income limit for eligibility for discounted care of 400.000000000000 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☐ Medical indigency			
e	☐ Insurance status			
f	☐ Underinsurance discount			
g	☐ Residency			
h	☐ 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?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	☑ The FAP was widely available on a website (list url): SEE PART VI			
b	☑ The FAP application form was widely available on a website (list url): SEE PART VI			
c	☑ A plain language summary of the FAP was widely available on a website (list url): SEE PART VI			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ 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	☐ 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	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

VANMATRE HEALTH SOUTH

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 ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☑ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☐ 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 ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☐ Actions that require a legal or judicial process			
e ☐ 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 ☐ 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 ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☐ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☐ Made presumptive eligibility determinations (if not, describe in Section C)			
e ☐ Other (describe in Section C)			
f ☐ 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		No
If "No," indicate why:			
a ☑ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility's policy was not in writing			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

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

VANMATRE HEALTH SOUTH

Name of hospital facility or letter of facility reporting group

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a ☐	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? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

Part V **Facility Information** *(continued)*

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

Form and Line Reference	Explanation
See Add'l Data	

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? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
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
PART I, LINE 7:	THE HOSPITAL UTILIZED BOTH THE MEDICARE COST REPORT CCR (COST-TO-CHARGE RATIO) AND OUR COST ACCOUNTING SYSTEM TO DETERMINE THE COST OF CHARGES, BAD DEBT AND CHARITY CARE EXPENSE INCLUDED IN LINE 7. THE SUBSIDIZED PROGRAMS ALSO INCLUDE THE COSTS (BASED ON A CALCULATED CCR) FROM THE RELATED COMPANY ROCKFORD HEALTH PHYSICIANS (RHPH) BECAUSE THERE ARE NO PHYSICIANS COSTS INCLUDED IN THE HOSPITAL COST ACCOUNTING ANALYSIS. BAD DEBT AND CHARITY AT COST HAVE BEEN REMOVED FROM LINES 7A/7F/7G SINCE THOSE COSTS WERE PREVIOUSLY INCLUDED.
PART III, LINE 2:	ALL CHARGES FOR ANY SERVICE PROVIDED BY JAVON BEA HOSPITAL ARE THE VERY SAME FOR EVERY INDIVIDUAL, REGARDLESS OF WHETHER IT IS FOR EMERGENCY OR STANDARD CARE AND REGARDLESS OF THE PATIENT'S ABILITY TO PAY. EACH PATIENT IS THEN ASSESSED FOR ELIGIBILITY FOR FINANCIAL ASSISTANCE BASED ON PREDEFINED CRITERIA OF FINANCIAL STATUS AND INCOME LEVEL. IF THE PATIENT QUALIFIES FOR FINANCIAL ASSISTANCE, THE EXPECTED REIMBURSEMENT IS BASED ON CHARITY CARE POLICY GUIDELINES. IF THE PATIENT HAS NO INSURANCE AND DOESN'T QUALIFY FOR FINANCIAL ASSISTANCE, THE EXPECTED REIMBURSEMENT IS 75% OF BILLED CHARGES. THE ORGANIZATION MAINTAINS A BAD DEBT RESERVE ON THE BALANCE SHEET. ANY BAD DEBT WRITE-OFFS OF PATIENT ACCOUNTS WILL GO AGAINST THE BAD DEBT RESERVE. AT EACH MONTH END BASED ON THE ACCOUNTS RECEIVABLE BY FINANCIAL CLASS AND AGING BUCKET, THE RESERVE AMOUNT IS RE-EVALUATED. THE AMOUNT NEEDED TO MAINTAIN THE APPROPRIATE RESERVE LEVEL IS THE BAD DEBT EXPENSE. ANY PAYMENTS RECEIVED ON PATIENT ACCOUNTS PREVIOUSLY WRITTEN OFF TO BAD DEBT WILL OFFSET THE BAD DEBT EXPENSE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4:	BAD DEBT EXPENSE IS ACCOUNTED FOR IN THE FOLLOWING MANNER (AS DETAILED IN NOTE 1 OF THE AUDITED FINANCIAL STATEMENTS OF MERCY HEALTH CORPORATION, INC.) MERCY HEALTH CORPORATION, INC. IS THE PARENT COMPANY OF JAVON BEA HOSPITAL.PATIENTS WHO ARE COVERED BY THIRD-PARTY PAYORS ARE RESPONSIBLE FOR RELATED DEDUCTIBLES AND COINSURANCE, WHICH VARY IN AMOUNT. THE CORPORATION ALSO PROVIDES SERVICES TO UNINSURED PATIENTS, AND OFFERS THOSE UNINSURED PATIENTS A DISCOUNT, EITHER BY POLICY OR LAW, FROM STANDARD CHARGES. THE CORPORATION ESTIMATES THE TRANSACTION PRICE FOR PATIENTS WITH DEDUCTIBLES AND COINSURANCE AND FROM THOSE WHO ARE UNINSURED BASED ON HISTORICAL EXPERIENCE AND CURRENT MARKET CONDITIONS. THE INITIAL ESTIMATE OF THE TRANSACTION PRICE IS DETERMINED BY REDUCING THE STANDARD CHARGE BY ANY CONTRACTUAL ADJUSTMENT, DISCOUNTS, AND IMPLICIT PRICE CONCESSIONS. SUBSEQUENT CHANGES TO THE ESTIMATE OF THE TRANSACTION PRICE ARE GENERALLY RECORDED AS ADJUSTMENTS TO PATIENT SERVICE REVENUE IN THE PERIOD OF THE CHANGE. SUBSEQUENT CHANGES THAT ARE DETERMINED TO BE THE RESULT OF AN ADVERSE CHANGE IN THE PATIENT'S ABILITY TO PAY ARE RECORDED AS BAD DEBT EXPENSE.CONSISTENT WITH THE CORPORATION'S MISSION, CARE IS PROVIDED TO PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. THEREFORE, THE CORPORATION HAS DETERMINED IT HAS PROVIDED IMPLICIT PRICE CONCESSIONS TO UNINSURED PATIENTS AND PATIENTS WITH OTHER UNINSURED BALANCES (FOR EXAMPLE, COPAYS AND DEDUCTIBLES). THE IMPLICIT PRICE CONCESSIONS INCLUDED IN ESTIMATING THE TRANSACTION PRICE REPRESENT THE DIFFERENCE BETWEEN AMOUNTS BILLED TO PATIENTS AND THE AMOUNTS THE CORPORATION EXPECTS TO COLLECT BASED ON ITS COLLECTION HISTORY WITH THOSE PATIENTS. THE CORPORATION'S POLICY IS TO PROVIDE A DISCOUNT FROM ESTABLISHED CHARGES TO UNINSURED PATIENTS. THIS POLICY DID NOT CHANGE IN 2021 AND 2020.
PART III, LINE 8:	REPORTED ON LINE 6 ARE ALLOWABLE MEDICARE COSTS PROVIDED BY THE COST REPORT. MEDICARE COSTS ARE ELIMINATED FROM THE SUBSIDIZED PROGRAMS ON PART 1, LN 7G AS CALCULATED BY OUR COST ACCOUNTING ANALYSIS. A COMBINATION OF COST ACCOUNTING AND THE MEDICARE CCR WAS USED FOR THE COMPUTATION OF SUBSIDIZED PROGRAMS.

