

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

- ▶ Do not enter Social Security numbers on this form as it may be made public.
- ▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2022

Open to Public Inspection

A For the **2022** calendar year, or tax year beginning 07/01/2022 and ending 06/30/2023

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization <u>NORTHWEST HOSPITAL CENTER, INC.</u>			D Employer identification number <u>52-1372665</u>
	Doing Business As			E Telephone number <u>(410) 601-5653</u>
	Number and street (or P.O. box if mail is not delivered to street address)		Room/suite	G Gross receipts \$ <u>344,327,097.</u>
	<u>5401 OLD COURT ROAD</u>			
City or town, state or province, country, and ZIP or foreign postal code <u>RANDALLSTOWN, MD 21133</u>			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
F Name and address of principal officer: <u>CRAIG CARMICHAEL</u> <u>SAME AS "C" ABOVE</u>			H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I 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			If "No," attach a list. (see instructions)	
J Website: <u>WWW.LIFEBRIDGEHEALTH.ORG/NORTHWEST</u>			H(c) Group exemption number ▶	
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: <u>1984</u> M State of legal domicile: <u>MD</u>	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: <u>TO IMPROVE THE HEALTH OF THE INDIVIDUALS AND COMMUNITIES WE SERVE THROUGH COMPASSIONATE, HIGH QUALITY CARE.</u>	
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3 Number of voting members of the governing body (Part VI, line 1a)	3 <u>27</u>
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4 <u>24</u>
	5 Total number of individuals employed in calendar year 2022 (Part V, line 2a)	5 <u>2,018</u>
	6 Total number of volunteers (estimate if necessary)	6 <u>51</u>
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a <u>NONE</u>
b Net unrelated business taxable income from Form 990-T, line 34	7b <u>NONE</u>	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year <u>2,523,953.</u> Current Year <u>3,778,517.</u>
	9 Program service revenue (Part VIII, line 2g)	<u>272,412,422.</u> <u>278,819,628.</u>
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<u>6,914,795.</u> <u>4,744,523.</u>
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<u>19,867,615.</u> <u>21,355,349.</u>
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<u>301,718,785.</u> <u>308,698,017.</u>
	COPY FOR PUBLIC INSPECTION	
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<u>NONE</u> <u>NONE</u>
	14 Benefits paid to or for members (Part IX, column (A), line 4)	<u>NONE</u> <u>NONE</u>
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<u>140,007,879.</u> <u>148,676,299.</u>
	16a Professional fundraising fees (Part IX, column (A), line 11e)	<u>NONE</u> <u>NONE</u>
	b Total fundraising expenses (Part IX, column (D), line 25) ▶ <u>634,596.</u>	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<u>161,885,455.</u> <u>165,897,712.</u>
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<u>301,893,334.</u> <u>314,574,011.</u>	
19 Revenue less expenses. Subtract line 18 from line 12	<u>-174,549.</u> <u>-5,875,994.</u>	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year <u>221,785,904.</u> End of Year <u>187,103,061.</u>
	21 Total liabilities (Part X, line 26)	<u>160,059,339.</u> <u>130,976,800.</u>
	22 Net assets or fund balances. Subtract line 21 from line 20	<u>61,726,565.</u> <u>56,126,261.</u>

Part II Signature Block

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

Sign Here	Signature of officer	<u>05/09/2024</u>			
	<u>DAVID KRAJEWSKI</u> Type or print name and title	<u>EXECUTIVE VP/CFO</u> Date			
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	<u>MARC BERGER</u>	<u>MARC BERGER</u>	<u>05/06/2024</u>	<input type="checkbox"/>	<u>P01871563</u>
	Firm's name ▶ <u>BDO USA</u>	Firm's EIN ▶ <u>13-5381590</u>	Firm's address ▶ <u>8401 GREENSBORO DRIVE, #800 MCLEAN, VA 22102</u>		
Phone no.			<u>703-893-0600</u>		

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2022)

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 [X] No

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

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 \$ 214,911,743. including grants of \$ NONE) (Revenue \$ 278,819,628.)

NORTHWEST HOSPITAL CENTER, INC. IS RESPONSIBLE FOR THE MANAGEMENT AND DAY-TO-DAY OPERATIONS OF THE 193 BED ACUTE-CARE AND 17 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.

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

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

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

4e Total program service expenses 214,911,743.

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1 through 21 regarding organizational requirements and financial reporting.

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. 2a 2,018		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		X
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation on Schedule O</i>		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		X
b	If "Yes," enter the name of the foreign country _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12 10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b		
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders 11a		
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note: See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b		
c	Enter the amount of reserves on hand 13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i>		
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.		X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		X
17	Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? If "Yes," complete Form 6069.		

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 on 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 3 columns: Question, Yes, No. Rows include: 1a (27), 1b (24), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

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

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed CA, MD,
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe on 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 10090 RED RUN BLVD. OWINGS MILLS, MD 21117

410-601-5653

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 X

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 the 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, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) 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.

See the instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/ 1099-MISC/ 1099-NEC)	(E) Reportable compensation from related organizations (W-2/ 1099-MISC/ 1099-NEC)	(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) DAVID KRAJEWSKI ASSIST TREAS, NW/ EVP/CFO, LBH	1.00 40.00			X				NONE	1,734,148.	526,937.
(2) JASON WEINER ASSIST SEC, NW/SVP/GEN CNCL, LBH	1.00 40.00			X				NONE	930,684.	146,203.
(3) ROBERT SALTZMAN, MD PHYSICIAN	40.00 NONE					X		1,017,027.	NONE	45,630.
(4) JONATHAN THIERMAN, MD FORMER DIRECTOR	NONE 40.00						X	NONE	711,827.	105,756.
(5) CRAIG CARMICHAEL PRESIDENT & COO, NORTHWEST	1.00 40.00	X		X				NONE	652,487.	82,166.
(6) JAMES ROBERGE VP CAPITAL IMPROVEMENTS	1.00 40.00				X			NONE	484,728.	94,821.
(7) SAMUEL SMITH VP CHIEF MEDICAL OFFICER	40.00 NONE				X			501,155.	NONE	27,388.
(8) LOU DUNAWAY VP BUDGET & CAPITAL PLANNING	1.00 40.00				X			NONE	409,293.	90,158.
(9) NANCY KANE VP FINANCIAL REPORTING	1.00 40.00				X			NONE	389,180.	105,840.
(10) CHAITANYA RAVI AVP, CHIEF CARE TRANSITIONS	40.00 NONE					X		462,413.	NONE	25,361.
(11) TERRENCE CARNEY VP SUPPLY CHAIN	1.00 40.00				X			NONE	447,427.	22,520.
(12) KIM BUSHNELL VP PATIENT CARE SERVICES/CNO	40.00 NONE				X			423,536.	NONE	15,121.
(13) CAMILLE UPCHURCH, MD CHIEF OF HOSPITAL MEDICINE	40.00 NONE					X		386,916.	NONE	30,973.
(14) HARSHINDER SIDHU, MD HOSPITALIST	40.00 NONE					X		382,650.	NONE	31,162.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) RICHARD ROHRS AVP PROVIDER OPERATIONS	40.00 NONE					X	357,124.	NONE	23,427.	
(16) DAVID MCCORMICK CFO, NW/ VP, LBH	1.00 40.00					X	NONE	274,893.	50,747.	
(17) NEERAJ VERMA, MD DIRECTOR/MED. STAFF PRESIDENT	1.00 NONE	X					NONE	NONE	NONE	
(18) RICHARD KEMPER CHAIR	1.00 NONE	X		X			NONE	NONE	NONE	
(19) HAROLD HACKERMAN VICE CHAIR	1.00 NONE	X		X			NONE	NONE	NONE	
(20) HAYDEN MOORE SECRETARY	1.00 NONE	X		X			NONE	NONE	NONE	
(21) PAT ISAAC TREASURER	1.00 NONE	X		X			NONE	NONE	NONE	
(22) RONALD ATTMAN DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(23) KENNETH BARNEY DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(24) JASON A. BLAVATT, ESQ. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(25) CHERYL BROWN, ESQ. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total							3,530,821.	6,034,667.	1,424,210.	
c Total from continuation sheets to Part VII, Section A							NONE	NONE	NONE	
d Total (add lines 1b and 1c)							3,530,821.	6,034,667.	1,424,210.	

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 ▶ 248

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) SERINA COPANAS DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(27) BITA DAYHOFF DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(28) GRACE DOYLE DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(29) GEORGE EVANS DDS DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(30) CHARLES FISHER, JR., ESQ. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(31) ALEX HENDLER DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(32) ELLIOTT HIRSHMAN, PH.D. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(33) GREGORY LAWRENCE, ESQ. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(34) AUDREY LIFCOVICH DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(35) JOSEPH MIGLIARA DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(36) BILL MILLER DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 ▶

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(37) MICHAEL O'HALLORAN DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(38) PAUL L. SAVAL DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(39) JASON SCHWARTZBERG DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(40) MARK SIMANOWITH DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(41) WILLIAM SMULYAN, MD DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(42) AMY SOLOMON DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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 ▶

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>		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
SEE SCHEDULE O		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 54

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants, and Other Similar Amounts	1a	Federated campaigns	1a					
	b	Membership dues	1b					
	c	Fundraising events	1c					
	d	Related organizations	1d					
	e	Government grants (contributions) . .	1e	2,450,804.				
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	1,327,713.				
	g	Noncash contributions included in lines 1a-1f	1g	\$				
	h	Total. Add lines 1a-1f			3,778,517.			
	Program Service Revenue	2a	PATIENT REVENUE	Business Code	621400	278,819,628.	278,819,628.	
b								
c								
d								
e								
f		All other program service revenue						
g		Total. Add lines 2a-2f			278,819,628.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)			84,265.	NONE	84,265.	
	4	Income from investment of tax-exempt bond proceeds .			NONE			
	5	Royalties			NONE			
	6a	Gross rents	(i) Real	300,999.				
			(ii) Personal					
	b	Less: rental expenses		NONE				
	c	Rental income or (loss)		300,999.	NONE			
	d	Net rental income or (loss)			300,999.		300,999.	
	7a	Gross amount from sales of assets other than inventory	(i) Securities	40,237,452.				
			(ii) Other					
	b	Less: cost or other basis and sales expenses . .		35,561,699.	15,495.			
	c	Gain or (loss)		4,675,753.	-15,495.			
	d	Net gain or (loss)			4,660,258.		4,660,258.	
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18			NONE				
		8b	Less: direct expenses		NONE			
		c	Net income or (loss) from fundraising events		NONE			
9a	Gross income from gaming activities. See Part IV, line 19			NONE				
		9b	Less: direct expenses		NONE			
		c	Net income or (loss) from gaming activities		NONE			
10a	Gross sales of inventory, less returns and allowances			95,369.				
		10b	Less: cost of goods sold		51,886.			
		c	Net income or (loss) from sales of inventory		43,483.		43,483.	
Miscellaneous Revenue	11a	PHARMACY SALES	Business Code	621990	19,058,246.		19,058,246.	
	b	CAFETERIA SALES		722210	1,275,366.		1,275,366.	
	c	OTHER OPERATING REVENUE		900099	677,255.		677,255.	
	d	All other revenue						
	e	Total. Add lines 11a-11d			21,010,867.			
12	Total revenue. See instructions				308,698,017.	278,819,628.	NONE	26,099,872.

