

**Exempt Organization Declaration and Signature for Electronic Filing**

For calendar year 2016, or tax year beginning JUL 1, 2016, and ending JUN 30, 2017

**2016**

Department of the Treasury  
Internal Revenue Service

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

Name of exempt organization

HOWARD COUNTY GENERAL HOSPITAL, INC.

Employer identification number

52-2093120

**Part I Type of Return and Return Information** (Whole Dollars Only)

Check the box for the type of return being filed with Form 8453-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a below and the amount on that line of the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a Form 990 check here	<input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	<u>268,531,230.</u>
2a Form 990-EZ check here	<input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a Form 1120-POL check here	<input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b	
4a Form 990-PF check here	<input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a Form 8868 check here	<input type="checkbox"/>	b Balance due (Form 8868, line 3c)	5b	

**Part II Declaration of Officer**

6  I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.

If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2016 electronic return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund.

Sign Here

Signature of officer

Date

5/14/18

VP FINANCE/CFO

Title

**Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer** (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-file (MeF) Information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

<b>ERO's Use Only</b>	ERO's signature	Date	Check if also paid preparer <input type="checkbox"/>	Check if self-employed <input type="checkbox"/>	ERO's SSN or PTIN
	Firm's name (or yours if self-employed), address, and ZIP code				EIN
					Phone no.

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN
	Firm's name				Firm's EIN
	Firm's address				Phone no.

Form **990**

**Return of Organization Exempt From Income Tax**

OMB No. 1545-0047

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

**2016**

Department of the Treasury  
Internal Revenue Service

▶ Do not enter social security numbers on this form as it may be made public.  
▶ Information about Form 990 and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Open to Public Inspection

**A** For the 2016 calendar year, or tax year beginning **JUL 1, 2016** and ending **JUN 30, 2017**


<b>B</b> Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<b>C</b> Name of organization <b>HOWARD COUNTY GENERAL HOSPITAL, INC.</b>		<b>D</b> Employer identification number <b>52-2093120</b>
	Doing business as		<b>E</b> Telephone number <b>(410)740-7730</b>
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	<b>G</b> Gross receipts \$ <b>282,741,227.</b>
	<b>3910 KESWICK RD, S BLDG</b>	<b>4300A</b>	
	City or town, state or province, country, and ZIP or foreign postal code <b>BALTIMORE, MD 21211</b>		
<b>F</b> Name and address of principal officer: <b>CLARO M. PIO RODA</b> <b>SAME AS C ABOVE</b>		<b>H(a)</b> Is this a group return for subordinates? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>I</b> Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) ( ) ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527		<b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>J</b> Website: ▶ <b>WWW.HCGH.ORG</b>		<b>H(c)</b> Group exemption number ▶	
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		<b>L</b> Year of formation: <b>1998</b>	
		<b>M</b> State of legal domicile: <b>MD</b>	

**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: <b>PROVISION OF INPATIENT AND OUTPATIENT HEALTHCARE SERVICES TO INDIVIDUALS.</b>		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a) .....	<b>3</b>	<b>23</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b) .....	<b>4</b>	<b>18</b>
	<b>5</b> Total number of individuals employed in calendar year 2016 (Part V, line 2a) .....	<b>5</b>	<b>2303</b>
	<b>6</b> Total number of volunteers (estimate if necessary) .....	<b>6</b>	<b>373</b>
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12 .....	<b>7a</b>	<b>0.</b>
<b>b</b> Net unrelated business taxable income from Form 990-T, line 34 .....	<b>7b</b>	<b>0.</b>	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h) .....	<b>Prior Year</b>	<b>Current Year</b>
	<b>9</b> Program service revenue (Part VIII, line 2g) .....	<b>3,732,233.</b>	<b>1,698,448.</b>
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d) .....	<b>256,956,718.</b>	<b>259,968,211.</b>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) .....	<b>820,148.</b>	<b>3,196,962.</b>
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) .....	<b>5,600,725.</b>	<b>3,667,609.</b>
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3) .....	<b>267,109,824.</b>	<b>268,531,230.</b>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4) .....	<b>4,345,528.</b>	<b>0.</b>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) .....	<b>0.</b>	<b>0.</b>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e) .....	<b>121,553,444.</b>	<b>127,189,240.</b>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ <b>0.</b>	<b>0.</b>	<b>0.</b>
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) .....	<b>130,326,748.</b>	<b>133,196,668.</b>
	<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) .....	<b>256,225,720.</b>	<b>260,385,908.</b>
<b>Net Assets or Fund Balances</b>	<b>19</b> Revenue less expenses. Subtract line 18 from line 12 .....	<b>10,884,104.</b>	<b>8,145,322.</b>
	<b>20</b> Total assets (Part X, line 16) .....	<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>21</b> Total liabilities (Part X, line 26) .....	<b>322,937,483.</b>	<b>359,101,868.</b>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20 .....	<b>231,002,415.</b>	<b>248,587,582.</b>
		<b>91,935,068.</b>	<b>110,514,286.</b>

**Part II Signature Block**

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

<b>Sign Here</b>	Signature of officer 	Date <b>5/14/18</b>			
	<b>CLARO M. PIO RODA, VP FINANCE/CFO</b> Type or print name and title				
<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature	Date	Check if self-employed <input type="checkbox"/>	PTIN
	Firm's name ▶	Firm's EIN ▶		Phone no.	
	Firm's address ▶				

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission: MISSION: HOWARD COUNTY GENERAL HOSPITAL, A MEMBER OF JOHNS HOPKINS MEDICINE, STRIVES TO PROVIDE THE HIGHEST QUALITY CARE TO IMPROVE THE HEALTH OF OUR ENTIRE COMMUNITY THROUGH INNOVATION, COLLABORATION, SERVICE EXCELLENCE, DIVERSITY AND A COMMITMENT TO PATIENT SAFETY. ITS

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [ ] Yes [X] No If "Yes," describe these changes on Schedule O.

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

4a (Code: ) (Expenses \$ 77,921,260. including grants of \$ 0.) (Revenue \$ 93,940,917.) DEPARTMENT OF MEDICINE AND SURGERY PURPOSE: HOWARD COUNTY GENERAL HOSPITAL OFFERS A BROAD SPECTRUM OF INPATIENT AND OUTPATIENT SURGICAL SERVICES FOR ADULT AND PEDIATRIC PATIENTS. A LIST OF SOME OF THE MORE COMMON TYPES OF SURGERY PERFORMED AT HCGH INCLUDE: COLORECTAL SURGERY, ENDOSCOPY, GENERAL SURGERY, MINIMALLY INVASIVE SURGERY, NEUROSURGERY, OPHTHALMOLOGY, ORAL SURGERY AND DENTISTRY, ORTHOPEDIC SURGERY, OTOLARYNGOLOGY, PLASTIC SURGERY, PODIATRY, UROLOGY, VASCULAR SURGERY.

HOWARD COUNTY GENERAL HOSPITAL'S INTENSIVE CARE UNIT IS A HIGHLY SPECIALIZED 16-BED UNIT DEDICATED TO THE NEEDS OF ADULT PATIENTS REQUIRING INTENSIVE MONITORING AND PATIENT CARE SERVICES INVOLVING

4b (Code: ) (Expenses \$ 28,949,027. including grants of \$ 0.) (Revenue \$ 39,734,354.) EMERGENCY DEPARTMENT

PURPOSE: OUR 36-BED EMERGENCY DEPARTMENT (ED) IS STAFFED 24-HOURS A DAY, SEVEN DAYS A WEEK BY BOARD-CERTIFIED JOHNS HOPKINS EMERGENCY MEDICINE PHYSICIANS. THE 24,000 SQUARE UNIT EXPANSION PROVIDES STATE-OF-THE-ART COMPREHENSIVE, INDIVIDUALIZED EMERGENCY MEDICAL CARE AND URGENT CARE TO THE CITIZENS OF HOWARD COUNTY AND THE SURROUNDING AREA. UPON ARRIVAL AT THE EMERGENCY DEPARTMENT, A REGISTERED NURSE ASSESSES EVERY PATIENT TO DETERMINE TREATMENT PRIORITY NEEDS. DEPENDING ON THE PATIENT'S NEEDS, TREATMENT WILL BE PROVIDED IN ONE OF THE FOLLOWING UNITS: MAIN EMERGENCY ROOM, URGENT CARE, PEDIATRIC ED/CHILDREN'S CARE CENTER, CHEST PAIN/SHORT STAY UNIT, OR PSYCHIATRIC

4c (Code: ) (Expenses \$ 29,975,306. including grants of \$ 0.) (Revenue \$ 33,043,549.) LABOR & DELIVERY/NURSERY/NICU

PURPOSE: TO ACCOMMODATE THE MORE THAN 3,000 BABIES BORN IN THE HOSPITAL'S LABOR/DELIVERY/RECOVERY (LDR) UNIT EACH YEAR, HOWARD COUNTY GENERAL HOSPITAL OFFERS 12 ATTRACTIVELY DECORATED BIRTHING ROOMS. MOTHER AND BABY CAN REMAIN IN THIS PRIVATE, COMFORTABLE ROOM THROUGHOUT LABOR, DELIVERY AND RECOVERY WITH THE SECURITY OF THE HOSPITAL'S ADVANCED TECHNOLOGY. CERTAIN MEDICAL CONDITIONS MAY REQUIRE A TEMPORARY SEPARATION OF MOTHER AND BABY.

WHILE THE MAJORITY OF NEWBORN INFANTS ARE BORN HEALTHY, MORE INTENSE MONITORING AND CARE ARE SOMETIMES NECESSARY. THE HOSPITAL'S 18-BED LEVEL III+ NICU FEATURES HIGHLY SOPHISTICATED EQUIPMENT SPECIALLY

4d Other program services (Describe in Schedule O.) (Expenses \$ 74,751,276. including grants of \$ ) (Revenue \$ 93,249,391.)

4e Total program service expenses 211,596,869.

**Part IV Checklist of Required Schedules**

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

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

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> .....	X	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? .....	X	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> .....		X
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> .....		X
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> .....	X	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> .....		X
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? .....		
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? .....		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....		
<b>25a</b> <b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> .....		X
<b>b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> .....		X
<b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> .....		X
<b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> .....		X
<b>28</b> Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
<b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> .....		X
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> .....		X
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> .....		X
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> .....		X
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> .....		X
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> .....	X	
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> .....	X	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? .....		X
<b>b</b> If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> .....		
<b>36</b> <b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> .....		X
<b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> .....		X
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? .....	X	

**Note.** All Form 990 filers are required to complete Schedule O .....

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

Input box for Schedule O

Table with columns for question numbers (1a-14b), Yes/No checkboxes, and numerical input fields. Contains questions about Form 1096, Form W-2G, Form W-3, and various IRS forms like 8886-T, 8899, 8282, 4966, 720, and 1041.

