

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
2019
Open to Public Inspection

A For the **2019** calendar year, or tax year beginning **01-01-2019**, and ending **12-31-2019**

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

C Name of organization
THEDACARE REGIONAL MEDICAL CENTER - APPLETON INC

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
PO BOX 8025

City or town, state or province, country, and ZIP or foreign postal code
APPLETON, WI 549128025

D Employer identification number
39-0824015

E Telephone number
(920) 735-5560

G Gross receipts \$ 320,108,478

F Name and address of principal officer:
IMRAN ANDRABI MD
PO BOX 8025
APPLETON, WI 549128025

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.THEDACARE.ORG

K Form of organization: Corporation Trust Association Other ▶

L Year of formation: 1958

M State of legal domicile: WI

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
IMPROVING THE HEALTH OF OUR COMMUNITY.

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	13
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	10
5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	0
6 Total number of volunteers (estimate if necessary)	6	252
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b Net unrelated business taxable income from Form 990-T, line 39	7b	-4,555

	Revenue	
	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	129,224	277,183
9 Program service revenue (Part VIII, line 2g)	313,186,346	319,830,701
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	50,109	594
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0	0
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	313,365,679	320,108,478
Expenses		
13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	2,407	0
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)	110,220,907	89,382,525
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶		
17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	144,486,688	160,802,569
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	254,710,002	250,185,094
19 Revenue less expenses. Subtract line 18 from line 12	58,655,677	69,923,384
Net Assets or Fund Balances		
20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	551,982,413	618,710,042
21 Total liabilities (Part X, line 26)	101,049	9,966,759
22 Net assets or fund balances. Subtract line 21 from line 20	551,881,364	608,743,283

Part II Signature Block

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

Sign Here
Signature of officer: *****
Date: 2020-11-14
Type or print name and title: MARK THOMPSON CFO & COO

Paid Preparer Use Only
Print/Type preparer's name: Preparer's signature: Date: 2020-11-14
Check if self-employed PTIN: P01469618
Firm's name: CLIFTONLARSONALLEN LLP Firm's EIN: 41-0746749
Firm's address: 10700 NORTHUP WAY SUITE 200 BELLEVUE, WA 98004 Phone no. (425) 250-6100

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:

TO PROVIDE THE HIGHEST QUALITY HEALTH CARE, DELIVERED IN THE MOST EFFICIENT AND COST-EFFECTIVE WAYS, AND ACCESSIBLE TO ALL MEMBERS OF THE COMMUNITY.

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

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

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

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

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

4a (Code:) (Expenses \$ 221,739,371 including grants of \$ 0) (Revenue \$ 318,586,942)
See Additional Data

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

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

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

4e Total program service expenses ▶ 221,739,371

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Yes/No response columns. Rows include questions 1 through 21, with sub-questions a through f for items 11 and 14.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question, Yes, No. Rows 22-38 covering various organizational requirements and schedules.

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 []

Table with 3 columns: Question, Yes, No. Rows 1a, 1b, 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

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

Main form area containing questions 2a through 16, including sub-questions like 2b, 3a, 3b, 4a, 4b, 5a, 5b, 5c, 6a, 6b, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 8, 9a, 9b, 10a, 10b, 11a, 11b, 12a, 12b, 13a, 13b, 13c, 14a, 14b, 15, and 16.

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

Table with 3 columns: Question, Yes, No. Rows include: 1a (13), 1b (10), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed
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.
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:

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) IMRAN ANDRABI MD PRESIDENT & CEO - SYSTEM	4.00 36.00	X		X				0 1,184,478	65,868	
(2) MARK THOMPSON SENIOR VP, CFO & COO - SYSTEM	4.00 36.00			X				0 681,900	62,765	
(3) GARY EDELMAN MD BOARD MEMBER / PHYSICIAN	1.00 39.00	X						0 493,876	61,247	
(4) NORMA TURK MD BOARD MEMBER / PHYSICIAN	1.00 39.00	X						0 434,487	50,790	
(5) JAMES ALBIN CIO	4.00 36.00			X				0 433,321	47,350	
(6) MAGGIE LUND CHRO	4.00 36.00			X				0 360,217	51,584	
(7) BRIAN STERNS FORMER KEY EMPLOYEE	4.00 36.00						X	0 189,442	57,247	
(8) TERRY TIMM CHAIR	1.00 2.00	X		X				0 0	0	
(9) JIM KOTEK VICE CHAIR & SECRETARY	1.00 2.00	X		X				0 0	0	
(10) TIM BERGSTROM BOARD MEMBER	1.00 3.00	X						0 0	0	
(11) PATRICK BRENNAN MD BOARD MEMBER	1.00 2.00	X						0 0	0	
(12) MARK BURSTEIN BOARD MEMBER	1.00 2.00	X						0 0	0	
(13) JOHN DAVIS BOARD MEMBER	1.00 2.00	X						0 0	0	
(14) DAVID KOEPER MD BOARD MEMBER	1.00 2.00	X						0 0	0	
(15) JIM MEYER BOARD MEMBER	1.00 3.00	X						0 0	0	
(16) KAREN TIMBERLAKE BOARD MEMBER	1.00 2.00	X						0 0	0	
(17) MARIA VAN LAANEN BOARD MEMBER	1.00 2.00	X						0 0	0	

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(18) CYRIL WALSH MD BOARD MEMBER (THROUGH AUG 2019)	1.00 2.00	X						0	0	0

1b Sub-Total			
c Total from continuation sheets to Part VII, Section A			
d Total (add lines 1b and 1c)		0	3,777,721
			396,851

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 ► 0

	Yes	No
3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>	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
MOSAIC FAMILY HEALTH 229 S MORRISON STREET APPLETON, WI 54911	MEDICAL SERVICES	3,558,335
TOTAL MSP LLC 10 E COLLEGE AVENUE SUITE 300 APPLETON, WI 54911	STAFFING SERVICES	2,114,717
DAILY CARE HOSPITALISTS LLC PO BOX 11934 GREEN BAY, WI 543071934	MEDICAL SERVICES	1,990,811
SPECIALTY CARE INC RESOURCES DEPT 1614 BIRMINGHAM, AL 352461614	MEDICAL SERVICES	888,960
CHILDREN'S HOSPITAL OF WISCONSIN PO BOX 1997 MILWAUKEE, WI 53226	MEDICAL SERVICES	834,642

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 ► 11

Part VIII Statement of Revenue

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

Table with 5 columns: (A) Total revenue, (B) Related or exempt function revenue, (C) Unrelated business revenue, (D) Revenue excluded from tax under sections 512 - 514. Rows include 1a-1g for Federated campaigns, membership dues, fundraising events, related organizations, government grants, and other contributions.

Table for Program Service Revenue with 5 columns: (A) Total revenue, (B) Related or exempt function revenue, (C) Unrelated business revenue, (D) Revenue excluded from tax under sections 512 - 514. Rows include 2a-2f for inpatient, outpatient, cafeteria, and other miscellaneous revenue.

Table for Other Revenue with 5 columns: (A) Total revenue, (B) Related or exempt function revenue, (C) Unrelated business revenue, (D) Revenue excluded from tax under sections 512 - 514. Rows include 3-12 for investment income, royalties, rental income, gain from sales of assets, fundraising events, gaming activities, and sales of inventory.

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				
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	323,766	254,411	69,355	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	48,998	48,998		
7 Other salaries and wages	72,494,671	61,118,015	11,376,656	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)				
9 Other employee benefits	16,515,090	13,132,040	3,383,050	
10 Payroll taxes				
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	31,348,240	18,227,932	13,120,308	
12 Advertising and promotion	18,251	18,251		
13 Office expenses	1,745,273	1,248,919	496,354	
14 Information technology				
15 Royalties				
16 Occupancy	3,817,333	3,817,333		
17 Travel	122,645	122,645		
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	159,421	159,421		
20 Interest	16,718	16,718		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	9,777,737	9,777,737		
23 Insurance	444,960	444,960		
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 CLIENT & PATIENT SERVIC	103,318,292	103,318,292		
b EQUIPMENT MAINTENANCE	5,076,511	5,076,511		
c BAD DEBT EXPENSE	4,957,188	4,957,188		
d				
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	250,185,094	221,739,371	28,445,723	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

Part X Balance 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		1	81,424,765
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	38,873,950	4	337,742,378
	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		7	
	8 Inventories for sale or use	4,011,603	8	4,011,603
	9 Prepaid expenses and deferred charges		9	1,058,681
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	284,147,348		
	b Less: accumulated depreciation	178,066,792	10b	106,080,556
	11 Investments—publicly traded securities		11	
	12 Investments—other securities. See Part IV, line 11		12	
	13 Investments—program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	403,601,843	15	88,392,059
16 Total assets. Add lines 1 through 15 (must equal line 34)	551,982,413	16	618,710,042	
Liabilities	17 Accounts payable and accrued expenses	101,049	17	9,741,576
	18 Grants payable		18	
	19 Deferred revenue		19	
	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	225,183
	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		25	
	26 Total liabilities. Add lines 17 through 25	101,049	26	9,966,759
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	551,881,364	27	608,743,283
	28 Net assets with donor restrictions		28	
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
32 Total net assets or fund balances	551,881,364	32	608,743,283	
33 Total liabilities and net assets/fund balances	551,982,413	33	618,710,042	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	320,108,478
2	Total expenses (must equal Part IX, column (A), line 25)	2	250,185,094
3	Revenue less expenses. Subtract line 2 from line 1	3	69,923,384
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	551,881,364
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	-13,061,465
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	608,743,283

Part XII Financial Statements and Reporting

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

- 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?
 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?
 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?
 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?
- 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.

