

**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 <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.</b> | Employer identification number<br><b>52-1341890</b> |
|---|---|

**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>614,187,591.</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 6/11/18 VP FINANCE/CFO  
Signature of officer Date 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

Department of the Treasury  
Internal Revenue Service

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

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

**2016**  
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:<br><input type="checkbox"/> Address change<br><input type="checkbox"/> Name change<br><input type="checkbox"/> Initial return<br><input type="checkbox"/> Final return/terminated<br><input type="checkbox"/> Amended return<br><input type="checkbox"/> Application pending | <b>C</b> Name of organization<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.</b>              |            | <b>D</b> Employer identification number<br>52-1341890   |
|  | Doing business as   |            | <b>E</b> Telephone number<br>(443) 997-5722   |
|  | Number and street (or P.O. box if mail is not delivered to street address)                      | Room/suite |   |
|  | 3910 KESWICK RD, S BLDG   |            | 4300A   |
|  | City or town, state or province, country, and ZIP or foreign postal code<br>BALTIMORE, MD 21211 |            | <b>G</b> Gross receipts \$ 626,835,188.   |
| <b>F</b> Name and address of principal officer: <b>CARL FRANCIOLI</b><br>4940 EASTERN AVENUE, BALTIMORE, MD 21224  |   |            | <b>H(a)</b> Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "No," attach a list. (see instructions) |
| <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>J</b> Website: ▶ <a href="http://WWW.HOPKINSMEDICINE.ORG/JOHNS_HOPKIN">HTTP://WWW.HOPKINSMEDICINE.ORG/JOHNS_HOPKIN</a>  |   |            |   |
| <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: 1984  |
|  |   |            | <b>M</b> State of legal domicile: MD  |

| Part I Summary   |   | Prior Year                                | Current Year                |
|--|---|---|-----------------------------|
| Activities & Governance  | 1 Briefly describe the organization's mission or most significant activities: <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER, A MEMBER OF JOHNS HOPKINS MEDICINE, PROVIDES COMPASSIONATE</b> |   |                             |
|  | 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.   |   |                             |
|  | 3 Number of voting members of the governing body (Part VI, line 1a)   | 3   | 14                          |
|  | 4 Number of independent voting members of the governing body (Part VI, line 1b)   | 4   | 9                           |
|  | 5 Total number of individuals employed in calendar year 2016 (Part V, line 2a)  | 5   | 3953                        |
|  | 6 Total number of volunteers (estimate if necessary)  | 6   | 454                         |
|  | 7a Total unrelated business revenue from Part VIII, column (C), line 12   | 7a  | 7,403,586.                  |
| b Net unrelated business taxable income from Form 990-T, line 34             | 7b  | -661,050.                                 |                             |
| Revenue  | 8 Contributions and grants (Part VIII, line 1h)   | 14,486,178.                               | 5,975,461.                  |
|  | 9 Program service revenue (Part VIII, line 2g)  | 543,997,463.                              | 554,641,438.                |
|  | 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)  | 2,029,711.                                | 2,379,858.                  |
|  | 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)   | 53,188,025.                               | 51,190,834.                 |
|  | 12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)   | 613,701,377.                              | 614,187,591.                |
| Expenses   | 13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)   | 200,715.                                  | 202,908.                    |
|  | 14 Benefits paid to or for members (Part IX, column (A), line 4)  | 0.  | 0.                          |
|  | 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)  | 257,755,152.                              | 258,386,676.                |
|  | 16a Professional fundraising fees (Part IX, column (A), line 11e)   | 0.  | 0.                          |
|  | b Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.  |   |                             |
| 17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)              | 338,508,204.  | 346,617,700.                              |                             |
| 18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) | 596,464,071.  | 605,207,284.                              |                             |
| 19 Revenue less expenses. Subtract line 18 from line 12                      | 17,237,306.   | 8,980,307.                                |                             |
| Net Assets or Fund Balances  | 20 Total assets (Part X, line 16)   | Beginning of Current Year<br>436,967,768. | End of Year<br>449,185,403. |
|  | 21 Total liabilities (Part X, line 26)  | 419,262,771.                              | 402,394,588.                |
|  | 22 Net assets or fund balances. Subtract line 21 from line 20   | 17,704,997.                               | 46,790,815.                 |

