

**Return of Organization Exempt From Income Tax**

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

**2014**  
Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

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

Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**A** For the 2014 calendar year, or tax year beginning **JUL 1, 2014** and ending **JUN 30, 2015**

<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization <b>NORTHWEST HOSPITAL CENTER, INC.</b>		<b>D</b> Employer identification number <b>52-1372665</b>
	Doing business as		<b>E</b> Telephone number <b>410-601-5653</b>
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	<b>5401 OLD COURT ROAD</b>		<b>G</b> Gross receipts \$ <b>271,717,906.</b>
	City or town, state or province, country, and ZIP or foreign postal code <b>RANDALLSTOWN, MD 21133</b>		<b>H(a)</b> Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>F</b> Name and address of principal officer: <b>BRIAN WHITE</b> <b>SAME AS C ABOVE</b>		<b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		<b>H(c)</b> Group exemption number	
<b>J</b> Website: <b>WWW.LIFEBRIDGEHEALTH.ORG/NORTHWEST</b>			
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other		<b>L</b> Year of formation: <b>1984</b> <b>M</b> State of legal domicile: <b>MD</b>	

**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: <b>NORTHWEST HOSPITAL EXISTS TO IMPROVE THE WELL-BEING OF THE COMMUNITY BY NURTURING RELATIONSHIPS</b>		
	<b>2</b> Check this box <input type="checkbox"/> 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>	<b>22</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>16</b>
	<b>5</b> Total number of individuals employed in calendar year 2014 (Part V, line 2a)	<b>5</b>	<b>1982</b>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	<b>196</b>
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>4,970.</b>
<b>b</b> Net unrelated business taxable income from Form 990-T, line 34	<b>7b</b>	<b>0.</b>	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	<b>Prior Year</b>	<b>Current Year</b>
	<b>9</b> Program service revenue (Part VIII, line 2g)	<b>2,395,954.</b>	<b>1,525,610.</b>
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<b>215,194,826.</b>	<b>226,374,623.</b>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8a, 9c, 10c, and 11e)	<b>7,216,542.</b>	<b>8,548,213.</b>
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<b>231,666,272.</b>	<b>244,847,921.</b>
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<b>0.</b>	<b>0.</b>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	<b>0.</b>	<b>0.</b>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<b>120,283,151.</b>	<b>122,468,826.</b>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	<b>21,158.</b>	<b>0.</b>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) <b>28,529.</b>		
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<b>93,175,239.</b>	<b>96,492,331.</b>
<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<b>213,479,548.</b>	<b>218,961,157.</b>	
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	<b>18,186,724.</b>	<b>25,886,764.</b>	
<b>Net Assets or Fund Balances</b>	<b>20</b> Total assets (Part X, line 16)	<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>21</b> Total liabilities (Part X, line 26)	<b>314,176,344.</b>	<b>332,447,752.</b>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	<b>124,625,585.</b>	<b>124,221,561.</b>
		<b>189,550,759.</b>	<b>208,226,191.</b>

**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.

<b>Sign Here</b>	Signature of officer <i>[Signature]</i>	<b>5/15/16</b>
	<b>DAVID KRAJEWSKI, SENIOR VP/CFO</b>	Date
Type or print name and title		

<b>Paid Preparer Use Only</b>	Print/Type preparer's name <b>LORI S. BURGHAUSER</b>	Preparer's signature <b>LORI S. BURGHAUSER</b>	Date <b>05/12/16</b>	Check <input type="checkbox"/> if self-employed	PTIN <b>P00370694</b>
	Firm's name <b>SC&amp;H TAX &amp; ADVISORY SERVICES, LLC</b>	Firm's EIN <b>20-5991824</b>			
	Firm's address <b>910 RIDGEBROOK ROAD SPARKS, MD 21152</b>		Phone no. <b>(410) 403-1500</b>		

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

Part III Statement of Program Service Accomplishments

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

X

1 Briefly describe the organization's mission:

SEE SCHEDULE O

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 X

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 X

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 \$ 159,444,132. including grants of \$ 0. ) (Revenue \$ 226,374,623. )
NORTHWEST HOSPITAL CENTER, INC. IS RESPONSIBLE FOR THE MANAGEMENT AND DAY-TO-DAY OPERATIONS OF THE 245 BED ACUTE-CARE AND 39 BED SUB ACUTE-CARE UNIT. THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. TOTAL CHARITY CARE AT COST WAS \$3,225,997.

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 159,444,132.

**Part IV Checklist of Required Schedules**

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

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

	Yes	No
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		X
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>		X
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	X	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a</i>		X
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
24b		
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
24c		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
24d		
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
25b		X
26 Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i>		X
26		X
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		X
27		X
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
28a		X
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>		X
28b		X
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i>	X	
28c	X	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
29		X
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
30		X
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
31		X
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		X
32		X
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>		X
33		X
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
34	X	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
35a		X
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		
35b		
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		X
36		X
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>		X
37		X
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	X	
38	X	

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

Main form area with questions 1a through 14b and corresponding Yes/No columns. Includes a large 'COPY' watermark.

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 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 [X]

Section A. Governing Body and Management

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 1a through 9 regarding governing body members, relationships, and documentation.

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

Table with columns for question number, description, and Yes/No checkboxes. Includes questions 10a through 16b regarding local chapters, conflict of interest, whistleblower, and joint ventures.

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed MD, CA
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection.
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: NANCY KANE - (410) 601-5653 2401 WEST BELVEDERE ROAD, BALTIMORE, MD 21215

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

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

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

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

- List all of the organization's current officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's current key employees, if any. See instructions for definition of "key employee."
- List the organization's five current highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's former officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's former directors or trustees that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DOUGLAS LEDERMAN CHAIR	1.00 0.00			X				0.	0.	0.
(2) PAUL L SAVAL VICE CHAIR (PART YEAR)	1.00 0.00	X		X				0.	0.	0.
(3) THOMAS F OBRECHT VICE CHAIR (PART YEAR)	1.00 0.00	X		X				0.	0.	0.
(4) JOEL R WOHL TREASURER	1.00 0.00	X		X				0.	0.	0.
(5) DONALD KIRSON SECRETARY (PART YEAR)	1.00 0.00	X		X				0.	828.	0.
(6) IRA HIMMEL SECRETARY (PART YEAR)	1.00 0.00	X		X				0.	0.	0.
(7) RONALD ATTMAN DIRECTOR	1.00 0.00	X						0.	828.	0.
(8) RICHARD AZRAEL DIRECTOR (PART YEAR)	1.00 0.00	X						0.	0.	0.
(9) ROBERT A. BAVAR DIRECTOR	1.00 0.00	X						0.	0.	0.
(10) JODY BERG DIRECTOR	1.00 0.00	X						0.	0.	0.
(11) DALLAS S. DANCE DIRECTOR	1.00 0.00	X						0.	0.	0.
(12) EUGENE FRIEDMAN DIRECTOR	1.00 0.00	X						0.	0.	0.
(13) HAROLD HACKERMAN DIRECTOR	1.00 0.00	X						0.	0.	0.
(14) JUAN JUANTEGUY MD DIRECTOR (PART YEAR)	1.00 0.00	X						0.	0.	0.
(15) RICHARD KEMPER DIRECTOR	1.00 0.00	X						0.	0.	0.
(16) AUDREY LIFCOVICH DIRECTOR	1.00 0.00	X						0.	828.	0.
(17) NICK MANGIONE, JR. DIRECTOR	1.00 0.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) JOSEPH MIGLIARA DIRECTOR	1.00 0.00	X					0.	0.	0.	
(19) BILL MILLER DIRECTOR	1.00 0.00	X					0.	0.	0.	
(20) RONALD SCHUSTER DIRECTOR / PHYSICIAN	40.00 0.00	X					7,500.	0.	0.	
(21) WILLIAM SMULYAN, MD DIRECTOR	1.00 0.00	X					0.	0.	0.	
(22) BARRY S WALTERS MD DIRECTOR	1.00 0.00	X					0.	0.	0.	
(23) BRIAN WHITE PRESIDENT/COO/DIRECTOR	40.00 0.00	X		X			0.	739,479.	78,417.	
(24) ALAN D YARBRO DIRECTOR (PART YEAR)	1.00 0.00	X					0.	0.	0.	
(25) N. PAUL ZEMANKIEWICZ, DO DIRECTOR	1.00 0.00	X					0.	0.	0.	
(26) NEIL MELTZER PRES & CEO, LIFE BRIDGE HEALTH	1.00 40.00			X			0.	1,500,322.	359,290.	
<b>1b Sub-total</b>							7,500.	2,242,285.	437,707.	
<b>c Total from continuation sheets to Part VII, Section A</b>							3,530,533.	1,057,421.	372,106.	
<b>d Total (add lines 1b and 1c)</b>							3,538,033.	3,299,706.	809,813.	

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization 137

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
CROTHALL SERVICES, 13028 COLLECTIONS CENTER DRIVE, CHICAGO, IL 60693	CONTRACT CLEANING	4,480,111.
ARAMARK HEALTHCARE 25271 NETWORK PLACE, CHICAGO, IL 60693	FOOD SERVICES	767,833.
HEALTHCARE PERFORMANCE PO BOX 405652, ATLANTA, GA 30384	RECRUITMENT CONSULTING	598,043.
DAVITA OWINGS MILLS PO BOX 403008, ATLANTA, GA 30384	RENAL DIALYSIS	580,984.
CHESAPEAKE MEDICAL 2401 YORK ROAD, LUTHERVILLE, MD 21093	STAFFING	482,696.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization 27

SEE PART VII, SECTION A CONTINUATION SHEETS



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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply)						(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			
(27) DAVID KRAJEWSKI SR VP/CFO, LIFEBRIDGE HEALTH	1.00 40.00			X				0.	722,617.	92,865.
(28) RONALD GINSBERG VP MEDICAL AFFAIRS	40.00 0.00			X				466,774.	0.	19,990.
(29) SUSAN JALBERT VP PATIENT CARE SERVICES	40.00 0.00			X				352,645.	0.	46,824.
(30) CANDACE HAMNER VP CARE MANAGEMENT	40.00 0.00			X				0.	394,804.	11,485.
(31) KELLY CORBI VP, OPERATIONS	40.00 0.00			X				321,747.	0.	52,275.
(32) ROBERT SALTZMAN, MD PHYSICIAN	40.00 0.00					X		796,369.	0.	32,687.
(33) JAMIE BARNES, DO PHYSICIAN	40.00 0.00					X		486,489.	0.	27,254.
(34) DAWN LEONARD MD SURGEON	40.00 0.00					X		406,870.	0.	35,408.
(35) JOGINDER MEHTA, MD HOSPITALIST	40.00 0.00					X		376,112.	0.	21,262.
(36) MAYER GORBATY MD PHYSICIAN	40.00 0.00					X		323,527.	0.	32,056.
<b>Total to Part VII, Section A, line 1c</b>								<b>3,530,533.</b>	<b>1,057,421.</b>	<b>372,106.</b>

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**Part VIII** Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a	Federated campaigns	47,809.				
	b	Membership dues					
	c	Fundraising events					
	d	Related organizations					
	e	Government grants (contributions)	787,140.				
	f	All other contributions, gifts, grants, and similar amounts not included above	690,661.				
	g	Noncash contributions included in lines 1a-1f: \$					
	h	<b>Total.</b> Add lines 1a-1f		1,525,610.			
Program Service Revenue	2 a	PATIENT REVENUE	621400	226,374,623.	226,374,623.		
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	<b>Total.</b> Add lines 2a-2f		226,374,623.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		3,239,548.	4,970.	3,234,578.	
	4	Income from investment of tax-exempt bond proceeds					
	5	Royalties					
	6 a	(i) Real		340,611.			
		(ii) Personal		0.			
		Less: rental expenses		340,611.			
		d Net rental income or (loss)			340,611.		340,611.
	7 a	(i) Securities		32,148,075.			
		(ii) Other		30,575.			
		Less: cost or other basis and sales expenses		26,869,985.			
		c Gain or (loss)		5,278,090.		30,575.	
	d	Net gain or (loss)		5,308,665.		5,308,665.	
	8 a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18					
	b	Less: direct expenses					
	c	Net income or (loss) from fundraising events					
9 a	Gross income from gaming activities. See Part IV, line 19						
b	Less: direct expenses						
c	Net income or (loss) from gaming activities						
10 a	Gross sales of inventory, less returns and allowances						
b	Less: cost of goods sold						
c	Net income or (loss) from sales of inventory						
Miscellaneous Revenue			Business Code				
11 a	PHARMACY SALES	621990	5,061,184.			5,061,184.	
b	CAFETERIA SALES	722210	1,644,575.			1,644,575.	
c	MISCELLANEOUS	900099	1,353,105.			1,353,105.	
d	All other revenue						
e	<b>Total.</b> Add lines 11a-11d		8,058,864.				
12	<b>Total revenue.</b> See instructions.			244,847,921.	226,374,623.	4,970.	
						16,942,718.	

**Part IX Statement of Functional Expenses**

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

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

X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,141,165.		1,112,636.	28,529.
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	96,424,379.	75,296,017.	21,128,362.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,677,638.	3,125,992.	551,646.	
9 Other employee benefits	14,778,643.	11,069,577.	3,709,066.	
10 Payroll taxes	6,447,001.	5,479,051.	967,050.	
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying	151,829.		151,829.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	163,915.		163,915.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	32,983,987.	17,168,917.	15,815,070.	
12 Advertising and promotion	338,161.	8,005.	330,156.	
13 Office expenses	5,164,465.	1,100,544.	4,063,921.	
14 Information technology				
15 Royalties				
16 Occupancy	4,427,597.	3,451,199.	976,398.	
17 Travel	58,873.	58,873.		
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	664,052.	354,521.	309,531.	
20 Interest	4,459,333.	4,459,333.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	11,508,561.	8,576,287.	2,932,274.	
23 Insurance	287,916.	287,916.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <b>SUPPLIES</b>	36,044,654.	28,964,261.	7,080,393.	
b <b>DUES AND MEMBERSHIPS</b>	238,988.	42,739.	196,249.	
c				
d				
e All other expenses				
25 <b>Total functional expenses.</b> Add lines 1 through 24e	218,961,157.	159,444,132.	59,488,496.	28,529.
26 <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here  if following SOP 98-2 (ASC 958-720)

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	1 Cash - non-interest-bearing	5,425.	1	5,428.
	2 Savings and temporary cash investments	74,469,293.	2	90,715,564.
	3 Pledges and grants receivable, net	1,228,654.	3	996,391.
	4 Accounts receivable, net	27,362,700.	4	25,650,345.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	3,211,437.	8	5,191,010.
	9 Prepaid expenses and deferred charges	694,505.	9	1,548,052.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 283,487,896.		
	b Less: accumulated depreciation	10b 169,447,125.	10c	114,040,771.
	11 Investments - publicly traded securities	89,612,070.	11	90,250,261.
	12 Investments - other securities. See Part IV, line 11		12	
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	2,777,802.	15	4,049,930.
16 <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)	314,176,344.	16	332,447,752.	
<b>Liabilities</b>	17 Accounts payable and accrued expenses	34,578,016.	17	35,552,484.
	18 Grants payable		18	
	19 Deferred revenue	214,661.	19	278,139.
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	89,832,908.	25	88,390,938.
	26 <b>Total liabilities.</b> Add lines 17 through 25	124,625,585.	26	124,221,561.
<b>Net Assets or Fund Balances</b>	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	182,473,296.	27	200,799,874.
	28 Temporarily restricted net assets	7,077,463.	28	7,426,317.
	29 Permanently restricted net assets		29	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 <b>Total net assets or fund balances</b>	189,550,759.	33	208,226,191.	
34 <b>Total liabilities and net assets/fund balances</b>	314,176,344.	34	332,447,752.	