	Yes	No
2a		No
2b	Yes	
2c	Yes	
3a		No
3b		

Additional Data

Software ID:

Software Version:

EIN: 39-0824015

Name: THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC

Form 990 (2019)

Form 990, Part III, Line 4a:

THEDACARE IS A TAX-EXEMPT, NON-PROFIT CORPORATION, AS DESCRIBED IN SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE. THEDACARE REGIONAL MEDICAL CENTER-APPLETON IS A 147-BED ACUTE CARE HOSPITAL, EMPLOYING MORE THAN 1,200 TEAM MEMBERS. THEDACARE REGIONAL MEDICAL CENTER-APPLETON OFFERS DIAGNOSTIC SERVICES SUCH AS X-RAY, ULTRASOUND, MRI, CAT SCAN, MAMMOGRAPHY AND MEDICAL LABORATORY TESTING, CANCER, CARDIOVASCULAR, ORTHOPEDIC, SPINE, NEUROLOGY, FAMILY BIRTH CARE, DIABETES, INTERNAL MEDICINE, EMERGENCY, OCCUPATIONAL HEALTH, PULMONOLOGY, WOMEN'S CARE, NEPHROLOGY, THERAPY SERVICES, OUTPATIENT SURGERY CENTERS AND WELLNESS PROGRAMS. THEDACARE REGIONAL MEDICAL CENTER-APPLETON HAS AN ACCREDITED CHEST PAIN AND RESUSCITATION CENTER ON CAMPUS. AS PART OF THE THEDACARE SYSTEM, WE OFFER PUBLIC AWARENESS CAMPAIGNS, CHARITY CARE, SUPPORT GROUPS AND EDUCATION PROGRAMS TARGETED TO LOCAL COMMUNITY NEEDS. THEDACARE IS COMMITTED TO COMMUNITY FOCUSED EFFORTS IDENTIFIED IN THE COMMUNITY NEEDS HEALTH ASSESSMENT IN COUNTIES (OUTAGAMIE) WHERE SERVICES ARE PROVIDED. EFFORTS INCLUDE PARTNERSHIPS WITH GOLD CROSS AMBULANCE SERVICE, CATALPA MENTAL HEALTH (MENTAL HEALTH AND WELLNESS FOR CHILDREN), MOSAIC (COMMUNITY PHYSICIAN TRAINING), UNITED WAY, THE WEIGHT OF THE FOX VALLEY (HEALTHY WEIGHT INITIATIVE) & PARTNERSHIP COMMUNITY HEALTH CENTER (AFFORDABLE MEDICAL, DENTAL AND BEHAVIORAL HEALTH SERVICES), STAR PROJECT (DIVERSITY), EARLY CHILDHOOD EDUCATION, VOICES OF MEN (SEXUAL ASSAULT AND DOMESTIC VIOLENCE) AND REACH OUT AND READ (CHILDHOOD LITERACY). ADDITIONALLY, THEDACARE PROVIDES SCHOLARSHIPS, CHARITY CARE, INTERPRETING AND EDUCATIONAL SERVICES AND VARIOUS OTHER COMMUNITY BENEFITS. THEDACARE OPERATES ON A NON-DISCRIMINATORY BASIS REGARDLESS OF RACE, COLOR, SEX, RELIGION, OR NATIONAL ORIGIN. THEDACARE PROVIDES A VARIETY OF FINANCIAL ASSISTANCE OPTIONS TO PATIENTS WHO MEET ESTABLISHED CRITERIA. SERVICES ARE ALSO PROVIDED TO BOTH MEDICARE AND MEDICAID PATIENTS AT SUBSTANTIAL DISCOUNTS FROM STANDARD FEES. HOSPITAL INPATIENT DAYS TOTALED 30,739 WITH 2,003 ADDITIONAL DAYS FOR NEWBORN CARE.

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
THEDACARE REGIONAL MEDICAL CENTER - APPLETON INC

Employer identification number
39-0824015

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

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). . .						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4. . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14	
15 Public support percentage for 2018 Schedule A, Part II, line 14	15	
16a 33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
b 33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
17a 10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
b 10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>		

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
c	Add lines 7a and 7b.						
8	Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9	Amounts from line 6.						
10a	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
b	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c	Add lines 10a and 10b.						
11	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests—2019. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization

b 33 1/3% support tests—2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 39-0824015

Name: THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC

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

Facts And Circumstances Test

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

2019
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 THEDACARE REGIONAL MEDICAL CENTER - APPLETON INC	Employer identification number 39-0824015
---	--

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) ▶ \$ _____

3 Volunteer hours for political campaign activities (see instructions)

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 ▶ \$ _____

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

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) 2016	(b) 2017	(c) 2018	(d) 2019	(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)		(b)
		Yes	No	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		10,860
j	Total. Add lines 1c through 1i			10,860
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 PORTION OF THE WHA DUES REPRESENT LOBBYING PERFORMED IN REGARD TO HEALTHCARE ISSUES. TOTAL DUES PAID IN 2019 WERE \$65,030. 16.7% OF THIS AMOUNT WAS SPENT ON LOBBYING.

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

OMB No. 1545-0047
2019
Open to Public Inspection

▶ 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.

Name of the organization
THEDACARE REGIONAL MEDICAL CENTER - APPLETON INC

Employer identification number
39-0824015

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

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

- 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? Yes No
- 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? Yes No

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

- 1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (e.g., recreation or education) Preservation of an historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space

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

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

- 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____
- 4 Number of states where property subject to conservation easement is located ▶ _____
- 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? Yes No
- 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____
- 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ _____
- 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? Yes No
- 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

- 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.
- b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:
- (i) Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____
- (ii) Assets included in Form 990, Part X ▶ \$ _____
- 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:
- a Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____
- b Assets included in Form 990, Part X ▶ \$ _____

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

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

Part IV Escrow and Custodial Arrangements.

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

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

Part V Endowment Funds.

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

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

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		3,569,238		3,569,238
b Buildings		163,576,731	90,151,696	73,425,035
c Leasehold improvements				
d Equipment		115,735,231	87,915,096	27,820,135
e Other		1,266,148		1,266,148
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				106,080,556

Part VII Investments—Other Securities.

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

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

Part VIII Investments—Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	88,392,059
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)	88,392,059

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.)	

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII

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

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

1	Total revenue, gains, and other support per audited financial statements		1	
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	
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Part XIII **Supplemental Information (continued)**

Return Reference	Explanation
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SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service

Hospitals

OMB No. 1545-0047
2019
 Open to Public Inspection

- ▶ 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.

Name of the organization
 THEDACARE REGIONAL MEDICAL CENTER - APPLETON INC

Employer identification number
 39-0824015

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	Yes	
1b If "Yes," was it a written policy?	Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>41000.0000000000</u> %	Yes	
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"?	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?		No
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	Yes	
b If "Yes," did the organization make it available to the public?	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)		1,388	1,159,607	1	1,159,606	0.470 %
b Medicaid (from Worksheet 3, column a)		18,587	23,596,297	16,093,931	7,502,366	3.060 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		19,975	24,755,904	16,093,932	8,661,972	3.530 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).	17	800,811	992,655		992,655	0.400 %
f Health professions education (from Worksheet 5)	3	37,162	423,696		423,696	0.170 %
g Subsidized health services (from Worksheet 6)	5	3	3,167,097		3,167,097	1.290 %
h Research (from Worksheet 7)	1	436	416,508	11,500	405,008	0.170 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	6	4,806,893	2,600,579		2,600,579	1.060 %
j Total. Other Benefits	32	5,645,305	7,600,535	11,500	7,589,035	3.090 %
k Total. Add lines 7d and 7j	32	5,665,280	32,356,439	16,105,432	16,251,007	6.620 %

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	1	91,682	25,557		25,557	0.010 %
3 Community support	1	1,395	53,639		53,639	0.020 %
4 Environmental improvements	1	29	52		52	0 %
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other	1	5,092	231,382		231,382	0.090 %
10 Total	4	98,198	310,630		310,630	0.120 %

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?		No
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.		
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.		
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	51,402,537
6 Enter Medicare allowable costs of care relating to payments on line 5	6	50,637,532
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	765,005
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

1

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

See Additional Data Table	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

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)
 THEDACARE REGIONAL MEDICAL CENTER - APPL

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ 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?		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.		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	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	Yes	
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	Yes	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE LINE 7D</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>SEE LINE 7D</u>	Yes	
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
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)

THEDACARE REGIONAL MEDICAL CENTER - APPL

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>410.000000000000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input checked="" type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input checked="" type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>HTTPS://WWW.THEDACARE.ORG/POLICIES-AND-LEGAL-FORMS/PAYMENT-OPTIONS</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>HTTPS://WWW.THEDACARE.ORG/POLICIES-AND-LEGAL-FORMS/PAYMENT-OPTIONS</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>HTTPS://WWW.THEDACARE.ORG/POLICIES-AND-LEGAL-FORMS/PAYMENT-OPTIONS</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

THEDACARE REGIONAL MEDICAL CENTER - APPL

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

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

THEDACARE REGIONAL MEDICAL CENTER - APPL

Name of hospital facility or letter of facility reporting group _____

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.
- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
 - b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - d** The hospital facility used a prospective Medicare or Medicaid method

23 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Section C.