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	NONE			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	NONE			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	NONE			
4 Benefits paid to or for members	NONE			
5 Compensation of current officers, directors, trustees, and key employees	12,691,906.	3,351,932.	8,705,378.	634,596.
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	NONE			
7 Other salaries and wages	106,611,543.	86,768,652.	19,842,891.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	3,860,458.	3,207,921.	652,537.	
9 Other employee benefits	17,862,795.	11,244,479.	6,618,316.	
10 Payroll taxes	7,649,597.	6,356,579.	1,293,018.	
11 Fees for services (nonemployees):				
a Management	NONE			
b Legal	27,125.		27,125.	
c Accounting	NONE			
d Lobbying	59,205.		59,205.	
e Professional fundraising services. See Part IV, line 17	NONE			
f Investment management fees	254,126.		254,126.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.)	SEE SCHE O 75,235,029.	51,223,362.	24,011,667.	NONE
12 Advertising and promotion	228,036.	13,562.	214,474.	
13 Office expenses	3,877,802.	431,286.	3,446,516.	
14 Information technology	NONE			
15 Royalties	NONE			
16 Occupancy	6,498,599.	3,585,134.	2,913,465.	
17 Travel	101,038.	9,681.	91,357.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	NONE			
19 Conferences, conventions, and meetings	102,466.	76,501.	25,965.	
20 Interest	2,802,815.	1,057,705.	1,745,110.	
21 Payments to affiliates	NONE			
22 Depreciation, depletion, and amortization	17,742,185.	11,605,046.	6,137,139.	
23 Insurance	60,802.	60,802.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a SUPPLIES	58,543,025.	35,855,164.	22,687,861.	
b DUES AND MEMBERSHIPS	365,459.	63,937.	301,522.	
c				
d				
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	314,574,011.	214,911,743.	99,027,672.	634,596.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	8,093.	1	7,730.
	2 Savings and temporary cash investments	52,664,955.	2	19,450,887.
	3 Pledges and grants receivable, net	526,507.	3	588,246.
	4 Accounts receivable, net	36,416,810.	4	32,291,576.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	5	NONE
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	NONE	6	NONE
	7 Notes and loans receivable, net	NONE	7	NONE
	8 Inventories for sale or use	5,576,390.	8	5,186,696.
	9 Prepaid expenses and deferred charges	1,139,116.	9	1,251,088.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 333,756,836.		
	b Less: accumulated depreciation	10b 242,453,233.		
		88,803,565.	10c	91,303,603.
	11 Investments - publicly traded securities	NONE	11	NONE
	12 Investments - other securities. See Part IV, line 11	3,731,048.	12	3,698,807.
	13 Investments - program-related. See Part IV, line 11	NONE	13	NONE
	14 Intangible assets	NONE	14	NONE
15 Other assets. See Part IV, line 11	32,919,420.	15	33,324,428.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	221,785,904.	16	187,103,061.	
Liabilities	17 Accounts payable and accrued expenses	53,061,338.	17	40,244,161.
	18 Grants payable	NONE	18	NONE
	19 Deferred revenue	13,997,592.	19	523,900.
	20 Tax-exempt bond liabilities	NONE	20	NONE
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	NONE	21	NONE
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	22	NONE
	23 Secured mortgages and notes payable to unrelated third parties	NONE	23	NONE
	24 Unsecured notes and loans payable to unrelated third parties	NONE	24	NONE
	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	93,000,409.	25	90,208,739.
	26 Total liabilities. Add lines 17 through 25	160,059,339.	26	130,976,800.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here and complete lines 27, 28, 32, and 33. <input checked="" type="checkbox"/>			
	27 Net assets without donor restrictions	53,157,631.	27	47,906,274.
	28 Net assets with donor restrictions	8,568,934.	28	8,219,987.
	Organizations that do not follow FASB ASC 958, check here and complete lines 29 through 33. <input type="checkbox"/>			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	61,726,565.	32	56,126,261.
33 Total liabilities and net assets/fund balances	221,785,904.	33	187,103,061.	

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	308,698,017.
2	Total expenses (must equal Part IX, column (A), line 25)	2	314,574,011.
3	Revenue less expenses. Subtract line 2 from line 1	3	-5,875,994.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	61,726,565.
5	Net unrealized gains (losses) on investments	5	4,394,970.
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 on Schedule O)	9	-4,119,280.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	56,126,261.

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F?
- 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 on Schedule O and describe any steps taken to undergo such audits

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

Form **990** (2022)

**SCHEDULE A
(Form 990)**

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2022

**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 12, check only one box.)

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

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

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

Schedule A (Form 990) 2022

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) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(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) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2022 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2021 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2022. 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 - 2021. 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 - 2022. 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 - 2021. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here . Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

Part III Support Schedule for Organizations Described in Section 509(a)(2)
 (Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II.
 If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5.						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2022 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2021 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2022 (line 10c, column (f), divided by line 13, column (f)).	17	%
18 Investment income percentage from 2021 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2022. 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 - 2021. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization . .

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>		
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>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>		
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>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
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
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described on line 11a above?		
c A 35% controlled entity of a person described on line 11a or 11b above? <i>If "Yes" to line 11a, 11b, or 11c, provide detail in Part VI.</i>		

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (<i>explain in detail in Part VI</i>):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	

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

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>)	5
6	Other distributions (<i>describe in Part VI</i>). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions.	8
9	Distributable amount for 2022 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2022	(iii) Distributable Amount for 2022
1	Distributable amount for 2022 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2022 (reasonable cause required - <i>explain in Part VI</i>). See instructions.			
3	Excess distributions carryover, if any, to 2022			
a	From 2017			
b	From 2018			
c	From 2019			
d	From 2020			
e	From 2021			
f	Total of lines 3a through 3e			
g	Applied to underdistributions of prior years			
h	Applied to 2022 distributable amount			
i	Carryover from 2017 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4	Distributions for 2022 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2022 distributable amount			
c	Remainder. Subtract lines 4a and 4b from line 4.			
5	Remaining underdistributions for years prior to 2022, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
6	Remaining underdistributions for 2022. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
7	Excess distributions carryover to 2023. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2018			
b	Excess from 2019			
c	Excess from 2020			
d	Excess from 2021			
e	Excess from 2022			

**Schedule B
(Form 990)**

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

Attach to Form 990 or Form 990-PF.
Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2022

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), 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 (entering "N/A" in column (b) instead of the contributor name and address), 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. Don't 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 isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990), 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 doesn't meet the filing requirements of Schedule B (Form 990).

Name of organization <p style="text-align: center;">NORTHWEST HOSPITAL CENTER, INC.</p>	Employer identification number <p style="text-align: center;">52-1372665</p>
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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	N/A <hr/> <hr/>	\$ 2,318,344.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	N/A <hr/> <hr/>	\$ 216,402.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	N/A <hr/> <hr/>	\$ 132,460.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	N/A <hr/> <hr/>	\$ 130,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	N/A <hr/> <hr/>	\$ 100,342.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	N/A <hr/> <hr/>	\$ 65,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization <p style="text-align: center;">NORTHWEST HOSPITAL CENTER, INC.</p>	Employer identification number <p style="text-align: center;">52-1372665</p>
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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	N/A <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	N/A <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	N/A <hr/> <hr/>	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	N/A <hr/> <hr/>	\$ 15,500.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	N/A <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	N/A <hr/> <hr/>	\$ 7,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization <p style="text-align: center;">NORTHWEST HOSPITAL CENTER, INC.</p>	Employer identification number <p style="text-align: center;">52-1372665</p>
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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	N/A <hr/> <hr/> <hr/>	\$ 7,000.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 2px;">Person</td> <td style="width:20%; text-align: center; padding: 2px;"><input checked="" type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Payroll</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Noncash</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>	Person	<input checked="" type="checkbox"/>	Payroll	<input type="checkbox"/>	Noncash	<input type="checkbox"/>
Person	<input checked="" type="checkbox"/>								
Payroll	<input type="checkbox"/>								
Noncash	<input type="checkbox"/>								
14	N/A <hr/> <hr/> <hr/>	\$ 6,000.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 2px;">Person</td> <td style="width:20%; text-align: center; padding: 2px;"><input checked="" type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Payroll</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Noncash</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>	Person	<input checked="" type="checkbox"/>	Payroll	<input type="checkbox"/>	Noncash	<input type="checkbox"/>
Person	<input checked="" type="checkbox"/>								
Payroll	<input type="checkbox"/>								
Noncash	<input type="checkbox"/>								
15	N/A <hr/> <hr/> <hr/>	\$ 5,000.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 2px;">Person</td> <td style="width:20%; text-align: center; padding: 2px;"><input checked="" type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Payroll</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Noncash</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>	Person	<input checked="" type="checkbox"/>	Payroll	<input type="checkbox"/>	Noncash	<input type="checkbox"/>
Person	<input checked="" type="checkbox"/>								
Payroll	<input type="checkbox"/>								
Noncash	<input type="checkbox"/>								
	<hr/> <hr/> <hr/>	\$	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 2px;">Person</td> <td style="width:20%; text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Payroll</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Noncash</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>	Person	<input type="checkbox"/>	Payroll	<input type="checkbox"/>	Noncash	<input type="checkbox"/>
Person	<input type="checkbox"/>								
Payroll	<input type="checkbox"/>								
Noncash	<input type="checkbox"/>								
	<hr/> <hr/> <hr/>	\$	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 2px;">Person</td> <td style="width:20%; text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Payroll</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Noncash</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>	Person	<input type="checkbox"/>	Payroll	<input type="checkbox"/>	Noncash	<input type="checkbox"/>
Person	<input type="checkbox"/>								
Payroll	<input type="checkbox"/>								
Noncash	<input type="checkbox"/>								
	<hr/> <hr/> <hr/>	\$	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 2px;">Person</td> <td style="width:20%; text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Payroll</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Noncash</td> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> </tr> </table> <p style="font-size: small; margin-top: 5px;">(Complete Part II for noncash contributions.)</p>	Person	<input type="checkbox"/>	Payroll	<input type="checkbox"/>	Noncash	<input type="checkbox"/>
Person	<input type="checkbox"/>								
Payroll	<input type="checkbox"/>								
Noncash	<input type="checkbox"/>								

Name of organization

NORTHWEST HOSPITAL CENTER, INC.