**Part XI Reconciliation of Net Assets**

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	244,847,921.
2	Total expenses (must equal Part IX, column (A), line 25)	2	218,961,157.
3	Revenue less expenses. Subtract line 2 from line 1	3	25,886,764.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	189,550,759.
5	Net unrealized gains (losses) on investments	5	-6,045,578.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-1,165,754.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	208,226,191.

**Part XII Financial Statements and Reporting**

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	X	

Form 990 (2014)

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

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.

▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2014**

Open to Public Inspection

Name of the organization: **NORTHWEST HOSPITAL CENTER, INC.**  
Employer identification number: **52-1372665**

**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 11, 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.)
  - 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 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.)
  - 10  An organization organized and operated exclusively to test for public safety. See section 509(a)(4).
  - 11  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 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g.
    - 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 1-9 above or IRC section (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 fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

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

14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2013 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2014. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 33 1/3% support test - 2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
17a 10% -facts-and-circumstances test - 2014. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 10% -facts-and-circumstances test - 2013. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions	<input type="checkbox"/>	

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

(Complete only if you checked the box on line 9 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) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 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 Public support.</b> (Subtract line 7c from line 6)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) 2014	(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 10c, 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 VII)						
<b>13 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 2014 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	%
<b>16</b> Public support percentage from 2013 Schedule A, Part III, line 15	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	%
<b>18</b> Investment income percentage from 2013 Schedule A, Part III, line 17	<b>18</b>	%

**19a 33 1/3% support tests - 2014.** 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 - 2013.** 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 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d 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>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>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>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>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>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below.</i>		
<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>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>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>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>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
<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 (a) its supported organizations; (b) individuals that are part of the charitable class benefited by one or more of its supported organizations; or (c) 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>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
<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).</i>		
<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>b</b> Did one or more disqualified persons (as defined in line 9(a)) 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>c</b> Did a disqualified person (as defined in line 9(a)) 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>10a</b> Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer (b) below.</i>		
<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>		

**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. 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, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) 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 (see instructions):		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test. Answer (a) and (b) below.		
<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>		
<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. Answer (a) and (b) below.		
<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? Provide details in Part VI.		
<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. See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	

Section C - Distributable Amount		(A) Prior Year	(B) Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	

7  Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions).

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 <b>Total annual distributions.</b> Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2014 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2014	(iii) Distributable Amount for 2014
1 Distributable amount for 2014 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2014 (reasonable cause required-see instructions)			
3 Excess distributions carryover, if any, to 2014:			
a			
b			
c			
d			
e From 2013			
f <b>Total</b> of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2014 distributable amount			
i Carryover from 2009 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2014 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2014 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2014, if any. Subtract lines 3g and 4a from line 2. If amount greater than zero, see instructions.			
6 Remaining underdistributions for 2014. Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions).			
7 <b>Excess distributions carryover to 2015.</b> Add lines 3j and 4c.			
8 Breakdown of line 7:			
a			
b			
c			
d Excess from 2013			
e Excess from 2014			

**Part VI** **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12.  
Also complete this part for any additional information. (See instructions).

Multiple horizontal lines for supplemental information.

Public Disclosure Copy

**Schedule B**

(Form 990, 990-EZ, or 990-PF)

Department of the Treasury  
Internal Revenue Service

**Schedule of Contributors**

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.  
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2014**

Name of the organization

Employer identification number

**NORTHWEST HOSPITAL CENTER, INC.**

**52-1372665**

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

**General Rule**

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

**Special Rules**

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

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

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

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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2014)

Name of organization

Employer identification number

**NORTHWEST HOSPITAL CENTER, INC.**

**52-1372665**

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		\$ 700,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2		\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3		\$ 125,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4		\$ 100,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5		\$ 81,425.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6		\$ 75,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Public Disclosure Copy

Name of organization

Employer identification number

**NORTHWEST HOSPITAL CENTER, INC.**

**52-1372665**

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7		\$ 47,809.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8		\$ 33,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10		\$ 25,005.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11		\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12		\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Public Disclosure Copy



Name of organization

Employer identification number

**NORTHWEST HOSPITAL CENTER, INC.**

**52-1372665**

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13		\$ 12,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14		\$ 12,140.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15		\$ 11,675.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Public Disclosure Copy

Name of organization

Employer identification number

**NORTHWEST HOSPITAL CENTER, INC.**

**52-1372665**

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19		\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20		\$ 6,064.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21		\$ 5,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22		\$ 5,150.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Public Disclosure Copy

Name of organization

Employer identification number

**NORTHWEST HOSPITAL CENTER, INC.**

**52-1372665**

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

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

Public Disclosure Copy

Name of organization **NORTHWEST HOSPITAL CENTER, INC.** Employer identification number **52-1372665**

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

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

Public Disclosure Copy

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

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

**2014**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

For Organizations Exempt From Income Tax Under section 501(c) and section 527  
 ▶ **Complete if the organization is described below.** ▶ Attach to Form 990 or Form 990-EZ.  
 ▶ Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

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

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

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

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

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

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

Name of organization **NORTHWEST HOSPITAL CENTER, INC.** Employer identification number **52-1372665**

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

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.
- 2 Political expenditures ..... ▶ \$ \_\_\_\_\_
- 3 Volunteer hours ..... \_\_\_\_\_

**Part I-B** Complete if the organization is exempt under section 501(c)(6).

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ..... ▶ \$ \_\_\_\_\_
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ..... ▶ \$ \_\_\_\_\_
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year?  Yes  No
- 4a Was a correction made?  Yes  No
- b If "Yes," describe in Part IV.

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

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ..... ▶ \$ \_\_\_\_\_
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ..... ▶ \$ \_\_\_\_\_
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ..... ▶ \$ \_\_\_\_\_
- 4 Did the filing organization file Form 1120-POL for this year?  Yes  No
- 5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ. Schedule C (Form 990 or 990-EZ) 2014

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

- A** Check  if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B** Check  if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....			
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....			
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....			
<b>d</b> Other exempt purpose expenditures .....			
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....			
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.			
<b>If the amount on line 1e, column (a) or (b) is:</b>	<b>The lobbying nontaxable amount is:</b>		
Not over \$500,000	20% of the amount on line 1e.		
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.		
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.		
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.		
Over \$17,000,000	\$1,000,000.		
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....			
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....			
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....			
<b>j</b> If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? .....			
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2011	(b) 2012	(c) 2013	(d) 2014	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column (e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

For each "Yes," response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?	X		
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		15,386.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		136,443.
j Total. Add lines 1c through 1i			151,829.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

1 Dues, assessments and similar amounts from members	1
2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	
a Current year	2a
b Carryover from last year	2b
c Total	2c
3 Aggregate amount reported in section 5033(e)(1)(A) notices of nondeductible section 162(e) dues	3
4 If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4
5 Taxable amount of lobbying and political expenditures (see instructions)	5

**Part IV Supplemental Information**

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

**PART II-B, LINE 1, LOBBYING ACTIVITIES:**

**LOBBYING INCLUDES A PORTION OF THE MARYLAND HOSPITAL ASSOCIATION DUES RELATED TO LOBBYING ACTIVITIES DURING THE YEAR ENDED JUNE 30, 2015 AND OTHER LOBBYING ACTIVITIES PERFORMED ON BEHALF OF THE HOSPITAL REGARDING COMMUNITY STABILIZATION AND DEVELOPMENT, INTERVENTIONAL CARDIOLOGY, HEALTH CARE MALPRACTICE, AND PROGRAM FUNDING.**

**SCHEDULE D**  
(Form 990)

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

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

OMB No. 1545-0047

**2014**  
Open to Public Inspection

▶ Information about Schedule D (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization

**NORTHWEST HOSPITAL CENTER, INC.**

Employer identification number

**52-1372665**

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year .....		
2 Aggregate value of contributions to (during year) .....		
3 Aggregate value of grants from (during year) .....		
4 Aggregate value at end of year .....		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? .....		<input type="checkbox"/> Yes <input type="checkbox"/> 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? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part II Conservation Easements.** Complete if the organization answered "Yes" to 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 a 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 Tax Year
a Total number of conservation easements .....	2a
b Total acreage restricted by conservation easements .....	2b
c Number of conservation easements on a certified historic structure included in (a) .....	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register .....	2d

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

4 Number of states where property subject to conservation easement is located ▶ \_\_\_\_\_

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

Yes  No

6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year ▶ \_\_\_\_\_

7 Amount of expenses incurred in monitoring, inspecting, 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" to 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 in 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 in 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" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

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

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment  %
  - b Permanent endowment  %
  - c Temporarily restricted endowment  %
- The percentages in lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- |                             | Yes    | No |
|-----------------------------|--------|----|
| (i) unrelated organizations | 3a(i)  |    |
| (ii) related organizations  | 3a(ii) |    |
- b If "Yes" to 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" to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		7,894,260.		7,894,260.
b Buildings		141,130,474.	64,776,446.	76,354,028.
c Leasehold improvements				
d Equipment		118,196,807.	104,670,679.	13,526,128.
e Other		16,266,355.		16,266,355.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				114,040,771.

**Part VII Investments - Other Securities.**

Complete if the organization answered "Yes" to 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> (Col. (b) must equal Form 990, Part X, col. (B) line 12.)		

**Part VIII Investments - Program Related.**

Complete if the organization answered "Yes" to 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> (Col. (b) must equal Form 990, Part X, col. (B) line 13.)		

**Part IX Other Assets.**

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) <b>CAPTIVE PROFESSIONAL LIABILITY</b>	<b>590,781.</b>
(3) <b>WORKERS COMPENSATION</b>	<b>641,270.</b>
(4) <b>DEFERRED COMPENSATION</b>	<b>163,035.</b>
(5) <b>ASSET RETIREMENT OBLIGATION</b>	<b>610,000.</b>
(6) <b>DUE TO AFFILIATES BONDS</b>	<b>77,142,286.</b>
(7) <b>OTHER L/T LIABILITIES</b>	<b>9,243,566.</b>
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	<b>88,390,938.</b>

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" to Form 990, Part IV, line 12a.

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-row labels (2a-2e, 4a-4c), and a final column for totals (1, 3, 5).

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-row labels (2a-2e, 4a-4c), and a final column for totals (1, 3, 5).

Part XIII Supplemental Information.

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

Series of horizontal lines provided for entering supplemental information.

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2014**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Information about Schedule H (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization: **NORTHWEST HOSPITAL CENTER, INC.** Employer identification number: **52-1372665**

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

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			2007919.		2007919.	.92%
b Medicaid (from Worksheet 3, column a)			547,817.		547,817.	.25%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
<b>d Total Financial Assistance and Means-Tested Government Programs</b>			<b>2555736.</b>		<b>2555736.</b>	<b>1.17%</b>
<b>Other Benefits</b>						
e Community health improvement services and community benefit operations (from Worksheet 4)			1673569.		1673569.	.76%
f Health professions education (from Worksheet 5)			732,793.		732,793.	.33%
g Subsidized health services (from Worksheet 6)			2604761.		2604761.	1.19%
h Research (from Worksheet 7)			69,748.		69,748.	.03%
i Cash and in-kind contributions for community benefit (from Worksheet 8)			130,746.		130,746.	.06%
<b>j Total Other Benefits</b>			<b>5211617.</b>		<b>5211617.</b>	<b>2.37%</b>
<b>k Total. Add lines 7d and 7j</b>			<b>7767353.</b>		<b>7767353.</b>	<b>3.54%</b>

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			233,411.		233,411.	.11%
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			233,411.		233,411.	.11%

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

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and JME)	5	102,650,436.		
6 Enter Medicare allowable costs of care relating to payments on line 5	6	81,828,645.		
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	20,821,791.		
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other				

Section C. Collection Practices

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

**Part IV Management Companies and Joint Ventures** (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities

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

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)

1 NORTHWEST HOSPITAL CENTER, INC.  
5401 OLD COURT ROAD  
RANDALLSTOWN, MD 21133  
WWW.LIFEBRIDGEHEALTH.ORG/NORTHWEST  
03-004

Table with columns: Licensed hospital, Gen. medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1: X, X, , , , , X, SUB-ACUTE



**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group NORTHWEST HOSPITAL CENTER, INC.

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

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

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group NORTHWEST HOSPITAL CENTER, INC.

		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? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:			
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300</u> % and FPG family income limit for eligibility for discounted care of <u>500</u> %		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input type="checkbox"/> Medical indigency		
<b>e</b>	<input type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance status		
<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? .....	<b>X</b>	
<b>15</b>	Explained the method for applying for financial assistance? .....	<b>X</b>	
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):			
<b>a</b>	<input 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>	Included measures to publicize the policy within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V</u>		
<b>b</b>	<input type="checkbox"/> The FAP application form was widely available on a website (list url): _____		
<b>c</b>	<input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): _____		
<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"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b>	<input 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"/> Other (describe in Section C)		

**Billing and Collections**

<b>17</b>	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 non-payment? .....	<b>X</b>	
<b>18</b>	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:		
<b>a</b>	<input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b>	<input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b>	<input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b>	<input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b>	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		



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

Name of hospital facility or letter of facility reporting group NORTHWEST HOSPITAL CENTER, INC.

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? .....

	Yes	No
19		X

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  Actions that require a legal or judicial process
- d  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  Notified individuals of the financial assistance policy on admission
- b  Notified individuals of the financial assistance policy prior to discharge
- c  Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d  Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- 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? .....

	Yes	No
21	X	

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)

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

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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b  The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c  The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d  Other (describe in Section C)


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

23		X

If "Yes," explain in Section C.

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

24	X	

If "Yes," explain in Section C.

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 3J: THERE WERE NO INFORMATION GAPS IDENTIFIED IN THE ASSESSMENT. IN ADDITION TO THE ITEMS LISTED IN LINE 3, THE CHNA DESCRIBES THE HOSPITAL'S DEMOGRAPHICS.