**Part VI Governance, Management, and Disclosure** For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

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

**Section A. Governing Body and Management**

		Yes	No
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
	<b>1a</b> 23		
<b>b</b>	Enter the number of voting members included in line 1a, above, who are independent		
	<b>1b</b> 18		
<b>2</b>	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		X
<b>3</b>	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?		X
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		X
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?		X
<b>6</b>	Did the organization have members or stockholders?	X	
<b>7a</b>	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	X	
<b>b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	X	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b>	The governing body?	X	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	X	
<b>9</b>	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		X

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

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates?		X
<b>b</b>	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		
<b>10b</b>			
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
<b>b</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13	X	
<b>b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
<b>c</b>	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	X	
<b>12c</b>		X	
<b>13</b>	Did the organization have a written whistleblower policy?	X	
<b>14</b>	Did the organization have a written document retention and destruction policy?	X	
<b>15</b>	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
<b>a</b>	The organization's CEO, Executive Director, or top management official	X	
<b>b</b>	Other officers or key employees of the organization	X	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?		X
<b>b</b>	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?		
<b>16b</b>			

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **MD**
- 18** Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
 Own website  Another's website  Upon request  Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records: **THE CORPORATION - 443-997-5724**  
**3910 KESWICK RD, SOUTH BLDG, 4TH FLOOR, STE. 4300A, BALTIMORE, MD 21211**



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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) W. BRIAN MCGOWAN TRUSTEE/CHAIRMAN	1.00	X		X				0.	0.	0.
(2) DENNIS MILLER TRUSTEE	1.00	X						0.	0.	0.
(3) STEVEN C. SNELGROVE PRESIDENT/TRUSTEE	59.00 1.00	X		X				0.	607,069.	126,183.
(4) MAURA ROSSMAN, M.D. TRUSTEE	1.00	X						0.	0.	0.
(5) DAVID CONDRON TRUSTEE/TREASURER	1.00	X		X				0.	0.	0.
(6) BILL SAWAY, M.D. TRUSTEE	1.00	X						0.	0.	0.
(7) KATHLEEN MURPHY WHITE, PH.D. TRUSTEE	1.00	X						0.	0.	0.
(8) KAREN BUTLER TRUSTEE	1.00	X						0.	0.	0.
(9) SCOTT BUTLER TRUSTEE	1.00	X						0.	0.	0.
(10) RENEE DEMSKI TRUSTEE	1.00 59.00	X						0.	309,795.	71,036.
(11) BRIAN WALTER TRUSTEE	1.00	X						0.	0.	0.
(12) ELIZABETH RENDON-SHERMAN TRUSTEE/SECRETARY	1.00	X		X				0.	0.	0.
(13) NICHOLAS KOUTRELAKOS, M.D. TRUSTEE	1.00	X						0.	0.	0.
(14) JONATHAN S. FISH, M.D. TRUSTEE	1.00	X						0.	0.	0.
(15) RONALD R. PETERSON CORPORATE VICE CHAIR/TRUSTEE	1.00 59.00	X		X				0.	2,263,048.	502,388.
(16) ALTON J. SCAVO TRUSTEE	1.00	X						0.	0.	0.
(17) MARY A. PIEPRZAK, M.D. TRUSTEE	1.00	X						0.	0.	0.



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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) KAYODE A. WILLIAMS, M.D. TRUSTEE	1.00	X						0.	0.	0.
(19) G. DANIEL SHEALER, JR. TRUSTEE	1.00 59.00	X						0.	833,719.	186,727.
(20) PAUL SKALNY TRUSTEE/VICE CHAIRMAN	1.00	X						0.	0.	0.
(21) W. GILL WYLIE TRUSTEE	1.00 59.00	X						0.	443,478.	67,040.
(22) DAVID POWELL TRUSTEE	1.00	X						0.	0.	0.
(23) STEPHEN T. VILANYI, M.D. TRUSTEE	1.00	X						0.	0.	0.
(24) RYAN BROWN VP OF OPERATIONS	60.00			X				0.	259,072.	40,550.
(25) KAREN DAVIS VP OF NURSING & CNO	60.00			X				0.	289,929.	120,364.
(26) ELIZABETH EDSALL KROMM VP FOR POPULATION HLTH	60.00			X				90,698.	83,865.	18,672.
<b>1b Sub-total</b>								90,698.	5,089,975.	1,132,960.
<b>c Total from continuation sheets to Part VII, Section A</b>								1,095,143.	1,330,734.	321,000.
<b>d Total (add lines 1b and 1c)</b>								1,185,841.	6,420,709.	1,453,960.

**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 **113**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
AMN HEALTHCARE, 2735 COLLECTION CENTER DR, CHICAGO, IL 60693	NURSING AGENCY, TECH PREMIUM FEES	4,185,780.
BROADWAY SERVICES INC 3709 E MONUMENT ST, BALTIMORE, MD 21205	SECURITY, CLEANING & MNGT SERVICES	2,408,197.
SODEXHO INC PO BOX 70060, CHICAGO, IL 60673	DIETARY FEES/MNGT, RENTS	1,299,382.
AMERICAN RED CROSS, 4701 MOUNT HOPE DR STE C, BALTIMORE, MD 21205	BLOOD LAB SERVICES	1,250,546.
SLEEP SERVICES OF AMERICA INC SLEEP SERVIC PO BOX 198320, ATLANTA, GA 30384	SLEEP LAB SERVICES	1,012,050.

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **58**

SEE PART VII, SECTION A CONTINUATION SHEETS



**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1 a</b> Federated campaigns .....	<b>1a</b>					
	<b>b</b> Membership dues .....	<b>1b</b>					
	<b>c</b> Fundraising events .....	<b>1c</b>					
	<b>d</b> Related organizations .....	<b>1d</b>	937,990.				
	<b>e</b> Government grants (contributions) .....	<b>1e</b>	474,418.				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above .....	<b>1f</b>	286,040.				
	<b>g</b> Noncash contributions included in lines 1a-1f: \$ .....						
	<b>h Total.</b> Add lines 1a-1f .....		1,698,448.				
<b>Program Service Revenue</b>	<b>2 a</b> DEPARTMENT OF MEDICINE AND SURGER	<b>Business Code</b> 621990	93,940,917.	93,940,917.			
	<b>b</b> PATIENT SERVICE REVENUE	900099	93,118,882.	93,118,882.			
	<b>c</b> EMERGENCY DEPARTMENT	621910	39,734,354.	39,734,354.			
	<b>d</b> LABOR & DELIVERY/NURSERY/NICU	621990	33,043,549.	33,043,549.			
	<b>e</b> COMMUNITY EDU.	900099	130,509.	130,509.			
	<b>f</b> All other program service revenue .....						
	<b>g Total.</b> Add lines 2a-2f .....		259,968,211.				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) .....		3,071,348.			3,071,348.	
	<b>4</b> Income from investment of tax-exempt bond proceeds .....						
	<b>5</b> Royalties .....						
	<b>6 a</b> Gross rents .....	(i) Real	888,383.				
		(ii) Personal	0.				
		<b>c</b> Rental income or (loss) .....	888,383.				
	<b>d</b> Net rental income or (loss) .....		888,383.			888,383.	
	<b>7 a</b> Gross amount from sales of assets other than inventory .....	(i) Securities	14,134,000.				
		(ii) Other					
		<b>b</b> Less: cost or other basis and sales expenses .....	14,008,386.				
	<b>c</b> Gain or (loss) .....	125,614.					
	<b>d</b> Net gain or (loss) .....		125,614.			125,614.	
	<b>8 a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 .....	<b>a</b>					
		<b>b</b> Less: direct expenses .....	<b>b</b>				
		<b>c</b> Net income or (loss) from fundraising events .....					
<b>9 a</b> Gross income from gaming activities. See Part IV, line 19 .....	<b>a</b>						
	<b>b</b> Less: direct expenses .....	<b>b</b>					
	<b>c</b> Net income or (loss) from gaming activities .....						
<b>10 a</b> Gross sales of inventory, less returns and allowances .....	<b>a</b>	394,211.					
	<b>b</b> Less: cost of goods sold .....	<b>b</b>	201,611.				
	<b>c</b> Net income or (loss) from sales of inventory .....		192,600.			192,600.	
<b>Miscellaneous Revenue</b>		<b>Business Code</b>					
<b>11 a</b> OTHER	900099	2,561,749.			2,561,749.		
<b>b</b> TELE.& VENDING REV.	900099	24,877.			24,877.		
<b>c</b> .....							
<b>d</b> All other revenue .....							
<b>e Total.</b> Add lines 11a-11d .....		2,586,626.					
<b>12 Total revenue.</b> See instructions. ....		268,531,230.	259,968,211.	0.	6,864,571.		

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	339,828.		339,828.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	99,434,776.	96,463,267.	2,971,509.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	4,392,515.	3,682,888.	709,627.	
9 Other employee benefits	15,054,439.	13,951,488.	1,102,951.	
10 Payroll taxes	7,967,682.	7,923,616.	44,066.	
11 Fees for services (non-employees):				
a Management				
b Legal	40,802.		40,802.	
c Accounting				
d Lobbying	54,352.		54,352.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	9,113,990.	6,469,254.	2,644,736.	
12 Advertising and promotion	304,355.	304,355.		
13 Office expenses	43,172,526.	39,322,685.	3,849,841.	
14 Information technology	1,763,018.	1,072,607.	690,411.	
15 Royalties				
16 Occupancy	969,325.	914,279.	55,046.	
17 Travel	131,861.	93,833.	38,028.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	138,228.		138,228.	
20 Interest	5,757,554.	4,713,134.	1,044,420.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	12,523,866.	10,252,037.	2,271,829.	
23 Insurance	1,606,569.		1,606,569.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a <b>PURCHASED SERVICES</b>	44,375,883.	14,805,091.	29,570,792.	
b <b>LAB SERVICES</b>	7,677,620.	7,559,654.	117,966.	
c <b>SUPPLIES</b>	3,032,951.	2,809,453.	223,498.	
d <b>SWAP INTEREST</b>	1,384,691.	1,133,508.	251,183.	
e All other expenses	1,149,077.	125,720.	1,023,357.	
<b>25 Total functional expenses.</b> Add lines 1 through 24e	<b>260,385,908.</b>	<b>211,596,869.</b>	<b>48,789,039.</b>	<b>0.</b>
<b>26 Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

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

**Part X Balance Sheet**

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

		(A)		(B)
		Beginning of year		End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	17,207,606.	<b>1</b>	7,445,178.
	<b>2</b> Savings and temporary cash investments .....	49,206.	<b>2</b>	49,048.
	<b>3</b> Pledges and grants receivable, net .....		<b>3</b>	
	<b>4</b> Accounts receivable, net .....	31,555,328.	<b>4</b>	30,675,495.
	<b>5</b> Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....		<b>7</b>	
	<b>8</b> Inventories for sale or use .....	4,948,212.	<b>8</b>	4,660,500.
	<b>9</b> Prepaid expenses and deferred charges .....	2,865,597.	<b>9</b>	2,542,317.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 268,035,116.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 123,638,510.		
	<b>11</b> Investments - publicly traded securities .....		<b>11</b>	
	<b>12</b> Investments - other securities. See Part IV, line 11 .....	119,975,721.	<b>12</b>	136,809,430.
	<b>13</b> Investments - program-related. See Part IV, line 11 .....		<b>13</b>	
	<b>14</b> Intangible assets .....		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 .....	2,234,655.	<b>15</b>	32,523,294.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) .....	322,937,483.	<b>16</b>	359,101,868.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	28,748,800.	<b>17</b>	26,925,477.
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....		<b>19</b>	401,471.
	<b>20</b> Tax-exempt bond liabilities .....		<b>20</b>	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....		<b>23</b>	
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	202,253,615.	<b>25</b>	221,260,634.
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	231,002,415.	<b>26</b>	248,587,582.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27 through 29, and lines 33 and 34.</b>			
	<b>27</b> Unrestricted net assets .....	91,801,431.	<b>27</b>	110,068,149.
	<b>28</b> Temporarily restricted net assets .....	133,637.	<b>28</b>	446,137.
	<b>29</b> Permanently restricted net assets .....		<b>29</b>	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here</b> <input type="checkbox"/> <b>and complete lines 30 through 34.</b>			
	<b>30</b> Capital stock or trust principal, or current funds .....		<b>30</b>	
	<b>31</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>31</b>	
	<b>32</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>32</b>	
<b>33</b> Total net assets or fund balances .....	91,935,068.	<b>33</b>	110,514,286.	
<b>34</b> Total liabilities and net assets/fund balances .....	322,937,483.	<b>34</b>	359,101,868.	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	268,531,230.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	260,385,908.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	8,145,322.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	91,935,068.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	4,710,807.
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	5,723,089.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	110,514,286.