Employer identification number

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

Name of organization NORTHWEST HOSPITAL CENTER, INC.	Employer identification number 52-1372665
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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 information once. See instructions.) \$ _____
 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
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	
(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____ _____ _____		_____ _____ _____	

**SCHEDULE C
(Form 990)**

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2022

Open to Public Inspection

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

Complete if the organization is described below. Attach to Form 990 or Form 990-EZ.

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

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

Name of organization NORTHWEST HOSPITAL CENTER, INC.	Employer identification number 52-1372665
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."
- 2 Political campaign activity expenditures. See instructions \$ _____
- 3 Volunteer hours for political campaign activities. See instructions _____

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

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

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

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

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

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

Schedule C (Form 990) 2022

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)														
b Total lobbying expenditures to influence a legislative body (direct lobbying)														
c Total lobbying expenditures (add lines 1a and 1b)														
d Other exempt purpose expenditures														
e Total exempt purpose expenditures (add lines 1c and 1d)														
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%; text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 65%; text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:													
Not over \$500,000	20% of the amount on line 1e.													
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.													
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.													
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.													
Over \$17,000,000	\$1,000,000.													
g Grassroots nontaxable amount (enter 25% of line 1f)														
h Subtract line 1g from line 1a. If zero or less, enter -0-														
i Subtract line 1f from line 1c. If zero or less, enter -0-														
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? <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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: Description, (a) Yes/No, and (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation... a Volunteers? b Paid staff or management... c Media advertisements? d Mailings to members... e Publications... f Grants to other organizations... g Direct contact with legislators... h Rallies, demonstrations... i Other activities? j Total... 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? 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).

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

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."

Table with 2 main columns: Description and Amount. Rows include: 1 Dues, assessments and similar amounts from members 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 b Carryover from last year c Total 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues. 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 expenditures next year? 5 Taxable amount of lobbying and political expenditures. See instructions.

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.

SEE PAGE 4

Blank lines for supplemental information.

Part IV Supplemental Information (continued)

SCHEDULE C, 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, 2023 AND OTHER LOBBYING ACTIVITIES PERFORMED ON BEHALF OF THE HOSPITAL REGARDING COMMUNITY STABILIZATION AND DEVELOPMENT, HEALTH CARE MALPRACTICE, AND PROGRAM FUNDING.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2022

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization

Employer identification number

NORTHWEST HOSPITAL CENTER, INC.

52-1372665

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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?, 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?

Part II Conservation Easements.

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

Table with 2 columns: Description, Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 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, 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?, 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

Schedule D (Form 990) 2022

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 make 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 program
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

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

Part V Endowment Funds.

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment _____ %
 - b Permanent endowment _____ %
 - c Term endowment _____ %
- The percentages on lines 2a, 2b, and 2c should equal 100%.

- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|--|---------------|----|
| (i) Unrelated organizations | 3a(i) | |
| (ii) Related organizations | 3a(ii) | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 3b | |

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		8,510,191.		8,510,191.
b Buildings		176,909,483.	122,479,861.	54,429,622.
c Leasehold improvements				
d Equipment		144,029,922.	119,973,372.	24,056,550.
e Other		4,307,240.		4,307,240.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				91,303,603.

Part VII Investments - Other Securities.

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

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) INTERCOMPANY RECEIVABLE	22,820,019.
(2) OTHER ASSETS	10,504,409.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	33,324,428.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO AFFILIATES BONDS	77,780,281.
(3) LEASING LIABILITY	10,609,359.
(4) ASSET RETIREMENT OBLIGATION	610,000.
(5) CAPTIVE PROFESSIONAL LIABILITY	590,781.
(6) WORKERS COMPENSATION	390,312.
(7) DEFERRED COMPENSATION	228,006.
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	90,208,739.

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 FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII .

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final column for totals. Rows include: 1 Total revenue, gains, and other support per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part VIII, line 12; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part VIII, line 12, but not on line 1; 5 Total revenue. Add lines 3 and 4c.

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final column for totals. Rows include: 1 Total expenses and losses per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part IX, line 25; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part IX, line 25, but not on line 1; 5 Total expenses. Add lines 3 and 4c.

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.

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information (continued)

SCHEDULE D, PART X, LINE 2:

LIFEBRIDGE HEALTH, INC. ("LIFEBRIDGE") AND ITS NOT-FOR-PROFIT SUBSIDIARIES HAVE BEEN RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE.

LIFEBRIDGE'S INCORPORATED FOR-PROFIT SUBSIDIARIES ACCOUNT FOR INCOME TAXES IN ACCORDANCE WITH FASB ASC TOPIC 740, INCOME TAXES. INCOME TAXES ARE ACCOUNTED FOR UNDER THE ASSET AND LIABILITY METHOD. DEFERRED TAX ASSETS AND LIABILITIES ARE RECOGNIZED FOR THE FUTURE TAX CONSEQUENCES ATTRIBUTABLE TO DIFFERENCES BETWEEN THE FINANCIAL STATEMENT CARRYING AMOUNTS OF EXISTING ASSETS AND LIABILITIES AND THEIR RESPECTIVE TAX BASES AND OPERATING LOSS AND TAX CREDIT CARRYFORWARDS. DEFERRED TAX ASSETS AND LIABILITIES ARE MEASURED USING ENACTED TAX RATES EXPECTED TO APPLY TO TAXABLE INCOME IN THE YEARS IN WHICH THOSE TEMPORARY DIFFERENCES ARE EXPECTED TO BE RECOVERED OR SETTLED. THE EFFECT ON DEFERRED TAX ASSETS AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF THE CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH ASC TOPIC 740.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2022

Open to Public Inspection

Complete if the organization answered "Yes" on Form 990, Part IV, question 20a.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

Department of the Treasury
Internal Revenue Service

Name of the organization 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	X	
1b If "Yes," was it a written policy?	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? 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>300.0000</u> %	X	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input 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>500.0000</u> %	X	
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"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
5c 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?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
6b If "Yes," did the organization make it available to the public?	X	

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)			4,054,476.		4,054,476.	1.29
b Medicaid (from Worksheet 3, column a)			279,607.		279,607.	0.09
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			4,334,083.		4,334,083.	1.38
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			6,699,363.	1,556,662.	5,142,701.	1.63
f Health professions education (from Worksheet 5)			1,341,632.		1,341,632.	0.43
g Subsidized health services (from Worksheet 6)			7,172,435.	4,963,145.	2,209,290.	0.70
h Research (from Worksheet 7)			483,412.		483,412.	0.15
i Cash and in-kind contributions for community benefit (from Worksheet 8)			135,257.		135,257.	0.04
j Total. Other Benefits			15,832,099.	6,519,807.	9,312,292.	2.95
k Total. Add lines 7d and 7j			20,166,182.	6,519,807.	13,646,375.	4.33

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			2,238,424.	1,147,468.	1,090,956.	0.35
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			2,238,424.	1,147,468.	1,090,956.	0.35

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 IME)	5	107,037,832.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	91,143,170.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	15,894,662.
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 %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)
 How many hospital facilities did the organization operate during the tax year? 1

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

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1	03-004	X	X				X		SUB-ACUTE	
NORTHWEST HOSPITAL CENTER, INC. 5401 OLD COURT ROAD RANDALLSTOWN MD 21133 WWW.LIFEBRIDGEHEALTH.ORG/NORTHWEST										
2										
3										
4										
5										
6										
7										
8										
9										
10										

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		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 If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: <u>2020</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	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		X
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
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: <u>20 20</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?		
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:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300.0000</u> % and FPG family income limit for eligibility for discounted care of <u>500.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SCHEDULE C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SCHEDULE C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SCHEDULE C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

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

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

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

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		
	a <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
	b <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
	c <input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
	d <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		X

Schedule H (Form 990) 2022

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 5:

NORTHWEST HOSPITAL PURSUED SEVERAL AVENUES TO ENSURE THAT ITS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) CAPTURED INPUT FROM PERSONS WHO REPRESENT THE BROAD INTEREST OF THE COMMUNITY SERVED BY THE HOSPITAL, INCLUDING THOSE WITH SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH. THE HOSPITAL PARTICIPATED IN A COLLABORATIVE PROCESS INCLUDING BALTIMORE COUNTY GOVERNMENT AND OTHER BALTIMORE COUNTY HOSPITALS. IN ADDITION TO THE HOSPITAL, PARTICIPANTS INCLUDED THE BALTIMORE COUNTY DEPARTMENT OF HEALTH, SHEPPARD PRATT HOSPITAL, GREATER BALTIMORE MEDICAL CENTER, UNIVERSITY OF MARYLAND ST. JOSEPH MEDICAL CENTER, AND MEDSTAR FRANKLIN SQUARE MEDICAL CENTER. THESE ORGANIZATIONS PROVIDED FOCUS GROUP AND SURVEY DATA. IN ADDITION, THE COLLABORATIVE UTILIZED THE SERVICES OF AN OUTSIDE CONSULTING FIRM TO GATHER SECONDARY DATA AND ANALYZE SURVEY AND FOCUS GROUP INPUT. A TOTAL OF 1755 RESIDENT SURVEYS, 46 KEY INFORMANT SURVEYS, AND 17 FOCUS GROUPS WERE CONDUCTED THROUGHOUT THE COUNTY, INCLUDING MANY THAT CAPTURED RESPONSES FROM GROUPS THAT HAD NOT PREVIOUSLY BEEN SURVEYED. A SUBSTANTIAL NUMBER OF THE RESPONSES WERE SPECIFIC TO THE NORTHWEST HOSPITAL SERVICE AREA.

IN ADDITION, BECAUSE THE HOSPITAL SERVES MANY RESIDENTS OF BALTIMORE CITY, THE HOSPITAL JOINED TOGETHER WITH THE BALTIMORE CITY HEALTH DEPARTMENT AND OTHER BALTIMORE CITY HOSPITALS TO COLLECT AND ANALYZE DATA AND TO DEVELOP A COORDINATED PLAN TO MEET THE NEEDS OF THE RESIDENTS OF BALTIMORE CITY. EACH PARTICIPATING HOSPITAL REACHED OUT TO ITS RESPECTIVE COMMUNITY TO GATHER ORGANIZATIONAL INPUT AND FOCUS GROUP PARTICIPANTS.