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 5: LIFEBRIDGE HEALTH, INC., A REGIONAL MARYLAND HEALTH SYSTEM WITH HOSPITALS LOCATED IN BOTH BALTIMORE CITY AND BALTIMORE COUNTY, INITIATED EARLY TALKS WITH BOTH BALTIMORE CITY AND BALTIMORE COUNTY HEALTH DEPARTMENTS AROUND LOCAL HEALTH IMPROVEMENT PLANS TO SUPPORT THE MARYLAND STATE HEALTH IMPROVEMENT PLAN (SHIP). BECAUSE NORTHWEST SERVES PATIENTS IN BALTIMORE COUNTY AS WELL AS BALTIMORE CITY, PARTNERSHIPS DEVELOPED WITH BOTH HEALTH DEPARTMENTS WERE IMPORTANT FOR ASSESSMENT COMPLETION AS WELL AS THE PLANNING AND IMPLEMENTATION OF COMMUNITY HEALTH IMPROVEMENT PROJECTS. IN SUPPORT OF NORTHWEST'S GROWING PARTNERSHIP WITH THE BALTIMORE COUNTY HEALTH DEPARTMENT AND THE BALTIMORE CITY HEALTH DEPARTMENT, REPRESENTATIVES FROM EACH WERE INVITED TO PRESENT THEIR LOCAL HEALTH IMPROVEMENT PLANS TO LIFEBRIDGE HEALTH, INC.'S COMMUNITY MISSION COMMITTEE(CMC), A LIFEBRIDGE BOARD COMMITTEE THAT GUIDES AND MONITORS COMMUNITY BENEFIT PROGRAMMING. BALTIMORE COUNTY HEALTH DEPARTMENT'S DEPUTY DIRECTOR, MS. DELLA LEISTER, PRESENTED THE BALTIMORE COUNTY HEALTH IMPROVEMENT PLAN AND MS. SARAH MORRIS-COMPTON, DIRECTOR OF POLICY AND PLANNING, PRESENTED THE BALTIMORE CITY HEALTH DEPARTMENT'S HEALTH IMPROVEMENT INITIATIVE, HEALTHY BALTIMORE 2015. DUE TO LOCATION OF HOSPITALS, SINAI HOSPITAL REPRESENTATIVES TAKE PRIMARY RESPONSIBILITY FOR

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

PARTNERSHIP WITH THE BALTIMORE CITY HEALTH DEPARTMENT, AND A NORTHWEST HOSPITAL REPRESENTATIVE PARTICIPATES AS A MEMBER OF THE BALTIMORE COUNTY HEALTH IMPROVEMENT COALITION. THE CHNA TEAM FURTHER STRENGTHENED NORTHWEST'S PARTNERSHIP WITH BALTIMORE COUNTY BY MEETING WITH BALTIMORE COUNTY HEALTH DEPARTMENT REPRESENTATIVES IN EARLY 2013 TO SHARE COMMUNITY FEEDBACK AND EXPLORE OPPORTUNITIES TO PARTNER ON THE DEVELOPMENT OF A COMMUNITY HEALTH IMPROVEMENT PROJECT IN RESPONSE TO NORTHWEST'S CHNA RESULTS. ANOTHER PARTICIPANT IN NORTHWEST'S CHNA PROCESS WAS THE NORTHWEST HOSPITAL HEALTH POLICY ADVISORY BOARD (NHPAB), A GROUP OF HOSPITAL AND COMMUNITY STAKEHOLDERS WHOSE GROUP PURPOSE IS TO ENGAGE COMMUNITY LEADERS AROUND IMPORTANT HEALTH ISSUES. THIS GROUP PROVIDED KEY GUIDANCE IN THE DEVELOPMENT OF A PROCESS FOR CONDUCTING THE CHNA. FOR EXAMPLE, THE GROUP PROVIDED AN EARLY RECOMMENDATION TO USE WRITTEN AND ELECTRONIC SURVEYS TO REACH COMMUNITY MEMBERS. TO SUPPLEMENT THE DATA RECEIVED FROM SURVEYS, THE CHNA TEAM DECIDED TO ALSO HOLD A COMMUNITY FEEDBACK SESSION AT THE RANDALLSTOWN COMMUNITY CENTER, A LOCATION RECOMMENDED BY A NHPAB MEMBER. OVERALL, THE NHPAB'S CONTRIBUTION TO THE ASSESSMENT PROCESS INCLUDED SPREADING THE WORD ABOUT THE ASSESSMENT THROUGH BOTH ORAL AND WRITTEN METHODS, DISTRIBUTING AND COLLECTING COMMUNITY SURVEYS WITHIN PERSONAL AND PROFESSIONAL NETWORKS, AT COMMUNITY MEETINGS AND EVENTS, OFFERING RECOMMENDATIONS FOR THE PLANNING OF COMMUNITY FORUMS, DISTRIBUTING COMMUNITY FORUM FLYERS AND ATTENDING KEY COMMUNITY EVENTS IN SUPPORT OF THE ASSESSMENT. NORTHWEST ALSO USED ITS ROUTINE PRACTICE OF COLLABORATING WITH COMMUNITY AND HUMAN SERVICE PARTNERS IN ORDER TO ENHANCE COMMUNITY INVOLVEMENT AND INPUT DURING THE CHNA PROCESS. PARTNERS WHO PROVIDED SUPPORT FOR THE CHNA INCLUDE: TONY BAYSMORE, SPECIAL ASSISTANT TO BALTIMORE COUNTY EXECUTIVE KEVIN KAMENETZ, THE RANDALLSTOWN COMMUNITY

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

CENTER, THE LOCAL CHAPTER OF DELTA SIGMA THETA SORORITY, AS WELL AS LOCAL AREA CHURCHES, FAITH-BASED INSTITUTIONS, SCHOOLS AND RECREATION-BASED PROGRAMS. IN ADDITION, A NEW PARTNERSHIP EMERGED FOLLOWING NORTHWEST'S FIRST COMMUNITY FEEDBACK SESSION IN NOVEMBER 2012. IN ATTENDANCE WAS AN ACTIVE MEMBER OF THE LIBERTY ROAD COMMUNITY COUNCIL (LRCC) WHO INVITED MEMBERS OF THE CHNA TEAM TO ATTEND A LRCC BOARD MEETING TO PRESENT AND RECEIVE FEEDBACK ABOUT COMMUNITY HEALTH NEEDS AND STRATEGIES FOR IMPROVING COMMUNITY HEALTH. ASSISTANCE FROM PARTNERS DESCRIBED ABOVE INCLUDED SPREADING THE WORD ABOUT THE ASSESSMENT, DISTRIBUTING AND COLLECTING COMMUNITY SURVEYS, PROVIDING SPACE AND ALLOCATING MEETING TIME FOR GATHERING COMMUNITY INPUT ON HEALTH NEEDS, AND OFFERING CONSISTENT SUPPORT FOR OTHER TASKS AS NEEDED. IN ADDITION, PARTNERS CONTRIBUTED THEIR OWN FEEDBACK ABOUT COMMUNITY HEALTH NEEDS. ANOTHER KEY ROLE OF COMMUNITY PARTNERS WILL BE PARTICIPATION IN PROJECT-PLANNING AS WE DETERMINE SPECIFIC COMPONENTS OF THE COMMUNITY-WIDE COMMUNITY HEALTH IMPROVEMENT PROJECT AND THE ROLE THAT EACH COMMUNITY PARTNER WILL PLAY IN ITS IMPLEMENTATION. THE FOLLOWING COMMUNITY MEMBERS WERE CONSULTED: DELLA J. LEISTER, DEPUTY HEALTH OFFICER BALTIMORE COUNTY HEALTH DEPARTMENT; SARAH MORRIS-COMPTON, DIRECTOR OFFICE OF POLICY AND PLANNING, BALTIMORE CITY HEALTH DEPARTMENT; TONY BAYSMORE, SPECIAL ASSISTANT TO BALTIMORE COUNTY EXECUTIVE KEVIN KAMENETZ BALTIMORE COUNTY EXECUTIVE OFFICE; GLORIA MARROW, M.A. DELTA SIGMA THETA SORORITY; L'AARON JOHNSON, LIBERTY ROAD COMMUNITY COUNCIL, INC.; NORTHWEST HOSPITAL HEALTH POLICY ADVISORY BOARD AND MEMBERS OF THE COMMUNITY WHO ATTENDED NORTHWEST HOSPITAL COMMUNITY FEEDBACK SESSIONS.

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 7D: COPIES OF THE CHNA WERE DISTRIBUTED TO KEY COMMUNITY PARTNERS.

NORTHWEST HOSPITAL CENTER, INC.

[HTTP://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/DOCUMENTS/COMMUNITY%20HEALTH/2013/NORTHWEST.PDF](http://www.lifebridgehealth.org/uploads/public/documents/community%20health/2013/northwest.pdf)

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 11: WHEN NORTHWEST HOSPITAL AND SINAI HOSPITAL MERGED IN 1988 TO FORM THE LIFEBRIDGE HEALTH, INC. SYSTEM, EACH HOSPITAL BROUGHT ITS OWN APPROACH TO COMMUNITY BENEFIT PROGRAMMING. NORTHWEST HOSPITAL CREATED COMMUNITY HEALTH EDUCATION PROGRAMS TO HELP ITS RESIDENTS STAY HEALTHY THROUGH HEALTH PROMOTION AND PREVENTION EFFORTS WHILE SINAI HOSPITAL BUILT SERVICES TO INTERVENE WITH AND TREAT SYMPTOMS OF EXTREME POVERTY EXPERIENCED BY AREA RESIDENTS. THESE PHILOSOPHIES CONTINUE TO DRIVE COMMUNITY BENEFIT PROGRAMMING AT EACH HOSPITAL.

NORTHWEST HOSPITAL RECOGNIZES THAT NOT ALL IDENTIFIED COMMUNITY NEEDS CAN BE ADDRESSED AND THAT DIFFICULT CHOICES MUST BE MADE TO PROPERLY ALLOCATE LIMITED RESOURCES TO THE AREAS OF GREATEST NEED. IF AN IDENTIFIED NEED IS OUTSIDE THE PURVIEW OF THE HOSPITAL'S KEY PURPOSE OF PROVIDING QUALITY HEALTHCARE, WE SEARCH FOR WAYS IN WHICH OUR COMMUNITY PARTNERS MAY BE ABLE TO ADDRESS OUR COMMUNITY'S NEEDS WHILE THE HOSPITAL PLAYS A MORE SECONDARY ROLE. FOR EXAMPLE, WHEN OUR PARTNER, THE BALTIMORE COUNTY DEPARTMENT OF

**Part V** Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2" "B, 3," etc.) and name of hospital facility.

HEALTH, IDENTIFIED INFANT MORTALITY AS A HEALTH PRIORITY FOR BALTIMORE COUNTY, NORTHWEST HOSPITAL DEFERRED TO OTHER BALTIMORE COUNTY PROVIDERS AND TO SINAI HOSPITAL, THE NEAREST BIRTHING HOSPITAL, TO ADDRESS THIS IMPORTANT NEED. THIS DECISION WAS MADE BECAUSE IT IS NOT IN NORTHWEST'S CORE MISSION TO PROVIDE MATERNITY CARE, AS THE HOSPITAL IS NOT A BIRTHING HOSPITAL. HOWEVER, IT IS IN THE BEST INTEREST OF NORTHWEST HOSPITAL TO SUPPORT INFANT MORTALITY REDUCTION EFFORTS INDIRECTLY THROUGH PARTNERSHIP BUILDING AND GENERAL HEALTH PROMOTION EFFORTS.

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 16I: [HTTP://WWW.LIFEBRIDGEHEALTH.ORG/NORTHWEST/NORTHWESTBILLINGANDFINANCIALCONSIDERATIONS.ASPX](http://www.lifebridgehealth.org/northwest/northwestbillingandfinancialconsiderations.aspx)

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 22D: CHARGES FOR ALL PATIENTS ARE STATE REGULATED. SERVICES ARE CHARGED TO ALL PATIENTS AT THE SAME RATE. CHARGES FOR INDIVIDUALS FOUND ELIGIBLE FOR FAP BASED ON 300% OR LESS OF THE FEDERAL POVERTY LEVEL (FPL) ARE WRITTEN-OFF IN FULL TO FAP (THERE IS NO PATIENT LIABILITY). CHARGES FOR INDIVIDUALS FOUND ELIGIBLE FOR FAP BASED ON THE HSCRC'S FINANCIAL HARDSHIP CRITERIA OF 301%-500% OF FPL ARE CHARGED 25% OF THE ANNUAL HOUSEHOLD INCOME PER THE HSCRC'S FINANCIAL HARDSHIP CRITERIA. THE DIFFERENCE BETWEEN THE TOTAL CHARGES AND THE CALCULATED 25% OF THE ANNUAL HOUSEHOLD INCOME IS WRITTEN OFF TO FAP.

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

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

NORTHWEST HOSPITAL CENTER, INC.:

PART V, SECTION B, LINE 24: ONLY THOSE PATIENTS APPROVED RETROSPECTIVELY (DETERMINED ELIGIBLE AFTER THE DATE OF SERVICE) WOULD HAVE BEEN CHARGED AT THE FULL ESTABLISHED RATES. ONCE ELIGIBILITY IS DETERMINED, CHARGES WOULD THEN BE ADJUSTED IN ACCORDANCE WITH THE CHARITY CARE POLICY AS SPECIFIED ABOVE.

