

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](http://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: AURORA MEDICAL CENTER BAY AREA INC  
 Doing business as  
 Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
 750 W VIRGINIA ST PO BOX 341880  
 City or town, state or province, country, and ZIP or foreign postal code  
 MILWAUKEE, WI 532341880

**D** Employer identification number: 39-1528430  
**E** Telephone number: (414) 299-1576  
**G** Gross receipts \$ 97,160,637

**F** Name and address of principal officer:  
 JEFFREY DALEN-BARD  
 750 W VIRGINIA ST PO BOX 341880  
 MILWAUKEE, WI 532341880

**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.AURORAHEALTHCARE.ORG

**K** Form of organization:  Corporation  Trust  Association  Other ▶  
**L** Year of formation: 1985 **M** State of legal domicile: WI

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities:  
 THE MISSION OF AURORA MEDICAL CENTER BAY AREA, INC. IS TO PROMOTE HEALTH, PREVENT ILLNESS AND PROVIDE STATE-OF-THE-ARE DIAGNOSIS AND TREATMENT TO PATIENTS IN LOCAL SERVICE MARKETS.

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	13
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	5
<b>5</b> Total number of individuals employed in calendar year 2019 (Part V, line 2a)	<b>5</b>	754
<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	90
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	665,818
<b>7b</b> Net unrelated business taxable income from Form 990-T, line 39	<b>7b</b>	0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	858,628	62,400
<b>9</b> Program service revenue (Part VIII, line 2g)	129,023,207	96,563,469
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,508,986	806,470
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	384,189	-375,115
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	131,775,010	97,057,224
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	55,665,234	38,839,488
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	78,157,849	56,271,808
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	133,823,083	95,111,296
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	-2,048,073	1,945,928

	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	215,003,263	206,850,392
<b>21</b> Total liabilities (Part X, line 26)	105,395,483	102,303,578
<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	109,607,780	104,546,814

**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: 2020-11-16

RACHEL HALVERSON VP-TAX AND ACCOUNTING SERVICES  
 Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name: Preparer's signature: Date: 2020-11-16  
 Check  if self-employed PTIN: P01833529

Firm's name ▶ WIPFLI LLP Firm's EIN ▶ 39-0758449

Firm's address ▶ 1502 LONDON ROAD SUITE 200  
 DULUTH, MN 55812 Phone no. (715) 845-3111

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

**Part III Statement of Program Service Accomplishments**

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

**1** Briefly describe the organization's mission:

AURORA MEDICAL CENTER BAY AREA, INC. IS A REGIONAL HEALTH CARE FACILITY PROVIDING A WIDE RANGE OF MEDICAL SERVICES TO THE RESIDENTS OF MARINETTE AND MENOMINEE COUNTIES AND THE SURROUNDING AREAS.

**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 \$ 80,083,160 including grants of \$ 0 ) (Revenue \$ 95,560,931 )  
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 ▶ 80,083,160

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Yes/No response. Rows include questions 1 through 21, covering various organizational requirements and financial reporting details.

**Part IV Checklist of Required Schedules (continued)**

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

**Part V Statements Regarding Other IRS Filings and Tax Compliance**  
 Check if Schedule O contains a response or note to any line in this Part V . . . . .

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .		70
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .		0
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .		
<b>1c</b>			



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 5 main rows and 3 sub-columns (1a, 1b, and Yes/No). Row 1a: 13 members. Row 1b: 5 independent members. Rows 2-9: Various governance questions with Yes/No responses.

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

Table with 16 rows and 3 columns (10a-16b, Yes, No). Contains questions about local chapters, conflict of interest, whistleblower policy, document retention, and compensation.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed (WI)
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: ADVOCATE AURORA HEALTH INC 750 WEST VIRGINIA STREET PO BOX MILWAUKEE, WI 54234 (414) 299-1576







**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b> Membership dues . . . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . . . .	<b>1c</b>					
	<b>d</b> Related organizations . . . . .	<b>1d</b>					
	<b>e</b> Government grants (contributions) . . . . .	<b>1e</b>					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above . . . . .	<b>1f</b>	62,400				
	<b>g</b> Noncash contributions included in lines 1a - 1f:\$ . . . . .	<b>1g</b>					
	<b>h Total.</b> Add lines 1a-1f . . . . .			62,400			
<b>Program Service Revenue</b>	<b>2a</b> NET PATIENT REVENUE	Business Code					
		621400	83,069,597	83,069,597			
	<b>b</b> PHYSICIAN SERVICE REVENUE	621400	11,647,192	11,647,192			
	<b>c</b> OTHER PROGRAM SERVICE REVENUE	900099	973,225	307,407	665,818		
	<b>d</b> RENTAL INCOME - MEDICAL OFFICES	531120	873,455	873,455			
	<b>e</b>						
	<b>f</b> All other program service revenue.						
<b>g Total.</b> Add lines 2a-2f. . . . .		96,563,469					
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		145,295			145,295	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .						
	<b>5</b> Royalties . . . . .						
	<b>6a</b> Gross rents	(i) Real	29,193				
		(ii) Personal					
		<b>b</b> Less: rental expenses	67,588				
		<b>c</b> Rental income or (loss)	-38,395				
	<b>d</b> Net rental income or (loss) . . . . .		-38,395			-38,395	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	624,650				
		(ii) Other	72,350				
		<b>b</b> Less: cost or other basis and sales expenses	0	35,825			
		<b>c</b> Gain or (loss)	624,650	36,525			
	<b>d</b> Net gain or (loss) . . . . .		661,175			661,175	
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . .	<b>8a</b>					
	<b>b</b> Less: direct expenses . . . . .	<b>8b</b>					
<b>c</b> Net income or (loss) from fundraising events . . . . .							
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .	<b>9a</b>						
<b>b</b> Less: direct expenses . . . . .	<b>9b</b>						
<b>c</b> Net income or (loss) from gaming activities . . . . .							
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .	<b>10a</b>						
<b>b</b> Less: cost of goods sold . . . . .	<b>10b</b>						
<b>c</b> Net income or (loss) from sales of inventory . . . . .							
Miscellaneous Revenue	Business Code						
<b>11a</b> INTEREST RATE SWAP VALUATION ADJU	900099	-336,720	-336,720				
<b>b</b>							
<b>c</b>							
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .		-336,720					
<b>12 Total revenue.</b> See instructions . . . . .		97,057,224	95,560,931	665,818	768,075		