**Part XII Financial Statements and Reporting**

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

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





**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) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge ...						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) .....						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources ...						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on ...						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> .....						<input type="checkbox"/>

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

<b>14</b> Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2015 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 33 1/3% support test - 2015.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>17a 10% -facts-and-circumstances test - 2016.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 10% -facts-and-circumstances test - 2015.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions .....		<input type="checkbox"/>

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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose .....						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>6 Total.</b> Add lines 1 through 5 .....						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year .....						
<b>c</b> Add lines 7a and 7b .....						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2012	(b) 2013	(c) 2014	(d) 2015	(e) 2016	(f) Total
<b>9</b> Amounts from line 6 .....						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources .....						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....						
<b>c</b> Add lines 10a and 10b .....						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on .....						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

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

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

<b>15</b> Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2015 Schedule A, Part III, line 15 .....	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2016 (line 10c, column (f) divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from 2015 Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2016.** 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 - 2015.** 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 in line 12 on Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

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

**Section E. Type III Functionally Integrated Supporting Organizations**

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test. Answer (a) and (b) below.		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? 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.		
<b>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? 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.		
<b>3</b> Parent of Supported Organizations. Answer (a) and (b) below.		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? Provide details in Part VI.		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.		

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

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

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

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

<b>Section C - Distributable Amount</b>			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions	Current Year
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	
<b>4</b> Amounts paid to acquire exempt-use assets	
<b>5</b> Qualified set-aside amounts (prior IRS approval required)	
<b>6</b> Other distributions (describe in <b>Part VI</b> ). See instructions	
<b>7 Total annual distributions.</b> Add lines 1 through 6	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ). See instructions	
<b>9</b> Distributable amount for 2016 from Section C, line 6	
<b>10</b> Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2016	(iii) Distributable Amount for 2016
<b>1</b> Distributable amount for 2016 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2016 (reasonable cause required- explain in Part VI). See instructions			
<b>3</b> Excess distributions carryover, if any, to 2016:			
<b>a</b>			
<b>b</b>			
<b>c</b> From 2013			
<b>d</b> From 2014			
<b>e</b> From 2015			
<b>f Total</b> of lines 3a through e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2016 distributable amount			
<b>i</b> Carryover from 2011 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
<b>4</b> Distributions for 2016 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2016 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from 4			
<b>5</b> Remaining underdistributions for years prior to 2016, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions			
<b>6</b> Remaining underdistributions for 2016. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions			
<b>7 Excess distributions carryover to 2017.</b> Add lines 3j and 4c			
<b>8</b> Breakdown of line 7:			
<b>a</b>			
<b>b</b> Excess from 2013			
<b>c</b> Excess from 2014			
<b>d</b> Excess from 2015			
<b>e</b> Excess from 2016			





**Schedule B**

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

Department of the Treasury  
Internal Revenue Service

**Schedule of Contributors**

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

OMB No. 1545-0047

**2016**

Name of the organization

HOWARD COUNTY GENERAL HOSPITAL, INC.

Employer identification number

52-2093120

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

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

501(c)(3) taxable private foundation

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

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

**General Rule**

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

**Special Rules**

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

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

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. 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, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2016)

Name of organization <b>HOWARD COUNTY GENERAL HOSPITAL, INC.</b>	Employer identification number <b>52-2093120</b>
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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	<hr/> <hr/> <hr/>	\$ <u>344,218.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	<hr/> <hr/> <hr/>	\$ <u>937,990.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	<hr/> <hr/> <hr/>	\$ <u>21,570.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	<hr/> <hr/> <hr/>	\$ <u>102,473.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	<hr/> <hr/> <hr/>	\$ <u>26,507.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	<hr/> <hr/> <hr/>	\$ <u>239,470.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization <b>HOWARD COUNTY GENERAL HOSPITAL, INC.</b>	Employer identification number <b>52-2093120</b>
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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	<hr/> <hr/> <hr/> <hr/>	\$ <u>25,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
	<hr/> <hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>HOWARD COUNTY GENERAL HOSPITAL, INC.</b>	Employer identification number  <b>52-2093120</b>
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**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
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____
	<hr/> <hr/> <hr/> <hr/>	\$ _____	_____

Name of organization  <b>HOWARD COUNTY GENERAL HOSPITAL, INC.</b>	Employer identification number  <b>52-2093120</b>
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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 info. once.) ▶ \$ \_\_\_\_\_  
Use duplicate copies of Part III if additional space is needed.

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

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

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

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

- ▶ **Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.**
- ▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

**If the organization answered "Yes," 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 <b>HOWARD COUNTY GENERAL HOSPITAL, INC.</b>	Employer identification number <b>52-2093120</b>
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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.

- 2 Political campaign activity expenditures ..... ▶ \$ \_\_\_\_\_
- 3 Volunteer hours for political campaign activities ..... \_\_\_\_\_

**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-.

**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.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
<b>1a</b> Total lobbying expenditures to influence public opinion (grass roots lobbying) .....														
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....	54,352.													
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....	54,352.													
<b>d</b> Other exempt purpose expenditures .....	260,331,556.													
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....	260,385,908.													
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.	1,000,000.													
<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.													
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....	250,000.													
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....	0.													
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....	0.													
<b>j</b> If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No												

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) Total
<b>2a</b> Lobbying nontaxable amount	1,000,000.	1,000,000.	1,000,000.	1,000,000.	4,000,000.
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					6,000,000.
<b>c</b> Total lobbying expenditures	35,096.	35,511.	48,864.	54,352.	173,823.
<b>d</b> Grassroots nontaxable amount	250,000.	250,000.	250,000.	250,000.	1,000,000.
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					1,500,000.
<b>f</b> Grassroots lobbying expenditures					



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

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

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

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

**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."**

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

**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.

FORM 990 SCH.C PART II-A LINE 1B

THE HOWARD COUNTY GENERAL HOSPITAL PAID ITS PARENT CORPORATION, THE JOHNS HOPKINS HEALTH SYSTEM CORPORATION \$54,352 DURING THE FISCAL YEAR ENDED JUNE 30, 2017 TO SUPPORT THEIR LOBBYING ACTIVITIES. THE JOHNS HOPKINS HEALTH SYSTEM MAINTAINS A DEPARTMENT OF GOVERNMENTAL RELATIONS. THE PRIMARY PURPOSE OF THIS DEPARTMENT IS TO MAINTAIN CONTACT WITH ELECTED AND



**SCHEDULE D**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

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

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

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

**Name of the organization** HOWARD COUNTY GENERAL HOSPITAL, INC. **Employer identification number** 52-2093120

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year .....		
2 Aggregate value of contributions to (during year) .....		
3 Aggregate value of grants from (during year) .....		
4 Aggregate value at end of year .....		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? .....		<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

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

	Held at the End of the Tax Year
a Total number of conservation easements .....	2a
b Total acreage restricted by conservation easements .....	2b
c Number of conservation easements on a certified historic structure included in (a) .....	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register .....	2d

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

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

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

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.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 .....

(ii) Assets included in Form 990, Part X .....

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:

a Revenue included on Form 990, Part VIII, line 1 .....

b Assets included in Form 990, Part X .....

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

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a  Public exhibition
- b  Scholarly research
- c  Preservation for future generations
- d  Loan or exchange programs
- e  Other \_\_\_\_\_

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?  Yes  No

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

	Amount
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 Temporarily restricted endowment  \_\_\_\_\_ %

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

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

	Yes	No
(i) unrelated organizations	3a(i)	
(ii) related organizations	3a(ii)	
b If "Yes" on 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		12,977,766.		12,977,766.
b Buildings		177,586,810.	71,603,555.	105,983,255.
c Leasehold improvements		757,671.	396,827.	360,844.
d Equipment		65,884,788.	51,043,876.	14,840,912.
e Other		10,828,081.	594,252.	10,233,829.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				144,396,606.

**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) U.S. T-BILLS	132,740,317.	END-OF-YEAR MARKET VALUE
(B) INVESTMENTS CMROC, LLC	600,592.	END-OF-YEAR MARKET VALUE
(C) INVESTMENTS - MOB	562,846.	END-OF-YEAR MARKET VALUE
(D) INV IN SUBS/JOINT VE	2,905,675.	END-OF-YEAR MARKET VALUE
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	<b>136,809,430.</b>	

**Part VIII Investments - Program Related.**

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
<b>Total.</b> (Col. (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) OTHER RECEIVABLES	921,319.
(2) OTHER LONG TERM ASSETS	30,133,037.
(3) OTHER LONG TERM ASSETS	343,286.
(4) DUE FROM AFFILIATES	334,601.
(5) DUE FROM OTHERS	791,051.
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.)	<b>32,523,294.</b>

**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	10,143,174.
(3) ADVANCES THIRD PARTY PAYORS	10,304,947.
(4) ESTIMATED MALPRACTICE COST	5,089,356.
(5) NOTES PAYABLE AFFILIATES	175,763,739.
(6) NET PENSION LIABILITY	1,649,000.
(7) TOTAL OTHER LIABILITIES	18,310,418.
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	<b>221,260,634.</b>

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

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

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

<b>1</b>	Total revenue, gains, and other support per audited financial statements	<b>1</b>	273,443,000.
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
<b>a</b>	Net unrealized gains (losses) on investments	<b>2a</b>	4,710,807.
<b>b</b>	Donated services and use of facilities	<b>2b</b>	
<b>c</b>	Recoveries of prior year grants	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII.)	<b>2d</b>	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b>	<b>2e</b>	4,710,807.
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b>	<b>3</b>	268,732,193.
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII.)	<b>4b</b>	-200,963.
<b>c</b>	Add lines <b>4a</b> and <b>4b</b>	<b>4c</b>	-200,963.
<b>5</b>	Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12.)	<b>5</b>	268,531,230.