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

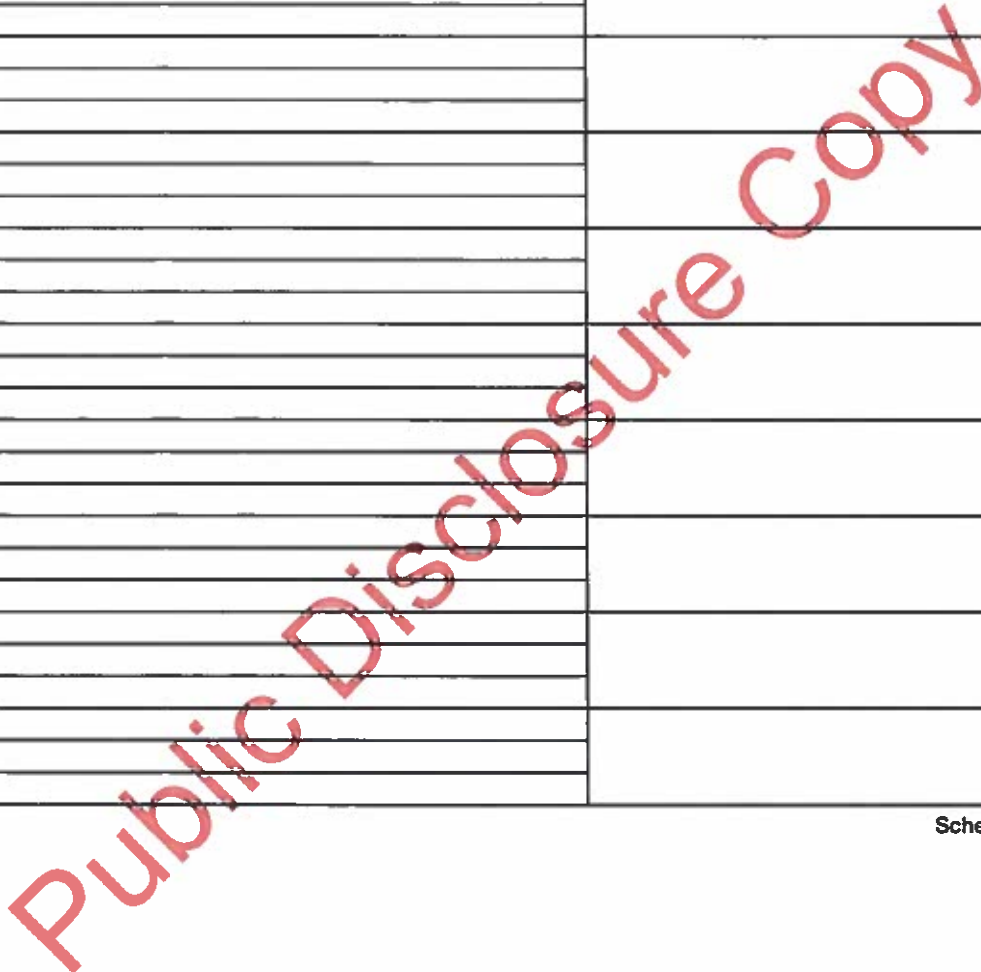
**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 0

Name and address	Type of Facility (describe)

Schedule H (Form 990) 2014





**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.

**PART I, LINE 3C:**

NORTHWEST HOSPITAL CENTER, INC. PROVIDES CARE WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES, TO PATIENTS WHO MEET THE CRITERIA OF ITS CHARITY CARE POLICY. IT DOES NOT PURSUE THE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE AND THOSE AMOUNTS ARE NOT REPORTED AS REVENUE. THE CRITERIA FOR CHARITY CARE CONSIDER GROSS INCOME AND FAMILY SIZE ACCORDING TO CURRENT FEDERAL POVERTY GUIDELINES. PATIENTS WITH AN ANNUAL INCOME UP TO 300% OF THE FEDERAL POVERTY LEVEL MAY HAVE 100% OF THEIR HOSPITAL BILLS COVERED BY FINANCIAL ASSISTANCE. TO QUALIFY, THE PATIENT MUST SHOW PROOF OF INCOME 300% OR LESS OF THE FEDERAL POVERTY GUIDELINES. PATIENTS SLIGHTLY ABOVE 300% ANNUAL INCOME MAY HAVE A PORTION OF THEIR MEDICAL BILLS COVERED BY FINANCIAL ASSISTANCE BASED ON A SLIDING SCALE. ELIGIBILITY IS CALCULATED BASED ON THE NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD.

**PART I, LINE 7:**

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW

**Part VI** Supplemental Information (Continuation)

COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAK-OUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. THE COST OF RENDERING SERVICES FOR MEDICAL ASSISTANCE PATIENTS IS EQUAL TO MEDICAID REVENUES IN MARYLAND. THUS, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

## PART II, COMMUNITY BUILDING ACTIVITIES:

DECISIONS REGARDING THE SELECTION OF COMMUNITY NEEDS TO ADDRESS DEPEND ON THE HOSPITAL DEPARTMENTS INVOLVED AND THE CONSTITUENCIES THEY SERVE. DECISIONS MAY ALSO INVOLVE HOW THE COMMUNITY ASSESSMENT WAS DONE, AND FOR WHAT PURPOSE. EACH YEAR, NORTHWEST HOSPITAL CONDUCTS DISASTER DRILLS, PROVIDES DISASTER READINESS EDUCATION, AND PURCHASES SUPPLIES IN ORDER TO PREPARE AND RESPOND TO LOCAL AND STATE EMERGENCIES. THE HOSPITAL ANNUALLY REVIEWS PREPAREDNESS STRATEGIES TO ENSURE THAT THEY RESPOND TO COMMUNITY NEEDS AND ALIGN WITH DISASTER PREPAREDNESS PRIORITIES OUTLINED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S OFFICE OF PREPAREDNESS AND RESPONSE. DURING FY 2015, THE HOSPITAL CONDUCTED SEVERAL CODE ORANGE DRILLS TO PREPARE FOR POTENTIAL LOCAL HAZMAT SITUATIONS AND PARTICIPATED IN A NATIONAL DISASTER MEDICAL SYSTEM DRILL. DISASTER PREPAREDNESS FUNDS ALSO SUPPORTED EDUCATIONAL PROGRAMS AND SUPPLY ACQUISITION TO ENSURE THAT THE HOSPITAL IS EQUIPPED AND PREPARED TO PROVIDE IMMEDIATE QUALITY CARE TO PATIENTS AND COMMUNITY RESIDENTS IN THE FACE OF EMERGENCIES.

**Part VI** Supplemental Information (Continuation)

## PART III, LINE 2:

BAD DEBT EXPENSE IS ESTIMATED BY USING HISTORICAL RATES FOR EACH PAYOR AND THE LENGTH OF TIME THE RECEIVABLE HAS BEEN OUTSTANDING. THESE RATES ARE REVISITED FROM TIME TO TIME AND ADJUSTED WHEN DEEMED APPROPRIATE. ANY ADDITIONAL RESERVES ARE DETERMINED BY THE HOSPITAL'S EXECUTIVES.

## PART III, LINE 3:

TO CALCULATE THE AMOUNT OF THE ORGANIZATIONS BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE FINANCIAL ASSISTANCE POLICY THE TOTAL BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS WAS USED. THIS TOTAL AMOUNT WAS THEN MULTIPLIED BY THE CALCULATION OF RATIO OF PATIENT CARE COSTS TO CHARGES. THE RATIO OF PATIENT CARE COSTS TO CHARGES WAS DETERMINED BY TAKING PATIENT CARE COSTS AND DIVIDING THIS BY THE GROSS PATIENT CHARGES. PATIENT CARE COSTS WERE CALCULATED BY TAKING TOTAL OPERATING EXPENSES OF THE ENTITY AND REMOVING ALL NONPATIENT CARE ACTIVITIES AND COMMUNITY BENEFIT AND BUILDING EXPENSES.

## PART III, LINE 4:

THE PREPARATION OF CONSOLIDATED FINANCIAL STATEMENTS, IN CONFORMITY WITH U.S. GENERALLY ACCEPTED ACCOUNTING PRINCIPLES, REQUIRES MANAGEMENT TO MAKE ESTIMATES AND ASSUMPTIONS. ALL PATIENT ACCOUNTS ARE HANDLED CONSISTENTLY AND APPROPRIATELY TO MAXIMIZE CASH FLOW AND TO IDENTIFY BAD DEBT ACCOUNTS TIMELY. ACTIVE ACCOUNTS ARE CONSIDERED BAD DEBT ACCOUNTS WHEN THEY MEET SPECIFIC COLLECTION ACTIVITY GUIDELINES AND/OR ARE REVIEWED BY THE APPROPRIATE MANAGEMENT AND DEEMED TO BE UNCOLLECTIBLE. EVERY EFFORT IS MADE TO IDENTIFY AND PURSUE ALL ACCOUNT BALANCE LIQUIDATION OPTIONS INCLUDING, BUT NOT LIMITED TO THIRD PARTY PAYOR REIMBURSEMENT, PATIENT

**Part VI** Supplemental Information (Continuation)

PAYMENT ARRANGEMENTS, MEDICAID ELIGIBILITY AND FINANCIAL ASSISTANCE. THIRD PARTY RECEIVABLE MANAGEMENT AGENCIES PROVIDE EXTENDED BUSINESS OFFICE SERVICES AND INSURANCE OUTSOURCE SERVICES TO ENSURE MAXIMUM EFFORT IS TAKEN TO RECOVER INSURANCE AND SELF-PAY DOLLARS BEFORE TRANSFER TO BAD DEBT. CONTRACTUAL ARRANGEMENTS WITH THIRD PARTY COLLECTION AGENCIES ARE USED TO ASSIST IN THE RECOVERY OF BAD DEBT DOLLARS AFTER ALL INTERNAL COLLECTION EFFORTS HAVE BEEN EXHAUSTED. IN SO DOING, THE COLLECTION AGENCIES MUST OPERATE CONSISTENTLY WITH NORTHWEST HOSPITAL CENTER'S GOAL OF MAXIMUM BAD DEBT RECOVERY AND STRICT ADHERENCE WITH FAIR DEBT COLLECTIONS PRACTICES ACT (FDCPA) RULES AND REGULATIONS, WHILE MAINTAINING POSITIVE PATIENT RELATIONS. SEE AUDITED FINANCIAL STATEMENTS PAGE 15.

## PART III, LINE 8:

TOTAL REVENUE RECEIVED FROM MEDICARE (DSH & IME) AND MEDICARE ALLOWABLE COSTS ARE DERIVED FROM THE ANNUAL MEDICARE COST REPORT. THE INPATIENT ROUTINE COSTS ARE DERIVED FROM THE STEP-DOWN METHODOLOGY BASED ON ACCEPTED STATISTICAL ALLOCATION WITH A UNIFORM PER DIEM COST FOR EACH PAYOR TYPE. THE ANCILLARY MEDICARE ALLOWABLE COSTS ARE INITIALLY DERIVED FROM THE STEP-DOWN METHODOLOGY BUT ARE ALLOCATED TO THE PAYOR TYPES BASED ON THE RATIO OF COST TO CHARGE FOR EACH PAYOR.

## PART III, LINE 9B:

PATIENTS CAN BE DETERMINED ELIGIBLE FOR FINANCIAL ASSISTANCE (F.A.) PROSPECTIVELY OR RETROSPECTIVELY. THE F.A. ELIGIBILITY PERIOD EXPIRES ONE YEAR FROM THE MONTH ELIGIBILITY IS APPROVED FOR MEDICALLY NECESSARY SERVICES. THE PATIENT IS ASKED TO PROVIDE THE F.A. APPROVAL LETTER FOR SERVICES PROVIDED WITHIN THE ELIGIBILITY PERIOD. THE HOSPITAL WILL MAKE EVERY EFFORT TO IDENTIFY PATIENTS ELIGIBLE FOR F.A., ALTHOUGH HOSPITAL

**Part VI** Supplemental Information (Continuation)

SYSTEMS DO NOT ALLOW FOR THIS TO BE AUTOMATED. BALANCES APPROVED FOR FINANCIAL ASSISTANCE ARE WRITTEN-OFF TO A ZERO BALANCE AND THEREFORE NOT PURSUED BY INTERNAL COLLECTION PROCESSES OR THIRD PARTY AGENCIES. BALANCES ALREADY PLACED WITH THIRD PARTY AGENCIES ARE WRITTEN-OFF TO A ZERO BALANCE AND THE ACCOUNTS ARE CLOSED AND RETURNED BY THE THIRD PARTY AGENCY.

## PART VI, LINE 2:

NORTHWEST HOSPITAL ("NORTHWEST") CONDUCTED ITS FIRST FEDERALLY REQUIRED COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN FISCAL YEAR 2013 (JULY 1, 2012 - JUNE 30, 2013). INVOLVEMENT OF RESIDENTS, STAKEHOLDERS AND COMMUNITY PARTNERS WAS AN ESSENTIAL COMPONENT OF THE CHNA PROCESS. NORTHWEST'S CHNA COMPLIES WITH THE NEW INTERNAL REVENUE SERVICE (IRS) MANDATE REQUIRING ALL NOT-FOR-PROFIT 501(C)(3) HOSPITALS TO CONDUCT A CHNA AND IMPLEMENT A COMMUNITY HEALTH IMPROVEMENT PROJECT ONCE EVERY THREE YEARS. THE PROCESS USED TO IDENTIFY HEALTH NEEDS OF NORTHWEST'S COMMUNITY INCLUDED ANALYZING PRIMARY AND SECONDARY HEALTH DATA AT BOTH THE HOSPITAL AND COMMUNITY LEVEL, AND INVOLVING PUBLIC HEALTH EXPERTS, COMMUNITY MEMBERS AND KEY COMMUNITY GROUPS IN FURTHER IDENTIFICATION OF PRIORITY CONCERNS AND NEEDS. THE CHNA TEAM COLLECTED AND ANALYZED 339 SURVEYS FROM INDIVIDUALS LIVING IN NORTHWEST'S PRIMARY SERVICE AREA ZIP CODES AND HELD A COMMUNITY FEEDBACK SESSION ATTENDED BY COMMUNITY RESIDENTS AND STAKEHOLDERS. THE CHNA TEAM EVALUATED RESULTS FROM SURVEYS, ONE COMMUNITY FEEDBACK SESSION AND PUBLIC HEALTH EXPERTS' RECOMMENDATIONS TO PRIORITIZE NORTHWEST'S TOP COMMUNITY HEALTH NEEDS. AN ASSESSMENT OF HOSPITAL RESOURCES, EXPERTISE AND CAPACITY LED TO A DECISION TO FOCUS THE RESULTING COMMUNITY HEALTH IMPROVEMENT PROJECT ON THE "HEART DISEASE CLUSTER" (INCLUDING HEART DISEASE, DIABETES AND STROKE). THROUGHOUT THE ASSESSMENT PROCESS, THE HOSPITAL WORKED TO ALIGN ITS PRIORITIES WITH LOCAL, STATE AND NATIONAL

**Part VI** Supplemental Information (Continuation)

HEALTH IMPROVEMENT INITIATIVES INCLUDING THE BALTIMORE COUNTY HEALTH IMPROVEMENT PLAN, MARYLAND STATE HEALTH IMPROVEMENT PLAN (SHIP), AND HEALTH PEOPLE 2020.