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Form and Line Reference	Explanation
PART III, LINE 9B:	JAVON BEA HOSPITAL HAS A STRONG COMMITMENT TO PROVIDE QUALITY PATIENT CARE FOR ALL INDIVIDUALS. OUR MISSION IS TO PROVIDE HEALTH CARE TO EVERYONE WHO COMES TO OUR DOOR, REGARDLESS OF THEIR ABILITY TO PAY. WE WILL SUBMIT A CLAIM TO ALL 3RD PARTY PAYORS ON BEHALF OF THE PATIENT. WE HELP PATIENTS APPLY FOR ALL POSSIBLE INSURANCE OR ASSISTANCE SUCH AS CRIME VICTIMS, AN AUTOMOBILE ACCIDENT, WORKERS COMPENSATION, MEDICAID, COBRA, LOCAL ASSISTANCE AND/OR HOSPITAL FINANCIAL ASSISTANCE. IF THEY DO NOT QUALIFY FOR ANY OF THESE, WE CAN EXTEND PAYMENT OPTIONS SUCH AS MONTHLY PAYMENTS, CREDIT CARD PAYMENTS OR FINANCIAL ASSISTANCE. THIS IS OFFERED TO PATIENTS WHO ARE EXPERIENCING LEGITIMATE FINANCIAL HARDSHIPS AND ARE UNABLE TO PAY FOR ALL OR PART OF THE PATIENT'S MEDICAL CARE. FORGIVENESS MAY APPLY TO AN AMOUNT AFTER APPLYING ALL PAYMENTS SUCH AS AN INSURNACE COMPANY, HEALTH PLAN OR PERSONAL PAYMENTS, ANY NEGOTIATED DISCOUNTS OR ANY UNINSURED DISCOUNTS. IF A PATIENT ELIGIBLE FOR CHARITY CARE OR PARTIAL FINANCIAL ASSISTANCE STILL HAS A PORTION OF THE OUTSTANDING BALANCE DUE, OTHER ARRANGEMENTS ARE MADE. MONTHLY STATEMENTS ARE SENT AS PAYMENT REMINDERS FOR CONTRACTED ARRANGEMENTS. IN CASE OF DEFAULT, ADDITIONAL LETTERS AND CALLS ARE MADE TO BRING IT TO A CURRENT STATUS. AN ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY ONLY AFTER NON-PAYMENT OR NO CONTACT IN 120 DAYS ALTHOUGH JBH WILL SUSPEND COLLECTION EFFORTS ONCE A COMPLETED APPLICATION HAS BEEN RECIEVED AND IS PENDING APPROVAL OR DENIAL.
PART V, SECTION A, LINE 3 FOOTNOTE VANMATRE:	VANMATRE HEALTH SOUTHDUE TO MAJOR COMPLICATIONS WITH COVID-19 ISSUES, THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) DID NOT GET POSTED ON TIME AND ONLINE. BUT IT IS POSTED NOW.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART V, SECTION A VANMATRE WEBSITE:	VANMATRE HEALTH SOUTHHTTPS://MERCYHEALTHSYSTEM.ORG/LOCATION/VAN-MATRE-ENCOMPASS-HEALTH-REHABILITATION-HOSPITAL/
PART VI, LINE 2:	IN ADDITION TO THE HEALTH NEEDS ASSESSMENT - MERCY HEALTH IS WORKING TO: WORK WITH OTHER COMMUNITY SERVICES AND THROUGH MEDICARE ACO TO PROACTIVELY MANAGE AND IMPROVE THE CHRONIC DISEASE STATE OF OUR PATIENTS, AND TO CONTINUE MEDICARE ACO WELLNESS VISITS TO PROACTIVELY MANAGE THE HEALTH OF MEDICARE PATIENTS, MAINTAIN CLINICAL TEAMS TO WORK WITH SELECTED NURSING HOME PATIENTS TO ENSURE APPROPRIATE TRANSITIONAL CARE AND MANAGE AND PROVIDE INTERVENTIONS AS NECESSARY FOR VARIOUS ACUTE AND CHRONIC DISEASES. IN ADDITION, SUB ACUTE CARE WAS ADDED TO ALLOW PATIENTS TO TRANSITION AFTER A MAJOR ILLNESS OR INJURY AND MAINTAIN A HEALTHY LIFESTYLE.MAINTAIN MULTIDISCIPLINARY PALLIATIVE CARE SERVICES FOR ADULTS TO FORMULATE PLANS OF CARE, IDENTIFY RESOURCES, AND PROVIDE SUPPORT FOR BOTH PATIENTS AND FAMILIES FOR VARIOUS CHRONIC AND ACUTE DISEASES.IMPROVE THE HEALTH OF PATIENTS WITH SPECIFIC NEEDS, INCLUDING GERIATRIC HEALTH NEEDS AND SUBSTANCE ABUSE BY OFFERING A WIDE ARRAY OF COMMUNITY EDUCATIONAL HEALTH & SCREENING PROGRAMS.REDUCE THE LIKELIHOOD OF OPIOID ADDICTION BEGINNING OR CONTINUING BY MONITORING OPIOID PRESCRIPTIONS AMONG PHYSICIANS, OFFERING PROVIDER EDUCATION AND OFFERING ADDICTION COUNSELING.MAINTAIN OUR COMMITMENT TO THE WOMEN AND CHILDREN OF THE COMMUNITY AS A PROVIDER OF COMPREHENSIVE TERTIARY SERVICES AND TO ENSURE EXCELLENT OUTCOMES FOR MOTHERS AND INFANTS BY REMAINING THE STATE OF IL REGIONAL PERINATAL CENTER FOR 11 COUNTIES AND PARTICIPATING IN ILPQC (ILLINOIS PERINATAL QUALITY COLLABORATIVE) INITIATIVES. LIKE PROMOTING VAGINAL BIRTH FOR LOW RISK FIRST PREGNANCY WOMEN, MAINTAINING THE HYPERTENSION BUNDLE TO ASSESS QUICK RESPONSE TO INCREASED BLOOD PRESSURES OF PERIPARTUM MOTHERS AND THE NEONATAL ABSTINENCE SYNDROME (NAS) BUNDLE FOCUSING ON INTERVENTION FOR BABIES OF ADDICTED MOTHERS.PROVIDE JOB TRAINING AND EMPLOYMENT OPPORTUNITIES TO DISABLED YOUNG ADULT COMMUNITY MEMBERS IN COLLABORATION WITH RAMP AND THE ILLINOIS DEPARTMENT OF HUMAN SERVICES BY ESTABLISHING PROJECT SEARCH.

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Form and Line Reference	Explanation
PART VI, LINE 3:	ALL UNINSURED PATIENTS ARE NOTIFIED OF MERCY'S FINANCIAL ASSISTANCE POLICY UPON REGISTRATION. INFORMATION IS ALSO AVAILABLE AT THE HEALTH SYSTEMS' WEBSITE, IN OUR EMERGENCY ROOMS, FINANCIAL ASSISTANCE OFFICES, AND WITH THE PATIENT FINANCIAL COUNSELORS. APPROPRIATE PERSONNEL HAVE BEEN TRAINED ON HOW TO INTERACT WITH PATIENTS ABOUT FINANCIAL AID AVAILABILITY, AND HOW TO DIRECT PATIENTS TO APPROPRIATE FINANCIAL AID STAFF. THE HOSPITALS AND CLINICS HAVE TRANSLATION SERVICES AVAILABLE AS NEEDED.
PART VI, LINE 4:	JAVON BEA HOSPITAL IS LOCATED IN ROCKFORD, IL (WINNEBAGO COUNTY). ACCORDING TO THE US CENSUS BUREAU FROM THE 2020 CENSUS THE POPULATION OF WINNEBAGO COUNTY WAS MEASURED AT 285,350. LOCATED IN NORTHERN ILLINOIS, THE COUNTY IS CHARACTERIZED AS LARGELY RURAL AND POPULATED WITH VERY SMALL COMMUNITIES WITH THE EXCEPTION OF THE NEIGHBORING CITIES OF ROCKFORD, LOVES PARK, AND MACHESNEY PARK WHICH COMPRISE MORE THAN 195,000 INDIVIDUALS. THE VAST MAJORITY OF THE POPULATION RESIDE IN URBAN AREAS AND THE MAJORITY OF PATIENTS RESIDE IN WINNEBAGO COUNTY. AS A COMMUNITY THAT RELIES HEAVILY ON MANUFACTURING COMPANIES AND SMALL BUSINESSES, THE AREA WAS PARTICULARLY HARD HIT IN RECENT YEARS. CURRENTLY, THE LARGEST EMPLOYERS INCLUDE THE ROCKFORD PUBLIC SCHOOLS AND THE THREE ROCKFORD HEALTH CARE PROVIDERS. THE MOST RECENT MEDIAN HOUSEHOLD INCOMES IN WINNEBAGO COUNTY WERE $55,310 COMPARED TO THE STATE MEDIAN HOUSEHOLD INCOME OF $68,428 AND THE NATIONAL MEDIAN INCOME OF $64,994. THESE DISPARITIES ARE ALSO REFLECTED IN EDUCATION AND POVERTY RATES. UNEMPLOYMENT RATES HAVE IMPROVED WITH MOST RECENT FIGURES FOR WINNEBAGO COUNTY AT 8.1% BUT ARE STILL HIGH COMPARED TO THE STATE AT 7.1% AND THE NATION AT 6.0%. ONLY 23.0% OF WINNEBAGO COUNTY RESIDENTS ATTAIN A BACHELOR'S DEGREE OR HIGHER COMPARED WITH THOSE IN THE STATE AT 35.5% AND 32.9% IN THE NATION. MORE THAN 15.64% OF THE RESIDENTS IN WINNEBAGO COUNTY LIVE BELOW THE POVERTY LINE COMPARED TO STATE LEVELS OF 11.0% AND NATIONAL LEVELS OF 14.6%. THIS IS IMPORTANT BECAUSE POVERTY CREATES BARRIERS TO ACCESS INCLUDING HEALTH SERVICES, HEALTHY FOOD, AND OTHER NECESSITIES THAT CONTRIBUTE TO POOR HEALTH STATUS AS WELL THE LACK OF INTERNET ACCESS FOR AN ESTIMATED 15.7% OF THE HOUSEHOLDS IN WINNEBAGO COUNTY.