24 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

If "Yes," explain in Section C.

	Yes	No
23		No
24		No

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? 1

Name and address	Type of Facility (describe)
1 1 - GROTH SURGERY CENTER 1818 N MEADE STREET APPLETON, WI 54911	OUTPATIENT SURGERY CENTER
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 3C:	IT IS THE ORGANIZATION'S POLICY THAT NO PATIENT SHOULD BE DENIED APPROPRIATE AND NECESSARY CARE ON THE BASIS OF INCOME. IN RESPONSE TO THIS POLICY, THE CARING HEARTS FINANCIAL ASSISTANCE PROGRAM WAS SET UP TO PROVIDE SHELTER TO THOSE PATIENTS WHO ARE UNABLE TO PAY FOR THEIR MEDICAL SERVICES. MEDICAL SERVICE FEES ARE WRITTEN OFF UNDER THE FINANCIAL ASSISTANCE PROGRAM THAT WOULD OTHERWISE HAVE BEEN SENT TO A COLLECTION AGENCY.
PART I, LINE 7:	THE COSTING METHODOLOGY USED TO CALCULATE THE AMOUNTS IN THE TABLE IS A COMBINATION OF AVERAGE COSTS AND ACTUAL COSTS PERTAINING TO SUPPLIES, WAGES, AND BENEFITS. FOR SUPPLIES, THE ACTUAL COST OF ITEMS USED FOR EACH EVENT IS APPLIED. IF NO ACTUAL COST IS AVAILABLE, WE THEN USE AN ESTIMATE. WAGES ARE CALCULATED BY MULTIPLYING THE AVERAGE WAGE RATE TIMES ACTUAL HOURS WORKED. THE BENEFIT RATE USED INCLUDES A FRINGE RATIO OF ALL BENEFITS RELATED TO THE ABOVE WAGE CALCULATION. THE COST ACCOUNTING SYSTEM DOES NOT DIFFERENTIATE BETWEEN DIFFERENT PAYER TYPES AND NO COST-TO-CHARGE RATIO IS USED.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G:	NO PHYSICIAN CLINICS ARE INCLUDED IN SUBSIDIZED HEALTH SERVICES.
PART I, LINE 7, COLUMN (F):	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$ 4,957,188.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>PART II, COMMUNITY BUILDING ACTIVITIES:</p>	<p>ECONOMIC DEVELOPMENT - THE PRIMARY AIM OF THE CHAMBER IS TO PROTECT THE INTEREST OF THE BUSINESS COMMUNITY AS A WHOLE. STRONG EMPLOYMENT IS A SOCIAL DETERMINANT OF HEALTH, REDUCING POVERTY AND PROVIDING INDIVIDUAL AND FAMILY SUSTAINABILITY. THEDACARE WORKS TOGETHER WITH LOCAL CHAMBERS OF COMMERCE IS IN ALL OF THE COMMUNITIES IT SERVES. COMMUNITY SUPPORT - CARING HEARTS IS A FINANCIAL ASSISTANCE PROGRAM DESIGNED FOR PATIENTS WHO ARE UNABLE TO PAY FOR MEDICALLY NECESSARY SERVICES PROVIDED BY ALL DIVISIONS WITHIN THEDACARE. THE CARING HEARTS PROGRAM COVERS SERVICES WHICH ARE DEEMED TO BE MEDICALLY NECESSARY AS DETERMINED BY THEIR PHYSICIAN. THIS COST IS FOR TIME AND EXPENSE NEEDED TO SUPPORT CARING HEARTS.THE CARING HEARTS FINANCIAL ASSISTANCE PROGRAM IS IN EFFECT AT ALL THEDACARE FACILITIES - THEDACARE REGIONAL MEDICAL CENTERS IN APPLETON AND NEENAH, THEDACARE MEDICAL CENTER- BERLIN, THEDACARE MEDICAL CENTER-NEW LONDON, THEDACARE MEDICAL CENTER-SHAWANO, THEDACARE MEDICAL CENTER-WAUPACA AND THEDACARE MEDICAL CENTER-WILD ROSE.ENVIRONMENTAL IMPROVEMENTS - SHARPS COLLECTION. COMMUNITY SHARPS CAN BE TAKEN FOR COLLECTION AND DISPOSAL TO ANY OF THE 7 THEDACARE HOSPITALS.COMMUNITY SHARPS CAN BE DISPOSED OF AT THEDACARE REGIONAL MEDICAL CENTER-APPLETON AND NEENAH, THEDACARE MEDICAL CENTER-BERLIN, THEDACARE MEDICAL CENTER-NEW LONDON, THEDACARE MEDICAL CENTER-SHAWANO, THEDACARE MEDICAL CENTER-WAUPACA AND THEDACARE MEDICAL CENTER WILD ROSE.COMMUNITY OTHER: SART/SANE - THE SEXUAL ASSAULT RESPONSE TEAM WORKS WITH LOCAL LAW ENFORCEMENT, DOMESTIC ABUSE AGENCIES, SEXUAL ASSAULT AGENCIES, MENTAL HEALTH FACILITIES, LOCAL MEDICAL PROVIDERS TO IMPROVE IMMEDIATE RESPONSE TO VICTIMS OF SEXUAL ASSAULT. SART/SANE PROGRAMMING IS BASED AT THEDACARE REGIONAL MEDICAL CENTER-APPLETON AND SERVES THEDACARE REGIONAL MEDICAL CENTER-NEENAH, THEDACARE MEDICAL CENTER-BERLIN, THEDACARE MEDICAL CENTER-NEW LONDON, THEDACARE MEDICARE CENTER-SHAWANO, THEDACARE MEDICAL CENTER-WAUPACA AND THEDACARE MEDICAL CENTER-WILD ROSE.</p>
<p>PART III, LINE 2:</p>	<p>PATIENT ACCOUNTS RECEIVABLE ARE UNCOLLATERALIZED PATIENT OBLIGATIONS THAT ARE STATED AT THE AMOUNT THAT REFLECTS THE CONSIDERATION TO WHICH THEDACARE EXPECTS TO BE ENTITLED IN EXCHANGE FOR PROVIDING PATIENT CARE. THESE OBLIGATIONS ARE PRIMARILY FROM LOCAL RESIDENTS, MOST OF WHOM ARE INSURED UNDER THIRD-PARTY PAYOR AGREEMENTS. THEDACARE BILLS THIRD-PARTY PAYORS ON THE PATIENTS' BEHALF, OR IF A PATIENT IS UNINSURED, THE PATIENT IS BILLED DIRECTLY. ONCE CLAIMS ARE SETTLED WITH THE PRIMARY PAYOR, ANY SECONDARY INSURANCE IS BILLED, AND PATIENTS ARE BILLED FOR COPAY AND DEDUCTIBLE AMOUNTS THAT ARE THE PATIENTS' RESPONSIBILITY. PAYMENTS ON ACCOUNTS RECEIVABLE ARE APPLIED TO THE SPECIFIC CLAIM IDENTIFIED ON THE REMITTANCE ADVICE OR STATEMENTS. THEDACARE DOES NOT HAVE A POLICY TO CHARGE INTEREST ON PAST DUE ACCOUNTS.PATIENT ACCOUNTS RECEIVABLE ARE RECORDED AT NET REALIZABLE VALUE BASED ON CERTAIN ASSUMPTIONS. FOR THIRD-PARTY PAYORS, INCLUDING MEDICARE, MEDICAID, MANAGED CARE AND COMMERCIAL PAYORS, THE NET REALIZABLE VALUE IS BASED ON THE ESTIMATED CONTRACTUAL REIMBURSEMENT PERCENTAGE, WHICH IS BASED ON CURRENT CONTRACT PRICES OR HISTORICAL PAID CLAIMS DATA BY PAYOR. FOR UNINSURED PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR A PORTION OF THE BILL), THE NET REALIZABLE VALUE IS DETERMINED USING ESTIMATES OF HISTORICAL COLLECTION EXPERIENCE. THESE ESTIMATES ARE ADJUSTED FOR EXPECTED RECOVERIES AND ANY ANTICIPATED CHANGES IN TRENDS, INCLUDING SIGNIFICANT CHANGES IN PAYOR MIX, ECONOMIC CONDITIONS OR TRENDS IN FEDERAL AND STATE GOVERNMENTAL HEALTH CARE COVERAGE.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3:	THE HOSPITAL IS REPORTING \$0 BECAUSE IT DOES NOT HAVE A METHOD OF REASONABLY ESTIMATING THE PORTION OF ITS BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS WHO WOULD QUALIFY FOR FINANCIAL ASSISTANCE BUT WHO DID NOT COMPLETE A FINANCIAL ASSISTANCE APPLICATION.
PART III, LINE 4:	SEE "PATIENT ACCOUNTS RECEIVABLE AND CREDIT POLICY" OF NOTE 1 ON PAGES 10-11 IN THE ATTACHED FINANCIAL STATEMENTS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8:	HOSPITALS MUST ACCEPT MEDICARE PATIENTS REGARDLESS OF WHETHER THEY MAKE A SURPLUS OR DEFICIT FROM PROVIDING SERVICES TO THOSE PATIENTS. WE DID NOT REPORT ANY SHORTFALL AS A COMMUNITY BENEFIT. THE COSTING METHODOLOGY USED TO DETERMINE THE MEDICARE ALLOWABLE COSTS REPORTED IN THE ORGANIZATION'S MEDICARE COST REPORT IS STEP DOWN.