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

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

<b>1</b>	Total expenses and losses per audited financial statements	<b>1</b>	258,421,000.
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
<b>a</b>	Donated services and use of facilities	<b>2a</b>	
<b>b</b>	Prior year adjustments	<b>2b</b>	
<b>c</b>	Other losses	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII.)	<b>2d</b>	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b>	<b>2e</b>	0.
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b>	<b>3</b>	258,421,000.
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII.)	<b>4b</b>	1,964,908.
<b>c</b>	Add lines <b>4a</b> and <b>4b</b>	<b>4c</b>	1,964,908.
<b>5</b>	Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18.)	<b>5</b>	260,385,908.

**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.

**PART X, LINE 2:**

FASB GUIDANCE ON ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES CLARIFIES THE ACCOUNTING FOR UNCERTAINTY OF INCOME TAX POSITIONS. THIS GUIDANCE DEFINES THE THRESHOLD FOR RECOGNIZING TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS AS MORE LIKELY THAN NOT THAT THE POSITION IS SUSTAINABLE, BASED ON ITS TECHNICAL MERITS. THIS GUIDANCE ALSO PROVIDES GUIDANCE ON THE MEASUREMENT, CLASSIFICATION AND DISCLOSURE OF TAX RETURN POSITIONS IN THE FINANCIAL STATEMENTS. THERE IS NO IMPACT ON HOWARD COUNTY GENERAL HOSPITAL INC FINANCIAL STATEMENTS DURING THE YEARS ENDED JUNE 30, 2017 AND 2016.

**PART XI, LINE 4B - OTHER ADJUSTMENTS:**

RECLASS OF COGS TO REVENUE -201,611.

**Part XIII** Supplemental Information (continued)

BOOK/AUDIT ADJUSTMENT 648.

TOTAL TO SCHEDULE D, PART XI, LINE 4B -200,963.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

SWAP INTEREST 1,384,691.

RECLASS OF COGS -201,611.

OTHER COMPONENTS OF PENSION 607,000.

NON OPERATING EXPENSES 175,609.

BOOK/AUDIT ADJUSTMENT -781.

TOTAL TO SCHEDULE D, PART XII, LINE 4B 1,964,908.



**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

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

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

Name of the organization **HOWARD COUNTY GENERAL HOSPITAL, INC.** Employer identification number **52-2093120**

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

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

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

	(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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1) .....			3,917,722.	0.	3,917,722.	1.50%
<b>b</b> Medicaid (from Worksheet 3, column a) .....						
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) .....						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs .....			3,917,722.		3,917,722.	1.50%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .....			15,247,919.	124,103.	15,123,816.	5.81%
<b>f</b> Health professions education (from Worksheet 5) .....			1,308,510.	0.	1,308,510.	.50%
<b>g</b> Subsidized health services (from Worksheet 6) .....						
<b>h</b> Research (from Worksheet 7) .....			358,340.	230,945.	127,395.	.05%
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....			825,686.	0.	825,686.	.32%
<b>j Total.</b> Other Benefits .....			17,740,455.	355,048.	17,385,407.	6.68%
<b>k Total.</b> Add lines 7d and 7j .....			21,658,177.	355,048.	21,303,129.	8.18%





**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 HOWARD COUNTY GENERAL HOSPITAL

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

	Yes	No
<b>Community Health Needs Assessment</b>		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted .....	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....		X
6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....		X
7 Did the hospital facility make its CHNA report widely available to the public? .....	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.HOPKINSMEDICINE.ORG/HOWARD_COUNTY_GEN</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 type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	X	
a If "Yes," (list url): <u>WWW.HOPKINSMEDICINE.ORG/HOWARD_COUNTY_GENERAL_HOSPIT</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 HOWARD COUNTY GENERAL HOSPITAL

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:		
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>500</u> %		
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Asset level		
<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
<b>e</b> <input type="checkbox"/> Insurance status		
<b>f</b> <input type="checkbox"/> Underinsurance status		
<b>g</b> <input checked="" type="checkbox"/> Residency		
<b>h</b> <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>X</b>	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>X</b>	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b> <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 HOWARD COUNTY GENERAL HOSPITAL

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? .....	<b>X</b>	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b> <input type="checkbox"/> 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		
<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....		<b>X</b>
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b> <input type="checkbox"/> 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		
<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> 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):		
<b>a</b> <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		
<b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process		
<b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications		
<b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

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

		Yes	No
<b>22</b>	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.		
<b>a</b>	<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>b</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		
<b>c</b>	<input 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		
<b>d</b>	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<b>23</b>	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.	23	X
<b>24</b>	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.	24	X

**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, 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.

HOWARD COUNTY GENERAL HOSPITAL:

PART V, SECTION B, LINE 5: HOWARD COUNTY GENERAL HOSPITAL (HCGH) TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL THROUGH VARIOUS WAYS LISTED BELOW:

A) PRIMARY DATA WAS GATHERED FROM MORE THAN 2,000 PARTICIPANTS VIA AN EXTENSIVE PHONE SURVEY IN THE HOWARD COUNTY HEALTH ASSESSMENT SURVEY (HCHAS) BETWEEN JULY 8 AND AUGUST 18, 2014. THE SURVEY WAS JOINTLY COMMISSIONED BY THE HORIZON FOUNDATION, THE HOWARD COUNTY HEALTH DEPARTMENT, HOWARD COUNTY GENERAL HOSPITAL, AND THE COLUMBIA ASSOCIATION.

B) THE LOCAL HEALTH IMPROVEMENT COALITION (LHIC), A PART OF THE STATE HEALTH IMPROVEMENT PLAN, SERVED AS THE TASK FORCE FOR IDENTIFYING AND PRIORITIZING THE HIGHEST NEEDS OF THE COMMUNITY IN HOWARD COUNTY IN NOVEMBER 2014. THE TASK FORCE INCLUDED LEADERS OF LOCAL HEALTH AND HUMAN SERVICE ORGANIZATIONS, COUNTY GOVERNMENT LEADERSHIP, LOCAL BUSINESS LEADERS AND HOSPITAL LEADERS WHO PROVIDED INPUT THROUGH THEIR PARTICIPATION IN THIS PROCESS.

C) HEALTH EXPERTS FOR THE AUGUST 2014 HEALTH SURVEY WERE MEMBERS OF THE HOWARD COUNTY SURVEY PLANNING COMMITTEE.

D) SECONDARY DATA FROM LOCAL, STATE AND FEDERAL SOURCES PROVIDED ESSENTIAL INFORMATION, INSIGHT AND KNOWLEDGE ON A BROAD RANGE OF HEALTH AND SOCIAL ISSUES AND A RESOURCE INVENTORY WAS COMPILED TO ASSESS THE AVAILABILITY OF SERVICES TO RESIDENTS IN HOWARD COUNTY.

HOWARD COUNTY GENERAL HOSPITAL:

PART V, SECTION B, LINE 11: HCGH'S COMMITMENT TO IMPROVING THE HEALTH OF



**Part V Facility Information** (continued)

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 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.

ITS COMMUNITY WILL BE EVIDENT THROUGH DELIBERATE COLLABORATIONS TARGETING SPECIFIC SEGMENTS OF OUR COMMUNITY EXPERIENCING GAPS IN ANY OF THE FOUR PRIORITY HEALTH AREAS AND PROVIDING IN-KIND AND FINANCIAL SUPPORT TO ORGANIZATIONS AND INITIATIVES THAT SHARE OUR COMMITMENT TO ADDRESSING THESE PRIORITIES.

HCGH'S BOARD OF TRUSTEES AND EXECUTIVE LEADERSHIP WILL ENSURE THE HOSPITAL'S STRATEGIC AND CLINICAL GOALS ARE ALIGNED WITH THE FOUR COMMUNITY HEALTH IMPROVEMENT INITIATIVES. THE IMPLEMENTATION PLAN FOCUSES ON CLOSE ALLIANCES WITH ORGANIZATIONS WHO HAVE COMMON GOALS AND ARE KEY STAKEHOLDERS. COLLABORATION YIELDS THE POTENTIAL FOR ENHANCED OUTCOMES AND EFFICIENCY OF RESOURCES. MOST ARE ALSO ACTIVE MEMBER OF THE LHIC AND ARE ALREADY COMMITTED TO BUILDING A HEALTHIER HOWARD COUNTY COMMUNITY.

HOWARD COUNTY GENERAL HOSPITAL

PART V, LINE 16A, FAP WEBSITE:

[WWW.HOPKINSMEDICINE.ORG/PATIENT\\_CARE/PAY\\_BILL/ASSISTANCE\\_POLICIES.HTML](http://WWW.HOPKINSMEDICINE.ORG/PATIENT_CARE/PAY_BILL/ASSISTANCE_POLICIES.HTML)

HOWARD COUNTY GENERAL HOSPITAL

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[WWW.HOPKINSMEDICINE.ORG/HOWARD\\_COUNTY\\_GENERAL\\_HOSPITAL/PATIENT\\_VISITOR/BILL](http://WWW.HOPKINSMEDICINE.ORG/HOWARD_COUNTY_GENERAL_HOSPITAL/PATIENT_VISITOR/BILL)

HOWARD COUNTY GENERAL HOSPITAL

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[WWW.HOPKINSMEDICINE.ORG/HOWARD\\_COUNTY\\_GENERAL\\_HOSPITAL/PATIENT\\_VISITOR/BILL](http://WWW.HOPKINSMEDICINE.ORG/HOWARD_COUNTY_GENERAL_HOSPITAL/PATIENT_VISITOR/BILL)

**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, 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.

PART V, SECTION B, LINE 22

MARYLAND IS THE ONLY STATE IN WHICH ALL PAYORS (GOVERNMENTALLY-INSURED, COMMERCIALY INSURED, OR SELF-PAY) ARE CHARGED THE SAME PRICE FOR SERVICES AT ANY GIVEN HOSPITAL. UNDER THIS SYSTEM, MARYLAND HOSPITALS ARE REGULATED BY A STATE AGENCY: THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC).



**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.).
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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.

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**PART I, LINE 7:**

A COST-TO-CHARGE RATIO (FROM WORKSHEET 2) IS USED TO CALCULATE THE AMOUNTS ON LINE 7A AND 7B (FINANCIAL ASSISTANCE AT COST AND UNREIMBURSED MEDICAID). THE AMOUNTS FOR LINES 7E-7I COMES FROM THE HSCRC COMMUNITY BENEFIT REPORT FILED WITH THE STATE OF MARYLAND AND IS NOT BASED ON A COST-TO CHARGE RATIO.

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**PART I, LINE 7G:**

HOWARD COUNTY GENERAL HOSPITAL, INC. DOES NOT HAVE ANY SUBSIDIZED HEALTH SERVICES.