## PART VI, LINE 3:

THE FOLLOWING DESCRIBES MEANS USED AT NORTHWEST HOSPITAL TO INFORM AND ASSIST PATIENTS REGARDING ELIGIBILITY FOR FINANCIAL ASSISTANCE UNDER GOVERNMENTAL PROGRAMS AND THE HOSPITAL'S CHARITY CARE PROGRAM. FINANCIAL ASSISTANCE NOTICES, INCLUDING CONTACT INFORMATION, ARE POSTED IN THE BUSINESS OFFICE AND ADMITTING, AS WELL AS POINTS OF ENTRY AND REGISTRATION THROUGHOUT THE HOSPITAL. PATIENT FINANCIAL SERVICES BROCHURE 'FREEDOM TO CARE' IS AVAILABLE TO ALL INPATIENTS. BROCHURES ARE ALSO AVAILABLE IN ALL OUTPATIENT REGISTRATION AND SERVICE AREAS. NORTHWEST HOSPITAL EMPLOYS A FINANCIAL ASSISTANCE LIAISON WHO IS AVAILABLE TO ANSWER QUESTIONS AND TO ASSIST PATIENTS AND FAMILY MEMBERS WITH THE PROCESS OF APPLYING FOR FINANCIAL ASSISTANCE. A PATIENT INFORMATION SHEET IS GIVEN TO ALL INPATIENTS PRIOR TO DISCHARGE AND MAILED TO ALL INPATIENTS WITH THE MARYLAND SUMMARY SHEET. NORTHWEST HOSPITAL'S UNINSURED (SELF-PAY) AND UNDER-INSURED (MEDICARE BENEFICIARY WITH NO SECONDARY) MEDICAL ASSISTANCE ELIGIBILITY PROGRAM SCREENS, ASSISTS WITH THE APPLICATION PROCESS AND ULTIMATELY CONVERTS PATIENTS TO VARIOUS MEDICAL ASSISTANCE COVERAGE AND INCLUDES ELIGIBILITY SCREENING AND ASSISTANCE WITH COMPLETING THE FINANCIAL ASSISTANCE APPLICATION AS PART OF THAT PROCESS. ALL HOSPITAL STATEMENTS AND ACTIVE ACCOUNTS RECEIVABLE OUTSOURCE VENDORS INCLUDE A MESSAGE REFERENCING THE AVAILABILITY OF FINANCIAL ASSISTANCE FOR THOSE WHO ARE EXPERIENCING FINANCIAL DIFFICULTY AND PROVIDES CONTACT INFORMATION TO DISCUSS NORTHWEST HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM. COLLECTION AGENCIES' INITIAL STATEMENT REFERENCES THE AVAILABILITY OF FINANCIAL

**Part VI** Supplemental information (Continuation)

ASSISTANCE FOR THOSE WHO ARE EXPERIENCING FINANCIAL DIFFICULTY AND PROVIDES CONTACT INFORMATION TO DISCUSS NORTHWEST HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM. ALL HOSPITAL PATIENT FINANCIAL SERVICES STAFF, ACTIVE ACCOUNTS RECEIVABLE OUTSOURCE VENDORS, COLLECTION AGENCIES AND MEDICAID ELIGIBILITY VENDORS ARE TRAINED TO IDENTIFY POTENTIAL FINANCIAL ASSISTANCE ELIGIBILITY AND ASSIST PATIENTS WITH THE FINANCIAL ASSISTANCE APPLICATION PROCESS. NORTHWEST HOSPITAL HOSTS AND PARTICIPATES IN VARIOUS DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND MARYLAND HOSPITAL ASSOCIATION SPONSORED CAMPAIGNS LIKE 'COVER THE UNINSURED WEEK'.

## PART VI, LINE 4:

NORTHWEST HOSPITAL IS LOCATED IN THE RANDALLSTOWN 21133 COMMUNITY OF BALTIMORE COUNTY, SERVING BOTH ITS IMMEDIATE NEIGHBORS AND OTHERS FROM THROUGHOUT THE BALTIMORE COUNTY REGION. THE COMMUNITY SERVED BY NORTHWEST HOSPITAL CAN BE DEFINED AS FOLLOWS:

(A) THE PRIMARY SERVICE AREA (PSA) IS COMPRISED OF ZIP CODES FROM WHICH THE TOP 60% OF PATIENT DISCHARGES ORIGINATE.

(B) THE COMMUNITY BENEFIT SERVICE AREA (CBSA) IS COMPRISED OF ZIP CODES OR GEOGRAPHIC AREAS, TARGETED FOR COMMUNITY BENEFIT PROGRAMMING DUE TO THE AREA'S DEMONSTRATION OF NEED. ZIP CODES 21133, 21244 AND THE COUNTY PORTION OF 21207 MAKE UP THE HOSPITAL'S COMMUNITY BENEFIT SERVICE AREA. AS A WHOLE, THE NORTHWEST HOSPITAL COMMUNITY BENEFIT SERVICE AREA IS HOME TO OVER 111,000 RESIDENTS WITH AN AVERAGE HOUSEHOLD INCOME OF \$66,486 COMPARED TO THE MARYLAND STATE AVERAGE OF \$73,538.

## PART VI, LINE 5:

NORTHWEST HOSPITAL'S COMMUNITY BENEFIT SERVICES ARE OPEN TO THE BROAD PUBLIC; HOWEVER, DUE TO THE HOSPITAL'S LOCATION WITHIN ZIP CODE 21133

**Part VI** Supplemental Information (Continuation)

(RANDALLSTOWN), THE MAJORITY OF COMMUNITY BENEFIT ACTIVITIES REACH COMMUNITY MEMBERS RESIDING IN 21133. AS NOTED, 10.6% OF MEDICAID-RECEIVING INPATIENTS LIVE IN BALTIMORE COUNTY WHICH SHOW THAT A PORTION OF PEOPLE LIVING IN THE HOSPITAL'S DIRECT SERVICE AREA WOULD BENEFIT FROM COMMUNITY BENEFIT ACTIVITIES. SOME OF NORTHWEST ACTIVITIES CENTER ON COMMUNITY EDUCATION AND THEREFORE REACH BEYOND RANDALLSTOWN AND INTO MORE DISTANT LOCATIONS WITHIN OUR PRIMARY SERVICE AREA INCLUDING GWYNN OAK (21207) AND WINDSOR MILL (21244).

IN FY15, PRIMARY SERVICE AREA ZIP CODES FOR NORTHWEST HOSPITAL (21133, 21208, 21207, 21244, 21136, 21282, AND 21117) ACCOUNTED FOR 40.78% OF TOTAL INPATIENT ADMISSIONS. MEDICAID PATIENTS (INCLUDING MEDICAID AND MEDICAID HMO PAYORS) ACCOUNTED FOR 24.5% OF PRIMARY SERVICE AREA ADMISSIONS IN FY 2015. SELF-PAY, OFTEN CONSIDERED "UNINSURED" PATIENTS ACCOUNTED FOR 1.6% OF ALL PATIENTS LIVING IN THE PRIMARY SERVICE AREA.

PART VI, LINE 6:

NORTHWEST HOSPITAL IS A COMMUNITY HOSPITAL WITH AN ATTENDING STAFF OF APPROXIMATELY 700 PHYSICIANS, INCLUDING SEVERAL SPECIALTIES. THOSE SPECIALTIES INCLUDE, BUT ARE NOT LIMITED TO CARDIOLOGY, PULMONARY, GENERAL SURGERY, ORTHOPEDICS, VASCULAR AND INFECTIOUS DISEASE. WHILE WE HAVE NARROWED THE GAPS IN GYNECOLOGY, OPHTHALMOLOGY, NEUROLOGY, NEUROSURGERY, VASCULAR AND COLORECTAL SURGERY, THERE ARE STILL GAPS IN DERMATOLOGY, RHEUMATOLOGY, INFECTIOUS DISEASES, PSYCHIATRY AND ORTHOPEDIC SPECIALTIES IN HAND AND SPINE.

PART VI, LINE 7:

THE COMMUNITY BENEFIT REPORT IS FILED IN THE STATE OF MARYLAND.



**Part VI** Supplemental Information (Continuation)

Public Disclosure Copy

**SCHEDULE J  
(Form 990)**

**Compensation Information**

OMB No. 1545-0047

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.

▶ Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

**2014**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

Name of the organization

**NORTHWEST HOSPITAL CENTER, INC.**

Employer identification number

**52-1372665**

**Part I Questions Regarding Compensation**

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

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

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

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

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

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

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

**a** Receive a severance payment or change-of-control payment?

**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?

**c** Participate in, or receive payment from, an equity based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

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

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

**a** The organization?

**b** Any related organization?

If "Yes" to line 5a or 5b, describe in Part III.

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

**a** The organization?

**b** Any related organization?

If "Yes" to line 6a or 6b, describe in Part III.

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

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

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

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

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

Schedule J (Form 990) 2014

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) BRIAN WHITE PRESIDENT/COO/DIRECTOR	(i) 0. (ii) 523,489. (iii) 0.	0. 185,004. 0.	0. 30,986. 0.	0. 58,290. 0.	0. 20,127. 0.	0. 817,896. 0.	0. 22,271. 0.
(2) NEIL MELTZER PRES & CEO, LIFEBRIDGE HEALTH	(i) 790,719. (ii) 0. (iii) 0.	419,867. 0. 0.	289,736. 0. 0.	334,475. 0. 0.	24,815. 0. 0.	1,859,612. 0. 0.	249,253. 0. 0.
(3) DAVID KRAJEWSKI SR VP/CFO, LIFEBRIDGE HEALTH	(i) 483,830. (ii) 0. (iii) 0.	171,876. 0. 0.	66,911. 0. 0.	172,116. 0. 0.	20,749. 0. 0.	815,482. 0. 0.	35,624. 0. 0.
(4) RONALD GINSBERG VP MEDICAL AFFAIRS	(i) 301,966. (ii) 0. (iii) 0.	85,382. 0. 0.	79,426. 0. 0.	3,802. 0. 0.	16,188. 0. 0.	486,764. 0. 0.	39,580. 0. 0.
(5) SUSAN JALBERT VP PATIENT CARE SERVICES	(i) 249,582. (ii) 0. (iii) 0.	73,437. 0. 0.	29,626. 0. 0.	30,107. 0. 0.	16,717. 0. 0.	399,469. 0. 0.	23,410. 0. 0.
(6) CANDACE HAMNER VP CARE MANAGEMENT	(i) 204,339. (ii) 0. (iii) 0.	70,415. 0. 0.	68,050. 0. 0.	3,839. 0. 0.	7,646. 0. 0.	346,289. 0. 0.	24,788. 0. 0.
(7) KELLY CORBI VP, OPERATIONS	(i) 231,640. (ii) 0. (iii) 0.	72,900. 0. 0.	17,207. 0. 0.	31,749. 0. 0.	20,526. 0. 0.	374,022. 0. 0.	0. 0. 0.
(8) ROBERT SALTZMAN, MD PHYSICIAN	(i) 621,870. (ii) 0. (iii) 0.	156,299. 0. 0.	17,500. 0. 0.	11,245. 0. 0.	21,442. 0. 0.	829,056. 0. 0.	0. 0. 0.
(9) JAMIE BARNES, DO PHYSICIAN	(i) 412,475. (ii) 0. (iii) 0.	73,325. 0. 0.	689. 0. 0.	5,200. 0. 0.	22,054. 0. 0.	513,743. 0. 0.	0. 0. 0.
(10) DAWN LEONARD MD SURGEON	(i) 392,633. (ii) 0. (iii) 0.	14,237. 0. 0.	0. 0. 0.	13,260. 0. 0.	22,148. 0. 0.	442,278. 0. 0.	0. 0. 0.
(11) JOGINDER MEHTA, MD HOSPITALIST	(i) 301,189. (ii) 0. (iii) 0.	65,808. 0. 0.	9,135. 0. 0.	0. 0. 0.	21,262. 0. 0.	397,374. 0. 0.	0. 0. 0.
(12) MAYER GORBATY MD PHYSICIAN	(i) 323,527. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	11,106. 0. 0.	20,950. 0. 0.	355,583. 0. 0.	0. 0. 0.
(i) 0. (ii) 0. (iii) 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.	0. 0. 0.

**Part III** Supplemental Information

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

**PART I, LINE 1A:**

ALL BOARD MEMBERS ARE ELIGIBLE FOR COMPLIMENTARY HEALTH CLUB MEMBERSHIPS.

THE BOARD MEMBERS RECEIVE A 1099 IF THEY SIGN UP AND RECEIVE THE

COMPLIMENTARY MEMBERSHIP.

**PART I, LINE 4B:**

DURING THE YEAR, THE FOLLOWING DIRECTORS AND OFFICERS PARTICIPATED IN A

LIFEBRIDGE HEALTH SPONSORED SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN:

NEIL MELTZER: \$ 305,095

SUSAN JALBERT: \$ 26,265

KELLY CORBI: \$ 26,880

DAVID KRAJEWSKI: \$ 66,916

BRIAN WHITE: \$ 56,001

DURING THE YEAR, THE FOLLOWING DIRECTORS AND OFFICERS RECEIVED PAYMENTS AS

PART OF THEIR PARTICIPATION IN A LIFEBRIDGE HEALTH SPONSORED SUPPLEMENTAL

NONQUALIFIED RETIREMENT PLAN:

**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.

NEIL MELTZER: \$ 249,253

SUSAN JALBERT: \$ 23,410

DAVID KRAJEWSKI: \$ 35,624

BRIAN WHITE: \$ 22,271

RONALD GINSBERG: \$ 39,580

CANDACE HAMNER: \$ 24,788

**COMPENSATION PROVIDED BY RELATED ORGANIZATIONS:**

MR. WHITE RECEIVED COMPENSATION AS PRESIDENT OF NORTHWEST HOSPITAL AND

POST-ACUTE SERVICES FOR LIFEBRIDGE HEALTH, INC. NOT AS A DIRECTOR.



**SCHEDULE L**

(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

### Transactions With Interested Persons

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

Attach to Form 990 or Form 990-EZ.

Information about Schedule L (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2014**

Open To Public  
Inspection

Name of the organization  
**NORTHWEST HOSPITAL CENTER, INC.**

Employer identification number  
**52-1372665**

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 \$

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization \$

**Part II Loans to and/or From Interested Persons.**

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

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No

Total \$

**Part III Grants or Assistance Benefiting Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

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

**Part IV Business Transactions Involving Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
ACME PAPER & SUPPLY CO.	INDIRECT BUSINESS	1,946,027.	NORTHWEST H		X
OBRECHT REALTY SERVICES AN	INDIRECT BUSINESS	103,701.	NORTHWEST H		X
BAVAR PROPERTIES GROUP, LL	INDIRECT BUSINESS	500,000.	NORTHWEST H		X
MEDIA WORKS	INDIRECT BUSINESS	220,006.	NORTHWEST H		X
BALTIMORE HEART ASSOCIATES	INDIRECT BUSINESS	150,000.	NORTHWEST H		X

**Part V Supplemental Information**

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

**SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:**

(A) NAME OF PERSON: ACME PAPER & SUPPLY CO.

(D) DESCRIPTION OF TRANSACTION: NORTHWEST HOSPITAL CENTER, INC. AND THE LIFEBRIDGE SUBSIDIARIES PURCHASED APPROXIMATELY \$1,946,027 IN PAPER SUPPLIES FROM ACME PAPER AND SUPPLY, CO. ONE OF THE DIRECTORS OF NORTHWEST HOSPITAL, MR. RONALD ATTMAN, IS AN OWNER OF THE COMPANY. ALL TRANSACTIONS WERE AT FAIR MARKET VALUE AND NEGOTIATED AT ARM'S LENGTH.