PART III, LINE 9B:	OUR POLICY IS NOT TO PURSUE PATIENT ACCOUNTS TO THE EXTENT ANY CHARGES ARE ELIGIBLE AND WRITTEN OFF THROUGH OUR CHARITY CARE/FINANCIAL ASISTANCE PROGRAM. IF ONLY A PORTION OF THE CHARGES ARE ELIGIBLE AND WRITTEN OFF THROUGH OUR CHARITY CARE/FINANCIAL ASISSTANCE PROGRAM, THE REMAINING BALANCE WILL BE BILLED TO THE PATIENT AND COLLECTED IN ACCORDANCE WITH OUR NORMAL COLLECTION POLICY.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2:	THEDACARE COVERS A 9 COUNTY PRIMARY SERVICE AREA SERVED BY 7 HOSPITALS. THEDACARE CONDUCTS A COMMUNITY NEEDS ASSESSMENT EVERY THREE YEARS FOR EACH HOSPITAL GATHERING DATA PERTINENT TO THAT COMMUNITY AND THE SURROUNDING AREAS. INFORMATION COLLECTED INCLUDES DATA FROM THE WISCONSIN COUNTY HEALTH RANKINGS, FOX CITIES LIFE STUDY (LOCAL INDICATORS FOR EXCELLENCE), THE BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY, INSIGHTS FROM INTERVIEWS OF PUBLIC HEALTH OFFICIALS, INSIGHTS FROM INTERVIEWS WITH REPRESENTATIVES OF VULNERABLE POPULATIONS, EMERGENCY DEPARTMENT PATIENT DATA AND INSIGHTS GATHERED FROM MONTHLY MEETINGS OF THE THEDACARE-LED CHAT TEAM (COMMUNITY HEALTH ACTION TEAM) COMPRISED OF COMMUNITY LEADERS IN BUSINESS, NON-PROFIT, CLERGY, EDUCATION, DIVERSE POPULATION GROUPS, HEALTHCARE, UNITED WAY, PUBLIC HEALTH AND THE LOCAL COMMUNITY FOUNDATIONS.
PART VI, LINE 3:	PATIENT EDUCATION BEGINS WHEN A PATIENT IS ADMITTED TO A THEDACARE HOSPITAL. ADMISSION SPECIALISTS MEET WITH EACH PERSON INDIVIDUALLY TO ASSESS INSURANCE STATUS AND FINANCIAL NEED. IF NECESSARY, SPECIALISTS REFER PATIENTS TO CARE MANAGEMENT SPECIALISTS WHO ASSIST WITH THE ENROLLMENT OF PATIENTS IN AN APPLICABLE PROGRAM. THE HOSPITAL PATIENT HANDBOOK IS PROVIDED TO ALL IN-PATIENTS. INTERNAL POLICIES SUCH AS DISCOUNTED SERVICES POLICY, CARING HEARTS POLICY AND PAYMENT FOR SERVICE POLICY FOR SELF-PAY BALANCES PROVIDE GUIDANCE. THE THEDACARE WEBSITE, WWW.THEDACARE.ORG , PROVIDES EDUCATION REGARDING THE AFFORDABLE CARE ACT IN EASY TO UNDERSTAND LANGUAGE. IT DISCUSSES OPTIONS AND WHERE TO GO FOR ASSISTANCE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4:	<p>THEDACARE REGIONAL MEDICAL CENTER-APPLETON SERVICE AREA CONSISTS OF OUTAGAMIE AND CALUMET COUNTIES AND IS LOCATED IN EAST-CENTRAL WISCONSIN. THE TWO-COUNTY AREA HOSTS A POPULATION OF OVER 225,000 COMBINED WITH CONCENTRATION IN THE FOX CITIES URBAN AREA. OUTAGAMIE COUNTY:- THE PERCENTAGE OF RESIDENTS LIVING BELOW THE FEDERAL POVERTY LEVEL IS 9%.- ACCORDING TO UNITED WAY 30% OF OUTAGAMIE HOUSEHOLDS LIVE BELOW THE ASSETS LIMITED, INCOME CONSTRAINED, EMPLOYED, (ALICE) AND POVERTY THRESHOLDS. ALICE REPRESENTS INDIVIDUALS AND FAMILIES WHO ARE WORKING BUT UNABLE TO AFFORD THE BASIC NECESSITIES OF HOUSING, FOOD, CHILDCARE, HEALTHCARE AND TRANSPORTATION. THIS IS BELOW THE STATE AVERAGE OF 37.5%.- THE PERCENTAGE OF CHILDREN ELIGIBLE FOR FREE AND REDUCED LUNCH IN OUTAGAMIE COUNTY IS 31%, BELOW THE STATE AVERAGE OF 40%.- IN OUTAGAMIE COUNTY 8% OF THE CHILDREN LIVE BELOW 100% OF THE FEDERAL POVERTY LEVEL.- OUTAGAMIE COUNTY HAS % OF RESIDENTS WHO ARE UNINSURED.- OUTAGAMIE COUNTY HIGH SCHOOL GRADUATION RATE IS 91%.- IN COMPARISON TO MORE RURAL COUNTIES IN THE THEDACARE SERVICE AREA, OUTAGAMIE AND CALUMET COUNTIES CONTINUE TO HAVE A HIGHER PERCENTAGE OF CHILDREN.- THE PERCENTAGE OF NON-CAUCASIAN POPULATION HAS GROWN FROM 9.3% TO 10.7%. EIGHTY NINE PERCENT OF THE SERVICE AREA IS CAUCASIAN WITH HISPANIC POPULATION OF 4.2%. THE LARGEST MINORITY POPULATIONS ARE LATINO (4.2%) AND ASIAN (3.4%). NATIVE AMERICANS ACCOUNT FOR APPROXIMATELY 1.9% OF THE POPULATION AND AFRICAN-AMERICANS REPRESENT 1.2%. CALUMET COUNTY:- THE PERCENTAGE OF RESIDENTS LIVING BELOW THE FEDERAL POVERTY LEVEL IS 6%.- ACCORDING TO UNITED WAY 29% OF CALUMET COUNTY HOUSEHOLDS LIVE BELOW THE ASSETS LIMITED, INCOME CONSTRAINED, EMPLOYED, (ALICE) AND POVERTY THRESHOLDS. ALICE REPRESENTS INDIVIDUALS AND FAMILIES WHO ARE WORKING BUT UNABLE TO AFFORD THE BASIC NECESSITIES OF HOUSING, FOOD, CHILDCARE, HEALTHCARE AND TRANSPORTATION. THIS IS BELOW THE STATE AVERAGE OF 37.5%.- THE PERCENTAGE OF CHILDREN ELIGIBLE FOR FREE AND REDUCED LUNCH IN CALUMET COUNTY IS 30%, BELOW THE STATE AVERAGE OF 30%.- IN CALUMET COUNTY 6% OF THE CHILDREN LIVE BELOW 100% OF THE FEDERAL POVERTY LEVEL.- CALUMET COUNTY HAS 4% OF RESIDENTS WHO ARE UNINSURED.- CALUMET COUNTY HIGH SCHOOL GRADUATION RATE IS 96%.- IN COMPARISON TO MORE RURAL COUNTIES IN THE THEDACARE SERVICE AREA, OUTAGAMIE AND CALUMET COUNTIES CONTINUE TO HAVE A HIGHER PERCENTAGE OF CHILDREN.- THE PERCENTAGE OF NON-CAUCASIAN POPULATION HAS GROWN FROM 9.3% TO 10.7%. NINETY ONE PERCENT OF THE SERVICE AREA IS CAUCASIAN WITH HISPANIC POPULATION OF 4.2%. THE LARGEST MINORITY POPULATIONS ARE LATINO (4.2%) AND ASIAN (2.4%). NATIVE AMERICANS ACCOUNT FOR APPROXIMATELY 0.5% OF THE POPULATION AND AFRICAN-AMERICANS REPRESENT 0.6%.</p>
PART VI, LINE 5:	<p>EACH YEAR THEDACARE SETS ASIDE A PERCENTAGE OF ANY MARGIN AND DESIGNATES THESE FUNDS TO SUPPORT EFFORTS AND INITIATIVES COMING FROM CHAT (COMMUNITY HEALTH ACTION TEAM). CHAT IS A GROUP OF COMMUNITY LEADERS WHO STUDY SYSTEMIC HEALTH ISSUES OUTSIDE THE WALLS OF OUR HOSPITALS AND CLINICS AND WORK TO IDENTIFY INNOVATIVE, COLLABORATIVE SOLUTIONS THAT DRAW UPON THE WIDE ARRAY OF RESOURCES AND STRENGTHS OF OUR COMMUNITY. THERE ARE THEDACARE LED CHAT'S IN EACH HOSPITAL AREA WILD ROSE, WAUPACA, FOX CITIES, SHAWANO, BERLIN AND NEW LONDON. THEDACARE PROVIDES FUNDING AND DEDICATED STAFF TO MAKE CHAT COMMUNITY HEALTH EFFORTS POSSIBLE.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6:	THEDACARE, THE PARENT ORGANIZATION, PROVIDES DIRECTION RELATED TO COMMUNITY HEALTH NEEDS ASSESSMENT FOR EACH HOSPITAL AND SURROUNDING COMMUNITIES WITHIN ITS SERVICE AREA. PLANS ARE APPROVED BY LOCAL HOSPITAL BOARDS. EACH THEDACARE HOSPITAL, ALONG WITH CHI STAFF AND COMMUNITY MEMBERS DETERMINE HOW BEST TO MEET LOCAL NEEDS. IMPLEMENTATION OF COMMUNITY PROGRAMMING OCCURS AT THE LOCAL LEVEL.
PART VI, LINE 7, REPORTS FILED WITH STATES	WI