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**PART II, COMMUNITY BUILDING ACTIVITIES:**

HCGH'S COMMUNITY BUILDING ACTIVITIES PROMOTE THE HEALTH OF THE COMMUNITY IT SERVES THROUGH A NUMBER OF INITIATIVES THEY HAVE DEVELOPED. HCGH PROMOTES THE IMPROVEMENT OF HEALTHY LIVING THROUGH CONSTRUCTION AND IMPROVEMENT OF COMMUNITY BASED INFRASTRUCTURES. FOR EXAMPLE, HCGH CONTINUES ITS SUPPORT OF THE HEALTHY CHILDRENS PLAY AREA IN THE COLUMBIA MALL, A CENTERPIECE OF THE HOWARD COUNTY COMMUNITY, TO PROMOTE HEALTHY

**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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HABITS IN A FUN EDUCATIONAL MANNER.

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PART III, LINE 2:

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THE PROVISION FOR BAD DEBTS IS BASED UPON A COMBINATION OF THE PAYOR SOURCE, THE AGING OF RECEIVABLES AND MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, TRENDS IN HEALTH INSURANCE COVERAGE, AND OTHER COLLECTION INDICATORS.

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PART III, LINE 3:

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MARYLAND HOSPITALS ARE RATE REGULATED UNDER THE HSCRC, WHICH INCLUDES BAD DEBT AS PART OF THE REIMBURSEMENT FORMULA FOR EACH HOSPITAL. DUE TO THE RATE REGULATION, HCGH CANNOT DETERMINE THE AMOUNT THAT REASONABLE COULD BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL'S CHARITY CARE POLICY.

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PART III, LINE 4:

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THE JOHNS HOPKINS HEALTH SYSTEM CORPORATION AND AFFILIATES AUDITED FINANCIAL STATEMENTS PAGE 14.

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**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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PART III, LINE 8:

THE TRIAL BALANCE EXPENSES ARE ADJUSTED TO ALLOWABLE EXPENSE IN ACCORDANCE WITH THE MEDICARE COST REPORTING RULES AND REGULATIONS.

PART III, LINE 9B:

THE HOSPITAL CONFORMS TO THE PRINCIPLES AND STANDARDS OF THE MHA HOSPITAL BILLING AND DEBT COLLECTION PRACTICES PRINCIPLES AS WELL AS THE MHA MINIMUM STANDARDS FOR FINANCIAL ASSISTANCE IN MARYLAND HOSPITALS.

PART VI, LINE 2:

OVER THE YEARS, THE COUNTY HAS PRIORITIZED THE HEALTH OF ITS RESIDENTS AND INVESTED IN PROGRAMS TO IMPROVE THE HEALTH AND WELLNESS OF THOSE WHO LIVE, WORK, LEARN, PLAN AND WORSHIP THERE. PRIOR TO THE PASSAGE OF THE AFFORDABLE CARE ACT, THE COUNTY CREATED THE HEALTHY HOWARD HEALTH PLAN - A PUBLIC-PRIVATE HEALTH CARE ACCESS PLAN FOR INDIVIDUALS MAKING TOO MUCH TO QUALIFY FOR PUBLIC ASSISTANCE BUT UNABLE TO OBTAIN PRIVATE INSURANCE BECAUSE OF COST, PRE-EXISTING CONDITIONS OR A LACK OF EMPLOYER SPONSORED

**Part VI Supplemental Information**

Provide the following information.

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**COVERAGE.**

AS PART OF COMMUNITY INTEGRATED MEDICAL HOME EFFORTS, HCGH AND HOWARD COUNTY DEPARTMENT OF HEALTH PARTNERED WITH PRIMARY CARE PHYSICIANS TO SUPPORT PRACTICE TRANSFORMATION ACTIVITIES LEADING TO IMPROVED CARE COORDINATION AND HEALTH OUTCOMES. UNDERSTANDING THE IMPORTANCE OF MENTAL/BEHAVIORAL HEALTH ISSUES, THE COUNTY HAS MADE STRATEGIC INVESTMENTS SUCH AS EMBEDDING A MENTAL HEALTH PROFESSIONAL IN THE COMMUNITY POLICING DIVISION OF THE POLICE DEPARTMENT AND A BEHAVIORAL HEALTH SPECIALIST TIED TO THE GRASSROOTS CRISIS INTERVENTION CENTER TO WORK WITH INDIVIDUALS DISCHARGED FROM HCGH'S EMERGENCY DEPARTMENT, AND DELIVER MENTAL HEALTH FIRST AID TRAINING. THESE RESOURCES HELP CONNECT HIGH-RISK INDIVIDUALS TO CARE, CREATE LINKAGES TO OTHER COMMUNITY RESOURCES, AND INCREASE AWARENESS OF MENTAL ILLNESS.

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**PART VI, LINE 3:**

HCGH WILL PUBLISH THE AVAILABILITY OF FINANCIAL ASSISTANCE ON A YEARLY BASIS IN THEIR LOCAL NEWSPAPERS, AND WILL POST NOTICES OF AVAILABILITY AT PATIENT REGISTRATION SITES, ADMISSIONS/BUSINESS OFFICE, THE BILLING

**Part VI Supplemental Information**

Provide the following information.

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OFFICE, AND AT THE EMERGENCY DEPARTMENT WITHIN HCGH. NOTICE OF AVAILABILITY WILL BE POSTED ON THEIR WEBSITE, WILL BE MENTIONED DURING ORAL COMMUNICATIONS, AND WILL ALSO BE SENT TO PATIENTS ON PATIENT BILLS. A PATIENT BILLING AND FINANCIAL ASSISTANCE INFORMATION SHEET WILL BE PROVIDED TO INPATIENTS BEFORE DISCHARGE AND WILL BE AVAILABLE TO ALL PATIENTS UPON REQUEST.

JHH HAS STAFF AVAILABLE TO DISCUSS AND ASSIST PATIENTS AND/OR THEIR FAMILIES WITH THE AVAILABILITY OF VARIOUS GOVERNMENT BENEFITS, SUCH AS MEDICAID OR STATE PROGRAMS, AND ASSISTS PATIENTS WITH QUALIFICATION FOR SUCH PROGRAMS, WHERE APPLICABLE.

PART VI, LINE 4:

HCGH GEOGRAPHIC SERVICE AREA IS SUBURBAN.

THE HOSPITAL CONSIDERS ITS COMMUNITY BENEFIT SERVICE AREA (CBSA) AS SPECIFIC POPULATIONS OR COMMUNITIES OF NEED TO WHICH THE HOSPITAL ALLOCATES RESOURCES THROUGH ITS COMMUNITY BENEFIT PLAN. THE HOSPITAL DEFINES ITS CBSA USING THE ZIP CODES CONTAINED WITHIN THE GEOGRAPHICAL BOUNDARIES OF THE HOWARD COUNTY JURISDICTION AS SET FORTH BY THE MARYLAND



**Part VI Supplemental Information**

Provide the following information.

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DEPARTMENT OF PLANNING AND ZONING.

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THE GENERAL DATA FOR THIS PRIMARY SERVICE AREA ARE AS FOLLOWS: TOTAL POPULATION WAS 422,799 OF WHICH 49.6% WERE MALES AND 50.4% WERE FEMALES, AVERAGE HOUSEHOLD INCOME WAS \$142,202, 4.0% OF RESIDENTS ARE UNINSURED, 9.7% OF RESIDENTS ARE COVERED BY MEDICAID/MEDICARE, AND 5.1% OF RESIDENTS HAVE INCOME BELOW THE FEDERAL POVERTY GUIDELINES.

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NUMBER OF OTHER HOSPITALS SERVING THE COMMUNITY OR COMMUNITIES: 1  
 FEDERALLY-DESIGNATED MEDICALLY UNDERSERVED AREAS OR POPULATIONS ARE NOT PRESENT IN THE COMMUNITY.

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PART VI, LINE 5:

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FOR THE LAST 30 YEARS, MARYLAND HOSPITALS HAVE MET THEIR COMMUNITY BENEFIT OBLIGATIONS IN A UNIQUE MANNER THAT BUILDS THE COSTS OF UNCOMPENSATED CARE, CHARITY CARE AND PATIENT BAD DEBT AND GRADUATE MEDICAL EDUCATION INTO THE RATES THAT HOSPITALS ARE REIMBURSED BY ALL PAYORS. THE SYSTEM IS BASED IN FEDERAL AND STATE LAW AND BENEFITS ALL MARYLAND RESIDENTS, INCLUDING THOSE IN NEED OF FINANCIAL ASSISTANCE TO PAY THEIR HOSPITAL BILLS.

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**Part VI Supplemental Information**

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MARYLAND IS THE ONLY STATE IN WHICH ALL PAYORS GOVERNMENTALLY-INSURED, COMMERCIALY INSURED, OR SELF-PAY ARE CHARGED THE SAME PRICE FOR SERVICES AT ANY GIVEN HOSPITAL.

UNDER THIS SYSTEM, MARYLAND HOSPITALS ARE REGULATED BY A STATE AGENCY THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) THAT IS REQUIRED TO:

PUBLICLY DISCLOSE INFORMATION ON THE COST AND FINANCIAL POSITION OF HOSPITALS;

REVIEW AND APPROVE HOSPITAL RATES;

COLLECT INFORMATION DETAILING TRANSACTIONS BETWEEN HOSPITALS AND FIRMS WITH WHICH THEIR TRUSTEES HAVE A FINANCIAL INTEREST; AND,

MAINTAIN THE SOLVENCY OF EFFICIENT AND EFFECTIVE HOSPITALS.

SINCE 2000, THE RATE SETTING COMMISSION HAS HAD ITS OWN FRAMEWORK FOR REPORTING HOSPITALS COMMUNITY BENEFITS AND ISSUING A REPORT ANNUALLY

REGARDING HOSPITALS COMMUNITY BENEFIT TOTALS. THAT REPORT IS AVAILABLE ON

**Part VI Supplemental Information**

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[HTTP://WWW.HSCRC.STATE.MD.US/COMMUNITY\\_BENEFITS/DOCUMENTS/](http://www.hscrc.state.md.us/community_benefits/documents/)  
[CBR\\_FY2007\\_FINAL\\_REPORT.PDF.](#)

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BECAUSE OF THIS UNIQUE STRUCTURE MARYLAND HOSPITALS COMMUNITY BENEFITS  
NUMBERS WILL NOT COMPARE WITH THE REST OF THE NATION'S HOSPITALS.  
HOWEVER, MARYLAND HOSPITALS MEET OR EXCEED THE COMMUNITY BENEFIT STANDARD  
ESTABLISHED BY THE IRS IN 1969. ADDITIONAL DETAIL ILLUSTRATING THIS CAN  
BE FOUND WITHIN THIS SCHEDULE H REPORT.

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LINE 7B - 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 PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND  
HOSPITALS TO BREAKOUT ANY DIRECTED OFFSETTING REVENUE RELATED TO  
UNCOMPENSATED CARE. COMMUNITY BENEFIT EXPENSES ARE EQUAL TO MEDICAID

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**Part VI** Supplemental Information

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REVENUES IN MARYLAND, AS SUCH, THE NET EFFECT IS ZERO. THE EXCEPTION TO THIS IS THE IMPACT ON THE HOSPITAL OF ITS SHARE OF THE MEDICAID ASSESSMENT. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

LINE 7F COLUMN (D) 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 PAYORS' RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAKOUT ANY OFFSETTING REVENUE RELATED TO HEALTH PROFESSIONS EDUCATION.