**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

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A)</b> Total expenses	<b>(B)</b> Program service expenses	<b>(C)</b> Management and general expenses	<b>(D)</b> Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .				
<b>4</b> Benefits paid to or for members . . . . .				
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	1,295,152		1,295,152	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .				
<b>7</b> Other salaries and wages . . . . .	30,808,524	28,383,208	2,425,316	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	1,239,173	1,161,440	77,733	
<b>9</b> Other employee benefits . . . . .	3,579,951	2,824,062	755,889	
<b>10</b> Payroll taxes . . . . .	1,916,688	1,672,684	244,004	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .				
<b>b</b> Legal . . . . .	123,879		123,879	
<b>c</b> Accounting . . . . .	123,450		123,450	
<b>d</b> Lobbying . . . . .				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees . . . . .				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	9,269,036	5,804,430	3,464,606	
<b>12</b> Advertising and promotion . . . . .	225,632	225,632		
<b>13</b> Office expenses . . . . .	3,780,712	2,557,623	1,223,089	
<b>14</b> Information technology . . . . .	972,108		972,108	
<b>15</b> Royalties . . . . .				
<b>16</b> Occupancy . . . . .	3,550,299	3,450,928	99,371	
<b>17</b> Travel . . . . .	70,222	42,750	27,472	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .				
<b>19</b> Conferences, conventions, and meetings . . . . .	38,337	35,103	3,234	
<b>20</b> Interest . . . . .	2,560,372	1,726,877	833,495	
<b>21</b> Payments to affiliates . . . . .				
<b>22</b> Depreciation, depletion, and amortization . . . . .	6,849,383	6,817,349	32,034	
<b>23</b> Insurance . . . . .	220,404		220,404	
<b>24</b> 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.)				
<b>a</b> DRUGS	8,929,318	8,929,318		
<b>b</b> MEDICAL SUPPLIES	7,497,773	7,497,773		
<b>c</b> BAD DEBTS	4,057,388	4,057,388		
<b>d</b> LAB TEST	3,470,634	3,470,634		
<b>e</b> All other expenses	4,532,861	1,425,961	3,106,900	
<b>25</b> Total functional expenses. Add lines 1 through 24e	95,111,296	80,083,160	15,028,136	0
<b>26</b> 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
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	3,425	<b>1</b>	843,117
	<b>2</b> Savings and temporary cash investments . . . . .	6,810,523	<b>2</b>	30,370,541
	<b>3</b> Pledges and grants receivable, net . . . . .		<b>3</b>	
	<b>4</b> Accounts receivable, net . . . . .	15,050,628	<b>4</b>	13,504,059
	<b>5</b> 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 . . . . .		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) . . . . .		<b>6</b>	
	<b>7</b> Notes and loans receivable, net . . . . .		<b>7</b>	
	<b>8</b> Inventories for sale or use . . . . .	3,044,988	<b>8</b>	2,494,219
	<b>9</b> Prepaid expenses and deferred charges . . . . .	1,385,914	<b>9</b>	690,666
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	163,219,040		
	<b>b</b> Less: accumulated depreciation	6,810,321		
	<b>11</b> Investments—publicly traded securities . . . . .	26,760,381	<b>11</b>	
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .		<b>12</b>	
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .		<b>13</b>	
	<b>14</b> Intangible assets . . . . .	464,996	<b>14</b>	444,992
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	865,292	<b>15</b>	2,094,079
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .	215,003,263	<b>16</b>	206,850,392	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	14,888,433	<b>17</b>	11,236,426
	<b>18</b> Grants payable . . . . .		<b>18</b>	
	<b>19</b> Deferred revenue . . . . .		<b>19</b>	
	<b>20</b> Tax-exempt bond liabilities . . . . .	83,305,440	<b>20</b>	0
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D		<b>21</b>	
	<b>22</b> 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 . . . . .		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .		<b>23</b>	81,465,000
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .		<b>24</b>	
	<b>25</b> 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	7,201,610	<b>25</b>	9,602,152
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	105,395,483	<b>26</b>	102,303,578
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions . . . . .	108,702,565	<b>27</b>	104,003,012
	<b>28</b> Net assets with donor restrictions . . . . .	905,215	<b>28</b>	543,802
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds		<b>31</b>	
<b>32</b> Total net assets or fund balances . . . . .	109,607,780	<b>32</b>	104,546,814	
<b>33</b> Total liabilities and net assets/fund balances . . . . .	215,003,263	<b>33</b>	206,850,392	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	97,057,224
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	95,111,296
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	1,945,928
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	109,607,780
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-7,006,894
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	104,546,814

**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
<b>2a</b>		No
<b>2b</b>	Yes	
<b>2c</b>	Yes	
<b>3a</b>		No
<b>3b</b>		

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 39-1528430

**Name:** AURORA MEDICAL CENTER BAY AREA INC

Form 990 (2019)

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**Form 990, Part III, Line 4a:**

INPATIENT HOSPITAL SERVICES FOR MEDICAL, SURGICAL AND OBSTETRICS/GYNECOLOGY PATIENTS - AMCBA PROVIDED CARE FOR 2,535 PATIENTS WHO WERE ADMITTED AS INPATIENTS DURING 2019. THESE SERVICES INCLUDED 24/7 CARE FOR PATIENTS ADMITTED WITH MEDICAL CONDITIONS WARRANTING A HOSPITAL STAY, PATIENTS ADMITTED FOR SURGICAL PROCEDURES EXTENSIVE ENOUGH TO REQUIRE A STAY OVERNIGHT OR FOR SEVERAL DAYS FOLLOWING THE PROCEDURES, AND PATIENTS ADMITTED FOR THE DELIVERY OF NEWBORNS. OUTPATIENT SURGICAL SERVICES - AMCBA PERFORMED 2,664 OUTPATIENT SURGICAL PROCEDURES FOR PATIENTS DURING 2019. THESE PROCEDURES INCLUDED ORTHOPEDIC, UROLOGICAL, GENERAL SURGERY, GYNECOLOGY, AND ENT SURGERIES.

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**Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

(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			
MICHAEL KARKKAINEN MD ..... PHYSICIAN	55.00 ..... 0.00					X		982,166	0	47,405
MOHAMED EL-JACK ..... PHYSICIAN	55.00 ..... 0.00					X		722,131	0	46,405
KIRSTEN BUCK MD ..... PHYSICIAN	55.00 ..... 0.00					X		558,156	0	44,640
BEHNAM HAJIHOSSAINLAU MD ..... PHYSICIAN	55.00 ..... 0.00					X		525,515	0	47,178
ALOK ARORA MD ..... PHYSICIAN	55.00 ..... 0.00					X		491,920	0	47,123
ROBERT MACCANI MD ..... PHYSICIAN	55.00 ..... 0.00						X	425,650	0	31,337
EDWARD HARDING ..... CEO	55.00 ..... 0.00			X				879,604	0	147,950
ROGER SNEATH ..... CFO (THROUGH JUNE)	55.00 ..... 0.00			X				0	0	0
JEFFREY DALEN-BARD ..... PRESIDENT & CHAIR, DIRECTOR	1.00 ..... 55.00	X		X				0	771,221	138,895
PAT KRAH ..... CHAIR (THROUGH MARCH)	1.00 ..... 0.00	X		X				0	0	0

**Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

(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			
CARRIE KILLORAN ..... VICE PRESIDENT, DIRECTOR	1.00 ..... 55.00	X		X				0	797,242	121,473
DOMINIC NAKIS ..... TREASURER	1.00 ..... 55.00	X		X				0	0	0
NAN NELSON ..... ASSISTANT TREASURER	1.00 ..... 55.00	X		X				0	1,072,348	167,410
JIM DOHENY ..... ASSISTANT TREASURER	1.00 ..... 55.00	X		X				0	0	0
LESLIE LENZO ..... ASSISTANT TREASURER	1.00 ..... 55.00	X		X				0	0	0
STEVE HUSER ..... ASSISTANT TREASURER	1.00 ..... 55.00	X		X				0	437,105	85,462
MICHAEL LAPPIN ..... SECRETARY	1.00 ..... 55.00	X		X				0	1,964,257	331,811
RACHELLE HART ..... ASSISTANT SECRETARY	1.00 ..... 55.00	X		X				0	702,838	132,786
MICHAEL GREBE ..... ASSISTANT SECRETARY	1.00 ..... 55.00	X		X				0	1,358,493	201,665
MICHAEL KERNS ..... ASSISTANT SECRETARY	1.00 ..... 55.00	X		X				0	0	0

**Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

(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			
JIM SLINKMAN ..... ASSISTANT SECRETARY	1.00 ..... 55.00	X		X				0	0	0
DENNIS POTTS ..... DIRECTOR	1.00 ..... 55.00	X						0	1,915,492	292,305
DR STEPHEN CASELTON ..... BOARD MEMBER (THROUGH MARCH)	1.00 ..... 0.00	X						0	0	0
SANDY EWALD ..... BOARD MEMBER (THROUGH MARCH)	1.00 ..... 40.00	X						0	574,422	64,934
TONY FURTON ..... BOARD MEMBER (THROUGH MARCH)	1.00 ..... 0.00	X						0	0	0
CHUCK HAWKINS ..... BOARD MEMBER (THROUGH MARCH)	1.00 ..... 0.00	X						0	0	0
MARC JAMO ..... BOARD MEMBER (THROUGH MARCH)	1.00 ..... 0.00	X						0	0	0
PATRICK O'HARA ..... BOARD MEMBER (THROUGH MARCH)	1.00 ..... 0.00	X						0	0	0



**SCHEDULE A**  
(Form 990 or 990-EZ)

**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](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047  
**2019**  
**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

**Name of the organization**  
AURORA MEDICAL CENTER BAY AREA INC

**Employer identification number**  
39-1528430

**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		
<b>Total</b>						

**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
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge..						
<b>4 Total.</b> Add lines 1 through 3						
<b>5</b> 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). . .						
<b>6 Public support.</b> 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
<b>7</b> Amounts from line 4. . .						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on. . .						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) . . . . .					<b>12</b>	
<b>13 First five years.</b> 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 <b>stop here</b> . . . . . <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