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Form and Line Reference	Explanation
PART VI, LINE 5:	LED BY A GOVERNING BODY COMPRISED OF A MAJORITY OF INDEPENDENT PERSONS REPRESENTATIVE OF THE COMMUNITY, JAVON BEA HOSPITAL (JBH) AND ITS AFFILIATES ARE VERY INVOLVED IN PROMOTING A HEALTHIER COMMUNITY. AS ONE OF ROCKFORD'S LARGEST EMPLOYERS, THE ORGANIZATION TAKES A LEADING ROLE IN FINANCIALLY SUPPORTING NOT ONLY HEALTH-RELATED INITIATIVES, BUT ALSO COMMUNITY-BUILDING ACTIVITIES ACROSS THE REGION. THIS INCLUDES PROVIDING FINANCIAL SUPPORT AND TALENT FOR ECONOMIC DEVELOPMENT AND BUSINESS-RELATED ACTIVITIES. AS WELL AS QUALITY OF LIFE AND EDUCATIONAL INITIATIVES. EMPLOYEES PARTICIPATE ON COMMUNITY BOARDS AND ARE ACTIVELY INVOLVED IN PROMOTING THE REGION AND ITS ASSETS. BASED ON THE RESULTS OF THE ROCKFORD HEALTH COUNCILS 2020 HEALTHY COMMUNITY STUDY, THE COMMUNITY BENEFIT IMPLEMENTATION PLAN IDENTIFIED SEVERAL KEY AREAS TO FOCUS EFFORTS. FOR EXAMPLE, AS THE PREDOMINANT PROVIDER OF PEDIATRIC SERVICES, JBH MAINTAINS ITS COMMITMENT TO THE CHILDREN OF OUR COMMUNITY. THIS IS EVIDENT IN OUR SUPPORT OF THE RONALD MCDONALD CARE MOBILE WHICH PROVIDES FREE MEDICAL CARE TO UNINSURED AND UNDERINSURED CHILDREN IN FIVE NORTHERN COUNTIES. THE 40-FOOT, 26,000 POUND MOBILE UNIT HOUSES TWO PATIENT EXAM ROOMS, A CENTRAL WAITING ROOM, AND A STERILIZATION AREA AND HAS PROVIDED CARE TO MORE THAN 9,301 CHILDREN SINCE THE INCEPTION OF THE PROGRAM IN 2003. THIS TOTALS MORE THAN $3.17 MILLION IN FREE CARE OVER THE LIFE OF THE PROGRAM. THE CARE MOBILE IS COMPLETELY FUNDED BY PHILANTHROPY FROM THE MERCYHEALTH DEVELOPMENT FOUNDATION, JAVON BEA HOSPITAL AUXILIARY AND THE RONALD MCDONALD CHARITIES OF MADISON. THE BRIDGE CLINIC IS YET ANOTHER VENUE FOR UN- AND UNDER-INSURED ADULTS TO RECEIVE FREE MEDICAL TREATMENT FOR CHRONIC MEDICAL ISSUES. SINCE ITS OPENING IN 2008, HUNDREDS OF PEOPLE FROM OUR COMMUNITY HAVE RECEIVED CARE. MANY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS GIVE FREELY OF THEIR TIME TO PROVIDE THESE SERVICES TO THE LESS FORTUNATE INDIVIDUALS IN OUR COMMUNITY TO BETTER MANAGE THEIR CHRONIC CONDITIONS. SINCE 2012, JBH CONTINUES TO PARTNER WITH A SILVER LINING FOUNDATION TO PROVIDE FREE BREAST HEALTH SERVICES TO THE UN- UNDER-INSURED WOMEN IN THE COMMUNITY. OVER 640 WOMEN HAVE RECEIVED FREE SCREENING MAMMOGRAMS AND OTHER BREAST RELATED SERVICES AND PROCEDURES SINCE THE PROGRAM'S INCEPTION. THESE ARE ONLY SOME OF THE MANY CONTRIBUTIONS THAT JBH MAKES TO PROMOTE AND IMPROVE THE HEALTH OF THE COMMUNITY. JBH REMAINS COMMITTED TO EDUCATING THE PUBLIC ABOUT VARIOUS HEALTH CARE ISSUES AND INITIATIVES AND IMPROVING THE LIVES OF OUR CITIZENS. JBH DOES NOT RESTRICT ADMISSION OF PROVIDERS AND PROVIDES AN OPEN MEDICAL STAFF.
PART VI, LINE 7, REPORTS FILED WITH STATES	IL

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Form and Line Reference	Explanation
PART V, LINE 16A, FAP WEBSITE:	VANMATRE HEALTH SOUTHVANMATREREHAB.COM/EN/PATIENTS-AND-FAMILY/FINANCIAL-ASSISTANCE
PART V, LINE 16B, FAP APPLICATION WEBSITE:	VANMATRE HEALTH SOUTHVANMATREREHAB.COM/EN/PATIENTS-AND-FAMILY/FINANCIAL-ASSISTANCE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:	VANMATRE HEALTH SOUTHVANMATREREHAB.COM/EN/PATIENTS-AND-FAMILY/FINANCIAL-ASSISTANCE

Additional Data

Software ID:
Software Version:
EIN: 36-2167847
Name: JAVON BEA HOSPITAL

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? **2** Name, address, primary website address, and state license number		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	JAVON BEA HOSPITAL 2400 N ROCKTON AVE ROCKFORD, IL 61103 HTTPS://MERCYHEALTHSYSTEM.ORG/ 0002048	X	X	X	X			X			
2	VANMATRE HEALTH SOUTH 950 S MULFORD RD ROCKFORD, IL 61108 WEBSITE: SEE SCH H, PART VI (PAGE 63) 0005215	X								REHABILITATION	