Additional Data**Software ID:****Software Version:****EIN:** 39-0824015**Name:** THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	THEDACARE REGIONAL MEDICAL CENTER - APPLETON PO BOX 8025 APPLETON, WI 54912 WWW.THEDACARE.ORG 169	X	X					X			

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

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

Form and Line Reference	Explanation
THEDACARE REGIONAL MEDICAL CENTER - APPLETON	PART V, SECTION B, LINE 5: AS PART OF THE NEEDS ASSESSMENT ADVISORY TEAM, THEDACARE CONSULTED WITH THE PUBLIC HEALTH DEPARTMENTS OF OUTAGAMIE COUNTY, WINNEBAGO COUNTY, CALUMET COUNTY, SHAWANO, GREEN LAKE, MARQUETTE, WAUSHARA, WAUPACA AND THE CITY OF APPLETON IN ADDITION, OVER THE COURSE OF A ONE YEAR PERIOD, SECONDARY DATA WAS COLLECTED, KEY INFORMANT INTERVIEWS WERE CONDUCTED, THEDACARE CHAT TEAMS (COMMUNITY HEALTH ACTION TEAM) PROVIDED INPUT AND PATIENT HEALTH DATA WAS STUDIED. VULNERABLE POPULATIONS INCLUDED LOW INCOME, RURAL FARM FAMILIES, OLDER ADULTS, VETERANS, HISPANIC/LATINO POPULATION, LESBIAN, GAY, BISEXUAL, TRANSGENDER (LGBT), HMONG POPULATION AND AFRICAN AMERICAN POPULATION.

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
THEDACARE REGIONAL MEDICAL CENTER - APPLETON	PART V, SECTION B, LINE 6A: THEDACARE REGIONAL MEDICAL CENTER-APPLETON IS A MEMBER OF THE FOX VALLEY COMMUNITY HEALTH IMPROVEMENT COALITION WHOSE MEMBERS INCLUDE THE PUBLIC HEALTH DEPARTMENTS OF CALUMET, OUTAGAMIE AND WINNEBAGO COUNTIES AND THE HEALTH DEPARTMENTS OF THE CITY OF APPLETON AND CITY OF MENASHA. MEMBERSHIP ALSO INCLUDES REPRESENTATIVES FROM CHILDREN'S HOSPITAL OF WISCONSIN, PARTNERSHIP COMMUNITY HEALTH CENTER (FQHC), AURORA HEALTH IN OSHKOSH AND AFFINITY HEALTH IN APPLETON. THIS COALITION WAS PART OF A JOINT CHNA PROCESS DURING 2019.

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
THEDACARE REGIONAL MEDICAL CENTER - APPLETON	PART V, SECTION B, LINE 7D: THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT AND IMPLEMENTATION STRATEGY ARE AVAILABLE ONLINE AT: HTTPS://WWW.THEDACARE.ORG/HOSPITALS-AND-CLINICS/THEDACARE-REGIONAL-MEDICAL-CENTER-APPLETON.ASPX .

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
<p>THEDACARE REGIONAL MEDICAL CENTER - APPLETON</p>	<p>PART V, SECTION B, LINE 11: THE THEDACARE COMMUNITY HEALTH IMPLEMENTATION STRATEGY WAS APPROVED BY THE THEDACARE BOARD OF TRUSTEES IN 2020. OBESITY, OVERWEIGHT AND OBESITY ARE DRIVERS OF PREVENTABLE CHRONIC DISEASE AND REDUCED QUALITY AND LENGTH OF LIFE. IT WAS RANKED AMONG THE TOP 3 HEALTH PRIORITIES IN BOTH THE 2016 AND 2019 CHNAs. 1. ALONG WITH UNITED WAY, CHAMPIONED TRANSFORMATION OF "WEIGHT OF THE FOX VALLEY" INTO MORE ROBUST "LIVWELL FOX VALLEY" MODEL. RECEIVED COMMITMENT FROM 5 HEALTH SYSTEMS. 2. ORGANIZATIONS OFFERING OBESITY-RELATED WORKSITE WELLNESS PROGRAMS INCREASED BY 233. EIGHT EARLY CARE & EDUCATION PROGRAMS ADDED STRATEGIES FOR SERVING WILLOW GROWN FRUITS AND VEGETABLES. 4. BREASTFEEDING FRIENDLY DESIGNATIONS REGARDING EARLY CARE & EDUCATION PROGRAMS AND WORKSITES INCREASED BY EIGHT. 5. THREE MUNICIPALITIES ADDED STREET POLICIES. 6. WAYFINDING SIGNAGE ON BICYCLE AND PEDESTRIAN TRAILS INCREASED BY 257. LIFESTYLE INTERVENTION PROGRAM ENROLLED 172 PEOPLE SINCE 2017 WITH AVERAGE WEIGHT LOSS OF 22 POUNDS. 8. HAT SCORE IMPROVEMENT OF 15 POINTS, REDUCTION OF PREDIABETES AMONG 53%, AND 44% REDUCTION IN METABOLIC SYNDROME. ENHANCING PROCESS TO ALLOW PROVIDERS TO MORE READILY REFER PEOPLE TO THE PROGRAM. 9. THE CORONARY HEALTH IMPROVEMENT PROGRAM ENROLLED 308 PEOPLE SINCE 2017 WITH AN AVERAGE DROP IN BMI OF 5% AND 20% DROP IN LIPIDS. 10. ATTAINED PRELIMINARY STATUS AS DIABETES PREVENTION PROGRAM PROVIDER BY CDC - THROUGHOUT THE APPLICATION PHASE OF 2017-2019 ENROLLED 159 PEOPLE - ON AVERAGE PARTICIPANTS REDUCED RISK OF DEVELOPING DIABETES BY 58%. FARMERS MARKETS - IN 2019, PROVIDED MAJOR SPONSORSHIP AND SUPPORT TO THE DOWNTOWN APPLETON FARMER'S MARKET. THE MARKET PROMOTES PURCHASING AND PREPARING HEALTHY FOODS. MENTAL HEALTH/AODATHE STATE OF MENTAL HEALTH, ACCESS TO MENTAL HEALTH SERVICES AND DRUG ABUSE, IN PARTICULAR OPIOID ADDICTION, WERE NAMED AMONG TOP 3 HEALTH PROBLEMS ACROSS ALL MARKETS IN BOTH THE 2016 AND 2019 CHNAs. 1. CATALPA HEALTH: IN 2019, THEDACARE PROVIDED IN-KIND LEADERSHIP AND FINANCIAL SUPPORT TO CATALPA HEALTH - CHILDREN'S MENTAL HEALTH PROVIDER WHICH PROVIDES MENTAL HEALTH SERVICES TO CHILDREN THROUGHOUT NORTHEAST WISCONSIN. 2. NEW MH CONNECTION IS A COALITION OF 70+ MENTAL HEALTH AGENCIES TO ADDRESS ACCESS TO MENTAL HEALTH CARE - TC CHAIRS BOARD OF NEW MH CONNECTION AND PROVIDES IN-KIND OFFICE SPACE AT TCBH ETC. CONTRIBUTES \$15,000 FUNDING ANNUALLY. - MYCONNECTIONNEW.ORG, SERVICE NAVIGATION SITE FOR ALL MENTAL HEALTH AND SUBSTANCE ABUSE PROVIDERS IN OUTAGAMIE, CALUMET, WINNEBAGO AND NOW BROWN COUNTY IN PARTNERSHIP WITH UNITED WAY'S 2-1-1 - IN 2019, THERE WERE 143,000 PAGE VIEWS. 1400 (673 IN 2018) PEOPLE COMPLETED ONLINE SCREENING FOR DEPRESSION OR OTHER MENTAL HEALTH CONDITIONS. - TOP VIEWED PAGES: MENTAL HEALTH SERVICE DIRECTORY, EMERGENCY SERVICES PAGE, LIBRARY, CALENDAR; TOP LIBRARY SEARCHES: DEPRESSION, ANXIETY, OPIOID ADDICTION, ANOREXIA, EARLY SOCIAL EMOTIONAL DEVELOPMENT. 3. FQHC SUPPORT: PROVIDED LEADERSHIP AND FUNDING FOR THE PARTNERSHIP</p>