FURTHER, THE HOSPITAL PARTICIPATED IN A SHARED CHNA DEVELOPMENT PROCESS WITH OTHER LIFEBRIDGE HEALTH FACILITIES THAT SERVE BALTIMORE CITY AND BALTIMORE COUNTY: SINAI HOSPITAL OF BALTIMORE, LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, AND GRACE MEDICAL CENTER. THIS PROCESS INCLUDED FOCUS GROUPS AND NUMEROUS CONVERSATIONS WITH KEY STAKEHOLDERS WITHIN THE PRIMARY SERVICE AREAS OF THE LIFEBRIDGE HEALTH FACILITIES, INCLUDING THAT OF NORTHWEST HOSPITAL. INFORMANTS INCLUDED COMMUNITY LEADERS AND ASSOCIATIONS, AS WELL AS MEMBERS AND REPRESENTATIVES OF DEMOGRAPHIC GROUPS KNOWN TO HAVE PARTICULAR NEEDS: PERSONS WITH DISABILITIES, RE-ENTRY RESIDENTS, AND SPANISH SPEAKERS.

SCHEDULE H, PART V, SECTION B, LINE 6A:

NORTHWEST HOSPITAL CENTER, INC. IS INCLUDED IN THE CHNA OF LIFEBRIDGE HEALTH, INC., WHICH ALSO INCLUDES RELATED HOSPITAL FACILITIES SINAI HOSPITAL OF BALTIMORE, LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, AND GRACE MEDICAL CENTER.

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 7D:

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/MAIN/COMMUNITY-HEALTH](https://www.lifebridgehealth.org/main/community-health)

SCHEDULE H, PART V, SECTION B, LINE 11:

DECISIONS ABOUT PRIORITIES WERE MADE BY THE HOSPITAL'S LEADERSHIP TEAM, IN CONSULTATION WITH THE DIRECTOR OF POPULATION HEALTH, THE DEPARTMENT CHARGED WITH IMPLEMENTATION OF COMMUNITY HEALTH IMPROVEMENT PLANS, AND SUBJECT TO THE OVERSIGHT AND FINAL APPROVAL OF THE LIFE BRIDGE HEALTH COMMUNITY MISSION COMMITTEE (SEE DISCUSSION REGARDING PART VI, LINE 5). THESE DECISIONS WERE BASED ON AN ANALYSIS OF THE FINDINGS OF THE CHNA AND ITS ASSESSMENTS OF THE HOSPITAL'S RESOURCES AND AN ASSESSMENT OF THE HOSPITAL'S ABILITY TO MAKE A MEANINGFUL IMPACT.

THE AREAS THAT WERE ULTIMATELY SELECTED AS PRIORITIES WERE:

CHRONIC DISEASE

COMMUNITY HEALTH EDUCATION

ACCESS TO INSURANCE

WORKFORCE DEVELOPMENT

FOLLOWING IS A SUMMARY OF THE EFFORTS THAT THE HOSPITAL HAS UNDERTAKEN AND WILL BE UNDERTAKING TO ADDRESS THESE PRIORITY AREAS:

CHRONIC DISEASE -

UTILIZE MOBILE CLINICS AND/OR COMMUNITY PARTNERSHIP TO IMPROVE HEALTH CARE ACCESS FOR CARDIOVASCULAR PATIENTS. OUTREACH TO ESTABLISHED PATIENTS WHO HAVE NOT BEEN SEEN IN PRIMARY CARE SETTING WITHIN THE LAST YEAR. MONITOR/IMPROVE SCREENING FOR HEART DISEASE IN PRIMARY CARE SETTINGS. EXPLORE EXPANSION OF HOME/REMOTE MONITORING (E.G., BLOOD PRESSURE CUFFS, SCALES). SCREEN REGULARLY TO IDENTIFY AND ADDRESS DEPRESSION. INCREASE ANNUAL VISITS WITH CARDIAC SPECIALISTS. WORK WITH AMERICAN HEART ASSOCIATION TO IDENTIFY AND IMPLEMENT RELEVANT AHA RESOURCES AND TOOLS TO SUPPORT THIS POPULATION.

COMMUNITY HEALTH EDUCATION -

THE HOSPITAL'S OFFICE OF COMMUNITY HEALTH EDUCATION HAS INCREASED STAFF TO EXPAND REACH INTO SURROUNDING COMMUNITIES. THE ADDITION OF A COMMUNITY PASTORAL OUTREACH COORDINATOR AND ADDITIONAL HEALTH EDUCATORS ALLOWED FOR AN INCREASE IN HEALTH EVENTS AND AN EXPANSION OF TOPICS. IN ADDITION TO INFORMATION REGARDING PREVENTION AND SPECIFIC ILLNESSES, INFORMATION WAS PROVIDED REGARDING THE CONNECTION BETWEEN FAITH AND HEALTH. ADDITIONAL INFORMATION WAS ALSO OFFERED REGARDING AVAILABLE COMMUNITY RESOURCES, WHICH FACILITATED ENHANCED ACCESS TO CARE.

Part V Facility Information (continued)

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

ACCESS TO INSURANCE -

THE HOSPITAL ENGAGES AND TRAINS COUNSELORS WHO CAN ASSIST PATIENTS WITH INSURANCE SIGNUPS. NORTHWEST IS CERTIFIED AS AN APPLICATION COUNSELOR SPONSORING ENTITY BY THE MARYLAND HEALTH BENEFIT EXCHANGE. COMMUNITY HEALTH WORKERS AND SOCIAL WORKERS IN THE OUTPATIENT CLINICS AND POPULATION HEALTH PROGRAMS HAVE BEEN TRAINED TO PROVIDE THESE SIGNUPS, AND THIS SERVICE WILL BE EXPANDED TO EMPLOYEES IN OTHER FACILITIES. IN ADDITION, STAFF WILL BE EQUIPPED WITH KNOWLEDGE ABOUT OTHER ORGANIZATIONS THAT ASSIST PATIENTS IN SIGNING UP FOR INSURANCE AND WILL REFER OR ACCOMPANY PATIENTS TO THOSE ORGANIZATIONS.

WORKFORCE DEVELOPMENT -

NORTHWEST HOSPITAL HAS DEVELOPED A PARTNERSHIP WITH A LOCAL PUBLIC MIDDLE SCHOOL AND A LOCAL PUBLIC HIGH SCHOOL TO PROVIDE CAREER EXPOSURE AND INTERNSHIPS FOR STUDENTS.

SEVERAL NEEDS WERE IDENTIFIED AS PRIORITIES BY INDIVIDUALS WHO PARTICIPATED IN THE CHNA DEVELOPMENT PROCESS, BUT ULTIMATELY WERE NOT CHOSEN AS PRIORITIES FOR IMPLEMENTATION.

NEIGHBORHOOD SAFETY/VIOLENCE -

ALTHOUGH THIS WAS THE TOP ENVIRONMENTAL/SOCIAL CONCERN, IT WAS NOT PRIORITIZED THIS YEAR SINCE THE HOSPITAL ALREADY SUPPORTS A ROBUST PROGRAM, THE STREET VIOLENCE INTERVENTION PROGRAM, THAT IS ACTIVELY WORKING TO PREVENT STREET VIOLENCE AND TO SUPPORT VICTIMS OF SUCH VIOLENCE.

HOUSING/HOMELESSNESS -

IT WAS DETERMINED THAT THIS IS A PROBLEM BETTER ADDRESSED BY GOVERNMENT AND OTHER ORGANIZATIONS THAT HAVE A MORE SPECIFIC FOCUS ON HOUSING AND HOMELESSNESS ISSUES.

LACK OF TRANSPORTATION -

THIS WAS NOT MADE A PRIORITY AREA BECAUSE THE HOSPITAL ALREADY ENGAGES IN A VARIETY OF ACTIVITIES TO ASSIST PATIENTS WITH TRANSPORTATION, INCLUDING PROVIDING DIRECT FUNDING FOR TRANSPORTATION.

INSURANCE NOT ACCEPTED -

ALTHOUGH MANY INFORMANTS IDENTIFIED PROVIDERS' UNWILLINGNESS TO ACCEPT PATIENTS' INSURANCE AS A BARRIER TO RECEIVING CARE, THIS ISSUE WAS NOT MADE A PRIORITY BECAUSE NORTHWEST HOSPITAL ALREADY ACCEPTS ALL FORMS OF INSURANCE. IT WAS DETERMINED THAT THIS WOULD BE BEST ADDRESSED BY PHYSICIAN OFFICES.

LIMITED ACCESS TO HEALTHY FOODS -

WHILE THERE IS SIGNIFICANT INTEREST THROUGHOUT BALTIMORE CITY IN THE ISSUE OF FOOD DESERTS, THIS WAS NOT EXPRESSED AS A PRIORITY BY RESIDENTS OF THE HOSPITAL'S PRIMARY SERVICE AREA.

Part V Facility Information (continued)

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

POVERTY -

SINCE THIS ISSUE HAS DEEP SYSTEMIC CAUSES, NORTHWEST DETERMINED IT COULD BE MORE EFFECTIVE BY ADDRESSING SOME MORE SPECIFIC PROBLEMS (SUCH AS WORKFORCE DEVELOPMENT AND TRANSPORTATION) ASSOCIATED WITH POVERTY.

POOR SCHOOLS/DROPOUTS -

WHILE THE HOSPITAL AND LIFE BRIDGE HEALTH ARE ENGAGED IN MANY WAYS WITH LOCAL SCHOOLS, THE HOSPITAL DOES NOT BELIEVE IT HAS THE ABILITY TO EFFECT SIGNIFICANT IMPROVEMENT IN OVERALL SCHOOL QUALITY.

WAIT FOR CARE -

MANY INFORMANTS IDENTIFIED LENGTHY WAITS FOR CARE AS A SIGNIFICANT ISSUE. A SYSTEM-WIDE EFFORT IS BEING UNDERTAKEN TO ADDRESS THROUGHPUT IN VARIOUS HOSPITAL SETTINGS. BROADER PROBLEMS, SUCH AS WAIT TIMES FOR SPECIFIC NONHOSPITAL SERVICES SUCH AS MENTAL HEALTH APPOINTMENTS IN THE COMMUNITY, ARE BEYOND THE SCOPE OF THE HOSPITAL.