PART VI, LINE 6:

JOHNS HOPKINS HEALTH SYSTEM CORPORATION (JHHS) IS INCORPORATED IN THE

**Part VI Supplemental Information**

Provide the following information.

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STATE OF MARYLAND TO, AMONG OTHER THINGS, FORMULATE POLICY AMONG AND PROVIDE CENTRALIZED MANAGEMENT FOR JHHS AND AFFILIATES. JHHS IS ORGANIZED AND OPERATED FOR THE PURPOSE OF PROMOTING HEALTH BY FUNCTIONING AS A PARENT HOLDING COMPANY OF AFFILIATES WHOSE COMBINED MISSION IS TO PROVIDE PATIENT CARE IN THE TREATMENT AND PREVENTION OF HUMAN ILLNESS WHICH COMPARES FAVORABLY WITH THAT RENDERED BY ANY OTHER INSTITUTION IN THIS COUNTRY OR ABROAD.

JHHS IS THE SOLE MEMBER OF THE JOHNS HOPKINS HOSPITAL (JHH), AN ACADEMIC MEDICAL CENTER, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC. (JHBMC), A COMMUNITY BASED TEACHING HOSPITAL AND LONG-TERM CARE FACILITY, HOWARD COUNTY GENERAL HOSPITAL, INC. (HCGH), A COMMUNITY BASED HOSPITAL, SUBURBAN HOSPITAL, INC. (SHI), A COMMUNITY BASED HOSPITAL, SIBLEY MEMORIAL HOSPITAL (SMH), A D.C. COMMUNITY BASED HOSPITAL, AND JOHNS HOPKINS ALL CHILDRENS HOSPITAL, INC (JHACH), A FL ACADEMIC CHILDRENS HOSPITAL.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

MD

**SCHEDULE I  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

**2016**

**Open to Public  
Inspection**

Name of the organization **HOWARD COUNTY GENERAL HOSPITAL, INC.** Employer identification number **52-2093120**

**Part I General Information on Grants and Assistance**

- 1** Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? .....  **Yes**  **No**
- 2** Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

**Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.** Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

<b>1 (a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section (if applicable)	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of noncash assistance	<b>(h)</b> Purpose of grant or assistance

- 2** Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... ▶ \_\_\_\_\_
- 3** Enter total number of other organizations listed in the line 1 table ..... ▶ \_\_\_\_\_

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

Schedule I (Form 990) (2016)

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance

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

PART I, LINE 2:

THE BOARD OF TRUSTEES HAS DELEGATED THE FACILITATION AND ACCOUNTING FOR ALL GRANT PROGRAMS ADMINISTERED BY HOWARD COUNTY GENERAL HOSPITAL, INC. TO THE OFFICERS, DIRECTORS, AND KEY EMPLOYEES OF THE ORGANIZATION.

**SCHEDULE J  
(Form 990)**

**Compensation Information**

OMB No. 1545-0047

**2016**

Open to Public Inspection

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

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

▶ Attach to Form 990.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
**HOWARD COUNTY GENERAL HOSPITAL, INC.**

Employer identification number  
**52-2093120**

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

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

**4** During the year, did any person listed 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
<b>1b</b>		
<b>2</b>		
<b>4a</b>	X	
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>	X	
<b>8</b>		X
<b>9</b>		

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

Schedule J (Form 990) 2016



**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 compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) STEVEN C. SNELGROVE PRESIDENT/TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	414,448.	169,563.	23,058.	101,527.	24,656.	733,252.	0.
(2) RENEE DEMSKI TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	235,250.	70,423.	4,122.	45,923.	25,113.	380,831.	0.
(3) RONALD R. PETERSON CORPORATE VICE CHAIR/TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	1,409,062.	705,810.	148,176.	477,286.	25,102.	2,765,436.	0.
(4) G. DANIEL SHEALER, JR. TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	515,473.	156,663.	161,583.	172,782.	13,945.	1,020,446.	113,292.
(5) W. GILL WYLIE TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	281,183.	88,891.	73,404.	39,971.	27,069.	510,518.	0.
(6) RYAN BROWN VP OF OPERATIONS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	202,124.	56,101.	847.	30,761.	9,789.	299,622.	0.
(7) KAREN DAVIS VP OF NURSING & CNO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	200,749.	50,244.	38,936.	103,275.	17,089.	410,293.	0.
(8) ELIZABETH EDSALL KROMM VP FOR POPULATION HLTH	(i)	79,766.	0.	10,932.	2,463.	3,941.	97,102.	0.
	(ii)	83,652.	0.	213.	2,166.	10,102.	96,133.	0.
(9) MOHAMMED SHAFEEQ AHMED, M.D. VP MEDICAL AFFAIRS & CMO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	154,649.	20,000.	3,605.	4,250.	9,756.	192,260.	0.
(10) JAMES E. YOUNG SR VP FINANCE & CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	249,859.	61,973.	43,960.	29,066.	25,293.	410,151.	0.
(11) SANDRA HARRIMAN VP OF DEVELOPMENT	(i)	150,476.	0.	1,276.	5,758.	9,298.	166,808.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) SHERYL DULSKY REGISTERED NURSE	(i)	190,177.	0.	486.	11,311.	3,731.	205,705.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) LEENA KADAMATTU JOSEPH REGISTERED NURSE	(i)	168,426.	0.	250.	7,455.	20,493.	196,624.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) DEBRA DEMPSEY-KELLY APPEALS MANAGER	(i)	103,894.	0.	91,741.	7,170.	15,241.	218,046.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) MANJUMOL ABRAHAM REGISTERED CLIN. NURSE	(i)	166,578.	0.	1,150.	8,221.	2,768.	178,717.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) SHARON ROSSI SR. DIR OF OPERATIONS	(i)	154,532.	0.	14,616.	6,323.	15,612.	191,083.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

**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 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				
(17) ERIC M. ALDRICH FORMER OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	150,339.	62,992.	45,592.	14,142.	12,660.	285,725.	0.
(18) JAY H. BLACKMAN FORMER OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	202,287.	29,640.	1,251.	34,558.	21,934.	289,670.	0.
(19) JUDY E. BROWN FORMER OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	94,320.	44,036.	34,302.	18,870.	12,237.	203,765.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

**Part III** Supplemental Information

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

**PART I, LINES 4A-B:**

THE FOLLOWING INDIVIDUALS LISTED ON THE 990 RECEIVED SEVERANCE FROM HOWARD COUNTY GENERAL HOSPITAL:

PAUL GLEICHAUF \$112,452.43

**MAKE WHOLE PLAN & SERP I PLAN:**

THE MAKE WHOLE AND SERP I PLANS ARE FROZEN, NON-TAX QUALIFIED DEFINED BENEFIT PLANS. PARTICIPATION IN THE PLANS IS LIMITED TO THE EXISTING PLAN PARTICIPANTS. THE BENEFITS UNDER THE PLANS ARE BASED UPON THE PARTICIPANT'S LENGTH OF SERVICE AND COMPENSATION. THE MAKE WHOLE PLAN WAS DESIGNED TO REPLACE THE BENEFITS THE PARTICIPANTS LOST DUE TO THE COMPENSATION LIMITS IMPOSED BY LAW UPON OUR QUALIFIED DEFINED BENEFIT PLAN. IN THE MANNER REQUIRED BY APPLICABLE IRS RULES, THE DESIGN OF EACH OF THESE ARRANGEMENTS WAS APPROVED AS REASONABLE, IN ADVANCE, BY AN INDEPENDENT COMPENSATION COMMITTEE, WHICH BASED ITS DECISION ON DATA PROVIDED BY AN INDEPENDENT COMPENSATION CONSULTANT. PARTICIPANTS' INTERESTS UNDER THESE ARRANGEMENTS ARE NOT GUARANTEED OR SECURED AT ANY WAY AND AT ALL TIMES ARE SUBJECT TO CLAIMS OF EMPLOYER'S BANKRUPTCY/INSOLVENCY CREDITORS. FURTHERMORE, IF A PARTICIPANT VOLUNTARILY TERMINATES EMPLOYMENT OR IS

**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.

TERMINATED BY THE EMPLOYER FOR CAUSE PRIOR TO THE APPLICABLE VESTING DATE UNDER THE MAKE WHOLE PLAN, THE PARTICIPANT'S ENTIRE MAKE WHOLE PLAN BENEFIT IS FORFEITED. IF A PARTICIPANT TERMINATES EMPLOYMENT FOR ANY REASON PRIOR TO THE APPLICABLE VESTING DATE UNDER THE SERP I, THE PARTICIPANT'S ENTIRE SERP I BENEFIT IS FORFEITED. IN ADDITION, UNDER CURRENT LAW, INTERESTS UNDER THESE ARRANGEMENTS ARE REPORTABLE AS TAXABLE COMPENSATION WHEN THEY BECOME VESTED, EVEN IF THOSE AMOUNTS ARE NOT YET PAYABLE TO THE PARTICIPANT (AND EVEN IF THOSE AMOUNTS ARE NEVER PAID TO THE PARTICIPANT). NO ROLLOVER OR OTHER TAX-DEFERRAL OPTIONS ARE AVAILABLE TO PARTICIPANTS. NOTE THAT ANY MAKE WHOLE PLAN OR SERP I VESTED AMOUNT OR PAYMENT BEING REPORTED AS COMPENSATION WAS ALSO REPORTED IN PREVIOUS YEAR(S) WHEN THAT INTEREST ACCRUED UNDER THE PLAN.

SERP II PLAN & SRP PLAN:

THE SERP II AND SRP PLANS ARE ACTIVE; NON-TAX QUALIFIED DEFINED CONTRIBUTION TARGET BENEFIT PLANS. THE PLANS ARE DESIGNED TO ACHIEVE A REASONABLE TARGETED RETIREMENT BENEFIT LEVEL FOR EACH PARTICIPANT (IN COMBINATION WITH THE OTHER RETIREMENT PROGRAMS OF THE EMPLOYER) BASED UPON CERTAIN CRITERIA, SUCH AS EACH PARTICIPANT'S LENGTH OF SERVICE AND

**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.

COMPENSATION. IN THE MANNER REQUIRED BY APPLICABLE IRS RULES, THE DESIGN OF EACH OF THESE ARRANGEMENTS WAS APPROVED AS REASONABLE, IN ADVANCE, BY AN INDEPENDENT COMPENSATION COMMITTEE, WHICH BASED ITS DECISION ON DATA PROVIDED BY AN INDEPENDENT COMPENSATION CONSULTANT. PARTICIPANTS' INTERESTS UNDER THESE ARRANGEMENTS ARE NOT GUARANTEED OR SECURED AT ANY WAY AND AT ALL TIMES ARE SUBJECT TO CLAIMS OF EMPLOYER'S BANKRUPTCY/INSOLVENCY CREDITORS. IF A PARTICIPANT VOLUNTARILY TERMINATES EMPLOYMENT OR IS TERMINATED BY THE EMPLOYER FOR CAUSE PRIOR TO THE APPLICABLE VESTING DATE UNDER EACH ARRANGEMENT, THE PARTICIPANT'S ACCOUNT IS FORFEITED. IN ADDITION, UNDER CURRENT LAW, INTERESTS UNDER THESE ARRANGEMENTS ARE REPORTABLE AS TAXABLE COMPENSATION WHEN THEY BECOME VESTED, EVEN IF THOSE AMOUNTS ARE NOT YET PAYABLE TO THE PARTICIPANT (AND EVEN IF THOSE AMOUNTS ARE NEVER PAID TO THE PARTICIPANT). NO ROLLOVER OR OTHER TAX-DEFERRAL OPTIONS ARE AVAILABLE TO PARTICIPANTS. NOTE THAT ANY SERP II OR SRP PLAN VESTED AMOUNT OR PAYMENT BEING REPORTED AS COMPENSATION WAS ALSO REPORTED IN PREVIOUS YEAR(S) WHEN THAT INTEREST ACCRUED UNDER THE PLAN.