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

Form and Line Reference	Explanation
<p>THEDACARE REGIONAL MEDICAL CENTER - APPLETON</p>	<p>IP COMMUNITY HEALTH CENTER WORKING TO IMPROVE THE HEALTH STATUS OF THE MEDICALLY UNDERSERVED BY PROVIDING COMPREHENSIVE PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES.4. PROVIDED \$190,000 IN SUBSIDIZED MENTAL HEALTH SERVICES.5. IN THE FALL OF 2019, THEDACARE SPONSORED PARTY AT THE PAC FOR THOUSANDS OF AREA YOUTH TO EDUCATE ON THE PERILS OF RISKY BEHAVIOR WHILE TEXTING/DRINKING AND DRIVING.6. OPIOID ABUSE PREVENTION: - MAT EXPANSION - MAT USE OF VIVITROL PILOTED IN WAUPACA AND EXPANDED TO SHAWANO AND APPLETON NORTH - DRUG TAKE BACK BOXES WERE PLACED IN 6 HOSPITALS THROUGHOUT SYSTEM - COMMUNITY AWARENESS CAMPAIGN.7. SEVENTEEN URBAN AND 6 RURAL SCHOOLS INITIATED SOURCES OF STRENGTH" HIGH SCHOOL PROGRAM, A SCHOOL-BASED RESILIENCY PROGRAM. THEDACARE COMMITTED \$300,000 OVER 3 YEARS TO IMPLEMENT THE SCHOOL-BASED PROGRAM.8. FOX CITIES AND WILD ROSE CHAT TEAMS HOSTED ADDICTION PLUNGE AUGUST 2019. MORE THAN 100 COMMUNITY LEADERS PARTICIPATED RESULTING IN NEW EFFORTS TO DEVELOP RECOVERY COACHING CAPACITY, EXPLORE A SUBSTANCE USE COALITION, EXPAND SOBER LIVING OPTIONS, AND IMPROVE ACCESS. THE FC CHAT TEAM APPROVED \$3000 TOWARD FACILITATION OF SUBSTANCE USE COALITION DEVELOPMENT.9. PROVIDED \$5000 IN FINANCIAL SUPPORT OF STUDY REGARDING TEEN SUICIDE-RELATED BEHAVIORS IN PARTNERSHIP WITH MEDICAL COLLEGE OF WISCONSIN/NEW MENTAL HEALTH CONNECTION.10. BEHAVIORAL HEALTH OPERATIONS: INITIATED PRIMARY CARE CONSULT. DR. PANZER AND DR. BELDO IN INITIAL REVIEW OF ALL REFERRALS AND IF URGENT, GET THEM INTO EXPEDITED CARE (PSYCH, MH OR AODA). OTHERWISE, CONSULT WITH PC. HELPS PCP MANAGE PATIENTS IF ON WAIT LIST. WAIT LIST FOR PSYCHIATRIC NEEDS DROPPED FROM 600+ TO 0.11. INITIATED NPPP (NORTH PRIMARY CARE PSYCHIATRIC PARTNERSHIP) PROVIDER INTEGRATED IN PCP CLINIC. SEES PATIENTS ON WAIT LIST UP TO 4 TIMES. REFERS TO PSYCHIATRIST FOR INITIAL TRIAGE AND IF URGENT GETS THEM INTO PSYCH, MH OR AODA CARE RIGHT AWAY. EXPANDING TO NEENAH AND TRAINING ANOTHER PROVIDER. SHAWANO PSYCHIATRIST EMBEDDED IN PCP CLINIC.12. INPATIENT PSYCH WENT TO 7 DAYS ON/7 OFF FOR HOSPITALIST. FREES UP OUTPATIENT PSYCH TIME.13. DEPRESSION SCREENING: DEPRESSION SCREENING IS TAKING PLACE IN 100% OF TC PEDIATRIC CLINICS AND FP CLINICS FOR PEOPLE AGE 12+.14. CONDUCTING COLUMBIA SCREENING AT EVERY MENTAL HEALTH INITIAL APPOINTMENT.15. CONDUCTING PHQ9 AT EVERY AODA INITIAL APPOINTMENT. EARLY CHILDHOOD/FAMILY SUPPORT THE WELL-BEING OF YOUNG CHILDREN WAS IDENTIFIED AS ONE OF TOP HEALTH CONCERNS IN 2016 AND 2019 CHNAs. IMPROVING EARLY CHILDHOOD ADDRESSES ROOT CAUSE OF MULTIPLE LONG-TERM PHYSICAL AND MENTAL HEALTH ISSUES.1. THEDACARE COMMITTED TO PROVIDING EVIDENCE-BASED REACH OUT AND READ EARLY CHILDHOOD READING PROGRAM IN ALL CLINICS BY 2019. - IN 2019, 23 OF 25 CLINICS WERE FULLY IMPLEMENTED AND TRAINED IN REACH OUT AND READ - 7,516 BOOKS WERE PROVIDED.2. IMPROVED BIRTH CENTER ASSESSMENT AND REFERRAL PROCESSES TO HOME VISITATION PROGRAMS - NUMBER OF HOSPITALS WITH HOME VISITATION REFERRAL INCREASED TO 4 FROM 2 - NUMBER OF ANNU</p>

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

Form and Line Reference	Explanation
<p>THEDACARE REGIONAL MEDICAL CENTER - APPLETON</p>	<p>AL HOME VISITATION ASSESSMENTS WERE 317 FROM 453. 2019 MAKE A DIFFERENCE DAY "MYSTERY BUSE S" ENGAGED 300 TC AND PARTNER BUSINESS EMPLOYEES VOLUNTEERING AT 10 NON-PROFIT LOCATIONS A CROSS ALL HOSPITAL MARKETS FOCUSED ON EARLY CHILDHOOD AND YOUTH.4. HOSTED 25 MATCHES THROU GH BACKYARD BUDDIES, MENTORING PARTNERSHIP WITH TCRMC NEENAH, CHILDREN'S HOSPITAL FOX VALL EY, ROOSEVELT SCHOOL AND BEST FRIENDS5. 2017 FOX CITIES CHAT PLUNGE ON EARLY CHILDHOOD PRO MPTED EFFORT TO IMPROVE ASQ SCREENING PROCESS/RATE; PILOTED ASQ SCREENING PROCESS WITH WIN NEBAGO COUNTY AND OSHKOSH TC CLINICHEALTH DISPARITIES1. THEDACARE IS A PARTNER WITH THE PO VERTY OUTCOMES & IMPROVEMENT TEAM (POINT), AN 18 MONTH INITIATIVE EQUIPPING THE ENTIRE FOX VALLEY REGION WITH CONTINUOUS IMPROVEMENT METHODOLOGIES FOCUSED ON POVERTY. POINT IS USIN G THESE PROCESSES TO STRENGTHEN EXISTING POVERTY REDUCTION EFFORTS, ADDRESS SERVICE GAPS, AND MEASURE PROGRESS ON REDUCING POVERTY IN NORTHEAST WISCONSIN. TC CONTRIBUTED \$200,000 P LUS PRESENCE ON THE LEADERSHIP TEAM. POINT COLLABORATED WITH BOSTON-BASED INSTITUTE FOR HE ALTHCARE IMPROVEMENT TO USE LEAN PROCESSES AND TOOLS TO HELP NON-PROFIT AGENCIES HELP PEOP LE BECOME SELF-SUFFICIENT. MORE THAN 40 NON-PROFIT AGENCIES ARE PARTICIPATING.2. OPPORTUNI TY GAP/STAR PROGRAM FOLLOWING "BEING BLACK IN FOX CITIES" PLUNGE OCT 2015, TC LED PROCESS WITH AFRICAN HERITAGE, INC., APPLETON/MENASHA SCHOOL DISTRICTS, BOYS & GIRLS CLUB, UNITED WAY, FOUR AREA COLLEGES AND OTHERS TO DEVELOP STAR PROGRAM (SCHOLARS ON TARGET TO ACHIEVE RESULTS) TO HELP REDUCE GRADUATION GAP BETWEEN BLACK AND WHITE STUDENTS. CHAT FUNDED \$30,0 00 PROGRAM DIRECTOR START-UP PERIOD WITH \$50,000 PER YEAR FOR THREE YEARS FOR PROGRAM OPER ATIONS. IN 2018-19 SCHOOL YEAR, 340 YOUTH WERE SERVED. CURRENT ENROLLMENT IS 450 STUDENTS. 3. RURAL HEALTH INITIATIVE ACCESS TO HEALTHCARE FOR RURAL FARM FAMILIES. - THEDACARE IS A MAJOR SUPPORTER OF THE RURAL HEALTH INITIATIVE WHICH TAKES HEALTHCARE SERVICES TO THE FARM REACHING A SIGNIFICANT VULNERABLE POPULATION OF LOW-INCOME FARMERS AND MIGRANT WORKERS, M ANY OF WHOM ARE UNINSURED. AS OF 10/21/2019, RHI HAS SERVED 190 FAMILIES. 116 REFERRALS WE RE MADE TO HEALTH CARE PROVIDERS. THESE NUMBERS ARE DECREASING AS FARMS DECREASE DUE TO TH E ECONOMY.GENERAL1. THEDACARE PARTNERS WITH ASCENSION HEALTH SYSTEM TO SPONSOR FOX VALLEY FAMILY RESIDENCY PROGRAM PROVIDING HANDS ON EXPERIENCE FOR MEDICAL STUDENTS AND ACCESS TO PRIMARY CARE AND MENTAL HEALTH SERVICES2. THEDACARE ALSO PARTNERS WITH AREA NURSING SCHOOL S SUCH AS UW OSHKOSH AND FOX VALLEY TECHNICAL COLLEGE TO PROVIDE PROFESSIONAL MENTORS FOR THEIR NURSING PROGRAMS AND VENUES FOR NURSING STUDENTS TO PRACTICE THEIR SKILLS3. THEDACAR E HOSPITALS PROVIDE FINANCIAL AS WELL AS DIAGNOSTIC AND LAB SUPPORT TO A PARTNERSHIP COMMU NITY HEALTH CENTER (FQHC) PROVIDING MEDICAL, BEHAVIORAL AND DENTAL CARE TO THE UNDERSERVED</p>