STIGMA/DISCRIMINATION -

STIGMA AND DISCRIMINATION AGAINST SPECIFIC GROUPS WERE IDENTIFIED AS AN ISSUE IN SOME FOCUS GROUPS. ALTHOUGH IT WAS NOT SELECTED AS CENTRAL FOCUS FOR THE HOSPITAL FOR THE NEXT THREE YEARS, THE CONCERNS WERE SHARED WITH OTHER PARTS OF THE HEALTH SYSTEM. THE LIFE BRIDGE HEALTH CLINICALLY INTEGRATED NETWORK HAS BEGUN TO ADDRESS STIGMA AND DISCRIMINATION AGAINST LGBTQ INDIVIDUALS BY INSTITUTING A LGBTQ-FRIENDLY PROVIDER NETWORK.

ACCESS TO DOCTORS' OFFICES -

SOME INDIVIDUALS EXPRESSED CONCERN ABOUT PATIENTS' ABILITY TO SECURE CARE FROM COMMUNITY PHYSICIANS. IT WAS DETERMINED THAT THIS COULD BEST BE ADDRESSED THROUGH THE HOSPITAL'S RELATIONSHIP WITH CHASE BREXTON HEALTH SERVICES, A COMMUNITY HEALTH CENTER LOCATED CLOSE TO THE HOSPITAL. CHASE BREXTON CURRENTLY BASES A NURSE AT NORTHWEST HOSPITAL TO FACILITATE POST-DISCHARGE ACCESS TO PRIMARY CARE. A PLAN TO EXPAND UTILIZATION OF THIS SERVICE AND TO FACILITATE ACCESS TO CHASE BREXTON PROVIDERS FOR OTHER PATIENTS WILL BE CREATED.

SCHEDULE H, PART V, SECTION B, LINE 16A - 16C:

[HTTPS://WWW.LIFE BRIDGE HEALTH.ORG/MAIN/FINANCIAL-ASSISTANCE](https://www.lifebridgehealth.org/main/financial-assistance)

Part V Facility Information (continued)

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

SCHEDULE H, PART V, SECTION B, LINE 22C:

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 NO MORE THAN 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 D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

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

Name and address	Type of facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, 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 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.

SCHEDULE H, 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 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 PAYOR'S RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAK-OUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. 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 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.

SCHEDULE H, PART I, LINE 7A - I:

THE FOLLOWING COSTING METHODOLOGIES WERE USED TO CALCULATE LINES 7A THROUGH 7I ON THE COMMUNITY BENEFIT REPORT.

OFFSETTING REVENUE - REVENUE FROM THE ACTIVITY DURING THE YEAR THAT OFFSETS THE TOTAL COMMUNITY BENEFIT EXPENSE OF THAT ACTIVITY, IT INCLUDES ANY REVENUE GENERATED BY THE ACTIVITY OR PROGRAM, SUCH AS A PAYMENT OR REIMBURSEMENT FOR SERVICES PROVIDED TO PROGRAM PATIENTS. OFFSETTING REVENUE INCLUDES RESTRICTED GRANTS OR CONTRIBUTIONS USED TO PROVIDE A COMMUNITY BENEFIT BUT DOES NOT INCLUDE UNRESTRICTED GRANTS OR CONTRIBUTIONS THAT THE ORGANIZATION USES TO PROVIDE COMMUNITY BENEFIT.

DIRECT COSTS - DIRECT COSTS INCLUDE SALARIES, EMPLOYEE BENEFITS, SUPPLIES, INTEREST ON FINANCING, TRAVEL AND OTHER COSTS THAT ARE DIRECTLY ATTRIBUTABLE TO THE SPECIFIC SERVICE AND THAT WOULD NOT EXIST IF THE SERVICE OR EFFORT DID NOT EXIST.

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.
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- 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.

INDIRECT COSTS - INDIRECT COSTS ARE COSTS NOT ATTRIBUTED TO PRODUCTS AND/OR SERVICES THAT ARE INCLUDED IN THE CALCULATION OF COSTS FOR COMMUNITY BENEFIT. THESE COULD INCLUDE, BUT ARE NOT LIMITED TO, SALARIES FOR HUMAN RESOURCES AND FINANCE DEPARTMENTS, INSURANCE AND OVERHEAD EXPENSES.

PART II, COMMUNITY BUILDING ACTIVITIES:

AS PART OF OUR OVERALL POPULATION HEALTH STRATEGY, WE WILL BE EXPANDING AND INTEGRATING OUR EXISTING COMMUNITY OUTREACH PROGRAMS AND PARTNERING WITH OTHER ENTITIES TO PROVIDE NEW SERVICES FOR OUR COMMUNITY. OUR OUTREACH PROGRAMS IN THE M. PETER MOSER COMMUNITY INITIATIVES DEPARTMENT ARE DESIGNED TO ATTEND TO NOT ONLY THE HEALTH BUT ALSO THE SOCIAL WELL-BEING OF THE PEOPLE IN OUR SURROUNDING NEIGHBORHOODS. FOR EXAMPLE, THE DIABETES MEDICAL HOME EXTENDER PROGRAM FOCUSES ON HELPING PEOPLE WITH POORLY CONTROLLED DIABETES WHO LIVE IN THE COMMUNITIES SURROUNDING THE HOSPITAL. CLIENTS, WHO ARE IDENTIFIED DURING THEIR INPATIENT STAY, ARE THEN PROVIDED NURSING AND COMMUNITY HEALTH WORKER SERVICES IN THEIR HOMES POST-HOSPITALIZATION TO CONNECT WITH SUPPORT SERVICES AND RECEIVE

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.
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- 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.

EDUCATION.

SCHEDULE H, 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.

SCHEDULE H, PART III, LINE 3:

NORTHWEST HOSPITAL DETERMINES ELIGIBILITY FOR FINANCIAL ASSISTANCE THROUGH OTHER VARIOUS MEANS SUCH AS ELIGIBLE FOR MEDICAID PROGRAMS, ENROLLED IN MEANS-TESTED SOCIAL PROGRAMS, ENROLLED IN STATE OF MARYLAND GRANT FUNDED PROGRAMS WHERE REIMBURSEMENT IS LESS THAN THE CHARGE, ELIGIBLE UNDER THE JEWISH FAMILY AND CHILDREN'S SERVICES PROGRAMS, OUT-OF-STATE MEDICAID PROGRAMS, MARYLAND MEDICAID ELIGIBLE.

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.
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- 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.

AFTER ADMISSION, MARYLAND MEDICAID 216 AND IF THE PATIENT WAS DENIED
MEDICAID FOR NOT MEETING DISABILITY REQUIREMENTS. OF THE REMAINING BAD
DEBT EXPENSE, IT IS ESTIMATED THAT \$3,019,947 IN COST IS ATTRIBUTABLE TO
PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE.

AS DESCRIBED ELSEWHERE, THE HOSPITAL ENGAGES IN MULTIPLE EFFORTS TO
INFORM PATIENTS OF THE AVAILABILITY OF FINANCIAL ASSISTANCE AND CHARITY
CARE. THE \$3,019,947 WAS BILLED TO PATIENTS ONLY BECAUSE THEY, DESPITE
THE HOSPITAL'S EFFORTS, DID NOT REQUEST, OR DID NOT COOPERATE WITH THE
HOSPITAL'S EFFORTS TO PROVIDE THEM WITH, THE AVAILABLE FINANCIAL
ASSISTANCE.

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.
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- 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.

SCHEDULE H, PART III, LINE 4:

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 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 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 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

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.
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- 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.

AND REGULATIONS, WHILE MAINTAINING POSITIVE PATIENT RELATIONS. SEE

AUDITED FINANCIAL STATEMENTS PAGE 17.

SCHEDULE H, 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 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.
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- 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.

SCHEDULE H, 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 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 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.
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- 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.

SCHEDULE H, PART VI, LINE 2:

THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITIES IT SERVES BY: A) ANALYZING PRIMARY AND SECONDARY HEALTH DATA AT THE HOSPITAL AND COMMUNITY LEVEL AND B) INVOLVING PUBLIC HEALTH EXPERTS, COMMUNITY MEMBERS AND KEY COMMUNITY GROUPS IN FURTHER IDENTIFYING PRIORITY CONCERNS AND NEEDS.

NORTHWEST HOSPITAL CENTER, INC. IS INVOLVED WITH THE BALTIMORE CITY HEALTH DEPARTMENT'S ACCOUNTABLE HEALTH COMMUNITIES PROJECT, IDENTIFYING AREAS OF SIGNIFICANT SOCIAL NEED AND TARGETING EFFORTS AROUND THESE AREAS. WE ALSO WORK REGULARLY WITH A GROUP OF BALTIMORE CITY HOSPITALS LOOKING CONTINUALLY AT NEEDS OF OUR SURROUNDING COMMUNITIES AND ADDRESSING THOSE NEEDS.

THROUGH OUR CARE COORDINATION PROGRAMS, WE USE ASSESSMENTS AND DATA ANALYTICS TO IDENTIFY NEEDS AND DEVELOP TARGETED POPULATION HEALTH PROGRAMS AS WELL AS INDIVIDUAL CARE GOALS.

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.
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- 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.

NORTHWEST HAS ALSO ARRANGED FOR ITS PATIENTS AND COMMUNITIES TO RECEIVE SERVICES THROUGH THE M. PETER MOSER COMMUNITY INITIATIVES DEPARTMENT OF NORTHWEST'S AFFILIATE HOSPITAL, SINAI HOSPITAL OF BALTIMORE. SINAI'S M. PETER MOSER COMMUNITY INITIATIVES DEPARTMENT PROVIDES SERVICES THAT RESPOND TO MORE THAN THE SPECIFIC MEDICAL CONDITION, TAKING INTO ACCOUNT THE SOCIAL DETERMINANTS OF HEALTH THAT MAY CONTRIBUTE TO AN INDIVIDUAL'S OR A COMMUNITY'S POOR HEALTH STATUS. SUCH SERVICES ARE BASED ON AN UNDERSTANDING THAT PERSONS WHO EXPERIENCE AN ACUTE MEDICAL CONDITION MAY WELL HAVE MUCH GREATER OBSTACLES TO POSITIVE HEALTH OUTCOMES THAN THE SPECIFIC DIAGNOSIS, AND THAT THE MEDICAL PRESENTATION MAY HAVE BEEN CAUSED OR AT LEAST EXACERBATED BY THE PERSON'S PSYCHOSOCIAL SITUATION THAT RESULTS FROM POVERTY AND INEQUALITIES THAT EXIST IN THE STRUCTURE OF OUR SOCIETY. THESE PROGRAMS INVOLVE A MEDICAL ASSESSMENT BY THE CLINICAL TEAM COORDINATOR NURSE AND AN ENROLLMENT ASSESSMENT. BOTH ASSESSMENTS ARE ESSENTIAL TO THE ENROLLMENT PROCESS; THE MEDICAL ASSESSMENT DETERMINES MEDICAL RISK AND ELIGIBILITY ACCORDING TO MEDICAL CRITERIA, AND THE COMMUNITY HEALTH WORKER DETERMINES READINESS AND POTENTIAL FOR BEHAVIOR

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.
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- 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.