<b>14</b> Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) . . . . .	<b>14</b>	
<b>15</b> Public support percentage for 2018 Schedule A, Part II, line 14 . . . . .	<b>15</b>	
<b>16a 33 1/3% support test—2019.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>		
<b>b 33 1/3% support test—2018.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>		
<b>17a 10%-facts-and-circumstances test—2019.</b> 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 <b>stop here.</b> 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>b 10%-facts-and-circumstances test—2018.</b> 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 <b>stop here.</b> 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>18 Private foundation.</b> 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
<b>1</b>	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
<b>2</b>	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						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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.						
<b>c</b>	Add lines 7a and 7b. . . . .						
<b>8</b>	<b>Public support.</b> (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
<b>9</b>	Amounts from line 6. . . . .						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
<b>c</b>	Add lines 10a and 10b.						
<b>11</b>	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . . . .						
<b>13</b>	<b>Total support.</b> (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**

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

**Section D. Computation of Investment Income Percentage**

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

**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
<b>1</b>	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>		
	<b>1</b>		
<b>2</b>	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>		
	<b>2</b>		
<b>3a</b>	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>		
	<b>3a</b>		
<b>b</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>		
	<b>3b</b>		
<b>c</b>	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>		
	<b>3c</b>		
<b>4a</b>	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>		
	<b>4a</b>		
<b>b</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>		
	<b>4b</b>		
<b>c</b>	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>		
	<b>4c</b>		
<b>5a</b>	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>		
	<b>5a</b>		
<b>b</b>	<b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
	<b>5b</b>		
<b>c</b>	<b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
	<b>5c</b>		
<b>6</b>	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>		
	<b>6</b>		
<b>7</b>	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>		
	<b>7</b>		
<b>8</b>	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>		
	<b>8</b>		
<b>9a</b>	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
	<b>9a</b>		
<b>b</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>		
	<b>9b</b>		
<b>c</b>	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>		
	<b>9c</b>		
<b>10a</b>	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
	<b>10a</b>		
<b>b</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>		
	<b>10b</b>		

**Part IV Supporting Organizations** (continued)

		Yes	No
<b>11</b>	Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b>	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>b</b>	A family member of a person described in (a) above?		
<b>c</b>	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
<b>1</b>	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>		
<b>2</b>	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
<b>1</b>	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
<b>1</b>	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?		
<b>2</b>	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>		
<b>3</b>	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**

<b>1</b>	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year ( <b>see instructions</b> ):		
<b>a</b>	<input type="checkbox"/> The organization satisfied the Activities Test. Complete <b>line 2</b> below.		
<b>b</b>	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete <b>line 3</b> below.		
<b>c</b>	<input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a government entity (see instructions)		
<b>2</b>	Activities Test. <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>b</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>		
<b>3</b>	Parent of Supported Organizations. <b>Answer (a) and (b) below.</b>		
<b>a</b>	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>b</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.

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors (explain in detail in Part VI):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by .035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<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)

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

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

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 39-1528430

**Name:** AURORA MEDICAL CENTER BAY AREA 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 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](http://www.irs.gov/Form990) for instructions and the latest information.

**Name of the organization**  
AURORA MEDICAL CENTER BAY AREA INC

**Employer identification number**  
39-1528430

**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
<b>1</b> Total number at end of year . . . . .		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> 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
<b>a</b> Total number of conservation easements . . . . .	<b>2a</b>
<b>b</b> Total acreage restricted by conservation easements . . . . .	<b>2b</b>
<b>c</b> Number of conservation easements on a certified historic structure included in (a) . . . . .	<b>2c</b>
<b>d</b> Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register . . . . .	<b>2d</b>

**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:

- c** Beginning balance . . . . .
- d** Additions during the year . . . . .
- e** Distributions during the year . . . . .
- f** Ending balance . . . . .

	Amount
<b>1c</b>	
<b>1d</b>	
<b>1e</b>	
<b>1f</b>	

- 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
<b>1a</b> Beginning of year balance . . . . .					
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .					

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

- a** Board designated or quasi-endowment ▶ .....
- b** Permanent endowment ▶ .....
- c** Temporarily restricted endowment ▶ .....

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

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

- (i)** unrelated organizations . . . . .
- (ii)** related organizations . . . . .

	Yes	No
<b>3a(i)</b>		
<b>3a(ii)</b>		
<b>3b</b>		

- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . .
- 4** Describe in Part XIII the intended uses of the organization's endowment funds.

**Part VI Land, Buildings, and Equipment.**

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
<b>1a</b> Land . . . . .		6,848,095		6,848,095
<b>b</b> Buildings . . . . .		116,183,065	2,075,564	114,107,501
<b>c</b> Leasehold improvements		2,278,811	686,786	1,592,025
<b>d</b> Equipment . . . . .		26,593,090	4,047,971	22,545,119
<b>e</b> Other . . . . .		11,315,979		11,315,979
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				156,408,719

**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)		
<b>Total.</b> (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)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 13.) ▶		

**Part IX Other Assets.**

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 15.) ▶	

**Part X Other Liabilities.**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	9,602,152

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.

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

**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.

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

**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](http://www.irs.gov/Form990EZ) for instructions and the latest information.**

**Name of the organization**  
 AURORA MEDICAL CENTER BAY AREA INC

**Employer identification number**  
 39-1528430

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	<b>1a</b> Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b> Yes	
<b>2</b> 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		
<b>3</b> 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. <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>25000.0000000000</u> %	<b>3a</b> Yes	
<b>b</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 type="checkbox"/> Other _____ %	<b>3b</b>	No
<b>c</b> 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.		
<b>4</b> 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"? . . . . .	<b>4</b> Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? . . . . .	<b>5a</b> Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	<b>5b</b>	No
<b>c</b> 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? . . . . .	<b>5c</b>	
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	<b>6a</b> Yes	
<b>b</b> If "Yes," did the organization make it available to the public? . . . . .	<b>6b</b> 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**

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a) Number of activities or programs (optional)</b>	<b>(b) Persons served (optional)</b>	<b>(c) Total community benefit expense</b>	<b>(d) Direct offsetting revenue</b>	<b>(e) Net community benefit expense</b>	<b>(f) Percent of total expense</b>
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			1,042,306		1,042,306	1.140 %
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			10,070,137	4,092,377	5,977,760	6.570 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .			3,752,715	3,519,824	232,891	0.260 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			14,865,158	7,612,201	7,252,957	7.970 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4). . . . .			221,693		221,693	0.240 %
<b>f</b> Health professions education (from Worksheet 5) . . . . .			2,400		2,400	0 %
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			44,710		44,710	0.050 %
<b>h</b> Research (from Worksheet 7) . . . . .						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			357,513		357,513	0.390 %
<b>j Total.</b> Other Benefits . . . . .			626,316		626,316	0.680 %
<b>k Total.</b> Add lines 7d and 7j . . . . .			15,491,474	7,612,201	7,879,273	8.650 %

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements			3,390		3,390	0 %
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building			969		969	0 %
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development			22,775		22,775	0.030 %
<b>9</b> Other						
<b>10 Total</b>			27,134		27,134	0.030 %

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>		No
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>		
			1,219,643
<b>3</b> 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.	<b>3</b>		0
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME)	<b>5</b>	22,274,325
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5	<b>6</b>	28,573,438
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall)	<b>7</b>	-6,299,113
<b>8</b> 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**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes
<b>b</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	<b>9b</b>	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 %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

**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)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										



**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
 AURORA MEDICAL CENTER BAY AREA INC

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
<b>Community Health Needs Assessment</b>			
<b>1</b>	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
<b>2</b>	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
<b>3</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<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)		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
<b>5</b>	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	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .		No
<b>b</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	
<b>7</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.AURORA.ORG/COMMBENEFITS</u>		
<b>b</b>	<input checked="" type="checkbox"/> Other website (list url): <u>WWW.AURORA.ORG</u>		
<b>c</b>	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b>	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	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>WWW.AURORA.ORG/COMMBENEFITS</u>	Yes	
<b>a</b>			
<b>b</b>	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	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.		
<b>12a</b>	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>b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	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)**

AURORA MEDICAL CENTER BAY AREA INC

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:			
<b>13</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>250.000000000000</u> % and FPG family income limit for eligibility for discounted care of _____ %		
<b>b</b>	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input checked="" type="checkbox"/> Asset level		
<b>d</b>	<input checked="" type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	Yes	
<b>15</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b>	<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		
<b>d</b>	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	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	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>** NEED **</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>** NEED **</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>** NEED **</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<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)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input 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		
<b>j</b>	<input checked="" type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