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

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

Form and Line Reference	Explanation
THEDACARE REGIONAL MEDICAL CENTER - APPLETON	PART V, SECTION B, LINE 13H: PATIENTS ARE SENT AN OVERVIEW LETTER EXPLAINING THE PROCESS FOR APPLYING FOR OUR ASSISTANCE PROGRAM OR OUR STAFF WALKS THEM THROUGH THE PROCESS. THEY ARE ASKED TO COMPLETE AN APPLICATION THAT INCLUDES REQUESTS FOR INFORMATION. THIS INFORMATION IS NEEDED IN ORDER TO MAKE A DECISION AS TO WHETHER THE PATIENT MEETS THE CRITERIA FOR ACCEPTANCE, AND IF ACCEPTED, WHAT LEVEL OF ASSISTANCE WILL BE PROVIDED. ONCE THE DECISION IS MADE, WE WILL NOTIFY THE PATIENT AND IF ACCEPTABLE, WRITE OFF THE BALANCE AS DETERMINED.

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
THEDACARE REGIONAL MEDICAL CENTER - APPLETON	PART V, SECTION B, LINE 15E: CONTRACTED WITH ELIGIBILITY VENDOR (CARDON) TO WORK DIRECTLY WITH THE UNINSURED PATIENT TO ASSIST THEM WITH INSURANCE ENROLLMENT AND EDUCATION.

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
THEDACARE REGIONAL MEDICAL CENTER - APPLETON	PART V, SECTION B, LINE 16J: THE FAP AND APPLICATION WERE AVAILABLE AT HOSPITAL CASHIER OFFICES, ON OUR WEB SITE AND OFFERED TO ALL PATIENTS THAT EXPRESSED A FINANCIAL HARDSHIP WHEN CALLING THE BILLING OFFICE. THE PLS WAS PRINTED ON EVERY STATEMENT AND A FOOTER WAS ADDED TO THE FRONT OF THE STATEMENT ADVISING PATIENT TO SEE REVERSE SIDE OF STATEMENT FOR FINANCIAL ASSISTANCE AND PAYMENT OPTIONS. NOTIFICATION OF FINANCIAL ASSISTANCE AVAILABILITY WAS ADDED TO THE INITIAL LETTER SENT BY THE THIRD PARTY COLLECTION AGENCY.

Schedule J
(Form 990)

Compensation Information

OMB No. 1545-0047
2019
Open to Public Inspection

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.**

Department of the Treasury
Internal Revenue Service

Name of the organization
THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC

Employer identification number
39-0824015

Part I Questions Regarding Compensation

	Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		
<input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Travel for companions <input type="checkbox"/> Tax idemnification and gross-up payments <input type="checkbox"/> Discretionary spending account		
<input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input checked="" type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
b If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b Yes	
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	2 Yes	
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.		
<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations		
<input type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a Receive a severance payment or change-of-control payment?	4a	No
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b 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 Yes	
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.	8	No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9	

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				
1 IMRAN ANDRABI MD PRESIDENT & CEO - SYSTEM	(i)	0	0	0	0	0	0	0
	(ii)	881,748	270,005	32,725	43,518	22,350	1,250,346	0
2 MARK THOMPSON SENIOR VP, CFO & COO - SYSTEM	(i)	0	0	0	0	0	0	0
	(ii)	557,906	100,979	23,015	43,518	19,247	744,665	0
3 GARY EDELMAN MD BOARD MEMBER / PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	486,784	2,763	4,329	42,000	19,247	555,123	0
4 NORMA TURK MD BOARD MEMBER / PHYSICIAN	(i)	0	0	0	0	0	0	0
	(ii)	285,839	89,079	59,569	42,000	8,790	485,277	0
5 JAMES ALBIN CIO	(i)	0	0	0	0	0	0	0
	(ii)	358,040	55,950	19,331	25,000	22,350	480,671	0
6 MAGGIE LUND CHRO	(i)	0	0	0	0	0	0	0
	(ii)	301,356	39,841	19,020	44,000	7,584	411,801	0
7 BRIAN STERNS FORMER KEY EMPLOYEE	(i)	0	0	0	0	0	0	0
	(ii)	158,264	8,161	23,017	38,000	19,247	246,689	0

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 1A	ALL EXECUTIVES AT A LEVEL OF VICE PRESIDENT AND ABOVE ARE ELIGIBLE TO HAVE HEALTH OR FITNESS CLUB FEES REIMBURSED TO THEM, AND TAXED UPON REIMBURSEMENT.
PART I, LINE 4B	SENIOR LEVEL EXECUTIVES OF THE COMPANY ARE ENTITLED TO AN ANNUAL FLEXIBLE BENEFIT EQUAL TO 20% OF THE MIDPOINT OF THEIR SALARY RANGE. THIS 457(F) SUPPLEMENTAL BENEFIT PLAN COMPLIES WITH THE FINAL REGULATIONS UNDER SECTION 409A AND 457(F) OF THE INTERNAL REVENUE CODE. PARTICIPANTS MAY ELECT THE BENEFIT TO BE USED TO PURCHASE PARTICULAR INSURANCE BENEFITS, INVEST IN A CAPITAL ACCUMULATION ACCOUNT, OR A COMBINATION OF THE TWO. BENEFITS ARE ACCRUED ON A MONTHLY BASIS AND ARE SUBJECT TO THE SUBSTANTIAL RISK OF FORFEITURE AGREEMENT SIGNED BY THE PARTICIPANTS. PLAN CONTRIBUTIONS ARE MADE ON A QUARTERLY BASIS.
PART I, LINE 7	EXECUTIVE AT RISK COMPENSATION PLAN: THE PLAN OBJECTIVES ARE TO ENHANCE THEDACARE INC'S ABILITY TO ACHIEVE ITS GOALS BY PROVIDING A TOOL FOR STIMULATING AND REWARDING SUPERIOR LEVELS OF PERFORMANCE AMONG LEADERS AND TO WORK TOGETHER AS A COHESIVE GROUP TOWARD COMMON GOALS. LEADERS FROM MANAGER LEVEL TO THE PRESIDENT AND CEO ARE ELIGIBLE TO PARTICIPATE IN THIS PLAN. THE PERCENTAGE FOR WHICH AN INDIVIDUAL IS ELIGIBLE IS DETERMINED BY THE PARAMETERS LISTED FOR THE LEADERSHIP POSITION AND IN THE PLAN DOCUMENT ON FILE. LEADERS MAKE RECOMMENDATIONS FOR THEIR MANAGEMENT LEVEL DIRECT REPORTS TO THEIR EXECUTIVE LEADER BASED ON PERFORMANCE RESULTS. THE PRESIDENT AND CEO ALSO REVIEWS AND APPROVES. FOR SENIOR VICE PRESIDENTS, THE EXECUTIVE LEADERSHIP TEAM, AND THE PRESIDENT AND CEO, THE RECOMMENDATIONS ARE REVIEWED AND APPROVED BY THE HUMAN RESOURCES AND GOVERNANCE COMMITTEE OF THE BOARD AND THE EXECUTIVE COMMITTEE OF THE BOARD. THESE COMMITTEES ALSO REVIEW THE TOTAL SPEND FOR THE INCENTIVE PLANS. THESE LEADERS MUST BE IN ACTIVE REGULAR SERVICE OF THEDACARE INC. FOR THE ENTIRE PLAN YEAR (JANUARY 1, 2019 TO DECEMBER 31, 2019) TO RECEIVE A 2020 BONUS. CARING FOR SUCCESS: THE PLAN OBJECTIVES ARE TO PROVIDE INCENTIVE TO FOCUS THE ORGANIZATION'S RESOURCES, ENERGY AND ATTENTION ON THE FULFILLMENT OF THEDACARE'S MISSION. EMPLOYEE ELIGIBILITY IS BASED ON THE NUMBER OF HOURS WORKED. ALL ELIGIBLE EMPLOYEES SHARE IN THE PAYOUT. THE PAYOUT AMOUNT IS A FLAT DOLLAR AMOUNT, DETERMINED BASED ON BOTH FINANCIAL AND QUALITY THRESHOLDS. THE AMOUNT PER EMPLOYEE IS DETERMINED BY DIVIDING THE TOTAL GAIN REALIZED (THE EMPLOYEE SHARE) BY HOURS PAID TO ALL ELIGIBLE EMPLOYEES. THE THEDACARE BOARD OF TRUSTEES APPROVES THE SPEND FOR THE PLAN.