CHANGE RELATED TO HEALTH BEHAVIORS AND SELF-HELP.

WE OFTEN USE INFORMATION GATHERED DURING OUR EDUCATIONAL PROGRAM EVALUATIONS (DONE BY SURVEY AND INFORMAL CONVERSATION) WHICH ASK IF THERE ARE (1) ANY CHANGES SUGGESTED TO THE PROGRAM; AND (2) ANY TOPICS PEOPLE WOULD LIKE TO SEE COVERED THAT WERE NOT COVERED IN THE PROGRAM. WE ALSO WORK IN CLOSE COLLABORATION WITH THE LOCAL HEALTH DEPARTMENTS (BALTIMORE CITY AND COUNTY) WITH REGARD TO THEIR HEALTH INITIATIVES, STATISTICS, AND ALSO DIRECTLY WITH ORGANIZATIONS TO MEET THEIR REQUESTS FOR SUBJECT MATTER. WE ALSO WORK WITH INTERNAL SPECIALTIES WITHIN LIFEBRIDGE HEALTH TO AID IN TARGETED HEALTH EDUCATION AS NEEDED.

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.
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- 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.

SCHEDULE H, 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

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.
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- 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.

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 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. FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS COVER SHEET ARE AVAILABLE IN RUSSIAN AND SPANISH. NORTHWEST HOSPITAL HOSTS AND PARTICIPATES IN VARIOUS DEPARTMENT OF HEALTH AND MARYLAND HOSPITAL ASSOCIATION SPONSORED CAMPAIGNS LIKE 'COVER THE UNINSURED WEEK'.

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.
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- 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.

SCHEDULE H, 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 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 246,000 RESIDENTS WITH AN AVERAGE HOUSEHOLD INCOME OF \$67,000 COMPARED TO THE MARYLAND STATE AVERAGE OF \$74,000.

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.

SCHEDULE H, PART VI, LINE 5:

THE MEMBERS OF THE SENIOR LEADERSHIP TEAM PROVIDE OVERSIGHT AND DIRECTION TO THE POPULATION HEALTH DEPARTMENT IN IDENTIFYING THE INTERVENTIONS THAT ARE SPECIFICALLY HELPFUL FOR THE NORTHWEST CBSA, INCLUDING COMMUNITY BENEFIT OUTPUT AND OTHER POPULATION HEALTH-RELATED INITIATIVES. THE MEMBERS OF THE CLINICAL LEADERSHIP TEAM PROVIDE MORE DIRECTED OVERSIGHT AND DIRECTION TO THE POPULATION HEALTH DEPARTMENT IN IDENTIFYING THE INTERVENTIONS THAT ARE SPECIFICALLY HELPFUL FOR THE NORTHWEST CBSA, INCLUDING COMMUNITY BENEFIT OUTPUT AND OTHER POPULATION HEALTH-RELATED INITIATIVES.

DIRECT SERVICE STAFF: IN THE DEPARTMENT OF POPULATION HEALTH, THE LIFEBRIDGE M. PETER MOSER COMMUNITY INITIATIVES DEPARTMENT EMPLOYS A STAFF OF 36 FULL TIME EQUIVALENT COMMUNITY HEALTH WORKERS, SOCIAL WORKERS, AND COUNSELORS TO IMPLEMENT AND DELIVER COMMUNITY BENEFIT PROGRAMMING. THE CORE FUNCTION OF COMMUNITY INITIATIVES IS TO PROVIDE SERVICES TO BENEFIT THE COMMUNITY AT NO CHARGE.

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.

COMMUNITY HEALTH IMPROVEMENT: LIFE BRIDGE HEALTH INC. CREATED THE OFFICE OF COMMUNITY HEALTH IMPROVEMENT TO IMPLEMENT COMMUNITY HEALTH IMPROVEMENT PROJECTS, AS WELL AS PROVIDE COMMUNITY HEALTH EDUCATION. ALTHOUGH THE DEPARTMENT PROVIDES SERVICES TO INDIVIDUALS LIVING IN OR AROUND NORTHWEST, SINAI AND LEVINDALE HOSPITALS' SURROUNDING COMMUNITIES, THE DEPARTMENT IS PHYSICALLY LOCATED AT NORTHWEST HOSPITAL.

OTHER CLINICAL DEPARTMENTS ALSO PROVIDE COMMUNITY BENEFIT PROGRAMMING IN ADDITION TO REGULAR CLINICAL FUNCTIONING.

SCHEDULE H, PART VI, LINE 6:

NORTHWEST HOSPITAL IS A COMMUNITY HOSPITAL WITH AN ATTENDING STAFF OF APPROXIMATELY 700 PHYSICIANS, REPRESENTING NUMEROUS SPECIALTIES. THOSE SPECIALTIES INCLUDE BUT ARE NOT LIMITED TO CARDIOLOGY, PULMONARY, GENERAL SURGERY, ORTHOPEDICS, VASCULAR AND INFECTIOUS DISEASE.

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.

FACULTY PHYSICIANS PROVIDE SERVICES TO PATIENTS THROUGH A FACULTY PRACTICE PLAN. WHEN PATIENTS REQUEST APPOINTMENTS IN THE FACULTY PRACTICE OFFICES, THEY ARE NOT SCREENED ON THE ABILITY TO PAY FOR SERVICES. PHYSICIAN FEES FOR UNINSURED PATIENTS ARE DETERMINED ON A SLIDING SCALE BASED ON INCOME. FEES MAY BE WAIVED IF A PATIENT HAS NO FINANCIAL RESOURCES. ADDITIONALLY, IN THOSE SPECIALTIES IN WHICH THE HOSPITAL DOES NOT HAVE A FACULTY, SUCH AS DENTISTRY AND OTOLARYNGOLOGY, WE CONTRACT WITH SPECIALISTS IN ORDER TO PROVIDE CONTINUOUS CARE FOR PATIENTS ADMITTED TO THE HOSPITAL THROUGH THE EMERGENCY DEPARTMENT. IN THESE CASES, THE HOSPITAL COVERS THESE SPECIALISTS' CONSULTATION FEES AND FEES FOR PROCEDURES FOR INDIGENT PATIENTS.

NORTHWEST HOSPITAL IS A COMPONENT OF LIFEBRIDGE HEALTH, A NONPROFIT HEALTH SYSTEM THAT PROVIDES A WIDE VARIETY OF HEALTH CARE AND RELATED SERVICES TO THE RESIDENTS OF CENTRAL MARYLAND. THE COMPONENTS OF THE LIFEBRIDGE SYSTEM WORK TOGETHER CLOSELY TO ENSURE THAT AS MANY AS POSSIBLE OF THE COMMUNITY'S NEEDS ARE MET IN AN INTEGRATED, NONDUPLICATIVE MANNER.

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.

SCHEDULE H, PART VI, LINE 7:

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

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2022

**Open to Public
Inspection**

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 on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax 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 (such as 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 on line 1a?

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

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

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

- a** Receive a severance payment or change-of-control payment?
- 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 on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

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

- a** The organization?
- b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

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

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

9 If "Yes" on 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		

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

Schedule J (Form 990) 2022

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't 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 and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
DAVID KRAJEWSKI 1 ASSIST TREAS, NW/ EVP/CFO, LBH	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	781,444.	642,476.	310,228.	505,167.	21,770.	2,261,085.	171,455.
JASON WEINER 2 ASSIST SEC,NW/SVP/GEN CNCL,LBH	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	464,254.	337,022.	129,408.	124,187.	22,016.	1,076,887.	NONE
CRAIG CARMICHAEL 3 PRESIDENT & COO, NORTHWEST	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	409,666.	205,059.	37,762.	53,641.	28,525.	734,653.	NONE
TERRENCE CARNEY 4 VP SUPPLY CHAIN	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	285,033.	80,353.	82,041.	19,951.	2,569.	469,947.	NONE
JAMES ROBERGE 5 VP CAPITAL IMPROVEMENTS	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	322,608.	85,535.	76,585.	69,962.	24,859.	579,549.	37,185.
NANCY KANE 6 VP FINANCIAL REPORTING	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	275,055.	69,683.	44,442.	83,353.	22,487.	495,020.	29,162.
LOU DUNAWAY 7 VP BUDGET & CAPITAL PLANNING	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	273,075.	74,222.	61,996.	69,518.	20,640.	499,451.	43,601.
SAMUEL SMITH 8 VP CHIEF MEDICAL OFFICER	(i)	364,229.	91,070.	45,856.	6,270.	21,118.	528,543.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROBERT SALTZMAN, MD 9 PHYSICIAN	(i)	667,803.	329,233.	19,991.	21,336.	24,294.	1,062,657.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
CHAITANYA RAVI 10 AVP, CHIEF CARE TRANSITIONS	(i)	380,294.	59,333.	22,786.	5,470.	19,891.	487,774.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
KIM BUSHNELL 11 VP PATIENT CARE SERVICES/CNO	(i)	279,169.	60,880.	83,487.	4,656.	10,465.	438,657.	31,213.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
CAMILLE UPCHURCH, MD 12 CHIEF OF HOSPITAL MEDICINE	(i)	305,631.	80,871.	414.	2,673.	28,300.	417,889.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
HARSHINDER SIDHU, MD 13 HOSPITALIST	(i)	347,356.	35,118.	176.	6,511.	24,651.	413,812.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
JONATHAN THIERMAN, MD 14 FORMER DIRECTOR	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	433,684.	203,360.	74,783.	80,238.	25,518.	817,583.	34,869.
DAVID MCCORMICK 15 CFO, NW/ VP, LBH	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	221,037.	51,966.	1,890.	26,891.	23,856.	325,640.	NONE
RICHARD ROHRS 16 AVP PROVIDER OPERATIONS	(i)	309,122.	25,116.	22,886.	6,275.	17,152.	380,551.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE

Schedule J (Form 990) 2022

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.

SCHEDULE J, PART I, LINE 1A:

THE ORGANIZATION PAYS MEMBERSHIP DUES FOR SELECT SENIOR EXECUTIVES AT A CLUB USED FOR BUSINESS MEETINGS AND EVENTS.