AURORA MEDICAL CENTER BAY AREA INC

**Name of hospital facility or letter of facility reporting group**

**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? . . . . .

	Yes	No
<b>17</b>	Yes	

**18** Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:

- a  Reporting to credit agency(ies)
- b  Selling an individual's debt to another party
- c  Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d  Actions that require a legal or judicial process
- e  Other similar actions (describe in Section C)
- f  None of these actions or other similar actions were permitted

**19** Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .

<b>19</b>		No
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If "Yes," check all actions in which the hospital facility or a third party engaged:

- a  Reporting to credit agency(ies)
- b  Selling an individual's debt to another party
- c  Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d  Actions that require a legal or judicial process
- e  Other similar actions (describe in Section C)

**20** Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):

- a  Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- b  Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- c  Processed incomplete and complete FAP applications (if not, describe in Section C)
- d  Made presumptive eligibility determinations (if not, describe in Section C)
- e  Other (describe in Section C)
- f  None of these efforts were made

**Policy Relating to Emergency Medical Care**

**21** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .

<b>21</b>	Yes	
-----------	-----	--

If "No," indicate why:

- a  The hospital facility did not provide care for any emergency medical conditions
- b  The hospital facility's policy was not in writing
- c  The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d  Other (describe in Section C)

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

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

AURORA MEDICAL CENTER BAY AREA INC

**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
<b>23</b>		No
<b>24</b>		No



**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? 2

Name and address	Type of Facility (describe)
<b>1</b> 1 - BAY AREA MOBILITY CENTER 3117 SHORE DRIVE MARINETTE, WI 54143	REHABILITATION SERVICES AND OCCUPATIONAL HEALTH
<b>2</b> 2 - BAY AREA REHAB SERVICES - CRIVITZ WI 218 S US HWY 141 SUITE 100 CRIVITZ, WI 54114	REHABILITATION SERVICES AND OCCUPATIONAL HEALTH
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**Part VI Supplemental Information**

Provide the following information.

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 7:	THE ORGANIZATIONS CALCULATES THE COST TO CHARGE RATIO USING WORKSHEET 2 FROM THE SCHEDULE H INSTRUCTIONS.
PART I, LN 7 COL(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 \$4,532,640

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	THE HOSPITAL ALIGNED FINANCIAL AND IN-KIND RESOURCES TO STATE AND LOCAL HEALTH DEPARTMENT (HD) INITIATIVES AND PARTICIPATED ON COMMUNITY TASK FORCES FOR DISEASE CONTROL AND PREVENTION AND OTHER PRIORITY HEALTH INITIATIVES. HOSPITAL ORGANIZATIONS SUPPORT THE FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND FREE COMMUNITY CLINICS IN THEIR SERVICE AREAS AND PARTNERED WITH SCHOOLS, FAITH COMMUNITIES, ECONOMIC AND JOB-CREATION COUNCILS, LAW ENFORCEMENT, AND OTHER NONPROFIT CHARITABLE AND CIVIC ORGANIZATIONS TO CONTRIBUTE TO COMMUNITY CAPACITY FOR ADDRESSING IDENTIFIED COMMUNITY HEALTH NEEDS AND SOCIAL DETERMINANTS OF HEALTH. FINANCIAL AND IN-KIND SUPPORT FOR LOCAL CHAMBERS WITHIN THE COUNTY; SERVE ON BOARDS AND/OR COMMITTEES OF HDS FREE CLINICS, AND LOCAL COMMUNITY NOT FOR PROFIT AGENCIES IN MANITOWOC COUNTY, INCLUDING:; SERVE ON BOARDS AND/OR COMMITTEES OF HDS FREE CLINICS, AND LOCAL COMMUNITY NOT FOR PROFIT AGENCIES IN BROWN COUNTY INCLUDING FAMILY SERVICE OF NE WI; BROWN CO. ALCOHOL AND DRUG TASK FORCE; GREEN BAY YMCA; BROWN CO. HD AND UNITED WAY; WELLO. ADVANCE HEALTH PROFESSIONS EDUCATION AS SITE FOR WISCONSIN ACADEMY OF RURAL MEDICINE (WARM). FINANCIAL AND IN-KIND SUPPORT FOR MULTIPLE CHAMBERS WITHIN THE COUNTY; SERVE ON BOARDS AND/OR COMMITTEES OF HDS FREE CLINICS, AND LOCAL COMMUNITY NOT FOR PROFIT AGENCIES IN MARINETTE COUNTY, INCLUDING: HEALTHY YOUTH COALITION, UNITED WAY ACTION NOW SUBSTANCE ABUSE TASK FORCE, MARINETTE COUNTY DRUG COURT, ANI OPIATE TASK FORCE, COMMUNITIES THAT CARE.
PART III, LINE 2:	THE HOSPITAL UTILIZED A COST TO CHARGE RATIO FOR DETERMINING THE COST OF BAD DEBT EXPENSE.