SCHEDULE O
(Form 990 or 990-EZ)**Supplemental Information to Form 990 or 990-EZ**

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2019**Open to Public Inspection**

Department of the Treasury

Name of the organization

THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC

Employer identification number

39-0824015

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 1	THE BOARD OF TRUSTEES HAS AN EXECUTIVE COMMITTEE CONSISTING OF THE BOARD'S CHAIR, VICE CHAIR, PRESIDENT, SECRETARY AND TREASURER. THE EXECUTIVE COMMITTEE HAS AND MAY EXERCISE, WHEN THE BOARD OF TRUSTEES IS NOT IN SESSION, THE POWER OF THE BOARD OF TRUSTEES IN THE MANAGEMENT OF THE ORGANIZATION'S AFFAIRS, EXCEPT ACTION WITH RESPECT TO ELECTION OF OFFICERS OR TRUSTEES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 3	ALL MANAGEMENT AND ADMINISTRATIVE FUNCTIONS ARE PROVIDED BY EMPLOYEES OF THEDACARE, INC., THE SOLE MEMBER AND PARENT COMPANY OF THEDACARE REGIONAL MEDICAL CENTER - APPLETON, INC.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THEDACARE REGIONAL MEDICAL CENTER - APPLETON, INC.'S SOLE MEMBER OF THE SINGLE CLASS OF VOTING MEMBERS IS THEDACARE, INC.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THEDACARE, INC. HAS SOLE AUTHORITY IN THE CORPORATION TO VOTE AND TAKE ANY ACTION WITH RESPECT TO THE ELECTION OF DIRECTORS AND OFFICERS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	THEDACARE, INC. HAS THE SOLE AUTHORITY WITH RESPECT TO THE FOLLOWING MATTERS: 1. AMENDMENT OF THE ARTICLES OF INCORPORATION; 2. ADOPTION AND AMENDMENT OF BYLAWS OF THE CORPORATION; 3. CONSOLIDATION, MERGER, AND DISSOLUTION OF THE CORPORATION; 4. MONITORING COMPLIANCE WITH LAWS AND REGULATIONS; 5. SELECTION, APPOINTMENT, AND REMOVAL OF A CHIEF OPERATING OFFICER; 6. PROVISION FOR LONG-RANGE FINANCIAL STABILITY OF THE HOSPITAL AND PROVISION FOR THE CONTROL AND AND USE OF THE PHYSICAL AND FINANCIAL RESOURCES OF THE HOSPITAL; 7. ESTABLISHMENT OF A LONG-RANGE PLANNING MECHANISM; 8. APPROVAL OF A HOSPITAL ORGANIZATION AND MAJOR AUTHORITY DELEGATION PATTERNS; 9. APPROVAL OF FINANCIAL, CAPITAL, AND OTHER ITEMS; 10. APPROVAL OF DEBT OR LEASES; AND 11. CONSIDERATION AND ACTION UPON POLICIES CONCERNING RELATIONS WITH EXTERNAL GROUPS AND ORGANIZATIONS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	A DRAFT OF THE FORM 990 IS PROVIDED TO THE ORGANIZATION'S DESIGNATED COMMITTEE OF THE BOARD OF DIRECTORS FOR REVIEW AND DISCUSSION AT A BOARD MEETING. THE FINAL VERSION OF THE FORM 990 IS EMAILED TO THE ENTIRE BOARD BEFORE THE RETURN IS FILED.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	QUESTIONNAIRES ARE SENT TO ALL MANAGERS, TRUSTEES, AND OFFICERS ANNUALLY. COMPLETED FORMS ARE RETURNED TO THE COMPLIANCE OFFICER. THE COMPLIANCE OFFICER REVIEWS THE QUESTIONNAIRES AND FOLLOWS UP WITH ANY QUESTIONS ABOUT THE MANAGERS' ANSWERS ON THE CONFLICT OF INTEREST FORMS. ALL EMPLOYEES AND BOARD MEMBERS ARE COVERED UNDER THE CONFLICT OF INTEREST POLICY. THE CORPORATE COMPLIANCE COMMITTEE REVIEWS THE POTENTIAL CONFLICT AND THE CFO/BOARD OF TRUSTEES REVIEW ALL CONFLICTS. AFTER DISCLOSURE OF THE CONFLICT, THE EMPLOYEE SHALL NOT PARTICIPATE IN THE DECISION WHETHER TO ENGAGE IN THE TRANSACTION IN WHICH THE EMPLOYEE HAS AN INTEREST.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THEDACARE HIRES AN OUTSIDE CONSULTING FIRM TO CONDUCT A THOROUGH MARKET REVIEW OF EXECUTIVE COMPENSATION EVERY OTHER YEAR. THE HUMAN RESOURCES AND GOVERNANCE COMMITTEE OF THE BOARD WAS FORMED IN DECEMBER, 2018. THE OUTSIDE CONSULTANT PRESENTED HIS FINDINGS TO THE CHIEF HUMAN RESOURCES OFFICER, THE PRESIDENT AND CEO. THE INFORMATION WAS THEN PRESENTED TO THE HUMAN RESOURCES AND GOVERNANCE COMMITTEE OF THE BOARD AND THEN TO THE EXECUTIVE COMMITTEE OF THE BOARD. BOTH COMMITTEES WERE PROVIDED THE INFORMATION FOR REVIEW, EDUCATION AND ACCEPTANCE IN DECEMBER, 2019 AND JANUARY, 2020.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THEDACARE REGIONAL MEDICAL CENTER - APPLETON, INC. DOES NOT MAKE ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND INTERNAL FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	OTHER FEES: PROGRAM SERVICE EXPENSES 18,227,932. MANAGEMENT AND GENERAL EXPENSES 13,120,30 8. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 31,348,240.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2019

**Open to Public
Inspection**

▶ **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.**

Department of the Treasury
Internal Revenue Service

Name of the organization
THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC

Employer identification number

39-0824015

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

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	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) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) N APPLETON AMBULATORY CARE CENTER BUILDING COMPANY LLC 122 E CAPITOL DR APPLETON, WI 54911 26-2497187	RENTAL	WI	N/A									

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

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

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

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: 39-0824015

Name: THEDACARE REGIONAL MEDICAL CENTER -
APPLETON INC

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
PO BOX 8025 APPLETON, WI 549128025 39-1509362	HEALTHCARE	WI	501(C)(3)	LINE 10	N/A		No
PO BOX 8025 APPLETON, WI 549128025 39-0830664	HOSPITAL	WI	501(C)(3)	LINE 3	THEDACARE INC		No
PO BOX 8025 APPLETON, WI 549128025 39-0869788	HOSPITAL	WI	501(C)(3)	LINE 3	THEDACARE INC		No
PO BOX 8025 APPLETON, WI 549128025 39-0871113	HOSPITAL	WI	501(C)(3)	LINE 3	THEDACARE INC		No
PO BOX 8025 APPLETON, WI 549128025 39-0807068	HOSPITAL	WI	501(C)(3)	LINE 3	THEDACARE INC		No
PO BOX 8025 APPLETON, WI 549128025 39-0806359	HOSPITAL	WI	501(C)(3)	LINE 3	THEDACARE INC		No
PO BOX 8025 APPLETON, WI 549128025 39-6089134	HOSPITAL	WI	501(C)(3)	LINE 3	THEDACARE INC		No
PO BOX 8025 APPLETON, WI 549128025 46-4112255	FOUNDATION	WI	501(C)(3)	LINE 7	THEDACARE INC		No