SCHEDULE J, PART I, LINE 3:

THE INDIVIDUAL WHO SERVES AS NORTHWEST HOSPITAL CENTER'S PRESIDENT ALSO SERVES AS SENIOR VICE PRESIDENT OF NORTHWEST'S PARENT ORGANIZATION, LIFEBRIDGE HEALTH, INC., AND HAS RESPONSIBILITIES THAT EXTEND ACROSS THE LIFEBRIDGE HEALTH SYSTEM. HIS COMPENSATION IS DETERMINED AT THE PARENT LEVEL BY LIFEBRIDGE HEALTH, INC. THE METHODS USED AT LIFEBRIDGE HEALTH, INC. INCLUDE A COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT CONTRACT, COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE.

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.

SCHEDULE J, PART I, LINE 4B:

THE FOLLOWING DIRECTORS AND OFFICERS PARTICIPATED IN A LIFEBRIDGE HEALTH SPONSORED SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN DURING THE YEAR. THE AMOUNTS REPORTED BELOW REPRESENT EMPLOYER CONTRIBUTIONS TO THE SECTION 457(F) PLAN MADE DURING THE YEAR:

DAVID KRAJEWSKI	\$467,587
JASON WEINER	\$ 96,460
JONATHAN THIERMAN	\$ 64,878
JAMES ROBERGE	\$ 56,167
NANCY KANE	\$ 50,338
CRAIG CARMICHAEL	\$ 48,805
LOU DUNAWAY	\$ 41,738

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.

DAVID KRAJEWSKI	\$	272,466
JASON WEINER	\$	98,198
JONATHAN THIERMAN	\$	71,273
LOU DUNAWAY	\$	58,267
JAMES ROBERGE	\$	47,468
SAMUEL SMITH	\$	45,678
TERRENCE CARNEY	\$	41,706
NANCY KANE	\$	37,432

MR. CARMICHAEL RECEIVED COMPENSATION AS PRESIDENT & COO OF NORTHWEST HOSPITAL, INC. AND A SENIOR VICE PRESIDENT OF LIFEBRIDGE HEALTH, INC., NOT AS A DIRECTOR OF NORTHWEST HOSPITAL.

MR. KRAJEWSKI RECEIVED COMPENSATION AS EXECUTIVE VICE PRESIDENT AND CFO OF LIFEBRIDGE HEALTH, INC. AND PRESIDENT OF LIFEBRIDGE HEALTH PARTNERS, INC., NOT AS AN OFFICER OF NORTHWEST HOSPITAL.

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.

MR. WEINER RECEIVED COMPENSATION AS SENIOR VP AND GENERAL COUNSEL OF
LIFEBRIDGE HEALTH, INC., NOT AS AN OFFICER OF NORTHWEST HOSPITAL.

DR. THIERMAN RECEIVED COMPENSATION AS THE CHIEF MEDICAL INFORMATION
OFFICER OF SINAI HOSPITAL OF BALTIMORE, INC., NOT AS A DIRECTOR OF
NORTHWEST HOSPITAL.

**SCHEDULE L
(Form 990)**

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.

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

OMB No. 1545-0047

2022

**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 section 501(c)(29) organizations only).

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

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

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

Part II Loans to and/or From Interested Persons.

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

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
			(1)									
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												
(8)												
(9)												
(10)												
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
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ACME PAPER & SUPPLY CO.	INDIRECT BUSINESS	365,518.	SEE PART V		X
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

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 \$3,067,935 IN PAPER PRODUCTS AND JANITORIAL 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.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2022

**Open to Public
Inspection**

Employer identification number

52-1372665

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-NINE 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
2023, THE HOSPITAL ADMITTED 8,197 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 EDUCATION THROUGH ITS COMMUNITY HEALTH
EDUCATION PROGRAMS. COUNTLESS HEALTH FAIRS, BLOOD PRESSURE SCREENINGS,
HEART HEALTH RISK ASSESSMENTS, DIABETES SUPPORT GROUP MEETINGS, FOOD AND

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

Department of the Treasury
Internal Revenue Service

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

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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.

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

THE CORPORATION SHALL HAVE ONE MEMBER, LIFEBRIDGE 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 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.

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

Department of the Treasury
Internal Revenue Service

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

THE LIFEBRIDGE EXEMPT ENTITIES 990'S ARE INITIALLY REVIEWED BY THE ASSISTANT VICE PRESIDENT OF FINANCIAL REPORTING. IN ADDITION, AN INDEPENDENT ACCOUNTING FIRM ALSO REVIEWS ALL OF THE 990 RETURNS. A FORMAL MEETING IS THEN SCHEDULED WITH THE CHIEF FINANCIAL OFFICER, VICE PRESIDENT OF FINANCIAL REPORTING, GENERAL COUNSEL AND THE ASSISTANT VICE PRESIDENT OF FINANCIAL REPORTING TO REVIEW IN THEIR ENTIRETY ALL OF THE LIFEBRIDGE EXEMPT ENTITIES 990'S.

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

ALL DIRECTORS, OFFICERS, EMPLOYEES, MEDICAL STAFF MEMBERS, AND VOLUNTEERS ARE EXPECTED TO RECOGNIZE AND DISCLOSE AT THE EARLIEST POSSIBLE TIME ACTUAL AND POTENTIAL CONFLICTS OF INTEREST.

AN INDIVIDUAL IS CONSIDERED TO HAVE A CONFLICT OF INTEREST WITH REGARD TO A MATTER OR TRANSACTION IF THE INDIVIDUAL OR A FAMILY MEMBER OF THE INDIVIDUAL HAS A PERSONAL OR FINANCIAL INTEREST THAT HAS THE POTENTIAL TO INFLUENCE THE ACTION TAKEN BY THE INDIVIDUAL ON BEHALF OF LIFEBRIDGE HEALTH. ADDITIONAL INFORMATION REGARDING WHAT CONSTITUTES A CONFLICT OF INTEREST AND HOW TO DISCLOSE A CONFLICT IS OUTLINED BELOW.

LIFEBRIDGE AND ALL OF ITS SUBSIDIARIES SHALL REQUIRE ALL EMPLOYEES, MEDICAL STAFF, AND MEMBERS OF THE BOARD TO DISCLOSE ANY ACTIVITIES THAT COULD RESULT IN A POSSIBLE CONFLICT OF INTEREST. IF A CONFLICT IS

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

Department of the Treasury
Internal Revenue Service

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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IDENTIFIED, THE PERSON INVOLVED WOULD RECUSE HIM/HERSELF FROM 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 LIFEBRIDGE 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 LIFEBRIDGE 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, DIRECTOR, TRUSTEE, OR KEY EMPLOYEE) 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, OR THEIR FAMILY MEMBER, (I) IS A PARTY TO THE TRANSACTION, (II) WILL BENEFIT PERSONALLY FROM THE TRANSACTION, OR (III) HAS, DIRECTLY OR INDIRECTLY, A CURRENT OR ANTICIPATED OWNERSHIP OR INVESTMENT IN, OR COMPENSATION ARRANGEMENT WITH, A PARTY TO THE TRANSACTION. AN OWNERSHIP INTEREST OF LESS THAN 5% IN AN ENTITY WILL NOT, IN AND OF ITSELF, GENERALLY BE CONSIDERED A FINANCIAL INTEREST; HOWEVER, TO THE EXTENT THE INDIVIDUAL'S COMPENSATION FROM THE ENTITY IS DIRECTLY LINKED TO THE ENTITY'S BUSINESS WITH LIFEBRIDGE HEALTH, SUCH COMPENSATION

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

Department of the Treasury
Internal Revenue Service

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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WILL CONSTITUTE A FINANCIAL INTEREST.

FOR THE PURPOSES OF THIS POLICY, A "FAMILY MEMBER" INCLUDES SPOUSE OR DOMESTIC PARTNER, PARENTS, BROTHERS AND SISTERS, CHILDREN (WHETHER NATURAL OR ADOPTED), GRANDPARENTS, GRANDCHILDREN, GREAT-GRANDCHILDREN, AND IN-LAWS, SPOUSES OF BROTHERS, SISTERS, CHILDREN, GRANDCHILDREN, AND GREAT-GRANDCHILDREN, AND ANY OTHER MEMBER OF A HOUSEHOLD OF THE INDIVIDUAL.

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 THE CHIEF COMPLIANCE OFFICER.

QUESTIONNAIRES ARE SENT OUT TO MEMBERS OF THE BOARD ON AN ANNUAL BASIS. IF QUESTIONS ARISE OR FURTHER GUIDANCE IS SOUGHT, INDIVIDUALS CAN CONTACT THE CHIEF COMPLIANCE OFFICER OR CONFIDENTIAL COMPLIANCE HOTLINE. 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 15A:

THE COMPENSATION OF NORTHWEST HOSPITAL, INC.'S PRESIDENT/COO IS

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

Department of the Treasury
Internal Revenue Service

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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Form 990 or 990-EZ or to provide any additional information.

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DETERMINED AT THE PARENT LEVEL BY LIFEBRIDGE HEALTH, INC. THE METHODS
USED AT LIFEBRIDGE HEALTH, INC. INCLUDE A COMPENSATION COMMITTEE,
INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT CONTRACT,
COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR COMPENSATION
COMMITTEE.

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

IT IS THE POLICY OF LIFEBRIDGE HEALTH INC. AND ITS SUBSIDIARIES TO MAKE
AVAILABLE UPON REQUEST THE AUDITED FINANCIAL STATEMENTS TO THE GENERAL
PUBLIC. THE LIFEBRIDGE 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 XI, LINE 9:

RELEASED FROM RESTRICTION	\$898,040
CHANGES IN FUND BALANCE	-\$118,947
TRANSFER FROM AFFILIATES	-\$4,898,373
TOTAL	-\$4,119,280

FORM 990, PART XII, LINE 2C:

THIS PROCESS HAS NOT CHANGED FROM THE PRIOR YEAR.

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Employer identification number

52-1372665

FORM 990, PART VII-COMPENSATION OF THE 5 HIGHEST PAID IND. CONTRACTORS

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
QUALIVIS, LLC 5930 CORNERSTONE COURT W., SUITE 300 SAN DIEGO, CA 92121	AGENCY NURSES	16,992,747.
AYA HEALTHCARE, INC. DEPT 3519 P.O. BOX 123519 DALLAS, TX 75312-3519	AGENCY NURSES	5,007,565.
CROTHALL HEALTHCARE 1500 LIBERTY RIDGE DRIVE, SUITE 210 WAYNE, PA 19087	CONTRACT CLEANING	4,002,114.
METZ CULINARY MGMT 2 WOODLAND DRIVE DALLAS, PA 18612	FOOD SERVICES	3,353,448.
NURSES PRN 1101 EAST SOUTH RIVER STREET APPLETON, WI 54915	AGENCY NURSES	2,497,170.