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
JAVON BEA HOSPITAL	PART V, SECTION B, LINE 5: JAVON BEA HOSPITAL COMPLETED AN INDEPENDENT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE ROCKFORD REGIONAL HEALTH COUNCIL 2020 HEALTHY COMMUNITY STUDY WAS A KEY SOURCE OF DATA USED TO INFORM THE ASSESSMENT AND IMPLEMENTATION PLAN. THE ROCKFORD REGIONAL COUNCIL IS A NON-PARTISAN ORGANIZATION THAT FOCUSES ON IMPROVING THE QUALITY OF OUR REGION'S HEALTH. THE COUNCIL RECEIVED THE MAJORITY OF THE INFORMATION FOR THE 2020 COMMUNITY ANALYSIS FROM THE CENTER FOR APPLIED RESEARCH & ENGAGEMENT SYSTEMS (CARES). CARES IS A TECHNOLOGY ORGANIZATION HOUSED IN EXTENSION AT THE UNIVERSITY OF MISSOURI WHICH PROVIDES COMPREHENSIVE REPORTS IN A STANDARDIZED FORMAT SO THAT RESEARCHERS NO LONGER HAVE TO DOWNLOAD INDIVIDUAL PIECES OF INFORMATION TO PREPARE THESE REPORTS. THE FOCUS OF THE COUNCIL IS ON IMPROVING THE QUALITY OF OUR REGION'S HEALTH THROUGH DATA GATHERING AND ANALYSIS, EDUCATION, ACTION, AND ADVOCACY. THE DATA AND FINDINGS FROM THIS COMPREHENSIVE STUDY PROVIDE THE FRAMEWORK FOR OUR ASSESSMENT AND IMPLEMENTATION PLAN WITH IDENTIFIED GOALS AND PRIORITIES. THE ROCKFORD REGIONAL HEALTH COUNCIL WORKED WITH A STEERING COMMITTEE CONSISTING OF BOONE COUNTY HEALTH DEPARTMENT, MERCYHEALTH, OSF HEALTHCARE, SWEDISHAMERICAN HEALTH SYSTEM, UNITED WAY OF ROCK RIVER VALLEY, UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE ROCKFORD, DEPARTMENT OF FAMILY & COMMUNITY MEDICINE, AND THE DIVISION OF HEALTH POLICY AND SOCIAL SCIENCE RESEARCH TO PREPARE THE COMMUNITY ANALYSIS 2020 HEALTHY COMMUNITY STUDY. THIS IS A WIDE ARRAY OF ORGANIZATIONS WHO SPECIALIZE IN HEALTHCARE AND IN MEETING COMMUNITY NEEDS IN A LARGE PORTION OF THE WINNEBAGO COMMUNITY WHO PARTNERED TOGETHER TO PREPARE THIS REPORT AND TO IDENTIFY AREAS OF THE COMMUNITY WHERE THERE ARE PUBLIC HEALTH CONCERNS. THE 2020 STUDY INCLUDED THE FOLLOWING FOUR COMPONENTS: 1) A COMMUNITY ANALYSIS - FROM THE CENTER FOR APPLIED RESEARCH AND ENGAGEMENT SYSTEMS (CARES) - A COMPILATION OF DATA ON THE REPORT LOCATION (WINNEBAGO AND BOONE COUNTIES) FOR A WIDE VARIETY OF COMMUNITY HEALTH ISSUES AND TRENDS. 2) A QUICK FACTS HEALTH INDICATORS REPORT - A "GAS GAUGE" CHART THAT SHOWS DATA POINTS FOR VARIOUS METRICS FOR THE REPORT LOCATION COMPARED TO THE STATE AND THE U.S. THIS VISUALIZATION PROVIDED A SUPERIOR "DATA AT A GLANCE" FORMAT IN COMPARISON TO THE REST OF THE STATE AND THE NATION. 3) THE 2019 ILLINOIS REPORT FOR COUNTY HEALTH RANKINGS (CHR) AND ROADMAPS INCLUDING KEY COMPONENTS OF DEMOGRAPHICS, PHYSICAL ENVIRONMENT, SOCIAL AND ECONOMIC FACTORS, CLINICAL CARE, HEALTH BEHAVIORS, AND HEALTH OUTCOMES. COMMUNITIES USE THE RANKINGS TO GARNER SUPPORT FOR LOCAL HEALTH IMPROVEMENT INITIATIVES AMONG GOVERNMENT AGENCIES, HEALTH CARE PROVIDERS, COMMUNITY ORGANIZATIONS, BUSINESS LEADERS, POLICYMAKERS, AND THE PUBLIC. 4) AN ALTERNATIVE ANALYSIS FOR THE CHR METHODOLOGY USING COMPARABLE COUNTIES AND MSAS FROM ACROSS THE U.S. THAT WAS SELECTED BY TRANSFORM ROCKFORD (A LOCAL ROCKFORD ORGANIZATION).

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
VANMATRE HEALTH SOUTH	PART V, SECTION B, LINE 5: VAN MATRE ENCOMPASS HEALTH REHABILITATION HOSPITAL COMPLETED AN INDEPENDENT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA). THE ROCKFORD REGIONAL HEALTH COUNCI L 2020 HEALTHY COMMUNITY STUDY WAS A KEY SOURCE OF DATA USED TO INFORM THE ASSESSMENT AND IMPLEMENTATION PLAN. THE ROCKFORD REGIONAL COUNCIL IS A NON-PARTISAN ORGANIZATION THAT FOC USES ON IMPROVING THE QUALITY OF OUR REGION'S HEALTH. THE COUNCIL RECEIVED THE MAJORITY OF THE INFORMATION FOR THE 2020 COMMUNITY ANALYSIS FROM THE CENTER FOR APPLIED RESEARCH & EN GAGEMENT SYSTEMS (CARES). CARES IS A TECHNOLOGY ORGANIZATION HOUSED IN EXTENSION AT THE UN IVERSITY OF MISSOURI WHICH PROVIDES COMPREHENSIVE REPORTS IN A STANDARDIZED FORMAT SO THAT RESEARCHERS NO LONGER HAVE TO DOWNLOAD INDIVIDUAL PIECES OF INFORMATION TO PREPARE THESE REPORTS. THE FOCUS OF THE COUNCIL IS ON IMPROVING THE QUALITY OF OUR REGION'S HEALTH THROU GH DATA GATHERING AND ANALYSIS, EDUCATION, ACTION, AND ADVOCACY. THE DATA AND FINDINGS FRO M THIS COMPREHENSIVE STUDY PROVIDE THE FRAMEWORK FOR OUR ASSESSMENT AND IMPLEMENTATION PLA N WITH IDENTIFIED GOALS AND PRIORITIES. THE ROCKFORD REGIONAL HEALTH COUNCIL WORKED WITH A STEERING COMMITTEE CONSISTING OF BOONE COUNTY HEALTH DEPARTMENT, MERCYHEALTH, OSF HEALTHC ARE, SWEDISHAMERICAN HEALTH SYSTEM, UNITED WAY OF ROCK RIVER VALLEY, UNIVERSITY OF ILLINOI S COLLEGE OF MEDICINE ROCKFORD, DEPARTMENT OF FAMILY & COMMUNITY MEDICINE, AND THE DIVISIO N OF HEALTH POLICY AND SOCIAL SCIENCE RESEARCH TO PREPARE THE COMMUNITY ANALYSIS 2020 HEAL THY COMMUNITY STUDY. THIS IS A WIDE ARRAY OF ORGANIZATIONS THAT SPECIALIZE IN HEALTHCARE A ND IN MEETING COMMUNITY NEEDS IN A LARGE PORTION OF THE WINNEBAGO COMMUNITY WHO PARTNERED TOGETHER TO PREPARE THIS REPORT AND TO IDENTIFY AREAS OF THE COMMUNITY WHERE THERE ARE PUB LIC HEALTH CONCERNS. THE 2020 STUDY INCLUDED THE FOLLOWING FOUR COMPONENTS: 1) A COMMUNITY ANALYSIS - FROM THE CENTER FOR APPLIED RESEARCH AND ENGAGEMENT SYSTEMS (CARES) - A COMPIL ATION OF DATA ON THE REPORT LOCATION (WINNEBAGO AND BOONE COUNTIES) FOR A WIDE VARIETY OF COMMUNITY HEALTH ISSUES AND TRENDS. 2) A QUICK FACTS HEALTH INDICATORS REPORT - A "GAS GAU GE" CHART THAT SHOWS DATA POINTS FOR VARIOUS METRICS FOR THE REPORT LOCATION COMPARED TO T HE STATE AND THE U.S. THIS VISUALIZATION PROVIDED A SUPERIOR "DATA AT A GLANCE" FORMAT IN COMPARISON TO THE REST OF THE STATE AND THE NATION. 3) THE 2019 ILLINOIS REPORT FOR COUNTY HEALTH RANKINGS (CHR) AND ROADMAPS INCLUDING KEY COMPONENTS OF DEMOGRAPHICS, PHYSICAL ENV IRONMENT, SOCIAL AND ECONOMIC FACTORS, CLINICAL CARE, HEALTH BEHAVIORS, AND HEALTH OUTCOME S. COMMUNITIES USE THE RANKINGS TO GARNER SUPPORT FOR LOCAL HEALTH IMPROVEMENT INITIATIVES AMONG GOVERNMENT AGENCIES, HEALTH CARE PROVIDERS, COMMUNITY ORGANIZATIONS, BUSINESS LEADE RS, POLICYMAKERS, AND THE PUBLIC. 4) AN ALTERNATIVE ANALYSIS FOR THE CHR METHODOLOGY USING COMPARABLE COUNTIES AND MSAS FROM ACROSS THE U.S. THAT WAS SELECTED BY TRANSFORM ROCKFORD (A LOCAL ROCKFORD ORGANIZATIO

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
VANMATRE HEALTH SOUTH	N).