THE FOLLOWING INDIVIDUALS LISTED ON FORM 990, PART VII, SECTION A, LINE 1A PARTICIPATED IN A NONQUALIFIED RETIREMENT PLAN AND RECEIVED ACCRUED

**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.

DEFERRED COMPENSATION THAT IS REPORTED ON SCHEDULE J, PART II, COLUMN (C):

RONALD R. PETERSON \$686,643.00; G. DANIEL SHEALER \$113,292.00; RYAN BROWN  
\$3,920; KAREN DAVIS \$8,334.00 AND STEVE SNELGROVE \$53,373.00.

THE FOLLOWING INDIVIDUALS LISTED ON FORM 990, PART VII, SECTION A, LINE 1A  
PARTICIPATED IN A NON QUALIFIED RETIREMENT PLAN AND RECEIVED PAYMENT FROM  
THE PLAN, IT IS REPORTED ON SCHEDULE J, PART II, COLUMN (B)(III) AS WELL AS  
SCHEDULE J, PART II, COLUMN (F) IF THEY WERE REQUIRED TO BE DISCLOSED ON  
PRIOR YEARS FORMS 990:

PAUL M. GLEICHAUF \$9,653.12; W. GILL WYLIE \$49,160.00; G. DANIEL SHEALER,  
JR \$265,838.35; ERIC ALDRICH \$19,044.00; VICTOR BROCCOLINO \$237,857.08;  
BRIAN GRAGNOLATI \$47,678.00.

PART I, LINE 7:

THE BONUSES ARE ON A WEIGHTED FORMULA BASED ON THE ATTAINMENT OF  
QUANTIFIABLE ORGANIZATION OBJECTIVES SET BY THE TRUSTEE COMPENSATION  
COMMITTEE EACH YEAR. THEY ARE REVIEWED BY MANAGEMENT  
THAT USES DISCRETION TO DETERMINE PAYMENT.

**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.

THE DEPENDENT TUITION REIMBURSEMENT PROGRAM REIMBURSE EMPLOYEES FOR THE  
MAXIMUM ANNUAL BENEFIT OF 50% OF \$20,000 OR \$10,000 FOR EACH ELIGIBLE  
DEPENDENT WITH A MAXIMUM OF TWO DEPENDENT CHILDREN PER EMPLOYEE AT ANY ONE  
TIME. THE BENEFIT IS LIMITED TO FOUR YEARS OF FULL-TIME UNDERGRADUATE  
STUDY.

TUITION REIMBURSEMENT IS AVAILABLE TO ELIGIBLE EMPLOYEES THAT HAVE  
COMPLETED SIX MONTHS OF SERVICE  
AT A MINIMUM OF 40 SCHEDULED HOURS PER PAY. TO RECEIVE REIMBURSEMENT  
EMPLOYEES MUST ATTEND ACCREDITED COLLEGES AND UNIVERSITIES FOR  
CAREER-RELATED COURSES. THE REIMBURSEMENT IS AS FOLLOWS: IF YOU ARE  
SCHEDULED BETWEEN 60-80 HOURS PER PAY PERIOD YOU MAY RECEIVE UP TO \$3,000  
PER FISCAL YEAR FOR UNDERGRADUATE COURSES OR \$5,000 PER FISCAL YEAR FOR  
GRADUATE COURSES. IF YOU ARE SCHEDULED BETWEEN 40-59 HOURS PER PAY PERIOD  
YOU MAY RECEIVE UP TO \$1,500 PER FISCAL YEAR FOR UNDERGRADUATE COURSES OR  
\$2,000 PER FISCAL YEAR FOR GRADUATE COURSES.

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

Department of the Treasury  
Internal Revenue Service

**Supplemental Information to Form 990 or 990-EZ**

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2016**

Open to Public  
Inspection

Name of the organization

HOWARD COUNTY GENERAL HOSPITAL, INC.

Employer identification number

52-2093120

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

VISION IS TO BE THE PREMIER COMMUNITY HOSPITAL IN MARYLAND.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

CARDIAC, MEDICAL AND SURGICAL CARE. STAFFED 24 HOURS A DAY BY HIGHLY

QUALIFIED PHYSICIANS, NURSES AND TECHNICIANS, THE UNIT FEATURES

STATE-OF-THE-ART MEDICAL EQUIPMENT INCLUDING A COMPUTERIZED MONITORING

SYSTEM. MEDICATIONS ARE ADMINISTERED USING A COMPUTERIZED MEDICATION

ADMINISTRATION RECORD WITH BARCODE SCANNING FOR PATIENT SAFETY. THE

UNIT IS DESIGNED SO THAT EVERY BED IS CLEARLY VISIBLE FROM THE NURSING

STATION.

HOWARD COUNTY GENERAL HOSPITAL HAS A PROGRAM FOR TOTAL KNEE AND HIP

REPLACEMENT PATIENTS CALLED THE JOINT ACADEMY. IT APPROACHES THE JOINT

REPLACEMENT SURGICAL EXPERIENCE IN A WHOLE NEW WAY, CREATING A

PARTNERSHIP AMONG THE PATIENT, DOCTOR AND HOSPITAL. BECAUSE AN

INFORMED PATIENT CAN MORE FULLY PARTICIPATE IN HIS OR HER OWN CARE AND

RECOVERY, WE FOCUS ON ENGAGING AND EDUCATING OUR PATIENTS THROUGHOUT

THE ENTIRE PROCESS FROM ADMISSION TO POST-DISCHARGE.

THE HEALTH CARE AND SURGERY CENTER (HCSC) IS LOCATED ADJACENT TO THE

HOSPITAL. THE HCSC IS THE PRIMARY LOCATION FOR OUTPATIENT PROCEDURES

AND ADDITIONAL OUTPATIENT SERVICES, INCLUDING MAGNETIC RESONANCE

IMAGING (MRI). THE HCSC OCCUPIES THE ENTIRE LOWER LEVEL OF THE

ADJACENT BUILDING AND CONSISTS OF SIX OPERATING ROOMS, ONE MINOR

PROCEDURE ROOM, A UROLOGY SUITE, AND A POST-ANESTHESIA CARE UNIT.

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

Schedule O (Form 990 or 990-EZ) (2016)



Name of the organization

HOWARD COUNTY GENERAL HOSPITAL, INC.

Employer identification number

52-2093120

SPACE AND PROGRAMS HAVE ALSO BEEN DESIGNED TO MEET THE NEEDS OF  
PEDIATRIC SURGERY PATIENTS AND THEIR FAMILIES.

FORM 990, PART III, LINE 4B, PROGRAM SERVICE ACCOMPLISHMENTS:  
UNIT.

FORM 990, PART III, LINE 4C, PROGRAM SERVICE ACCOMPLISHMENTS:  
DESIGNED TO CARE FOR CRITICALLY-ILL NEWBORNS IN AN ENVIRONMENT THAT  
FOSTERS HEALTHY DEVELOPMENT. MOST IMPORTANTLY, NICU PATIENTS BENEFIT  
FROM THE CONTINUOUS CARE AND OBSERVATION OF JOHNS HOPKINS'S  
NEONATOLOGISTS AND REGISTERED NURSES WHO ARE EXPERIENCED WITH THE  
SPECIAL NEEDS OF NEWBORN PREMATURE BABIES.

THE CENTER FOR MATERNAL AND FETAL MEDICINE AT HOWARD COUNTY GENERAL  
HOSPITAL IS EQUIPPED TO MANAGE ANY HIGH-RISK SITUATION THAT MAY ARISE  
DURING YOUR PREGNANCY AND TO PROVIDE YOU WITH COMPREHENSIVE CARE. THE  
CENTER PROVIDES:

COVERAGE BY BOARD-CERTIFIED MATERNAL FETAL SPECIALISTS  
CONSULTATIVE SERVICES FOR ALL MEDICAL COMPLICATIONS OF PREGNANCY  
CERTIFIED GENETIC COUNSELORS  
FIRST-TRIMESTER SCREENING TO BETTER DELINEATE THE RISKS OF DOWN  
SYNDROME, TRISOMY 13 AND TRISOMY 18  
4D IMAGING TO STUDY YOUR BABY'S ANATOMICAL DEVELOPMENT AND FETAL GROWTH  
FETAL ASSESSMENT CENTER FOR ANTENATAL TESTING PROFILES  
TESTING FOR MATERNAL DIABETES AND HYPERTENSION  
FETAL ECHOCARDIOGRAM PROGRAM

Name of the organization

HOWARD COUNTY GENERAL HOSPITAL, INC.

Employer identification number

52-2093120

## DIABETES IN PREGNANCY PROGRAM

THE CENTER FOR MATERNAL AND FETAL MEDICINE EMPLOYS SPECIALLY TRAINED AND CERTIFIED SONOGRAPHERS TO PERFORM ROUTINE FIRST-TRIMESTER SCREENINGS AND 20-WEEK FETAL ANATOMY SCREENINGS THAT ARE MORE DETAILED THAN THOSE TYPICALLY OFFERED BY OB/GYN OFFICES. HOWARD COUNTY GENERAL HOSPITAL ENCOURAGES ANY PATIENT, HIGH-RISK OR OTHERWISE, WHO IS INTERESTED IN HAVING THESE STATE-OF-THE-ART TESTS TO GET A REFERRAL FROM HER DOCTOR.

THE CENTER FOR MATERNAL AND FETAL MEDICINE OFFERS A MULTIDISCIPLINARY TEAM APPROACH WORKING WITH THE MOTHER'S OWN OB/GYN, PERINATOLOGIST, NEONATOLOGIST, PEDIATRIC SUBSPECIALIST, GENETIC COUNSELORS AND PATIENT EDUCATIONS THROUGHOUT THE PREGNANCY AND, IF NEEDED, DURING YOUR DELIVERY AT HOWARD COUNTY GENERAL HOSPITAL. HOWARD COUNTY GENERAL HOSPITAL'S GOAL IS TO DEVELOP A HEALTH CARE PLAN THAT ADDRESSES THE NEEDS OF THE MOTHER AND BABY.