Name of the organization

Employer identification number

NORTHWEST HOSPITAL CENTER, INC.

52-1372665

FORM 990, PART IX - OTHER FEES

=====

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
-----	-----	-----	-----	-----
OTHER PURCHASED SERVICES	32,912,945.	15,562,991.	17,349,954.	NONE
AGENCY NURSES	29,209,089.	29,042,134.	166,955.	NONE
PROFESSIONAL & TECHNICAL	7,692,320.	4,809,869.	2,882,451.	NONE
CONTRACT CLEANING	5,420,675.	1,808,368.	3,612,307.	NONE
TOTALS	----- 75,235,029. =====	----- 51,223,362. =====	----- 24,011,667. =====	----- NONE =====

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

NORTHWEST HOSPITAL CENTER, INC.

Related Organizations and Unrelated Partnerships

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

Attach to Form 990.

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

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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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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
SEE SUPPLEMENTAL PAGE							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) 2022

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) SEE SUPPLEMENTAL PAGE												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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
(1) SEE SUPPLEMENTAL PAGE									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

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

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	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)		X

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)				
(2)				
(3)				
(4)				
(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 section 501(c)(3) organizations?		(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		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
CARROLL HOSPITAL CENTER INC 200 MEMORIAL AVENUE	52-1452024 WESTMINSTER, MD 21157 HOSPITAL	MD	501(C)(3)	3	CCHS		X
BRIDGINGLIFE INC 292 STONER AVENUE	52-1565870 WESTMINSTER, MD 21157 HOSPICE	MD	501(C)(3)	7	CHC		X
CARROLL HOSPITAL CENTER FOUNDATION INC 200 MEMORIAL AVENUE	52-1115038 WESTMINSTER, MD 21157 FOUNDATION	MD	501(C)(3)	12A, I	CHC		X
PARTNERSHIP FOR A HEALTHIER CARROLL CTY 535 OLD WESTMINSTER PIKE, #102	52-2156892 WESTMINSTER, MD 21157 HEALTH SVCS	MD	501(C)(3)	7	CHC		X
LEVINDALE HEBREW GERIATRIC CENTER HOSP 2434 WEST BELVEDERE AVENUE	52-0607913 BALTIMORE, MD 21215 HOSPITAL	MD	501(C)(3)	3	LBH		X
SINAI HOSPITAL OF BALTIMORE INC 2401 WEST BELVEDERE AVENUE	52-0486540 BALTIMORE, MD 21215 HOSPITAL	MD	501(C)(3)	3	LBH		X
COURTLAND GARDENS NURSING AND REHAB CTR 2434 WEST BELVEDERE AVENUE	52-0607907 BALTIMORE, MD 21215 NURSING	MD	501(C)(3)	10	LBH		X
CHILDRENS HOSPITAL OF BALTIMORE CITY INC 2401 WEST BELVEDERE AVENUE	52-0591592 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
THE BALTIMORE JEWISH HEALTH FDN INC 2401 WEST BELVEDERE AVENUE	52-2111541 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
CHILDRENS HOSPITAL AT SINAI FOUNDATION 2401 WEST BELVEDERE AVENUE	52-2167587 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R. See instructions.

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
THE BALTIMORE JEWISH ELDERCARE FDN 2401 WEST BELVEDERE AVENUE	52-2337669 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
CENTER FOR HOPE INC 5400 PREAKNESS WAY	52-1681279 BALTIMORE, MD 21215 CHILD SVCS	MD	501(C)(3)	7	LBH		X
GRACE MEDICAL CENTER INC 2000 W BALTIMORE STREET	52-0591555 BALTIMORE, MD 21223 HOSPITAL	MD	501(C)(3)	3	LBH		X
WEST BALTIMORE RENAISSANCE FDN INC 2401 WEST BELVEDERE AVENUE	84-3355332 BALTIMORE, MD 21215 COMMUNITY CTR	MD	501(C)(3)	7	LBH		X
CARROLL COUNTY HEALTH SERVICES CORP 200 MEMORIAL AVENUE	52-0691413 WESTMINSTER, MD 21157 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
LIFEBRIDGE CENTER FOR HOPE INC 2401 WEST BELVEDERE AVENUE	85-3920012 BALTIMORE, MD 21215 REAL ESTATE	MD	501(C)(3)	12A, I	SHB		X
LIFEBRIDGE HEALTH INC 2401 WEST BELVEDERE AVENUE	52-1402373 BALTIMORE, MD 21215 SUPPORT	MD	501(C)(3)	12C, III	N/A		X
THE FAMILY TREE, INC. 2108 N. CHARLES STREET	52-1110645 BALTIMORE, MD 21218 CHILD SVCS	MD	501(C)(3)	7	LBH		X

NORTHWEST HOSPITAL CENTER, INC.

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990 SCH R, PART III-IDENTIFICATION OF REL. ORG. TAXABLE AS PARTNERSHIP

(A) NAME/ADDRESS/EIN	B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) PREDOMINANT INCOME	(F) SHARE OF TOT INCOME	(G) SHARE EOY	(H) DISPROPORTIONATE		(I) CODE V-UBI	(J) PARTNER		(K) % OWNERSHIP
							YES	NO		YES	NO	
CARROLL COUNTY RADIOLOGY, LLC 7523 AMBASSADOR ROAD BALTIMORE	RADIOLOGY	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
CARROLL OCCUPATIONAL HEALTH, L 7001 CORPORATE CENTER COURT WE	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
CARDIOVASCULAR ASSOCIATES OF M 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE RADIOLOGY OF PARKV 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE COMMUNITY GASTROENT 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE COMMUNITY PEDIATRIC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE COMMUNITY PULMONOLO 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE GYNECOLOGY OF PIKES 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE MEDICAL ASSOCIATES, 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE NEUROSCIENCES, LLC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	

990 SCH R, PART III-IDENTIFICATION OF REL. ORG. TAXABLE AS PARTNERSHIP

(A) NAME/ADDRESS/EIN	B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) PREDOMINANT INCOME	(F) SHARE OF TOT INCOME	(G) SHARE EOY	(H) DISPROPORTIONATE		(I) CODE V-UBI	(J) PARTNER		(K) % OWNERSHIP
							YES	NO		YES	NO	
LIFEBRIDGE PRIMARY CARE OF ELD 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE PRIMARY CARE OF NOR 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
HEMOCARE MARYLAND, LLC 26-1378 8028 RITCHIE HIGHWAY PASADENA,	HOME HEALTH SRVC	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE REHABILITATION SERV 2401 WEST BELVEDERE AVENUE BAL	REHAB SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
ELLCOTT CITY ASC MANAGEMENT, 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
SURGICENTER OF BALTIMORE, LLC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
SPRINGWELL PARTNERS, LLC 27-19 2200 PINE HILL FARMS LANE HUNT	ASSISTED LIVING	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE SUBURBAN PHYSICIAN 5401 OLD COURT ROAD RANDALLSTO	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE LAB MANAGEMENT, LLC 2401 WEST BELVEDERE AVENUE BAL	LAB SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
LIFEBRIDGE METROPOLITAN PHYSIC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	

990 SCH R, PART III-IDENTIFICATION OF REL. ORG. TAXABLE AS PARTNERSHIP

(A) NAME/ADDRESS/EIN	B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) PREDOMINANT INCOME	(F) SHARE OF TOT INCOME	(G) SHARE EOY	(H) DISPROPORTIONATE		(I) CODE V-UBI	(J) PARTNER		(K) % OWNERSHIP
							YES	NO		YES	NO	
LIFEBRIDGE MULTI-SPECIALTY, LL 41 MAGNA WAY, SUITE 100 WESTMI	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
ELLICOTT CITY AMBULATORY SURGE 2850 N RIDGE ROAD ELLICOTT CIT	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
OAK FARM SOLUTIONS, LLC 47-494 1122 KENILWORTH DRIVE TOWSON,	HOME HEALTH SRVC	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
MNR INDUSTRIES, LLC 33-1095434 5 BEL AIR SOUTH PARKWAY BEL AI	URGENT CARE SRVC	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
MNR OF FREDERICK COUNTY, LLC 8 5 BEL AIR SOUTH PARKWAY BEL AI	URGENT CARE SRVC	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
BAKER REHAB GROUP, LLC 88-0864 197 THOMAS JOHNSON DRIVE FREDE	REHAB SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	
ADVANCED ENDO CTR OF HOWARD CT 8875 CENTRE PARK DRIVE COLUMBI	MEDICAL SERVICES	MD	N/A	N/A	NONE	NONE	X		NONE	X	NONE	

NORTHWEST HOSPITAL CENTER, INC.

52-1372665

990 SCH R, PART IV-IDENTIFICATION OF REL. ORG. TAXABLE AS CORP/TRUST

(A) NAME/ADDRESS/EIN	(B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) ENTITY TYPE	(F) SHARE OF TOT INCOME	(G) SHARE OF EOY	(H) % OWNERSHIP	(I) SEC 512(B)(13) YES NO
CARROLL COUNTY MED-SERVICES, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	CCMS INC	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE INVESTMENTS, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	INVESTMENT	MD	LBH	C CORP	NONE	NONE	NONE	X
HEALTHSTAR MEDICAL SERVICES, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	HEALTHCARE	MD	LB INV INC	C CORP	NONE	NONE	NONE	X
PRACTICE DYNAMICS, INC 124 BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136	MANAGEMENT	MD	LB INV INC	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE INSURANCE COMPANY, LTD PO BOX 1109 GRAND CAYMAN, CJ KY1-1102	INSURANCE	CJ	LBH	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE COMMUNITY PHYSICIANS, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	HEALTHCARE	MD	LB INV INC	C CORP	NONE	NONE	NONE	X
CARROLL BILLING SERVICES, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	BILLING SERVICES	MD	CHC INC	C CORP	NONE	NONE	NONE	X
CARROLL COUNTY GEN. HOSP. SOUTH CARROLL 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	REAL ESTATE	MD	N/A	C CORP	NONE	NONE	NONE	X
MED-SERVICES HOLDINGS, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	CCMS INC	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE HEALTH ISRAEL, LTD 16 ABBA HILLEL ROAD RAHMAT GAN, IS 5250608	HEALTHCARE	IS	LB INV INC	C CORP	NONE	NONE	NONE	X