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 4:	THE HOSPITAL ANALYZES PAST RESULTS AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND PROVISION FOR BAD DEBTS. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. SPECIFICALLY, FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, BAY AREA ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THIRD-PARTY PAYORS HAS NOT YET PAID, OR FOR PAYORS WHO ARE KNOWN TO HAVE FINANCIAL DIFFICULTIES THAT MAKE REALIZATION OF AMOUNTS DUE UNLIKELY. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WITH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), BAY AREA RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE.
PART III, LINE 8:	AMOUNTS ABOVE USE STANDARD MEDICARE DETERMINATION OF ALLOWABLE AND UNALLOWABLE DEPARTMENTS, STANDARD/RECOMMENDED MEDICARE ALLOCATION OF ADMINISTRATION AND GENERAL DEPARTMENTS COSTS TO ALLOWABLE AND UNALLOWABLE DEPARTMENTS BY THE USE OF BAY AREA MEDICAL CENTER'S MEDICARE COST REPORT. THE MEDICARE COST REPORT WAS CALCULATED ON A COST TO CHARGE RATIO. THE COST TO CHARGE RATIO FOLLOWS THE REGULATIONS FOR FILING THE MEDICARE COST REPORT.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B:	THE HOSPITAL WILL PROVIDE NEEDED HOSPITAL CARE TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY FOR THESE SERVICES. COMMUNITY CARE IS ALLOCATED TO PATIENTS BASED ON SET GUIDELINES ESTABLISHED BY THE ORGANIZATION. A FULL OR PARTIAL ADJUSTMENT WILL BE DETERMINED BY COMPARING THE PATIENT'S FINANCIAL STATUS TO A SLIDING FEE SCHEDULE BASED ON THE MOST RECENTLY PUBLISHED FEDERAL POVERTY GUIDELINES.IT IS THE POLICY OF THE HOSPITAL TO WRITE-OFF BOTH PARTIAL AND FULL PATIENT BALANCES FOR ACCOUNTS THAT QUALIFY FOR COMMUNITY CARE. THERE ARE NO FURTHER COLLECTIONS EFFORTS RELATED TO THOSE WHO QUALIFY FOR A FULL COMMUNITY CARE WRITE-OFF. PATIENTS THAT HAVE HAD PARTIAL WRITE-OFFS THAT DO NOT COOPERATE WITH COLLECTION EFFORTS ON THE BALANCES REMAINING WILL BE REFERRED TO A THIRD-PARTY COLLECTION AGENCY. IF STILL UNCOLLECTIBLE, THE PATIENT ACCOUNT WILL BE WRITTEN OFF TO BAD DEBT.
PART VI, LINE 2:	SINCE 2003, AURORA, THE CORPORATE PARENT, HAS COLLABORATED WITH LOCAL HEALTH DEPARTMENTS EVERY THREE YEARS TO SURVEY RESIDENTS ON THEIR HEALTH STATUS AND HABITS AND TO: GATHER INFORMATION BASED ON BEHAVIORAL AND LIFESTYLE HABITS, HEALTH CONDITIONS, RISK FACTORS, AND DEMOGRAPHICS; IDENTIFY THEMES, TRENDS AND DISPARITIES, AND; COMPARE TO STATE AND NATIONAL MEASUREMENTS. THESE REPORTS HAVE BEEN PART OF A COMPREHENSIVE SURVEY OF EASTERN WISCONSIN TO IDENTIFY AREAS OF GREATEST NEED AND PRODUCE A REPORT OF FINDINGS THAT IS SHARED WITH EACH COMMUNITY AT-LARGE (SEE <a href="https://www.aurorahealthcare.org/about-aurora/community-benefits/our-research/community-health-data#methodology">HTTPS://WWW.AURORAHEALTHCARE.ORG/ABOUT-AURORA/COMMUNITY-BENEFITS/OUR-RESEARCH/COMMUNITY-HEALTH-DATA#METHODODOLOGY</a> ). THE FINDINGS OF THE SURVEYS ARE AN INSTRUMENT THROUGH WHICH THE MUNICIPAL HDS ENGAGE COMMUNITY PARTICIPATION TO GENERATE COMMUNITY HEALTH IMPROVEMENT PLANS ALIGNED WITH HEALTHY WISCONSIN 2010 AND 2020.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 3:	THE ORGANIZATION'S PATIENT FINANCIAL ADVOCATES MEET WITH EVERY PATIENT OR PATIENTS FAMILY WHO PRESENTS FOR SERVICES AND HAS NO INSURANCE, WITH THE PURPOSE OF SHARING OPTIONS FOR COVERAGE UNDER FEDERAL, STATE OR LOCAL GOVERNMENT PROGRAMS, AS WELL AS A THE ORGANIZATION'S INTERNAL PATIENT FINANCIAL ASSISTANCE PROGRAM. THE PATIENT FINANCIAL ADVOCATE WILL ASSIST THE PATIENT AND/OR PATIENT'S FAMILY IN PREPARING THE PAPERWORK TO APPLY FOR ANY GOVERNMENT COVERAGE AND SLASH OR AURORA'S INTERNAL FINANCIAL ASSISTANCE. NOTICES REGARDING THE ELIGIBILITY FOR ASSISTANCE UNDER FEDERAL, STATE, OR LOCAL GOVERNMENT PROGRAMS, OR UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE PROGRAM ARE ALSO POSTED IN THE ELEMENTARY ROOMS, ADMISSIONS OFFICES, AND WAITING AREAS.
PART VI, LINE 4:	THIS HOSPITAL SERVES THE RESIDENTS OF MARINETTE COUNTY IN WISCONSIN AND MENOMINEE COUNTY IN MICHIGAN. MARINETTE COUNTY HAS A POPULATION OF 40,491. THE MEDIAN AGE IS 48 WITH 23.1% AGE 65 AND OLDER. THE MEDIAN FAMILY INCOME IS \$54,562 AND 95.78% OF RESIDENTS ARE NON-HISPANIC WHITE. MENOMINEE COUNTY HAS A POPULATION OF 23,281. THE MEDIAN AGE IS 48 WITH 16.2% AGE 65 AND OLDER. THE MEDIAN FAMILY INCOME IS \$51,659 AND 93.56% OF RESIDENTS ARE NON-HISPANIC WHITE.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 5:	EACH AURORA HOSPITAL FACILITY PUBLISHED A 2019 COMMUNITY BENEFIT REPORT PUBLICLY AVAILABLE AT <a href="http://WWW.AURORA.ORG/COMMBENEFITS.AMCBA">WWW.AURORA.ORG/COMMBENEFITS.AMCBA</a> (ONE HOSPITAL), PROVIDED SUPPORT TO TWIN COUNTIES FREE CLINIC; SUPPORTED THE PHYSICAL EDUCATION PROGRAM FOR MARINETTE, MENOMINEE, PESHTIGO, AND CRIVITZ SCHOOL DISTRICTS; HELPED COLLECT 660 POUNDS OF DRUGS DURING A LOCAL PRESCRIPTION DRUG COLLECTION PROGRAM
PART VI, LINE 6:	AURORA'S INTEGRATED HEALTH CARE SYSTEM INCLUDES PHYSICIAN GROUPS AND CLINICS, PHARMACIES, HOME CARE, HOME HOSPICE, AND SOCIAL SERVICES SERVING EASTERN WISCONSIN. AURORA PROVIDES URGENT CARE, FAMILY PRACTICE, AND SPECIALIST SERVICES FOR UNDERSERVED POPULATIONS IN THE HEART OF THE COMMUNITIES IN WHICH OUR HOSPITALS RESIDE, INCLUDING BUT NOT LIMITED TO: AURORA FAMILY SERVICE, INC. (AFS), A 501(C)(3), IS AURORA'S SOCIAL SERVICE ARM THAT APPLIES A FAMILY WELLNESS AND STABILITY MODEL TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH IMPACTING OUR PATIENTS AND COMMUNITIES. A TEAM OF 81 DEDICATED PRACTITIONERS PROVIDE A FULL CONTINUUM OF SERVICES IN THE COMMUNITY TO PROMOTE SELF-SUFFICIENCY THROUGH EVERY STAGE OF LIFE, INTEGRATING HEALTH, MENTAL HEALTH, SOCIAL SERVICES, FAMILY AND MARRIAGE THERAPY, COMPREHENSIVE SERVICES FOR SENIORS, PARENTING EDUCATION, HOME VISITATION, AND A WIDE VARIETY OF FINANCIAL WELLNESS PROGRAMMING. AURORA AT HOME, INC., A 501(C) (3) ENTITY, IS A COMPREHENSIVE SOURCE OF HOME CARE SERVICES IN EASTERN WISCONSIN COMMITTED TO KEEPING PEOPLE INDEPENDENT IN THEIR HOMES. AURORA CONSOLIDATED LABS (ACL) PROVIDES PRO-BONO LABORATORY SERVICES FOR OUR FREE CLINIC PARTNERS. AURORA PHARMACY PROVIDES ESSENTIAL MEDICATIONS TO PATIENTS WHO CAN'T AFFORD THEM. AURORA HEALTH CARE FOUNDATION, INC. (AHCf) PROVIDES GRANT RESEARCH AND GRANT WRITING TO SUPPORT COMMUNITY HEALTH INITIATIVES. AURORA RESEARCH INSTITUTE (ARI) PROVIDED \$3,071,211 IN UNFUNDED RESEARCH-RELATED EXPENSES. THEIR RESEARCH RESULTS ARE ALWAYS PUBLISHED FOR PUBLIC REVIEW AND BENEFIT.

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	WI

**Additional Data****Software ID:****Software Version:****EIN:** 39-1528430**Name:** AURORA MEDICAL CENTER BAY AREA INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		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	AURORA MEDICAL CENTER BAY AREA INC 3003 UNIVERSITY DR MARINETTE, WI 54143 WWW.BAMC.ORG 2419-800	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
AURORA MEDICAL CENTER BAY AREA, INC	PART V, SECTION B, LINE 5: AMONG THE KEY INFORMANTS WERE THE HEALTH OFFICERS FOR LOCAL HDS, LEADERS OF ACADEMIC CENTERS, HEALTH COALITIONS, FOUNDATIONS AND COMMUNITY ORGANIZATIONS FOCUSED ON A RANGE OF PUBLIC HEALTH ISSUES AND HEALTH DISPARITIES. EACH AURORA HOSPITAL CONDUCTED KEY INFORMANT INTERVIEWS IN THEIR MOST RECENT CHNA. KEY INFORMANTS WERE ASKED TO RANK ORDER THE TOP 3 TO 5 MAJOR HEALTH-RELATED ISSUES FOR THEIR COUNTY, BASED ON THE FOCUS AREAS OUTLINED IN THE STATE HEALTH PLAN, HEALTHIEST WISCONSIN 2020. FOR EACH TOP-RANKED HEALTH TOPIC, THE INFORMANT WAS ASKED TO SPECIFY EXISTING STRATEGIES TO ADDRESS THE ISSUE, BARRIERS OR CHALLENGES TO ADDRESSING THE ISSUE, ADDITIONAL STRATEGIES NEEDED, AND KEY GROUPS THAT HOSPITALS SHOULD COLLABORATE WITH TO IMPROVE COMMUNITY HEALTH.
AURORA MEDICAL CENTER BAY AREA, INC	PART V, SECTION B, LINE 6B: AMCBA WITH MARINETTE CO. HEALTH AND HUMAN SERVICES AND THE DELTA & MENOMINEE CO. HD.