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

JOHNS HOPKINS HEALTH SYSTEM, INC., A IRC 501(C)(3) TAX EXEMPT ORGANIZATION, IS THE SOLE CORPORATE MEMBER OF HOWARD COUNTY GENERAL HOSPITAL, INC.

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

JOHNS HOPKINS HEALTH SYSTEM CORPORATION, A IRC 501(C)(3) TAX EXEMPT PARENT ORGANIZATION OF HOWARD COUNTY GENERAL HOSPITAL, INC. ELECTS THE MAJORITY OF THE BOARD OF TRUSTEES.

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

Name of the organization HOWARD COUNTY GENERAL HOSPITAL, INC.	Employer identification number 52-2093120
--	--

THE GOVERNING BODY OF HOWARD COUNTY GENERAL HOSPITAL, INC. IS EMPOWERED BY ITS BY-LAWS TO MAKE CERTAIN DECISIONS; ALL OTHER DECISIONS ARE SUBJECT TO APPROVAL OF THE PARENT ORGANIZATION JOHNS HOPKINS HEALTH SYSTEM CORPORATION.

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

A COPY OF THE FORM 990 IS SENT BY EMAIL TO THE ORGANIZATION'S GOVERNING BODY BEFORE IT IS FILED.

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

THE CONFLICT OF INTEREST POLICY IS A PART OF THE ANNUAL FINANCIAL AUDIT CONFIRMATION PROCESS PROVIDED ONLINE. ALL OFFICERS, DIRECTORS, TRUSTEES AND KEY EMPLOYEES ARE REQUIRED TO COMPLY ON AN ANNUAL BASIS.

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

EVERY THREE YEARS AN INDEPENDENT STUDY IS CONDUCTED GATHERING INDUSTRY COMPENSATION AVERAGES FROM SELECT PEER INSTITUTIONS. EVERY YEAR THE JOHNS HOPKINS BOARD OF TRUSTEES COMPENSATION COMMITTEE REVIEWS COMPENSATION AMOUNTS FOR OFFICERS AND ALL EMPLOYEES AT THE DIRECTOR AND HIGHER LEVELS.

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

INTERNAL POLICIES, INCLUDING CONFLICT OF INTERST POLICY, ARE PROVIDED TO THE PUBLIC ON THE ORGANIZATION'S WEBSITE. FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST, THE GOVERNING DOCUMENTS HAVE BEEN MADE AVAILABLE IN OUR PUBLIC FILING WITH THE STATE OF MARYLAND AND THE INTERNAL REVENUE SERVICE.

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



**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

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

OMB No. 1545-0047

**2016**

Open to Public Inspection

Name of the organization **HOWARD COUNTY GENERAL HOSPITAL, INC.** Employer identification number **52-2093120**

**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
HCGH DIAGNOSTIC HEALTH SERVICE - 52-2326835 5755 CEDAR LANE COLUMBIA, MD 21044	HEALTHCARE SERVICES	MARYLAND	0.	0.	HOWARD COUNTY GENERAL HOSPITAL, INC.
CENTRAL MARYLAND MANAGEMENT SERVICES, LLC - 81-2768743, 10211 WINCOPIN CIRCLE, SUITE 600, COLUMBIA, MD 21044	MANAGEMENT SERVICES	MARYLAND	0.	0.	HOWARD COUNTY GENERAL HOSPITAL, INC.

**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
JOHNS HOPKINS HEALTH SYSTEM CORPORATION - 52-1465301, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	SUPPORTING ORGANIZATION	MARYLAND	501(C)(3)	11, III FI	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
HOWARD HOSPITAL FOUNDATION, INC. - 52-1072778, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	FUNDRAISING/SUPPORTING ORGANIZATION	MARYLAND	501(C)(3)	11, III FI	N/A		X
JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC. - 52-1341890, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	HOSPITAL	MARYLAND	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
JOHNS HOPKINS COMMUNITY PHYSICIANS, INC. - 52-1467441, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	HEALTHCARE SERVICES	MARYLAND	501(C)(3)	11, III FI	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X

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

Schedule R (Form 990) 2016

SEE PART VII FOR CONTINUATIONS

**Part II** Continuation of Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
JOHNS HOPKINS MEDICAL SERVICES CORPORATION - 52-1232569, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21218	HEALTHCARE SERVICES	MARYLAND	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
THE JOHNS HOPKINS HOSPITAL - 52-0591656 3910 KESWICK RD, S BLDG, STE. 4300A BALTIMORE, MD 21218	HOSPITAL	MARYLAND	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
JOHNS HOPKINS HOSPITAL ENDOWMENT FUND, INC. - 23-7252596, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21218	SUPPORTING ORGANIZATION	MARYLAND	501(C)(3)	11, III FI	JOHNS HOPKINS HOSPITAL ENDOWMENT FUND,		X
SUBURBAN HOSPITAL HEALTHCARE SYSTEM, INC. - 52-2052354, 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814	HEALTHCARE SERVICES	MARYLAND	501(C)(3)	11, III FI	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
HOWARD COUNTY LIQUIDATION CORPORATION - 52-0892284, 5755 CEDAR LANE, COLUMBIA, MD 21044	INACTIVE TAX-EXEMPT ORGANIZATION	MARYLAND	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
SUBURBAN HOSPITAL, INC. - 52-0610545 8600 OLD GEORGETOWN ROAD BETHESDA, MD 20814	HOSPITAL	MARYLAND	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
LUCY WEBB HAYES NATIONAL TRAINING SCHOOL FOR DEACONESSES - 53-0196602, 5255 LOUGHBORO RD NW, WASHINGTON, DC 20016	HEALTHCARE SERVICES	DISTRICT OF COLUMBIA	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X
POTOMAC HOME SUPPORT INC. - 52-1750383 6001 MONTROSE RD NO 1020 ROCKVILLE, MD 20852	HOME HEALTH CARE	MARYLAND	501(C)(3)	9	N/A		X
SIBLEY SUBURBAN HOME HEALTH AGENCY - 52-1450142, 6001 MONTROSE RD NO 1020, ROCKVILLE, MD 20852	HOME HEALTH CARE	MARYLAND	501(C)(3)	9	N/A		X
PEDIATRIC PHYSICIAN SERVICES, INC. - 59-3425191, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	PEDIATRIC MEDICAL SERVICES	MARYLAND	501(C)(3)	9	ALL CHILDREN'S HEALTH SYSTEM, INC.		X
JOHNS HOPKINS ALL CHILDREN'S FOUNDATION INC. - 59-2481738, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	FOUNDATION	FLORIDA	501(C)(3)	7	ALL CHILDREN'S HEALTH SYSTEM, INC.		X
JOHNS HOPKINS ALL CHILDREN'S HOSPITAL INC. - 59-0683252, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	HOSPITAL	FLORIDA	501(C)(3)	3	JOHNS HOPKINS HEALTH SYSTEM CORPORATION		X



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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
OPHTHALMOLOGY ASSOCIATES, LLC - 52-1890957, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	OPHTHALMOLOGY SERVICES	MD	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A
SUBURBAN WELLNESS CENTER, LLC - 56-2296930, 20500 GOLDENROD LANE, GERMANTOWN, MD 20874	REAL ESTATE	MD	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A
GCM SUBURBAN IMAGING, LLC - 52-2326237, 1201 SEVEN LOCKS ROAD, STE. 200, ROCKVILLE, MD 20854	OUTPATIENT RADIOLOGY	MD	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A
CHEVY CHASE IMAGING, LLC - 14-1944126, 1201 SEVEN LOCKS ROAD, STE. 200, ROCKVILLE, MD 20854	RADIOLOGY SERVICES	MD	N/A	N/A	N/A	N/A	N/A		N/A	N/A		N/A

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
HCP VENTURE ONE CORPORATION - 52-1558858 3910 KESWICK RD, S BLDG, STE. 4300A BALTIMORE, MD 21211	MEDICAL SERVICES	MD	HOWARD COUNTY GENERAL HOSPITAL, INC.	C CORP			100.00%		X
HSI MEDICAL SERVICES CORPORATION - 52-1847705, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	HEALTHCARE-SLEEP DIAGNOSTICS	MD		C CORP	N/A	N/A	N/A		X
HOWARD COUNTY HEALTH SERVICES, INC. - 52-1434783, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	HEALTHCARE MANAGEMENT	MD		C CORP	N/A	N/A	N/A		X
JOHNS HOPKINS MEDICAL MANAGEMENT CORPORATION - 52-1250028, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	NURSING SERVICES	MD		C CORP	N/A	N/A	N/A		X
JOHNS HOPKINS EMPLOYER HEALTH PROGRAMS INC. - 52-1947678, 3910 KESWICK RD, S BLDG, STE. 4300A, BALTIMORE, MD 21211	BENEFIT PLANS	MD		C CORP	N/A	N/A	N/A		X







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

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

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

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

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

**PART II, IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS:**

NAME OF RELATED ORGANIZATION:

JOHNS HOPKINS HOSPITAL ENDOWMENT FUND, INC.

DIRECT CONTROLLING ENTITY: JOHNS HOPKINS HOSPITAL ENDOWMENT FUND, INC.

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

NAME OF RELATED ORGANIZATION:

SUBURBAN WELLNESS CENTER, LLC

DIRECT CONTROLLING ENTITY: SUBURBAN HEALTH ENTERPRISES, INC

NAME OF RELATED ORGANIZATION:

GCM SUBURBAN IMAGING, LLC

DIRECT CONTROLLING ENTITY: SUBURBAN HEALTH ENTERPRISES, INC

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

HEALTHCARE SUPPLY CHAIN INNOVATIONS, LLC

EIN: 47-2509307

3910 KESWICK RD, S BLDG, 4TH FL, STE 4300A

BALTIMORE, MD 21211

DIRECT CONTROLLING ENTITY: JOHNS HOPKINS MEDICAL MANAGEMENT CORPORATION

NAME, ADDRESS, AND EIN OF RELATED ORGANIZATION:

JOHNS HOPKINS REGIONAL SUPPLY CHAIN NETWORK, LLC

EIN: 47-2912848

3910 KESWICK RD, S BLDG, 4TH FL, STE 4300A

BALTIMORE, MD 21211

**Part VII** Supplemental Information.

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

DIRECT CONTROLLING ENTITY: JOHNS HOPKINS MEDICAL MANAGEMENT CORPORATION

PART IV, IDENTIFICATION OF RELATED ORGANIZATIONS TAXABLE AS CORP OR TRUST:

NAME OF RELATED ORGANIZATION:

TCAS, INC.

DIRECT CONTROLLING ENTITY: JOHNS HOPKINS MEDICAL MANAGEMENT CORPORATION

NAME OF RELATED ORGANIZATION:

SUBURBAN HEALTH ENTERPRISES, INC.

DIRECT CONTROLLING ENTITY: SUBURBAN HOSPITAL HEALTHCARE SYSTEM INC.