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
JAVON BEA HOSPITAL	PART V, SECTION B, LINE 6B: ROCKFORD REGIONAL HEALTH COUNCIL

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
VANMATRE HEALTH SOUTH	PART V, SECTION B, LINE 6B: ROCKFORD REGIONAL HEALTH COUNCILWINNEBAGO COUNTY HEALTH DEPARTMENT

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
JAVON BEA HOSPITAL	PART V, SECTION B, LINE 11: THE HOSPITAL USED THE ROCKFORD REGIONAL HEALTH COUNCIL'S 2020 HEALTHY COMMUNITY STUDY FOR THE LOCAL ASSESSMENT OF NEEDS AND THE COMMUNITY BENEFIT IMPLEMENTATION PLAN WAS COMPLETED IN 2020 BASED ON THIS STUDY. THE PLAN IS TO DEVELOP AND IMPLEMENT A MULTIFACETED COMMUNITY BENEFIT PLAN TO IMPROVE THE HEALTH AND WELL BEING OF RESIDENTS IN THE PRIMARY SERVICE AREA.THE SURVEY IDENTIFIED MULTIPLE NEEDS WITHIN THE COMMUNITY. THE NEEDS IDENTIFIED INCLUDED ALCOHOL, OPIOID & OTHER SUBSTANCE ABUSE ISSUES, CHRONIC DISEASE, MATERNAL/PRENATAL/EARLY CHILDHOOD HEALTH, GERIATRIC HEALTH NEEDS, HEALTH EQUITY, AND A SHORTAGE OF MENTAL HEALTH SERVICES, JOB TRAINING AND EMPLOYMENT FOR PEOPLE WITH DISABILITIES.THE IMPLEMENTATION PLAN FOCUSES ON MANY OF THE AREAS IDENTIFIED TO HELP TO IMPROVE THE GENERAL HEALTH OF INDIVIDUALS LIVING IN THE PRIMARY SERVICE AREA INCLUDING:IMPROVE HEALTH CARE ACCESS BY DEVELOPING AND OFFERING VARIOUS ACCESS SITES AND VENUES FOR PRIMARY CARE MEDICAL SERVICES. ESTABLISH PHYSICIAN RESIDENCY PROGRAMS IN ROCKFORD. SUPPORT BRIDGE CLINIC SERVICES AND THE RONALD MCDONALD CARE MOBILE FOR NON- AND UNDER-INSURED PATIENTS AND CHILDREN.SAFE CARE COMMITMENT - IN RESPONSE TO COVID-19 AND TO EFFECTIVELY CARE FOR THE NEEDS OF THE COMMUNITY, JAVON BEA HOSPITAL PROVIDED ALTERNATIVE EDUCATION TO EMERGENCY MEDICAL SERVICE (EMS) PERSONNEL FOR ENHANCED SAFETY AND TREATMENT PROTOCOLS. JAVON BEA HOSPITAL EXPANDED TELEMEDICINE SERVICES TO INCREASE VIRTUAL ACCESS FOR OUR PATIENTS AND ALLOW EMS CREWS TO BE AVAILABLE FOR THOSE WITH CRITICAL ILLNESSES. JAVON BEA HOSPITAL PROVIDED COMMUNITY EDUCATION VIDEOS ADDRESSING COVID-19 QUESTIONS AND CONCERNS ALONG WITH HOW TO SAFELY WEAR A MASK.JAVON BEA HOSPITAL PARTNERS WITH MULTIPLE COMMUNITY-BASED ORGANIZATIONS IN WINNEBAGO COUNTY TO ACCOMPLISH SUCCESSFUL IMPLEMENTATION OF THESE STRATEGIES. DURING THE COURSE OF THIS TAX YEAR 2020 (FISCAL YEAR JULY 1, 2020-JUNE 30, 2021), AND THE PRIOR TAX YEARS, JAVON BEA HOSPITAL PARTICIPATED IN NUMEROUS COMMUNITY HEALTH FAIRS, PROVIDED FREE SCREENINGS AT OUR CLINICS AND IN CONJUNCTION WITH COMMUNITY-BASED ORGANIZATIONS, OFFERED SCREENINGS TO FREE AND SLIDING FEE SCHEDULE PRIMARY CARE CLINICS, AND SCHOOL DISTRICTS IN THE COUNTY. JAVON BEA HOSPITAL ALSO PROVIDES FINANCIAL INCENTIVES FOR THEIR EMPLOYEES TO PARTICIPATE IN SMOKING CESSATION PROGRAMS. ALL OF THESE EFFORTS ARE SUPPORTED THROUGH BROAD BASED MARKETING AND ADVERTISING PROGRAMS DIRECTED TO AUDIENCES IN BOTH COUNTIES PROMOTING THESE PROGRAMS.THE IMPLEMENTATION PLAN DOES NOT ADDRESS ISSUES AROUND VIOLENCE IN THE COMMUNITY, AS THIS NEED IS BETTER ADDRESSED BY ORGANIZATIONS MORE VERSED IN THE MULTIDIMENSIONAL FACTORS AFFECTING COMMUNITY VIOLENCE & CRIME.

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
VANMATRE HEALTH SOUTH	PART V, SECTION B, LINE 11: THE HOSPITAL USED THE ROCKFORD REGIONAL HEALTH COUNCIL'S 2020 HEALTHY COMMUNITY STUDY FOR THE LOCAL ASSESSMENT OF NEEDS AND THE COMMUNITY BENEFIT IMPLEMENTATION PLAN WAS COMPLETED IN 2020 BASED ON THIS STUDY. THE PLAN IS TO DEVELOP AND IMPLEMENT A MULTIFACETED COMMUNITY BENEFIT PLAN TO IMPROVE THE HEALTH AND WELL BEING OF RESIDENTS IN THE PRIMARY SERVICE AREA.THE SURVEY IDENTIFIED MULTIPLE NEEDS WITHIN THE COMMUNITY. THE NEEDS IDENTIFIED INCLUDED ALCOHOL, OPIOID & OTHER SUBSTANCE ABUSE ISSUES, CHRONIC DISEASE, MATERNAL/PRENATAL/EARLY CHILDHOOD HEALTH, GERIATRIC HEALTH NEEDS, HEALTH EQUITY, AND A SHORTAGE OF MENTAL HEALTH SERVICES, JOB TRAINING AND EMPLOYMENT FOR PEOPLE WITH DISABILITIES.THE IMPLEMENTATION PLAN FOCUSES ON MANY OF THE AREAS IDENTIFIED TO HELP TO IMPROVE THE GENERAL HEALTH OF INDIVIDUALS LIVING IN THE PRIMARY SERVICE AREA INCLUDING:IMPROVE HEALTH CARE ACCESS BY DEVELOPING AND OFFERING VARIOUS ACCESS SITES AND VENUES FOR PRIMARY CARE MEDICAL SERVICES. ESTABLISH FAMILY PRACTICE AND INTERNAL MEDICINE PHYSICIAN RESIDENCY PROGRAMS IN ROCKFORD. SUPPORT BRIDGE CLINIC SERVICES AND THE RONALD MCDONALD CARE MOBILE FOR NON- AND UNDER-INSURED PATIENTS AND CHILDREN AND OFFER A WIDE VARIETY OF COMMUNITY EDUCATION HEALTH AND SCREENING PROGRAMS.SAFE CARE COMMITMENT - IN RESPONSE TO COVID-19 TO EFFECTIVELY CARE FOR THE NEEDS OF OUR COMMUNITY AND TO ENSURE UP-TO-DATE EDUCATION AND PREPAREDNESS DURING A PANDEMIC. COORDINATE WITH LOCAL, REGIONAL AND STATE ORGANIZATIONS REGARDING EMS SURGE PLANNING, RESPONSE AND INFORMATION SHARING. PROVIDE ALTERNATIVE EDUCATION FOR EMERGENCY MEDICAL SERVICES. INCLUDING ENHANCED SAFETY AND TREATMENT PROTOCOLS BY OUR EMS SYSTEM AND THE REACT AIR MEDICAL CRITICAL CARE TRANSPORT PROGRAM. EXPANDED TELEMEDICINE SERVICES TO INCREASE VIRTUAL ACCESS FOR OUR PATIENTS AND ALLOW EMS CREWS TO BE AVAILABLE FOR THOSE WITH CRITICAL ILLNESSES DURING PANDEMIC. EXPANDED COVID 19 RESPONSE, SCREENING, AND EFFECTIVE TRANSPORT OF PATIENTS SUSPECTED OR CONFIRMED FOR COVID-19. REASSURE PATIENTS OF EXTRA SAFETY PRECAUTIONS TAKEN TO ENSURE THE HEALTH AND SAFETY OF OUR PATIENTS INCLUDING ENHANCED CLEANING, MASKING, SCREENING AND SOCIAL DISTANCING AT ALL FACILITIES.THE IMPLEMENTATION PLAN DOES NOT ADDRESS ISSUES AROUND VIOLENCE IN THE COMMUNITY, AS THIS NEED IS BETTER ADDRESSED BY ORGANIZATIONS MORE VERSED IN THE MULTIDIMENSIONAL FACTORS AFFECTING COMMUNITY VIOLENCE & CRIME.