**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
AURORA MEDICAL CENTER BAY AREA, INC	PART V, SECTION B, LINE 7D: REFERENCED IN NEWS RELEASES AND ANNUAL COMMUNITY BENEFIT REPORTS.
AURORA MEDICAL CENTER BAY AREA, INC	<p>PART V, SECTION B, LINE 11: DURING 2019, AURORA HOSPITAL FACILITY LEADERS PRIORITIZED SIGNIFICANT NEEDS BASED ON THE FOLLOWING CRITERIA: MEETS A DEFINED COMMUNITY NEED (I.E., ACCESS FOR UNDERSERVED POPULATIONS) ALIGNS COMMUNITY BENEFIT TO ORGANIZATIONAL PURPOSE AND CLINICAL SERVICE COMMITMENT TO COORDINATE CARE ACROSS THE CONTINUUM ALIGNS WITH HOSPITAL RESOURCES AND EXPERTISE AND THE ESTIMATED FEASIBILITY FOR THE HOSPITAL TO EFFECTIVELY IMPLEMENT ACTIONS TO ADDRESS HEALTH ISSUES AND POTENTIAL IMPACT REDUCES AVOIDABLE HOSPITAL COSTS BY REDIRECTING PEOPLE TO LESS COSTLY FORMS OF CARE AND EXPANDS THE CARE CONTINUUM HAS EVIDENCE-BASIS IN CROSS-SECTION OF THE LITERATURE FOR MANAGEMENT OF CHRONIC DISEASES IN DEFINED POPULATIONS LEVERAGES EXISTING PARTNERSHIPS WITH FREE AND COMMUNITY CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) RESONATES WITH KEY STAKEHOLDERS AS A MEANINGFUL PRIORITY FOR THE AURORA HOSPITAL TO ADDRESS POTENTIAL EXISTS TO LEVERAGE ADDITIONAL RESOURCES TO EXTEND IMPACT INCREASES COLLABORATIVE PARTNERSHIPS WITH OTHERS IN THE COMMUNITY BY EXPANDING THE CARE CONTINUUM IMPROVES THE HEALTH OF PEOPLE IN THE COMMUNITY BY PROVIDING HIGH-QUALITY PREVENTIVE AND PRIMARY CARE ALIGNS HOSPITAL RESOURCES AND EXPERTISE TO SUPPORT STRATEGIES IDENTIFIED IN MUNICIPAL HEALTH DEPARTMENT COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) ALIGNS WITH ADVOCATE AURORA HEALTH COMMUNITY STRATEGY QUANTIFYING HEALTH ISSUES BASED ON THE HANLON METHOD FOR PRIORITIZING HEALTH PROBLEMSUSING THESE CRITERIA, EACH HOSPITAL PRIORITIZED AMONG ALL NEEDS IDENTIFIED IN THE CHNA REPORT WITHIN THREE FOCUS AREAS: 1) ACCESS, 2) BEHAVIORAL HEALTH, AND 3) SOCIAL DETERMINANTS OF HEALTH OR OTHER HEALTH NEEDS UNIQUE TO THE HOSPITAL'S DEFINED COMMUNITY AND SERVICE OFFERINGS. DETAILED EXPLANATIONS OF IDENTIFIED COMMUNITY NEEDS CAN BE FOUND IN EACH HOSPITAL'S CHNA REPORT POSTED AT <a href="http://WWW.AURORA.ORG/COMMBENEFITS">WWW.AURORA.ORG/COMMBENEFITS</a>. THERE ARE GENERAL REASONS FOR OUR HOSPITALS NOT TO ADDRESS A NEED THAT HAS BEEN IDENTIFIED. THESE REASONS INCLUDE:1. RESOURCE CONSTRAINTS2. OTHER FACILITIES OR ORGANIZATIONS IN THE COMMUNITY ARE ADDRESSING THE NEED 3. A LACK OF IDENTIFIED EFFECTIVE INTERVENTIONS TO ADDRESS THE NEED</p> <p>AMBCA: AMBCA PRIORITIZED SIGNIFICANT NEEDS BASED ON THE FOLLOWING CRITERIA: IMPORTANCE OF THE PROBLEM TO THE COMMUNITY AS EVIDENCED BY ORGANIZATIONS ALREADY ADDRESSING THE HEALTH ISSUE OR INDICATING SUPPORT FOR INITIATIVES, PRIMARY AND SECONDARY DATA THAT INDICATES AN OPPORTUNITY FOR IMPROVEMENT, AVAILABILITY OF EXISTING RESOURCES TO ADDRESS THE ISSUES, ESTIMATED RESOURCES, TIMEFRAME AND SIZE OF IMPACTED POPULATION, AND APPROPRIATENESS OF AMBCA AS A CHANGE AGENT (AS A PARTNER, A ROLE AS KNOWLEDGE-SHARING OR PROVIDING DIRECT FUNDING, ETC.)</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
AURORA MEDICAL CENTER BAY AREA, INC	PART V, SECTION B, LINE 16J: A FINANCIAL BROCHURE IS OFFERED TO PATIENTS UPON REGISTRATION AND IS AVAILABLE ONLINE AT <a href="https://www.bamc.org/media/1013/financail_brochure.pdf">HTTPS://WWW.BAMC.ORG/MEDIA/1013/FINANCAIL_BROCHURE.PDF</a> . BILLING STATEMENTS REFERENCE THE FAP POLICY AND INSTRUCTIONS ON WHO TO CONTACT TO RECEIVE FINANCIAL ASSISTANCE INFORMATION BUT DO NOT INCLUDE THE DETAILED POLICY. SECTION B, LINE 16E: THE ORGANIZATION DOES NOT HAVE ANY LEP POPULATIONS IN THEIR IDENTIFIED SERVICES AREA, AND THUS ONLY HAVE MATERIALS IN ENGLISH, THE PRIMARY LANGUAGE SPOKEN.

**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](http://www.irs.gov/Form990) for instructions and the latest information.**

Department of the Treasury  
Internal Revenue Service

Name of the organization AURORA MEDICAL CENTER BAY AREA INC	Employer identification number 39-1528430
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**Part I Questions Regarding Compensation**

	Yes	No
<b>1a</b> 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 type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<b>b</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	<b>1b</b>	
<b>2</b> 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?	<b>2</b>	
<b>3</b> 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 checked="" type="checkbox"/> Form 990 of other organizations <input checked="" type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee		
<b>4</b> 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:		
<b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>	No
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	<b>4c</b>	No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> 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:		
<b>a</b> The organization?	<b>5a</b>	No
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III.	<b>5b</b>	No
<b>6</b> 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:		
<b>a</b> The organization?	<b>6a</b>	No
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III.	<b>6b</b>	No
<b>7</b> 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.	<b>7</b>	No
<b>8</b> 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.	<b>8</b>	No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>	



**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 4B	EDWARD HARDING PARTICIPATED IN A NON-QUALIFIED RETIREMENT PLAN. IN 2019, A CONTRIBUTION OF \$106,587 WAS MADE TO A 457(F) PLAN.

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 39-1528430  
**Name:** AURORA MEDICAL CENTER BAY AREA INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1MICHAEL KARKKAINEN MD PHYSICIAN	(i)	639,620	246,176	96,370	21,000	26,405	1,029,571	0
	(ii)	0	0	0	0	0	0	0
1MOHAMED EL-JACK PHYSICIAN	(i)	627,127	51,000	44,004	21,000	25,405	768,536	0
	(ii)	0	0	0	0	0	0	0
2KIRSTEN BUCK MD PHYSICIAN	(i)	462,977	26,249	68,930	19,235	25,405	602,796	0
	(ii)	0	0	0	0	0	0	0
3BEHNAM HAJIHOSSAINLAU MD PHYSICIAN	(i)	303,021	113,883	108,611	20,807	26,371	572,693	0
	(ii)	0	0	0	0	0	0	0
4ALOK ARORA MD PHYSICIAN	(i)	292,120	97,875	101,925	20,718	26,405	539,043	0
	(ii)	0	0	0	0	0	0	0
5ROBERT MACCANI MD PHYSICIAN	(i)	312,818	33,464	79,368	21,000	10,337	456,987	0
	(ii)	0	0	0	0	0	0	0
6EDWARD HARDING CEO	(i)	439,718	250,796	189,090	127,587	20,363	1,027,554	0
	(ii)	0	0	0	0	0	0	0
7JEFFREY DALEN-BARD PRESIDENT & CHAIR, DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	498,125	243,675	29,421	118,391	20,504	910,116	0
8CARRIE KILLORAN VICE PRESIDENT, DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	520,513	248,414	28,315	121,473	0	918,715	0
9NAN NELSON ASSISTANT TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	481,008	227,115	364,225	166,423	987	1,239,758	0
10STEVE HUSER ASSISTANT TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	308,464	105,266	23,375	71,558	13,904	522,567	0
11MICHAEL LAPPIN SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	746,368	569,981	647,908	311,307	20,504	2,296,068	0
12RACHELLE HART ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	498,921	177,092	26,825	112,282	20,504	835,624	0
13MICHAEL GREBE ASSISTANT SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	562,400	403,812	392,281	201,665	0	1,560,158	0
14DENNIS POTTS DIRECTOR	(i)	0	0	0	0	0	0	0
	(ii)	835,852	463,125	616,515	278,576	13,729	2,207,797	0
15SANDY EWALD BOARD MEMBER (THROUGH MARCH)	(i)	0	0	0	0	0	0	0
	(ii)	299,987	142,601	131,834	59,489	5,445	639,356	0