(A) NAME OF PERSON: OBRECHT REALTY SERVICES AND CARLSON LANE LLC

(D) DESCRIPTION OF TRANSACTION: NORTHWEST HOSPITAL CENTER, INC. AND THE LIFEBRIDGE SUBSIDIARIES PAID APPROXIMATELY \$103,701 FOR CONSTRUCTION SERVICES TO OBRECHT REALTY SERVICES AND CARLSON LANE LLC. ONE OF THE DIRECTORS OF NORTHWEST HOSPITAL CENTER, MR. THOMAS OBRECHT, IS AN OWNER OF THESE COMPANIES. ALL TRANSACTIONS WERE AT FMV AND NEGOTIATED AT ARM'S LENGTH.

(A) NAME OF PERSON: BAVAR PROPERTIES GROUP, LLC

(D) DESCRIPTION OF TRANSACTION: NORTHWEST HOSPITAL CENTER, INC. AND THE LIFEBRIDGE SUBSIDIARIES PAID APPROXIMATELY \$500,000 FOR RENT OF OFFICE SPACE FROM BAVAR PROPERTIES GROUP, LLC. ONE OF THE DIRECTORS OF

**Part V** Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

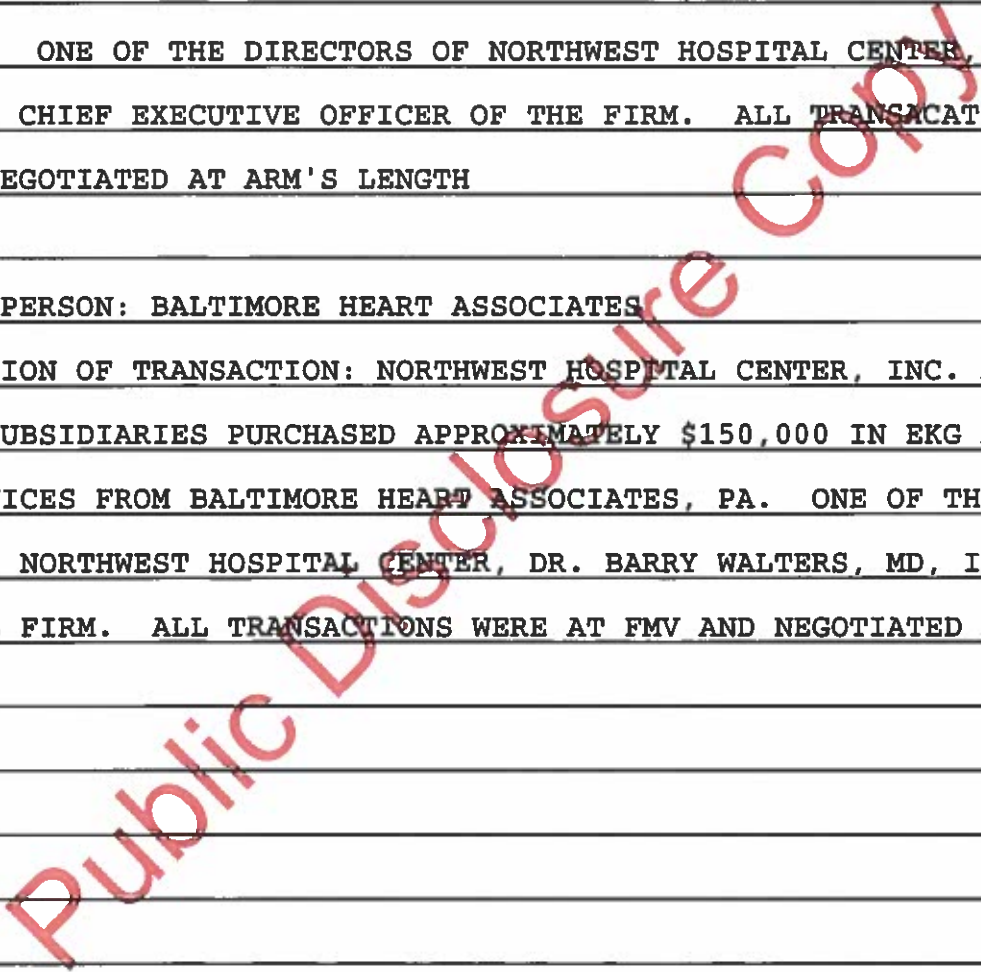
NORTHWEST HOSPITAL, MR. ROBERT BAVAR, IS AN OWNER OF THE COMPANY. ALL TRANSACTIONS WERE AT FMV AND NEGOTIATED AT ARM'S LENGTH.

(A) NAME OF PERSON: MEDIA WORKS

(D) DESCRIPTION OF TRANSACTION: NORTHWEST HOSPITAL CENTER, INC. AND THE LIFEBRIDGE SUBSIDIARIES PURCHASED APPROXIMATELY \$220,006 OF SERVICES FROM MEDIA WORKS. ONE OF THE DIRECTORS OF NORTHWEST HOSPITAL CENTER, MS. JODY BERG, IS THE CHIEF EXECUTIVE OFFICER OF THE FIRM. ALL TRANSACTIONS WERE AT FMV AND NEGOTIATED AT ARM'S LENGTH

(A) NAME OF PERSON: BALTIMORE HEART ASSOCIATES

(D) DESCRIPTION OF TRANSACTION: NORTHWEST HOSPITAL CENTER, INC. AND THE LIFEBRIDGE SUBSIDIARIES PURCHASED APPROXIMATELY \$150,000 IN EKG AND ECHO READING SERVICES FROM BALTIMORE HEART ASSOCIATES, PA. ONE OF THE DIRECTORS OF NORTHWEST HOSPITAL CENTER, DR. BARRY WALTERS, MD, IS AN OWNER OF THE FIRM. ALL TRANSACTIONS WERE AT FMV AND NEGOTIATED AT ARM'S LENGTH.





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

Department of the Treasury  
Internal Revenue Service

Name of the organization

**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.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2014**

Open to Public  
Inspection

Employer identification number  
52-1372665

**NORTHWEST HOSPITAL CENTER, INC.**

**FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:**

**BETWEEN THE HOSPITAL, MEDICAL STAFF AND OUR PATIENTS.**

**FORM 990, PART III, LINE 1:**

**NORTHWEST HOSPITAL EXISTS TO IMPROVE THE WELL-BEING OF THE COMMUNITY BY  
NURTURING RELATIONSHIPS BETWEEN THE HOSPITAL, MEDICAL STAFF AND OUR  
PATIENTS.**

**NORTHWEST HOSPITAL CENTER HAS ALWAYS HAD A VISION OF BEING A RECOGNIZED  
LEADER IN CLINICAL QUALITY AND CUSTOMER CARE - A VISION THAT HAS NOT  
LOST FOCUS IN THE FIFTY-TWO YEARS SINCE THIS RANDALLSTOWN, MARYLAND  
HOSPITAL OPENED ITS DOORS. NORTHWEST HOSPITAL HAS KEPT PACE WITH THE  
GROWTH OF THE COMMUNITY AND TODAY SERVES MORE THAN 250,000 HOUSEHOLDS  
IN NORTHWEST BALTIMORE CITY AND PORTIONS OF BALTIMORE, CARROLL AND  
HOWARD COUNTIES. IN 2015, THE HOSPITAL ADMITTED 11,235 PATIENTS, MOST  
OF WHOM ACCESSED HOSPITAL SERVICES THROUGH THE EMERGENCY DEPARTMENT. IN  
KEEPING WITH THE HOSPITAL'S MISSION TO IMPROVE THE WELLBEING OF THE  
COMMUNITY, NORTHWEST HOSPITAL ADHERES TO ITS LONGSTANDING POLICY OF  
PROVIDING CARE FOR ANY AND ALL WHO SEEK MEDICAL TREATMENT REGARDLESS OF  
RACE, RELIGION OR ABILITY TO PAY. THE HOSPITAL'S CHARITY CARE POLICY IS  
WELL POSTED AND OFFERS A REASONABLE AMOUNT OF CARE AT NO CHARGE OR AT  
REDUCED RATES TO ELIGIBLE PERSONS WHO DO NOT HAVE INSURANCE, MEDICARE  
OR MEDICAL ASSISTANCE. ELIGIBILITY FOR FREE CARE, REDUCED RATES AND  
EXTENDED PAYMENT PLANS IS DETERMINED ON A CASE BY CASE BASIS. A  
HALLMARK OF NORTHWEST HOSPITAL'S COMMITMENT TO THE COMMUNITY IS ITS  
ONGOING EFFORTS TO PROVIDE FREE HEALTH SCREENINGS AND USEFUL HEALTH**

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

Schedule O (Form 990 or 990-EZ) (2014)

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EDUCATION THROUGH ITS COMMUNITY HEALTH EDUCATION PROGRAMS. COUNTLESS HEALTH FAIRS, BLOOD PRESSURE SCREENINGS, HEART HEALTH RISK ASSESSMENTS, DIABETES SUPPORT GROUP MEETINGS, FOOD AND NUTRITION COUNSELING AND SMOKING CESSATION CLASSES ARE OFFERED IN SENIOR CENTERS, CHURCH BASEMENTS, COMMUNITY CENTERS AND AREA SCHOOLS THROUGHOUT THE YEAR. NORTHWEST HOSPITAL HAS DEDICATED FULL-TIME STAFF, INCLUDING NURSE EDUCATORS, WHO DEVELOP PROGRAMS TO SHARE VALUABLE HEALTH-RELATED INFORMATION WITH MEMBERS OF THE COMMUNITY.

ONE SUCH PROGRAM, THE NORTHWEST CHANGING HEARTS PROGRAM IS DESIGNED TO IMPROVE THE CARDIOVASCULAR HEALTH OF INDIVIDUALS IN THE SURROUNDING COMMUNITY. THE PROGRAM IS DESIGNED TO: 1- HELP INDIVIDUALS UNDERSTAND THEIR IDENTIFIED RISK(S); 2- DEMONSTRATE HOW TO MINIMIZE/MODIFY THOSE RISK FACTORS AND 3- PROVIDE EDUCATION ON HOW TO MAINTAIN A HEALTHY LIFESTYLE TO PREVENT HEART DISEASE. DURING FY15 THERE WERE 889 TOTAL ENCOUNTERS, 23 ACTIVE PROGRAM PARTICIPANTS, 73 HOME VISITS AND 29 WORKSHOP PARTICIPANTS. 75% OF THE PARTICIPANTS DEMONSTRATED A DECREASE IN OVERALL BMI AND 75% OF THE PARTICIPANTS DEMONSTRATED AT LEAST A 10 PT DROP IN SYSTOLIC AND AT LEAST A 5 PT DROP IN DIASTOLIC READINGS.

FORM 990, PART VI, SECTION A, LINE 6:

THE CORPORATION SHALL HAVE ONE MEMBER, LIFE BRIDGE HEALTH, INC. (THE "MEMBER"), A MARYLAND NON-STOCK CORPORATION. MEMBERSHIP IN THE CORPORATION SHALL NOT BE TRANSFERABLE.

FORM 990, PART VI, SECTION A, LINE 7A:

THE MEMBER SHALL HAVE THE EXCLUSIVE POWER AND AUTHORITY TO TAKE THE

Name of the organization

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FOLLOWING ACTIONS: (1) EXCEPT FOR EX OFFICIO DIRECTORS AS PROVIDED FOR IN THE BYLAWS, TO NOMINATE, ELECT, AND REMOVE, WITH OR WITHOUT CAUSE, THE DIRECTORS OF THE CORPORATION; (2) TO APPOINT THE PRESIDENT OF THE CORPORATION WITH THE ADVICE AND CONSENT OF THE BOARD OF DIRECTORS; (3) TO NOMINATE AND ELECT THE CORPORATION'S CHAIR, VICE CHAIR, SECRETARY, AND TREASURER; AND (4) TO REMOVE EACH OF THE ABOVE-NAMED OFFICERS (WITH OR WITHOUT CAUSE), PROVIDED THAT THE BOARD OF DIRECTORS OF THE CORPORATION SHALL ALSO HAVE THE POWER TO REMOVE ANY OFFICER OF THE CORPORATION.

FORM 990, PART VI, SECTION A, LINE 7B:

THE MEMBER HAS POWER TO APPOINT AND/OR REMOVE MEMBERS OF THE GOVERNING BODY.

FORM 990, PART VI, SECTION B, LINE 11:

THE LIFEBRIDGE EXEMPT ENTITIES 990'S ARE INITIALLY REVIEWED BY THE CORPORATE DIRECTOR OF FINANCE. IN ADDITION, AN INDEPENDENT ACCOUNTING FIRM ALSO REVIEWS ALL THE 990 RETURNS. A FORMAL MEETING IS THEN SCHEDULED WITH THE CHIEF FINANCIAL OFFICER, VICE PRESIDENT OF FINANCE, GENERAL COUNSEL AND THE CORPORATE DIRECTOR OF FINANCE TO REVIEW IN THEIR ENTIRETY ALL THE LIFEBRIDGE EXEMPT ENTITIES 990'S. MANAGEMENT THEN PROVIDES A COPY OF THE 990'S TO THE AUDIT AND COMPLIANCE COMMITTEE OF THE LIFEBRIDGE HEALTH BOARD AND TO EACH INDIVIDUAL BOARD DIRECTOR PRIOR TO THE FILING DATE FOR REVIEW.