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
VANMATRE HEALTH SOUTH	PART V, SECTION B, LINE 16J: HTTPS://ENCOMPASSHEALTH.COM/LOCATIONS/VANMATREREHAB/FINANCIAL-ASSISTANCE

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
JAVON BEA HOSPITAL	PART V, SECTION B, LINE 18E: 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.

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
PART V, SECTION B, LINE 22D:	JAVON BEA HOSPITALTHE 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.

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
PART V, SECTION B, LINE 22D:	VANMATRE HEALTH SOUTHTHE HOSPITAL FACILITY USED A PROSPECTIVE MEDICARE OR MEDICAID METHOD.

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

Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments and Individuals in the United States

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☑ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 8

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶ 0

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

Part IV **Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

Return Reference	Explanation
PART I, LINE 2:	APPLICATIONS ARE SUBMITTED TO THE HOSPITAL VERIFYING A NEED FOR FUNDS OR PRODUCTS (IE AUTOMATIC ELECTRONIC DEFIBRILLATORS-AED). A DETERMINATION IS MADE THROUGH A PREDETERMINED SCORING METHOD AS TO WHAT ORGANIZATIONS WILL BE RECIPIENTS OF THE FUNDS OR PRODUCTS. CASH CONTRIBUTIONS ARE MADE ONLY TO RECOGNIZED CHARITIES FOR WHICH GOOD FAITH REGARDING FUND USE HAS BEEN ESTABLISHED. THE CONTRIBUTION IS ONLY FOR THE AMOUNT OF THE APPEAL AND FOR A SPECIFIED NEED.

Additional Data

Software ID:
Software Version:
EIN: 36-2167847
Name: JAVON BEA HOSPITAL

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
AMERICAN CANCER SOCIETY 255 N MICHIGAN AVE STE 1200 CHICAGO, IL 60601	13-1788491	501(C)(3)	5,000				PROGRAM SUPPORT
THE HAVEN NETWORK 124 N WATER ST ROCKFORD, IL 61107	20-0620800	501(C)(3)	5,000				PROGRAM SUPPORT

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
REGIONAL ACCESS MOBILIZATION PROJECT INC 202 MARKET ST ROCKFORD, IL 61107	36-3149827	501(C)(3)	5,000				PROGRAM SUPPORT
ROCKFORD UNIVERSITY 5050 E STATE ST ROCKFORD, IL 61107	36-2167842	501(C)(3)	5,000				PROGRAM SUPPORT

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNIVERSITY OF IL FOUNDATION 1305 W GREEN ST URBANA, IL 618012900	37-6006007	501(C)(3)	50,000				PROGRAM SUPPORT
ROCK RIVER DEVELOPMENT PARTNERSHIP 124 N WATER ST ROCKFORD, IL 611073960	27-1153597	501(C)(3)	40,000				PROGRAM SUPPORT

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
WINNEBAGO COUNTY ETSB (PULSEPOINT) - CITY OF ROCKFORD FIRE DEPT 204 SOUTH FIRST STREET ROCKFORD, IL 61104	36-6006082	501(C)(3)	13,000				PROGRAM SUPPORT
REMEDIES RENEWING LIVES 220 EASTON PARKWAY ROCKFORD, IL 61108	36-2464898	501(C)(3)	5,000				PROGRAM SUPPORT

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate 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.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ 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**		
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**		
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.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ 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**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
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 accured 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**		

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

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

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

(A) Name and Title	**(B)** Breakdown of W-2 and/or 1099-MISC compensation			**(C)** Retirement and other deferred compensation	**(D)** Nontaxable benefits	**(E)** Total of columns (B)(i)-(D)	**(F)** Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table							

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
PART I, LINE 3	THE CEO IS PAID FROM A RELATED ORGANIZATION, MERCY HEALTH SYSTEM CORPORATION (MHSC). MHSC USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE CEO: COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, FORM 990 OF OTHER ORGANIZATIONS, WRITTEN EMPLOYMENT CONTRACT, COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE. THE MERCY COMPENSATION COMMITTEE OF MHSC IS COMPRISED OF THE BOARD CHAIRPERSON, VICE CHAIR, AND SECRETARY/TREASURER. THE COMPENSATION COMMITTEE IS ASSISTED BY INDEPENDENT LEGAL COUNSEL AND AN INDEPENDENT COMPENSATION CONSULTANT. THE COMPENSATION COMMITTEE, LEGAL COUNSEL, AND THE COMPENSATION CONSULTANT MEET THROUGHOUT THE YEAR AND REPORT DIRECTLY TO THE BOARD OF DIRECTORS ANNUALLY. THIS PROCESS WAS COMPLETED FOR 2020.
PART I, LINES 4A-B	PAUL VAN DEN HEUVEL RECEIVED SEVERANCE OF $27,693 IN 2020 FROM MERCY HEALTH SYSTEM CORPORATION, A RELATED ORGANIZATION. INCENTIVE PLAN DISTRIBUTION: JAVON R. BEA - $2,627,335. THE FOLLOWING INDIVIDUALS PARTICIPATED IN A SUPPLEMENTAL NON-QUALIFIED RETIREMENT PLAN DURING FY2021 THAT WAS SPONSORED BY THE ORGANIZATION: JOHN DORSEY AND SUE SCHRIEBER. THERE WERE NO AMOUNTS PAID TO ANY PARTICIPANTS DURING THE YEAR UNDER THE PLAN.
PART II, LINE 2:	JAVON R. BEA - DEFERRED COMPENSATION PAYMENT MR. BEA HAS BEEN EMPLOYED BY MHSC AS PRESIDENT AND CEO OVER THE PAST 30 YEARS. DURING THIS TIME, MR. BEA HAS LED AN INCREDIBLE TRANSFORMATION TAKING A SMALL, SINGLE, STAND-ALONE COMMUNITY HOSPITAL AND CREATING A VERTICALLY INTEGRATED HEALTH SYSTEM WITH 85 FACILITIES IN 50 COMMUNITIES THROUGHOUT SOUTHERN WISCONSIN AND NORTHERN ILLINOIS, INCREASING GROSS REVENUE FROM $33 MILLION TO OVER $3.3 BILLION IN FY2021. THIS HAS ALLOWED THE HEALTH SYSTEM TO GO FROM SERVING 89,000 PATIENTS IN 1989 TO OVER 2.1 MILLION PATIENTS TODAY WORKING TOGETHER WITH OVER 7,300+ PARTNERS IN HEALTH CARE. TODAY, MHSC HAS BECOME THE LARGEST EMPLOYER IN SOUTHERN WISCONSIN AND NORTHERN ILLINOIS. THIS GROWTH CAN BE ATTRIBUTED TO MR. BEA'S VISIONARY LEADERSHIP. LEADERSHIP THAT HAS LED TO MHSC RECEIVING NUMEROUS NATIONAL RECOGNIZED AWARDS INCLUDING BEING NAMED THE FIRST FULLY INTEGRATED HEALTH SYSTEM TO RECEIVE THE MALCOLM BALDRIGE NATIONAL QUALITY AWARD, THE MAGNET RECOGNITION AWARD, BEING RANKED #1 AND #2 ON AARP'S TOP 100 BEST PLACES TO WORK FOR WORKERS OVER 50, AND BEING RANKED IN THE TOP 25 ON THE TOP 100 INTEGRATED HEALTHCARE NETWORKS LIST BY MODERN HEALTHCARE FOR OVER 11 STRAIGHT YEARS. THE TURNAROUND OF MHSC IMPLEMENTED BY MR. BEA IS UNPARALLELED. BY PIONEERING A "PARTNERSHIP MODEL" OF COMPENSATION AND DESIGNING A CUSTOM CULTURE OF EXCELLENCE, MR. BEA IS VITAL TO THE DECADES-LONG AND CONTINUING GROWTH AT MHSC. THIS SUCCESS HAS MADE MR. BEA A HIGHLY SOUGHT AFTER SPEAKER AND CONSULTANT AS HE IS NOW WELL-RENOWNED FOR HIS INNOVATIONS IN THE AREAS OF INTEGRATED HEALTHCARE AND PHYSICIAN PARTNERSHIP MODELS. THE TREMENDOUS SUCCESS OF MHSC UNDER THE LEADERSHIP OF MR. BEA HAS ALLOWED HIM TO RECEIVE PAYOUTS FROM A DEFERRED COMPENSATION PACKAGE WHICH MHSC HAS BEEN PAYING INTO OVER MANY YEARS. THESE PAYMENTS ONLY BECAME PAYABLE IF MHSC ATTAINED CERTAIN DEFINED FINANCIAL AND STRATEGIC GOALS AND THE AMOUNTS ARE AT RISK EVERY SINGLE YEAR. AS INDICATED ABOVE, MANY OF THESE GOALS WERE ACHIEVED WITHIN THE PAST TWO YEARS RESULTING IN A RELEASE OF THESE DEFERRED PAYMENTS WHICH IMPACTED MR. BEA'S COMPENSATION REPORTING. THE SETTING OF THESE GOALS WERE LAID OUT BY THE BOARD OF DIRECTORS IN COOPERATION WITH NATIONALLY RECOGNIZED COMPENSATION ATTORNEYS AND CONSULTANTS TO MAKE SURE ALL FACTORS WERE TAKEN INTO CONSIDERATION. MR. BEA'S COMPENSATION HAS ALSO BEEN SCRUTINIZED BY NUMEROUS OUTSIDE ORGANIZATIONS AND MOST IMPORTANTLY, THE INTERNAL REVENUE SERVICE; AND HAS PASSED INSPECTION IN EACH CASE. TOTAL COMPENSATION IS APPROVED ANNUALLY BY THE BOARD OF DIRECTORS OF MHSC.