**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](http://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

AURORA MEDICAL CENTER BAY AREA INC

Employer identification number

39-1528430

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 4	THE ORGANIZATION MERGED WITH AURORA HEALTH CARE SYSTEM. AS SUCH THE ORGANIZATION EXPERIENCED CHANGES TO ARTICLES OF INCORPORATION AND BYLAWS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 6	THE SOLE MEMBER OF THE CORPORATION SHALL BE AURORA HEALTH CARE, INC., A WISCONSIN NONSTOCK CORPORATION. THE SOLE MEMBER HAS THE RIGHT TO APPOINT AND TERMS OF BOARD OF DIRECTORS.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	SUBJECT TO THE PROVISIONS OF THE BYLAWS. THE NUMBER AND MANNER OF ELECTION OR APPOINTMENT OF DIRECTORS AND THEIR TERMS OF OFFICE SHALL BE AS PROVIDED IN THE BYLAWS, BUT THE NUMBER OF DIRECTORS SHALL NOT BE LESS THAN THREE (3).



**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 7B	THE CORPORATE MEMBERS HAVE RETAINED THE FOLLOWING RESERVED POWERS OVER THE CORPORATION SUCH THAT NONE OF SUCH ACTIONS MAY BE TAKEN BY THE CORPORATION WITHOUT THE UNANIMOUS APPROVAL OF ALL CORPORATE MEMBERS, AND THE CORPORATE MEMBERS, ACTING UNANIMOUSLY, MAY INITIATE AND TAKE SUCH ACTIONS: - TO CHANGE THE CORPORATION'S MISSION OR PURPOSE; - TO APPROVE ANY AMENDMENT TO THE ARTICLES OF INCORPORATION, BYLAWS OR OTHER GOVERNING DOCUMENTS OF THE CORPORATION, INCLUDING THE CONFLICT OF INTEREST, INSIDER TRANSACTION, AND CONFIDENTIALITY POLICY ADOPTED BY THE BOARD OF DIRECTORS FROM TIME TO TIME; - TO APPROVE ALL MATTERS RELATING TO THE MEMBERSHIP OF THE CORPORATION OR ANY RIGHTS ARISING FROM SUCH MEMBERSHIP, INCLUDING THE ISSUING OF ADDITIONAL MEMBERSHIPS IN THE CORPORATION, RECLASSIFYING MEMBERSHIPS IN THE CORPORATION, CREATING A NEW CLASS OF MEMBERSHIP IN THE CORPORATION, BRINGING ON A NEW MEMBER OF THE CORPORATION, TRANSFERRING MEMBERSHIPS IN THE CORPORATION OR ANY RIGHTS ARISING THEREFROM OR REDEEMING MEMBERSHIPS IN THE CORPORATION OR ANY RIGHTS ARISING FROM THEREFROM; - TO APPROVE ANY INDEBTEDNESS FOR BORROWED MONEY TO BE INCURRED OR GUARANTEED ON BEHALF OF THE CORPORATION, EXCEPT THAT FINANCING FOR A FACILITY PLAN DEVELOPED IN 2014 OR 2015 AND APPROVED BY SUPER-MAJORITY BOARD APPROVAL DOES NOT REQUIRE THE UNANIMOUS APPROVAL OF ALL CORPORATE MEMBERS; - TO APPROVE CAPITAL LEASES IN EXCESS OF \$3,000,000 IN THE AGGREGATE (AS DETERMINED BY TOTAL LEASE AND OTHER PAYMENTS);

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE 2019 FORM 990 WAS REVIEWED BY SENIOR LEADERSHIP OF ADVOCATE AURORA HEALTH, INC. A COPY OF THE FINAL RETURN WAS MADE AVAILABLE TO THE ADVOCATE AURORA HEALTH, INC. BOARD OF DIRECTORS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 12C	OFFICERS, DIRECTORS AND KEY EMPLOYEES ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST STATEMENT ON AN ANNUAL BASIS. ADVOCATE AURORA HEALTH'S LEADERSHIP REVIEWS THESE STATEMENTS FOR COMPLIANCE WITH THE ESTABLISHED POLICY. WHEN A CONFLICT IS DISCOVERED, THE GOVERNING BODY DETERMINES IF SUCH CONFLICT WARRANTS A RESTRICTION ON THE CAPACITY OF THE BOARD MEMBER OR KEY EMPLOYEE INVOLVED (E.G. RECUSAL FROM DECISION-MAKING OR UTILIZING ANOTHER METHOD OF NON-PARTICIPATION IN AN ACTIVITY).

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 15	THE FOLLOWING COMPENSATION REVIEW PROCESS WAS CONDUCTED IN 2019: THE CEO AND THE CEO'S EXECUTIVE TEAM HAVE THEIR COMPENSATION REVIEWED ANUALLY BY THE COMPENSATION COMMITTEE OF THE ADVOCATE AURORA HEALTH BOARD OF DIRECTORS. ALL OTHER EMPLOYEES HAVE THEIR COMPENSATION REVIEWED AND APPROVED BY THEIR LEADER WITHIN MARKET-BASED GUIDELINES PRESCRIBED BY THE ORGANIZATION'S HUMAN RESOURCES FUNCTION. THESE MARKET-BASED GUIDELINES ARE ESTABLISHED USING APPLICABLE COMPARABILITY DATA AND SIMILAR COMPENSATION METRICS THAT ARE BASED ON SIMILARLY-QUALIFIED PERSONS IN FUNCTIONALLY-COMPARABLE POSITIONS AT SIMILARLY-SITUATED ORGANIZATIONS. DOCUMENTATION AND RECORDKEEPING FOR THESE DELIBERATIONS AND DECISIONS ARE MAINTAINED.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE ORGANIZATION DEEMS THESE DOCUMENTS PROPRIETARY SO THEY ARE NOT MADE AVAILABLE TO THE PUBLIC, EXCEPT THAT THE AUDITED FINANCIAL STATEMENTS ARE ATTACHED TO THE FORM 990.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART XI, LINE 9:	ADJUSTMENT TO NET ASSETS DUE TO MERGER -7,006,894.

**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](http://www.irs.gov/Form990) for instructions and the latest information.**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
AURORA MEDICAL CENTER BAY AREA INC

**Employer identification number**

39-1528430

**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	
<b>(1)</b> BAYCARE AURORA LLC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1947472	HOSPITAL	WI	AURORA MEDICAL GROUP INC	RELATED				No			No	61.880 %
<b>(2)</b> AURORA CONSOLIDATED LABS A CO-TENANCY 8901 WEST LINCOLN AVENUE MILWAUKEE, WI 53227 39-1898089	LABORATORY SERVICES	WI	N/A	N/A				No			No	
<b>(3)</b> NORTH SHORE SURGICAL CENTER LTD 7007 RANGE LINE ROAD GLENDALE, WI 53209 39-1548024	SUGICAL SERVICES	WI	N/A	N/A				No			No	
<b>(4)</b> WISCONSIN SURGERY CENTER LLC 4131 WEST LOOMIS ROAD SUITE 210 GREENFIELD, WI 53221 38-3661215	SUGICAL SERVICES	WI	N/A	N/A				No			No	
<b>(5)</b> AURORA GI ASC 2801 WEST KK RIVER PKWY 1030 MILWAUKEE, WI 53215 46-1848055	PHYSICIAN SERVICES	WI	N/A	N/A				No			No	
<b>(6)</b> WAUKESHA PAIN CENTER LLC 4131 WEST LOOMIS ROAD SUITE 300 GREENFIELD, WI 53221 90-0928071	PHYSICIAN SERVICES	WI	N/A	N/A				No			No	
<b>(7)</b> AURORA BAY AREA MEDICAL GROUP LLC 3100 SHORE DRIVE MARINETTE, WI 54143 47-3548414	PHYSICIAN SERVICES	WI	AURORA MEDICAL CENTER BAY AREA INC	RELATED				No			No	73.000 %