FORM 990, PART VI, SECTION B, LINE 12C:

LIFEBRIDGE AND ALL OF ITS SUBSIDIARIES REQUIRE ALL EMPLOYEES, MEDICAL STAFF, MEMBERS OF THE BOARD, AND THE EXECUTIVE STAFF TO DISCLOSE ANY ACTIVITIES THAT COULD RESULT IN A POSSIBLE CONFLICT OF INTEREST. IF A CONFLICT IS IDENTIFIED, THE PERSON INVOLVED WOULD RECUSE HIM/HERSELF FROM

Name of the organization

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DELIBERATIONS REGARDING THE TRANSACTIONS. AN INDIVIDUAL IS CONSIDERED TO HAVE A CONFLICT OF INTEREST WITH REGARD TO A MATTER OR TRANSACTION IF THE INDIVIDUAL HAS A PERSONAL OR FINANCIAL INTEREST THAT HAS THE POTENTIAL TO INFLUENCE THE ACTION TAKEN BY THE INDIVIDUAL ON BEHALF OF LIFE BRIDGE OR ANY OF ITS SUBSIDIARIES. AN INDIVIDUAL IS CONSIDERED TO HAVE A "PERSONAL INTEREST" IN A MATTER IF IT IS LIKELY TO HAVE A DIRECT AND MATERIAL IMPACT ON THE INDIVIDUAL'S RELATIONSHIP WITH LIFE BRIDGE OR ANY OF ITS SUBSIDIARIES (E.G., THE INDIVIDUAL'S CONTINUED MEMBERSHIP ON A SUBSIDIARY HOSPITAL'S MEDICAL STAFF), OR ON THE INDIVIDUAL'S OWN HEALTH CARE, OR THE INDIVIDUAL IS PERSONALLY INVOLVED IN A SUBSTANTIAL WAY (E.G., SERVES AS AN OFFICER OR DIRECTOR) WITH ANOTHER ORGANIZATION THAT HAS A SIGNIFICANT INTEREST IN THE MATTER. AN INDIVIDUAL IS CONSIDERED TO HAVE A "FINANCIAL INTEREST" IN A TRANSACTION IF THE INDIVIDUAL IS A PARTY TO THE TRANSACTION, OR IF THE INDIVIDUAL HAS, DIRECTLY OR INDIRECTLY A CURRENT OR POTENTIAL OWNERSHIP OR INVESTMENT INTEREST IN A PARTY TO THE TRANSACTION OR A CURRENT OR POTENTIAL COMPENSATION ARRANGEMENT WITH A PARTY TO THE TRANSACTION. A "COMPENSATION ARRANGEMENT" INCLUDES DIRECT AND INDIRECT REMUNERATION AS WELL AS GIFTS OR FAVORS OF A SUBSTANTIAL NATURE. AN INDIVIDUAL WILL BE CONSIDERED TO HAVE A CONFLICT OF INTEREST WITH RESPECT TO A MATTER OR TRANSACTION IF A MEMBER OF THE INDIVIDUAL'S IMMEDIATE FAMILY HAS SUCH A CONFLICT. FOR THESE PURPOSES, A "MEMBER" OF AN INDIVIDUAL'S "IMMEDIATE FAMILY" MEANS AN INDIVIDUAL'S SPOUSE, MOTHER, FATHER, MOTHER-IN-LAW, FATHER-IN-LAW, GRANDFATHER, GRANDMOTHER, BROTHER, SISTER, BROTHER-IN-LAW, SISTER-IN-LAW, SON, DAUGHTER, SON-IN-LAW, OR DAUGHTER-IN-LAW. "STEP" RELATIONSHIPS (E.G., STEPCHILDREN AND STEPPARENTS) WILL BE TREATED THE SAME AS BLOOD RELATIONSHIPS, EXCEPT AS DETERMINED OTHERWISE IN A SPECIFIC CIRCUMSTANCE BY THE LIFE BRIDGE CEO OR THE PRESIDENT OR DESIGNEE OF THE APPROPRIATE LIFE BRIDGE SUBSIDIARY.

ORDINARILY, OWNERSHIP OF LESS THAN 5% OF AN ENTITY DOES NOT CONSTITUTE AN

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OWNERSHIP INTEREST FOR WHICH DISCLOSURE IS NEEDED. CONFLICTS OF INTEREST ARE TO BE REPORTED BY EMPLOYEES TO THEIR SUPERVISOR, WHO WILL BE RESPONSIBLE FOR DETERMINING WHETHER FURTHER DISSEMINATION IS NECESSARY. MEMBERS OF THE MEDICAL STAFF SHOULD REPORT CONFLICTS TO THE CHIEF OF THEIR DEPARTMENT, AND MEMBERS OF THE BOARD SHOULD REPORT THEM TO EITHER THE CHAIRMAN OF THE BOARD OR THE OFFICE OF GENERAL COUNSEL. ONE OR MORE QUESTIONNAIRES ARE SENT OUT TO MEMBERS OF THE BOARD ON AN ANNUAL BASIS. IF QUESTIONS ARISE OR FURTHER GUIDANCE IS SOUGHT, CONFLICTS SHOULD ALSO BE REPORTED TO THE INTEGRITY HOTLINE OR OFFICE OF GENERAL COUNSEL. NOTHING IN THIS DEFINITION IS INTENDED TO RELIEVE ANY PERSON OF ANY ADDITIONAL OBLIGATIONS THAT MAY BE IMPOSED BY STATE OR FEDERAL LAW.

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

EXECUTIVE COMPENSATION AT LIFEBRIDGE HEALTH IS OVERSEEN BY THE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS. COMMITTEE MEMBERS MAY NOT HAVE ANY FINANCIAL TIES TO THE ORGANIZATION AND MUST BE BOARD MEMBERS OF LIFEBRIDGE HEALTH OR A LIFEBRIDGE HOSPITAL. THE CHAIR OF THE LIFEBRIDGE HEALTH BOARD OF DIRECTORS SERVES AS COMMITTEE CHAIR. THE COMMITTEE PROVIDES A REPORT OF ITS ACTIVITIES TO THE FULL BOARD OF DIRECTORS AT LEAST ANNUALLY. COMPENSATION PACKAGES HAVE BEEN DESIGNED TO ATTRACT AND RETAIN SKILLED AND EXPERIENCED EXECUTIVES AND TO INCENTIVIZE THEM TO WORK TOWARD KEY STRATEGIC OBJECTIVES. THE COMMITTEE EMPLOYS INDEPENDENT CONSULTANTS TO ENSURE THAT COMPENSATION LEVELS ARE CONSISTENT WITH MARKET NORMS. GREATEST EMPHASIS IS PLACED UPON DATA FROM HEALTHCARE ORGANIZATIONS OF COMPARABLE SIZE AND ORGANIZATIONAL COMPLEXITY IN THE MID-ATLANTIC REGION. ALL EXECUTIVE INCENTIVE AND BENEFIT PROGRAMS ARE ESTABLISHED BY THE COMPENSATION COMMITTEE, AS IS THE BASE SALARY OF THE CHIEF EXECUTIVE OFFICER AND ALL EXECUTIVE AND SENIOR VICE PRESIDENTS. BASE SALARIES OF OTHER EXECUTIVES ARE

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SET BY THEIR RESPECTIVE SUPERVISORS, IN ACCORDANCE WITH GUIDELINES ESTABLISHED BY THE COMMITTEE AND SUBJECT TO THE COMMITTEE'S OVERSIGHT. A SUBSTANTIAL PORTION OF ALL EXECUTIVES' TOTAL COMPENSATION IS CONTINGENT UPON THE ACHIEVEMENT OF BOTH SYSTEM-WIDE AND INDIVIDUAL OBJECTIVES. EACH YEAR'S SYSTEM-WIDE OBJECTIVES ARE APPROVED BY THE COMPENSATION COMMITTEE AND TYPICALLY INCLUDE BOTH FINANCIAL AND NONFINANCIAL GOALS. AN EXECUTIVE WHO FAILS TO ACHIEVE THE OBJECTIVES ESTABLISHED FOR THE INCENTIVE PROGRAMS WILL EARN BELOW MARKET LEVELS; CONVERSELY, THE ATTAINMENT OF EXTRAORDINARY RESULTS WILL BE REWARDED BY ABOVE-AVERAGE COMPENSATION. THERE IS CONTEMPORANEOUS DOCUMENTATION AND RECORDKEEPING FOR DELIVERATIONS AND DECISION REGARDING THE COMPENSATION ARRANGEMENTS.

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

IT IS THE POLICY OF LIFE BRIDGE HEALTH INC. AND ITS SUBSIDIARIES TO MAKE AVAILABLE UPON REQUEST THE AUDITED FINANCIAL STATEMENTS TO THE GENERAL PUBLIC. THE LIFE BRIDGE HEALTH INC. AND SUBSIDIARY GOVERNING DOCUMENTS ARE NOT MADE AVAILABLE TO THE GENERAL PUBLIC UPON REQUEST OR VIA A WEBSITE. THE CONFLICT OF INTEREST POLICY IS INCLUDED ON SCHEDULE O.

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

PROFESSIONAL AND TECHNICAL:

PROGRAM SERVICE EXPENSES	7,223,115.
MANAGEMENT AND GENERAL EXPENSES	1,904,574.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	9,127,689.

AGENCY NURSES:

PROGRAM SERVICE EXPENSES	1,770,846.
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Name of the organization <b>NORTHWEST HOSPITAL CENTER, INC.</b>	Employer identification number <b>52-1372665</b>
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**MANAGEMENT AND GENERAL EXPENSES** 0.

**FUNDRAISING EXPENSES** 0.

**TOTAL EXPENSES** 1,770,846.

**OTHER PURCHASED SERVICES:**

**PROGRAM SERVICE EXPENSES** 4,386,902.

**MANAGEMENT AND GENERAL EXPENSES** 2,196,893.

**FUNDRAISING EXPENSES** 0.

**TOTAL EXPENSES** 6,583,795.

**CORPORATE ALLOCATION:**

**PROGRAM SERVICE EXPENSES** 3,528,814.

**MANAGEMENT AND GENERAL EXPENSES** 8,922,263.

**FUNDRAISING EXPENSES** 0.

**TOTAL EXPENSES** 12,451,077.

**CONTRACT CLEANING:**

**PROGRAM SERVICE EXPENSES** 16,751.

**MANAGEMENT AND GENERAL EXPENSES** 2,729,993.

**FUNDRAISING EXPENSES** 0.

**TOTAL EXPENSES** 2,746,744.

**PURCHASED TEMPORARY HELP:**

**PROGRAM SERVICE EXPENSES** 242,489.

**MANAGEMENT AND GENERAL EXPENSES** 61,347.

**FUNDRAISING EXPENSES** 0.

**TOTAL EXPENSES** 303,836.

**TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A** 32,983,987.

Name of the organization

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

TRANSFER TO AFFILIATE

-1,165,754.

FORM 990, PART XII, LINE 2C:

THIS PROCESS HAS NOT CHANGED FROM PRIOR YEAR.

DUE TO AFFILIATES - BONDS

ON JANUARY 8, 2008, LIFEBRIDGE HEALTH, INC., TOGETHER WITH ITS AFFILIATES SINAI HOSPITAL OF BALTIMORE, NORTHWEST HOSPITAL CENTER, LEVINDALE HEBREW AND GERIATRIC CENTER, CHILDREN'S HOSPITAL AT SINAI FOUNDATION, AND THE BALTIMORE JEWISH HEALTH FOUNDATION (COLLECTIVELY, THE OBLIGATED GROUP) BORROWED \$285,815,000 FROM THE MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY (THE AUTHORITY) TO FINANCE THE ADVANCE REFUNDING OF THE 2004 SERIES A AND 2004 SERIES B BONDS AND TO FINANCE VARIOUS CONSTRUCTION AND RENOVATION PROJECTS. THE AUTHORITY OBTAINED THE FUNDS FOR THIS FINANCING THROUGH THE ISSUANCE OF BONDS UNDER THE MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY (MHHEFA) REVENUE BONDS, LIFEBRIDGE HEALTH ISSUE, SERIES 2008, COLLATERALIZED BY ALL RECEIPTS OF THE OBLIGATED GROUP. THE BONDS WERE ISSUED AT A PREMIUM OF \$3,278,562, OF WHICH NORTHWEST'S PORTION IS \$834,106, WHICH IS BEING AMORTIZED OVER THE LIFE OF THE BOND ISSUE. THE MEMBERS OF THE OBLIGATED GROUP ARE JOINTLY AND SEVERALLY LIABLE FOR REPAYMENT OF THE PRINCIPAL AND LOAN AND INTEREST THEREON. AS OF JUNE 30, 2015, \$268,652,386 OF THE TOTAL AMOUNT BORROWED APPEARS AS DUE TO LIFEBRIDGE HEALTH, OF WHICH NORTHWEST'S PORTION IS \$68,348,406. ALL THE BONDS WERE ISSUED IN THE NAME OF LIFEBRIDGE AND ARE REPORTED ON



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## SCHEDULE K OF ITS FORM 990.

ON MARCH 30, 2011, LIFE BRIDGE HEALTH, INC., TOGETHER WITH ITS AFFILIATES SINAI HOSPITAL OF BALTIMORE, NORTHWEST HOSPITAL CENTER, LEVINDALE HEBREW AND GERIATRIC CENTER, CHILDREN'S HOSPITAL AT SINAI FOUNDATION, AND THE BALTIMORE JEWISH HEALTH FOUNDATION (COLLECTIVELY, THE OBLIGATED GROUP) BORROWED \$50,695,000 FROM THE MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY (THE AUTHORITY) TO FINANCE A CONSTRUCTION AND EXPANSION PROJECT OF LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL AND TO FINANCE VARIOUS CONSTRUCTION AND RENOVATION PROJECTS AT SINAI HOSPITAL OF BALTIMORE AND NORTHWEST HOSPITAL CENTER. THE AUTHORITY OBTAINED THE FUNDS FOR THIS FINANCING THROUGH THE ISSUANCE OF BONDS UNDER THE MARYLAND HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY (MHHEFA) REVENUE BONDS, LIFE BRIDGE HEALTH ISSUE, SERIES 2011, COLLATERALIZED BY ALL RECEIPTS OF THE OBLIGATED GROUP. THE BONDS WERE ISSUED AT A DISCOUNT OF \$55,766, OF WHICH, NORTHWEST'S PORTION IS \$10,199, WHICH IS BEING AMORTIZED OVER THE LIFE OF THE BOND ISSUE. THE MEMBERS OF THE OBLIGATED GROUP ARE JOINTLY AND SEVERALLY LIABLE FOR REPAYMENT OF THE PRINCIPAL AND LOAN AND INTEREST THEREON. AS OF JUNE 30, 2015, \$48,270,642 OF THE TOTAL AMOUNT BORROWED, OF WHICH NORTHWEST'S PORTION IS \$8,827,816, APPEARS AS DUE TO LIFE BRIDGE HEALTH. ALL THE BONDS WERE ISSUED IN THE NAME OF LIFE BRIDGE AND ARE REPORTED ON SCHEDULE K OF ITS FORM 990.

ON MAY 1, 2015, A SINGLE OBLIGATED GROUP (THE OBLIGATED GROUP) WAS FORMED, CONSISTING OF LIFE BRIDGE HEALTH INC, SINAI HOSPITAL OF BALTIMORE INC, NORTHWEST HOSPITAL CENTER INC, LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL INC, THE BALTIMORE JEWISH HEALTH FOUNDATION

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INC, CHILDREN'S HOSPITAL AT SINAI FOUNDATION INC, CARROLL COUNTY HEALTH SERVICES CORPORATION, CARROLL HOSPITAL CENTER INC, CARROLL COUNTY MED SERVICES INC, CARROLL HEALTH GROUP LLC, CARROLL HOSPICE INC, AND CARROLL REGIONAL CANCER CENTER PHYSICIANS LLC. MEMBERS OF THE OBLIGATED GROUP ARE JOINTLY AND SEVERALLY LIABLE FOR ALL OF THE OUTSTANDING BONDS. THE BONDS INCLUDE THE ONES DETAILED ABOVE AS WELL AS THE BONDS ORIGINALLY OBTAINED BY CARROLL COUNTY HEALTH SERVICES INC AND ITS RELATED SUBSIDIARIES. THESE BONDS ISSUED BY THE AUTHORITY ON BEHALF OF LIFEBRIDGE HEALTH INC AND CARROLL COUNTY HEALTH SERVICES INC AND THEIR RESPECTIVE AFFILIATES, TOGETHER WITH THE OTHER OBLIGATIONS ON PARITY WITH SUCH BONDS. ALL THE BONDS ARE REPORTED ON SCHEDULE K OF THE LIFEBRIDGE HEALTH INC FORM 990.