Additional Data

Software ID:
Software Version:
EIN: 36-2167847
Name: JAVON BEA HOSPITAL

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1JAVON R BEA PRESIDENT & CEO (SEE PAGES 74-77)	(i)	0	0	0	0	0	0	0
	(ii)	1,471,858	0	3,586,128	7,056,412	17,748	12,132,146	0
1JOHN DORSEY VP CLINICAL INTERGRATION	(i)	448,378	161,638	4,572	34,353	17,463	666,404	0
	(ii)	0	0	0	0	0	0	0
2TODD ANDERSON VP & CFO (AS OF 05/2020)	(i)	0	0	0	0	0	0	0
	(ii)	355,005	182,313	5,540	0	18,158	561,016	0
3MARK L GOELZER MD DIRECTOR/PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	355,312	142,289	4,364	11,400	17,748	531,113	0
4ROBERT WALTERS VP HOME CARE	(i)	217,148	77,410	1,246	8,687	34,098	338,589	0
	(ii)	0	0	0	0	0	0	0
5 SHANNON DUNPHY-ALEXANDER SR EXECUTIVE DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	237,151	75,861	229	11,400	4,517	329,158	0
6WENDI AUBRY REGIONAL PHARMACY MANAGER	(i)	185,615	13,765	847	12,772	75,319	288,318	0
	(ii)	0	0	0	0	0	0	0
7 PAUL VAN DEN HEUVEL FORMER VICE PRESIDENT (THROUGH 04/2020)	(i)	0	0	0	0	0	0	0
	(ii)	141,873	66,244	32,741	17,847	9,710	268,415	0
8MATTHEW PYCIOR PERFUSIONIST	(i)	213,898	0	6,630	35,568	927	257,023	0
	(ii)	0	0	0	0	0	0	0
9SUE SCHRIEBER VP BUSINESS INTELLIGENCE	(i)	81,343	5,436	134,116	5,668	15,604	242,167	0
	(ii)	0	0	0	0	0	0	0

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 2	IN MAY 2021, THE LONG-TERM CARE DEPARTMENT (SUB-ACUTE CARE) OPENED.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART III, LINE 3	AFTER OPENING THE LONG-TERM CARE DEPARTMENT (SUB-ACUTE CARE) IN MAY 2021, JBH REDUCED THE LICENSE FOR PSYCHIATRIC BEDS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 1	THE VOTING MEMBERS OF THE EXECUTIVE COMMITTEE CONSISTS OF SEVEN INDIVIDUALS, EACH OF WHOM SHALL HAVE A VOTE, INCLUDING THE CEO, THE CHAIRMAN, VICE-CHAIRMAN, IMMEDIATE PAST CHAIRMAN , TREASURER, AND TWO ADDITIONAL DIRECTORS OF THE BOARD. AT LEAST ONE MEMBER OF THE EXECUTI VE COMMITTEE SHALL BE A PHYSICIAN. THE EXECUTIVE COMMITTEE SHALL IN ALL INSTANCES BE COMPR ISED OF AT LEAST 51% COMMUNITY MEMBERS. IN THE EVENT THAT ONE OR MORE OF THE AFOREMENTIONE D VOTING MEMBERS OF THE EXECUTIVE COMMITTEE IS UNABLE TO SERVE IN SUCH CAPACITY, THEN THE CHAIRMAN OF THE CORPORATION SHALL DESIGNATE A REPLACEMENT FROM AMONG THE BOARD MEMBERS. TH E EXECUTIVE COMMITTEE SHALL MEET AS NEEDED. WHEN THE BOARD OF DIRECTORS IS NOT IN SESSION, THE EXECUTIVE COMMITTEE SHALL HAVE ALL THE POWERS, DUTIES, RESPONSIBILITIES AND AUTHORITY OF THE BOARD, EXCEPT AS PROHIBITED BY LAW.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	MERCY HEALTH CORPORATION (MHC) IS THE SOLE CORPORATE MEMBER OF JAVON BEA HOSPITAL (JBH). T HE SOLE MEMBER SHALL HAVE POWERS AND VOTING RIGHTS TO DO THE FOLLOWING: (A) APPOINT ALL TH E DIRECTORS OF THE CORPORATION. (B) NOMINATE TO CORPORATION'S BOARD OF DIRECTORS ALL CANDI DATES FOR SELECTION AS THE CORPORATION PRESIDENT. (C) APPROVE EXPRESSLY ALL AMENDMENTS TO THE CORPORATION'S ARTICLES OF INCORPORATION AND BYLAWS. (D) APPROVE ANNUAL BUDGETS, AND ST RATEGIC, LONG-RANGE AND HEALTH MANPOWER DEVELOPMENT PLANS OF THE CORPORATION. (E) REQUIRE THE CORPORATION'S BOARD OF DIRECTORS TO TAKE ANY ACTION (INCLUDING AUTHORIZING THE PLEDGE OR TRANSFER OF ASSETS TO MHC OR AS DIRECTED BY MHC, OR THE EXECUTION OF CONTRACTS) WHICH W OULD IMPROVE THE CREDIT WORTHINESS OR OTHERWISE RESULT IN FINANCIAL BENEFIT TO MHC AND ITS TAX-EXEMPT AFFILIATED CORPORATIONS (PROVIDED THAT UNDER NO CIRCUMSTANCES MAY MHC REQUIRE TRANSFER OF ASSETS IN VIOLATION OF LAW OR THE TERMS OF ANY CHARITABLE TRUST OR DONATION). (F) APPROVE ALL CONTRACTS OF INDEBTEDNESS EFFECTIVE FOR LONGER THAN EIGHTEEN MONTHS. (G) A PPROVE ALL PLANS OF MERGER OR CONSOLIDATION. (H) APPROVE THE SALE, LEASE, EXCHANGE, MORTGA GE, PLEDGE OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL, THE PROPERTY AND ASSETS OF TH E CORPORATION. (I) APPROVE A VOLUNTARY DISSOLUTION OF THE CORPORATION. (J) APPROVE MATERIA L AMENDMENTS TO THE CORPORATIONS STANDARD FORM OF PHYSICIAN EMPLOYMENT AGREEMENT, PROVIDED THE CORPORATION SHALL HAVE THE AUTHORITY TO NEGOTIATE THE TERMS AND CONDITIONS OF INDIVID UAL PHYSICIAN EMPLOYMENT AGREEMENTS SO LONG AS THE NEGOTIATED TERMS AND CONDITIONS ARE CON SISTENT WITH THE REQUIREMENTS OF APPLICABLE LAW AND THE STRATEGIC, LONG-RANGE AND HEALTH M ANPOWER DEVELOPMENT PLANS APPROVED BY MHC. (K) APPROVE MATERIAL AMENDMENTS TO THE STANDARD COMPENSATION SYSTEM USED BY THE CORPORATION TO ESTABLISH INDIVIDUAL PHYSICIAN COMPENSATIO N. (L) REQUIRE THE CORPORATION'S BOARD OF DIRECTORS TO TAKE ANY ACTION (INCLUDING AMENDING THE ARTICLES OF INCORPORATION OR BYLAWS), OR TO MODIFY OR RESCIND AN ACTION ALREADY TAKEN , IF MHC DETERMINES THAT FAILURE TO TAKE THE ACTION, OR TO MODIFY OR RESCIND AN ACTION ALR EADY TAKEN, MAY RESULT IN THE CORPORATIONS FAILURE TO OBTAIN OR MAINTAIN ITS EXEMPTION AS AN ORGANIZATION DESCRIBED IN SECTION 501(C)(3) OF THE CODE.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	SEE NARRATIVE FOR PART VI, LINE 6.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	SEE NARRATIVE FOR PART VI, LINE 6.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	MANAGEMENT REVIEWS THE FORM 990 BEFORE FILING AND IT IS AVAILABLE TO THE BOARD OF DIRECTORS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	BY WRITTEN POLICY, MHC SENDS OUT, ON AN ANNUAL BASIS, THE CORPORATE CONFLICT AND DUALITY O F INTEREST POLICY TO ALL BOARD MEMBERS, CORPORATE OFFICERS AND OTHER KEY INDIVIDUALS (THOS E HAVING RESPONSIBILITY AND AUTHORITY TO MAKE FINAL DECISIONS REGARDING THE ACQUISITION OF PRODUCTS OR SERVICES). EACH RECIPIENT IS REQUIRED TO COMPLETE A FINANCIAL INTEREST DISCLO SURE STATEMENT, WHICH IS SUBMITTED TO THE MHC COMPLIANCE DEPARTMENT FOR REVIEW. WITH RESPE CT TO PHYSICIANS AND MANAGERS WHO ARE KEY INDIVIDUALS, ANY POTENTIAL CONFLICT OF INTEREST IS REVIEWED WITH THE APPROPRIATE EXECUTIVE STAFF MEMBER FOR FOLLOW UP WITH THE DISCLOSING PARTY IN ORDER TO REVIEW THE MATTER IN MORE DETAIL. THIS INCLUDES EMPHASIZING THAT THE DIS CLOSING PARTY IS NOT PERMITTED TO PARTICIPATE IN ANY NEGOTIATIONS FOR THE PURCHASE OF ANY PRODUCTS OR SERVICES WHERE THE CONFLICT IS DEEMED MATERIAL OR AUTHORIZE THE SUBSEQUENT PUR CHASE OF RELATED GOODS AND SERVICES. THE DISCLOSING PARTY IS ALSO REQUIRED TO IDENTIFY EAC H AND EVERY INSTANCE OF A POTENTIAL CONFLICT AS THEY MAY ARISE IN THE ORDINARY COURSE OF B USINESS. A SIMILAR PROCESS IS FOLLOWED FOR THE BOARD OF DIRECTORS, EXCEPT THAT ANY POTENTI AL CONFLICT IS REVIEWED BY THE BOARD'S GOVERNANCE COMMITTEE. BOARD MEMBERS MAY COMMENT ON TRANSACTIONS WHERE THERE IS A POTENTIAL CONFLICT BUT CANNOT VOTE ON THE RELATED MATTER AND MAY BE REQUIRED TO LEAVE ANY MEETING WHERE THE POTENTIAL CONFLICT IS REVIEWED BY THE BOAR D OR WHERE THE BOARD TAKES ACTION TO EITHER APPROVE OR NOT APPROVE THE PROPOSED TRANSACTIO N. A BOARD MEMBER ALSO HAS A CONTINUING DUTY TO REPORT ANY CONFLICTS AS THEY MAY ARISE IN THE ORDINARY COURSE OF BUSINESS. IN THE EVENT THAT A POTENTIAL CONFLICT OF INTEREST IS REP ORTED OR DISCOVERED OUTSIDE THE ESTABLISHED PROCESS, APPROPRIATE REVIEW AND ACTION WOULD B E TAKEN. THIS PROCESS WAS LAST COMPLETED IN 2021, WHEN THE QUESTIONNAIRES WERE SENT TO ADD RESS ANY 2020 CONFLICTS IDENTIFIED. MHC AND JBH HAVE THE SAME BOARD, AND THEREFORE THE MHC QUESTIONNAIRE IS USED TO ALSO ADDRESS POTENTIAL AND ACTUAL CONFLICTS FOR THE FILING ORGAN IZATION. THE MHC CONFLICT OF INTEREST POLICY IS AVAILABLE UPON REQUEST.