**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.

See Additional Data Table

(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
<b>1</b> 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?		
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .		No
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	Yes	
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	Yes	
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .		No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .		No
<b>f</b> Dividends from related organization(s) . . . . .		No
<b>g</b> Sale of assets to related organization(s) . . . . .	Yes	
<b>h</b> Purchase of assets from related organization(s) . . . . .		No
<b>i</b> Exchange of assets with related organization(s) . . . . .		No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	Yes	
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .		No
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .	Yes	
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	Yes	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	Yes	
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	Yes	
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .		No
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	Yes	
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .		No
<b>s</b> 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
(1)AURORA BAY AREA MEDICAL GROUP LLC	B	7,941,084	FMV
(2)AURORA HEALTH CARE FOUNDATION INC	C	62,400	FMV
(3)AURORA BAY AREA MEDICAL GROUP LLC	J	10,704,347	FMV



**Part VII**    **Supplemental Information**

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

<b>Return Reference</b>	<b>Explanation</b>

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 39-1528430  
**Name:** AURORA MEDICAL CENTER BAY AREA 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
750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1442285	SUPPORT SERVICES	WI	501(C)(3)	LINE 12D, III-O	N/A		No
750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 26-4041287	PHYSICIAN SERVICES	IL	501(C)(3)	LINE 3	AURORA MEDICAL GROUP INC	Yes	
1220 DEWEY AVENUE WAUWATOSA, WI 53213 26-1516765	SCHOOL	WI	501(C)(3)	LINE 2	AURORA PSYCHIATRIC HOSPITAL INC	Yes	
3200 HIGHLAND BOULEVARD MILWAUKEE, WI 53233 39-0806174	SOCIAL SERVICES	WI	501(C)(3)	LINE 11	AURORA HEALTH CARE INC	Yes	
750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1678306	PHYSICIAN SERVICES	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
2900 WEST OKLAHOMA AVENUE MILWAUKEE, WI 53215 39-0806181	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
2636 EASTERN AVENUE PLYMOUTH, WI 53073 39-0930748	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE METRO INC	Yes	
1220 DEWEY AVENUE WAUWATOSA, WI 53213 39-0872192	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE METRO INC	Yes	
252 MCHENRY STREET BURLINGTON, WI 53105 39-0806347	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
855 NORTH WESTHAVEN DRIVE OSHKOSH, WI 54904 39-1027676	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE NORTH INC	Yes	
8901 WEST LINCOLN AVENUE WEST ALLIS, WI 53227 39-1022464	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE METRO INC	Yes	
1032 EAST SUMNER STREET HARTFORD, WI 53027 39-1150165	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE METRO INC	Yes	
3003 WEST GOOD HOPE ROAD GLENDALE, WI 53209 39-1595302	PHYSICIAN SERVICES	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
5000 MEMORIAL DRIVE TWO RIVERS, WI 54241 39-1211629	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
11333 WEST NATIONAL AVENUE WEST ALLIS, WI 53227 39-0806180	HOME CARE SERVICES	WI	501(C)(3)	LINE 7	AURORA HEALTH CARE INC	Yes	
1020 NORTH 12TH STREET MILWAUKEE, WI 53233 39-1136738	PHYSICIAN SERVICES	WI	501(C)(3)	LINE 11	AURORA MEDICAL GROUP INC	Yes	
975 PORT WASHINGTON AVENUE GRAFTON, WI 53024 27-2953799	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 47-4167075	PHYSICIAN SERVICES	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	
3075 HIGHLAND PARKWAY DOWNERS GROVE, IL 60515 82-4184596	SUPPORT SERVICES	DE	501(C)(16)	LINE 12D, III-O	N/A		No
3100 SHORE DRIVE MARINETTE, WI 54143 39-1528430	HOSPITAL	WI	501(C)(3)	LINE 3	AURORA HEALTH CARE INC	Yes	

**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
750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-6044569	FOUNDATION	WI	501(C)(3)	LINE 7	AURORA HEALTH CARE INC	Yes	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership												
(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	
BAYCARE AURORA LLC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1947472	HOSPITAL	WI	AURORA MEDICAL GROUP INC	RELATED				No			No	61.880 %
AURORA CONSOLIDATED LABS A CO-TENANCY 8901 WEST LINCOLN AVENUE MILWAUKEE, WI 53227 39-1898089	LABORATORY SERVICES	WI	N/A	N/A				No			No	
NORTH SHORE SURGICAL CENTER LTD 7007 RANGE LINE ROAD GLENDALE, WI 53209 39-1548024	SUGICAL SERVICES	WI	N/A	N/A				No			No	
WISCONSIN SURGERY CENTER LLC 4131 WEST LOOMIS ROAD SUITE 210 GREENFIELD, WI 53221 38-3661215	SUGICAL SERVICES	WI	N/A	N/A				No			No	
AURORA GI ASC 2801 WEST KK RIVER PKWY 1030 MILWAUKEE, WI 53215 46-1848055	PHYSICIAN SERVICES	WI	N/A	N/A				No			No	
WAUKESHA PAIN CENTER LLC 4131 WEST LOOMIS ROAD SUITE 300 GREENFIELD, WI 53221 90-0928071	PHYSICIAN SERVICES	WI	N/A	N/A				No			No	
AURORA BAY AREA MEDICAL GROUP LLC 3100 SHORE DRIVE MARINETTE, WI 54143 47-3548414	PHYSICIAN SERVICES	WI	AURORA MEDICAL CENTER BAY AREA INC	RELATED				No			No	73.000 %

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(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
AURORA HEALTH CARE VENTURES INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1513129	FOR-PROFIT PARENT COMPANY	WI	N/A	C				Yes	
AURORA HEALTH NETWORK INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1817175	INACTIVE	WI	N/A	C				Yes	
AURORA PHARMACY INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1733325	RETAIL PHARMACY	WI	N/A	C				Yes	
DIVERSIFIED CARE INC 4811 SOUTH 76TH STREET GREENFIELD, WI 53220 39-1609054	TEMPORARY STAFFING AGENCY	WI	N/A	C				Yes	
AURORA RETAIL STORES INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 39-1722937	INACTIVE	WI	N/A	C				Yes	
ADVANCED HEALTHCARE INC 3003 WEST GOOD HOPE ROAD GLENDALE, WI 53209 39-1195501	PHYSICIAN SERVICES	WI	N/A	C				Yes	
NOR DOOR CLINIC BUILDING CONDOMINIUM ASSOCIATION OF UNIT OWNERS 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204	CONDO ASSOCIATION	WI	N/A	C					No
ST LUKE'S PHYSICIAN OFFICE CONDOMINIUM 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204	CONDO ASSOCIATION	WI	N/A	C					No
AURORA HEALTH CENTER OF KENOSHA CONDOMINIUM ASSOCIATION INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204	CONDO ASSOCIATION	WI	N/A	C					No
HEALTH CARE RE LTD 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 98-1063814	HEALTH SERVICES	CJ	N/A	C					No
83 TECH HARBOR INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 83-1836945	FOR-PROFIT PARENT COMPANY	WI	N/A	C					No
83 TECH HARBOR INVESTMENTS INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 83-1845943	HEALTH CARE INVESTMENTS	WI	N/A	C					No
83 TECH HARBOR INNOVATIONS INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204 83-1864540	HEALTH CARE INNOVATION	WI	N/A	C					No
NORTHSHORE HEALTH NETWORK INC 3100 SHORE DRIVE MARINETTE, WI 54143 27-1389366	MANAGED CARE CONTRACTING	WI	N/A	C					No
AURORA HEALTH CENTER OF OSHKOSH CONDOMINIUM ASSOCIATION INC 750 WEST VIRGINIA STREET MILWAUKEE, WI 53204	CONDO ASSOCIATION	WI	N/A	C					No