Public Disclosure Copy

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

▶ Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2014**

Open to Public Inspection

Name of the organization

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**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.

(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
LIFEBRIDGE HEALTH, INC. - 52-1402373 2401 WEST BELVEDERE AVE BALTIMORE, MD 21215	TO SUPPORT THE CHARITABLE MISSIONS OF ITS SUBSIDIARIES.	MARYLAND	501(C)(3)	11A	N/A		X
SINAI HOSPITAL OF BALTIMORE, INC. - 52-0486540, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	PROVIDE MEDICAL CARE, EDUCATE STUDENTS, PERFORM MEDICAL RESEARCH	MARYLAND	501(C)(3)	3	LIFEBRIDGE HEALTH, INC.		X
LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC. - 52-0607913, 2434 WEST BELVEDERE AVE, BALTIMORE, MD 21215	GERIATRIC HOSPITAL DEDICATED TO PROVIDING SERVICE TO THE AGED	MARYLAND	501(C)(3)	3	LIFEBRIDGE HEALTH, INC.		X
COURTLAND GARDENS NURSING AND REHABILITATION CENTER - 52-0607907, 2434 WEST BELVEDERE AVE, BALTIMORE, MD 21215	SKILLED NURSING CARE FOR THE ELDERLY AND DISABLED	MARYLAND	501(C)(3)	3	LEVINDALE		X

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

Schedule R (Form 990) 2014

**Part II** Continuation of 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 organization?	
						Yes	No
CHILDREN'S HOSPITAL OF BALTIMORE CITY - 52-0591592, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR SINAI HOSPITAL OF BALTIMORE INC	MARYLAND	501(C)(3)	11B	LIFEBRIDGE HEALTH, INC.		X
THE BALTIMORE JEWISH HEALTH FOUNDATION, INC. - 52-2111541, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR SINAI HOSPITAL OF BALTIMORE INC	MARYLAND	501(C)(3)	11B	LIFEBRIDGE HEALTH, INC.		X
CHILDREN'S HOSPITAL AT SINAI FOUNDATION - 52-2167587, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR SINAI HOSPITAL OF BALTIMORE INC	MARYLAND	501(C)(3)	11B	LIFEBRIDGE HEALTH, INC.		X
THE BALTIMORE JEWISH ELDERCARE FOUNDATION - 52-2337669, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	CHARITY SUPPORT FOR LEVINDALE HEBREW GERIATRIC CENTER HOSPITAL	MARYLAND	501(C)(3)	11B	LIFEBRIDGE HEALTH, INC.		X
CARROLL COUNTY HEALTH SERVICES CORPORATION - 52-0691413, 200 MEMORIAL AVENUE, WESTMINSTER, MD 21157	CHARITY SUPPORT FOR CARROLL HOSPITAL CENTER, INC.	MARYLAND	501(C)(3)	11C	LIFEBRIDGE HEALTH, INC.		X
CARROLL HOSPITAL CENTER, INC. - 52-1452024 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	A HOSPITAL COMMITTED TO THE HIGHEST QUALITY HEALTH CARE	MARYLAND	501(C)(3)	3	CARROLL COUNTY HEALTH SERVICES CORPORATION		X
CARROLL HOSPITAL CENTER FOUNDATION, INC. - 52-1115038, 200 MEMORIAL AVENUE, WESTMINSTER, MD 21157	CHARITY SUPPORT FOR CARROLL HOSPITAL CENTER, INC. & CARROLL HOSPICE	MARYLAND	501(C)(3)	11A	CARROLL HOSPITAL CENTER INC.		X
CARROLL HOSPICE, INC. - 52-1565870 292 STONER AVENUE WESTMINSTER, MD 21157	HOSPICE	MARYLAND	501(C)(3)	7	CARROLL HOSPITAL CENTER INC.		X

**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	
CARROLL OCCUPATIONAL HEALTH, LLC - 20-2769332, 7001 CORPORATE CENTER COURT, WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A
CARROLL COUNTY RADIOLOGY, LLC - 52-2190849, 7253 AMBASSADOR ROAD, BALTIMORE, MD 21244	RADIOLOGY	MD	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A
CARDIOVASCULAR ASSOCIATES OF MARYLAND, LLC - 46-2935110, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A
LIFEBRIDGE CARDIOLOGY OF PARKVILLE, LLC - 46-3742313, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A		N/A	N/A		N/A	N/A

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
LIFEBRIDGE INVESTMENTS, INC. - 52-1483166 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	INVESTMENT	MD	N/A	C CORP	N/A	N/A	N/A		X
HEALTHSTAR MEDICAL SERVICES, INC. - 52-1829098, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	HEALTHCARE	MD	N/A	C CORP	N/A	N/A	N/A		X
PRACTICE DYNAMICS, INC. - 52-1960319 124 BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136	MANAGEMENT	MD	N/A	C CORP	N/A	N/A	N/A		X
SURGICAL ONCOLOGY ASSOCIATES, INC. - 52-1804659, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	HEALTHCARE	MD	N/A	C CORP	N/A	N/A	N/A		X
LIFEBRIDGE INSURANCE COMPANY, LTD. 98-0415396, PO BOX 1109 KY1-1102, GRAND CAYMAN, CAYMAN ISLANDS	INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A		X

**Part III** Continuation of 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	
LIFEBRIDGE COMMUNITY												
GASTROENTEROLOGY, LLC - 46-2863298, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE COMMUNITY												
PEDIATRICS, LLC - 46-2842468, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE COMMUNITY												
PULMONOLOGY, LLC - 46-1401312, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE GYNECOLOGY OF PIKESVILLE, LLC - 46-2949092, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE MEDICAL ASSOCIATES, LLC - 46-2941505, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE ORTHOPEDIC SPECIALISTS, LLC - 45-0719598, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE PRIMARY CARE OF ELDERSBURG, LLC - 38-3897702, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
LIFEBRIDGE PRIMARY CARE OF NORTH CARROLL, LLC - 80-0883321, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	MEDICAL SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HOME CARE MARYLAND, LLC - 26-1378175, 8028 RITCHIE HIGHWAY, SUITE 210B, PASADENA, MD 21122	HOME HEALTH SERVICES	MD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**Part IV** Continuation of 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
LIFEBRIDGE COMMUNITY PHYSICIANS, INC. - 80-0719005, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215	HEALTHCARE	MD	N/A	C CORP	N/A	N/A	N/A		X
CEN-MAR ASSURANCE COMPANY - 98-6011607 PO BOX 1085 GRAND CAYMAN, CAYMAN ISLANDS	INSURANCE	CAYMAN ISLANDS	N/A	C CORP	N/A	N/A	N/A		X
CARROLL COUNTY GENERAL HOSPITAL SOUTH CARROLL MEDICAL CENTER CONDOMINIUM, 200 MEMORIAL AVENUE, WESTMINSTER, MD 21157	REAL ESTATE	MD	N/A	S CORP	N/A	N/A	N/A		X
MED-SERVICES HOLDINGS, INC. 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	N/A	C CORP	N/A	N/A	N/A		X
CARROLL COUNTY MED-SERVICES, INC. - 52-1891102, 200 MEMORIAL AVENUE, WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	N/A	C CORP	N/A	N/A	N/A		X
CARROLL HEALTH GROUP, LLC - 27-1956453 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	HEALTHCARE	MD	N/A	C CORP	N/A	N/A	N/A		X
CARROLL URGENT CARE, LLC - 46-5739154 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	HEALTHCARE	MD	N/A	C CORP	N/A	N/A	N/A		X
CARROLL BILLING SERVICES, INC. - 30-0026598 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	BILLING SERVICES	MD	N/A	C CORP	N/A	N/A	N/A		X

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

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

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

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

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)	PRACTICE DYNAMICS, INC	P	867,254.FMV	
(2)	PRACTICE DYNAMICS, INC	O	200,632.FMV	
(3)	LIFEBRIDGE HEALTH, INC.	C	1,165,757.FMV	
(4)	LIFEBRIDGE HEALTH, INC.	P	29,730,414.FMV	
(5)				
(6)				



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

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

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



**Part VII** Supplemental Information

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

**PART III, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS PARTNERSHIP:**

**NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:**

LIFEBRIDGE COMMUNITY GASTROENTEROLOGY, LLC

EIN: 46-2863298

2401 WEST BELVEDERE AVENUE

BALTIMORE, MD 21215

**NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:**

LIFEBRIDGE COMMUNITY PULMONOLOGY, LLC

EIN: 46-1401312

2401 WEST BELVEDERE AVENUE

BALTIMORE, MD 21215

**NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:**

LIFEBRIDGE ORTHOPEDIC SPECIALISTS, LLC

EIN: 45-0719598

2401 WEST BELVEDERE AVENUE

BALTIMORE, MD 21215

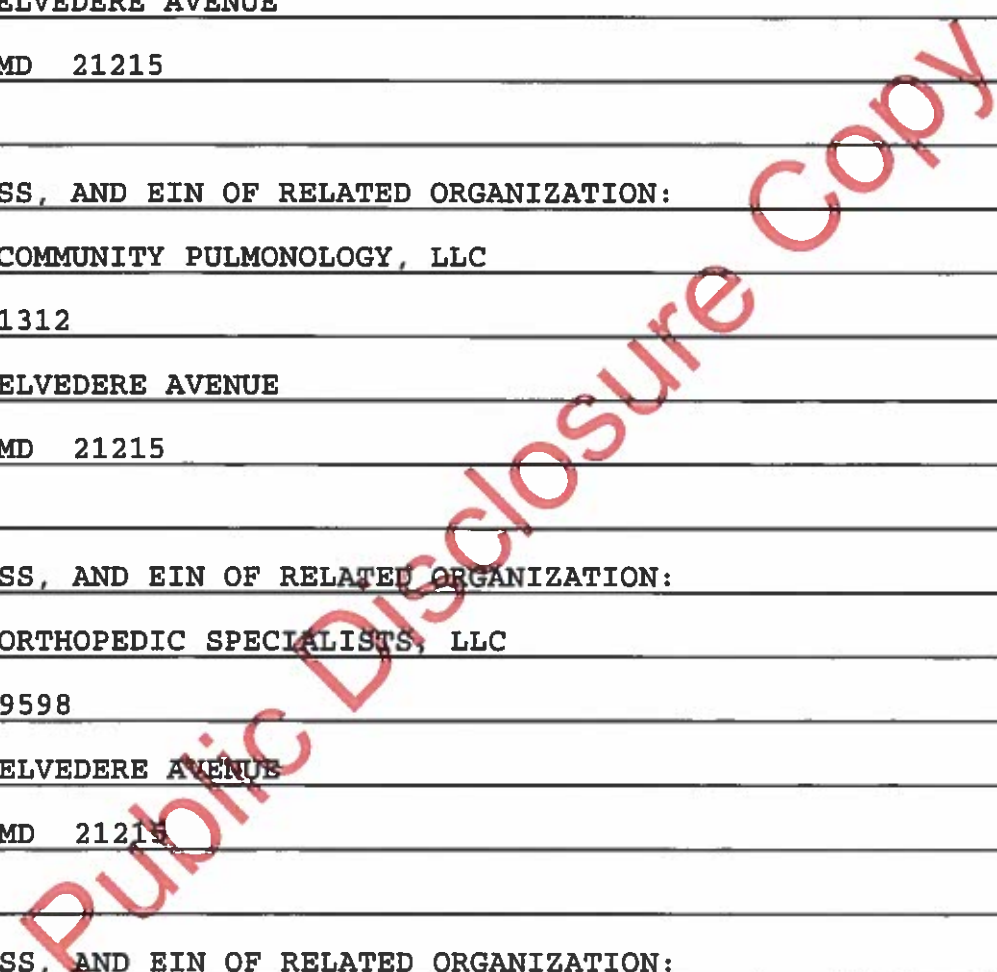
**NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:**

LIFEBRIDGE PRIMARY CARE OF NORTH CARROLL, LLC

EIN: 80-0883321

2401 WEST BELVEDERE AVENUE

BALTIMORE, MD 21215



• If you are filing for an **Additional (Not Automatic) 3-Month Extension**, complete only **Part II** and check this box  **X**

**Note.** Only complete Part II if you have already been granted an automatic 3-month extension on a previously filed Form 8868.

• If you are filing for an **Automatic 3-Month Extension**, complete only **Part I** (on page 1).

**Part II Additional (Not Automatic) 3-Month Extension of Time.** Only file the original (no copies needed).

Enter filer's identifying number, see instructions

Type or print	Name of exempt organization or other filer, see instructions. <b>NORTHWEST HOSPITAL CENTER, INC.</b>	Employer identification number (EIN) or <b>52-1372665</b>
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. <b>5401 OLD COURT ROAD</b>	Social security number (SSN)
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. <b>RANDALLSTOWN, MD 21133</b>	

Enter the Return code for the return that this application is for (file a separate application for each return) 01

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01		
Form 990-BL	02	Form 1041-A	08
Form 4720 (Individual)	03	Form 4720 (other than individual)	09
Form 990-PF	04	Form 5227	10
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 6069	11
Form 990-T (trust other than above)	06	Form 8870	12

**STOP! Do not complete Part II if you were not already granted an automatic 3-month extension on a previously filed Form 8868.**

**NANCY KANE**

• The books are in the care of ▶ **2401 WEST BELVEDERE ROAD - BALTIMORE, MD 21215**  
 Telephone No. ▶ **(410) 601-5653** Fax No. ▶ **(410) 601-8362**

• If the organization does not have an office or place of business in the United States, check this box  **X**  
 • If this is for a Group Return, enter the organization's four digit Group Exemption Number (GEN) \_\_\_\_\_ . If this is for the whole group, check this box  . If it is for part of the group, check this box  and attach a list with the names and EINs of all members the extension is for.

4 I request an additional 3-month extension of time until **MAY 16, 2016**  
 5 For calendar year \_\_\_\_\_, or other tax year beginning **JUN 1, 2014**, and ending **JUN 30, 2015**  
 6 If the tax year entered in line 5 is for less than 12 months, check reason:  Initial return  Final return  
 Change in accounting period

7 State in detail why you need the extension  
**ADDITIONAL TIME IS NEEDED TO PREPARE A COMPLETE AND ACCURATE RETURN.**

8a If this application is for Forms 990-BL, 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	8a	\$	0.
8b If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit and any amount paid previously with Form 8868.	8b	\$	0.
8c <b>Balance due.</b> Subtract line 8b from line 8a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	8c	\$	0.

**Signature and Verification must be completed for Part II only.**

Under penalties of perjury, I declare that I have examined this form, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that I am authorized to prepare this form.

Signature ▶ \_\_\_\_\_ Title ▶ **CPA** Date ▶ \_\_\_\_\_