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	CHANGES IN PENSION OBLIGATION OTHER THAN PENSION EXPENSE 11,356,503. POST RETIREMENT MEDIC AL BENEFIT ADJUSTMENT -426,093. NET TRANSFERS TO AFFILIATES -6,137,281. UPMIFA 143,693. NE T CHANGE IN BENEFICIAL INTEREST IN TRUST 531,077. MISCELLANEOUS ADJUSTMENT -274,224. RHIL TRANSFER 5,038.

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization
JAVON BEA HOSPITAL

Employer identification number
36-2167847

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) ROCKFORD HEALTH SYSTEM VENTURES LLC 2400 N ROCKTON AVE ROCKFORD, IL 61103 36-4366881	HEALTHCARE	IL	3,499,732	12,691,768	JAVON BEA HOSPITAL

Part II **Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

See Additional Data Table

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)ROCKFORD HEALTH INSURANCE LTD WELLESLEY HOUSE SO 2ND FL PEMBROKE HM BD	INSURANCE	BD	JAVON BEA HOSPITAL	C	-584,106	4,230,266	100.000 %	Yes	
(2)JANESVILLE MEDICAL CENTER INC 1000 MINERAL POINT AVE JANESVILLE, WI 53548 39-1520130	MANAGEMENT OF UNION EMPLOYEES	WI	N/A	C					No
(3)MERCYCARE INSURANCE COMPANY 580 N WASHINGTON ST JANESVILLE, WI 53546 39-1768192	INSURANCE	WI	N/A	C					No
(4) MERCYCARE HMO INC - CONSOLIDATED WITH MERCYCARE INSURANCE CO 580 N WASHINGTON ST JANESVILLE, WI 53546 20-1482553	INSURANCE	WI	N/A	C					No

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

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

		Yes	No
1 During the tax year, did the orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity	1a		No
b Gift, grant, or capital contribution to related organization(s)	1b		No
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e	Yes	
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k		No
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m		No
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n	Yes	
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p	Yes	
q Reimbursement paid by related organization(s) for expenses	1q	Yes	
r Other transfer of cash or property to related organization(s)	1r	Yes	
s Other transfer of cash or property from related organization(s)	1s		No

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)ROCKFORD HEALTH INSURANCE LTD	R	153,061	NET BOOK VALUE
(2)ROCKFORD HEALTH INSURANCE LTD	R	836,000	AMOUNTS PAID

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 36-2167847
Name: JAVON BEA HOSPITAL

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
4223 E STATE STREET ROCKFORD, IL 61108 36-2167945	HEALTHCARE	IL	501(C)(3)	LINE 10	MERCY HEALTH CORPORATION		No
2400 N ROCKTON AVEYUP ROCKFORD, IL 61103 36-3197918	SUPPORT OF HEALTHCARE	IL	501(C)(3)	LINE 12A, I	MERCY HEALTH CORPORATION		No
2400 N ROCKTON AVE ROCKFORD, IL 61103 36-3907436	HEALTHCARE	IL	501(C)(3)	LINE 3	MERCY HEALTH CORPORATION		No
2400 N ROCKTON AVE ROCKFORD, IL 61103 47-2158680	SUPPORT OF HEALTHCARE	IL	501(C)(3)	LINE 12B, II	N/A		No
1000 MINERAL POINT AVE JANESVILLE, WI 53548 39-0912682	SUPPORT OF HEALTHCARE	WI	501(C)(3)	LINE 12C, III-FI	MERCY HEALTH SYSTEM CORPORATION		No
1000 MINERAL POINT AVE JANESVILLE, WI 53548 39-0816848	HEALTHCARE	WI	501(C)(3)	LINE 3	MERCY HEALTH CORPORATION		No
901 MINERAL POINT AVE JANESVILLE, WI 53548 39-1035110	HEALTHCARE	WI	501(C)(3)	LINE 10	MERCY HEALTH CORPORATION		No
901 GRANT STREET HARVARD, IL 60033 31-1551871	HEALTHCARE	IL	501(C)(3)	LINE 3	MERCY HEALTH CORPORATION		No
200 LAKE AVE WOODSTOCK, IL 60098 20-1673011	NONE	IL	501(C)(3)	LINE 3	MERCY HEALTH CORPORATION		No