|   |                            |                      |           |  |
|---|----------------------------|----------------------|-----------|--|
| <b>Part II Signature Block</b>  |                            |                      |           |  |
| Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge. |                            |                      |           |  |
| Sign Here   | Signature of officer       | Date                 |           |  |
|   | <i>Carl Francioli</i>      | 5-11-18              |           |  |
| Paid Preparer Use Only  | 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. |  |

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

**Part III Statement of Program Service Accomplishments**

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

1 Briefly describe the organization's mission:  
JOHNS HOPKINS BAYVIEW MEDICAL CENTER'S DEPARTMENT OF MEDICINE IS COMMITTED TO THE PRACTICE OF PRIMARY AND SPECIALITY MEDICAL CARE, THE TEACHING OF MEDICAL STUDENTS, RESIDENTS, FELLOWS, ALLIED HEALTH PROFESSIONALS, AND PHYSICIANS, RESEARCH AND DEVELOPMENT IN BASIC

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?  Yes  No  
If "Yes," describe these new services on Schedule O.

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

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

4a (Code: ) (Expenses \$ 124,530,061. including grants of \$ 0. ) (Revenue \$ 91,548,163. )  
DEPARTMENT OF MEDICINE: THE DEPARTMENT OF MEDICINE IS COMMITTED TO THE PRACTICE OF PRIMARY AND SPECIALITY MEDICARE CARE, THE TEACHING OF MEDICAL STUDENTS, RESIDENTS, FELLOWS, ALLIED HEALTH PROFESSIONALS, AND PHYSICIANS, RESEARCH AND DEVELOPMENT IN BASIC SCIENCE, CLINICAL CARE, HEALTH SERVICES DELIVERY, AND MEDICAL EDUCATION, ADMINISTRATION OF MEDICAL ACTIVITIES AT JOHNS HOPKINS BAYVIEW MEDICAL CENTER.

4b (Code: ) (Expenses \$ 32,105,215. including grants of \$ 0. ) (Revenue \$ 31,217,703. )  
SPECIALTY HOSPITAL PROGRAMS: THE JOHNS HOPKINS SPECIALTY HOSPITAL PROGRAMS OFFER A RANGE OF CONTINUING CARE SERVICES TO THE COMMUNITY. LOCATED IN THE JOHN R. BURTON PAVILION, ON THE CAMPUS OF THE JOHNS HOPKINS BAYVIEW MEDICAL CENTER, THE JOINT COMMISSION AND CARF (COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES) ACCREDITED FACILITY PROVIDES VENTILATOR/RESPIRATORY CARE, INPATIENT REHABILITATION, COMPLEX MEDICAL CARE, SPECIALIZED WOUND THERAPY AND PALLIATIVE CARE. OFFERING A BRIDGE BETWEEN HOSPITAL AND HOME FOR MANY PATIENTS, THE SHP'S FOCUS IS ON IMPROVING THE HEALTH AND WELL-BEING OF THESE PATIENTS BEFORE THEY RETURN TO THEIR OWN ENVIRONMENTS. OUR EXPERIENCE IN ALL ASPECTS OF CARING FOR OLDER ADULTS COMES FROM YEARS OF SPECIALIZED MEDICAL EDUCATION AND RESEARCH. OUR PHYSICIANS ARE

4c (Code: ) (Expenses \$ 87,641,585. including grants of \$ 0. ) (Revenue \$ 97,621,972. )  
DEPARTMENT OF SURGERY: THE DEPARTMENT OF SURGERY OFFERS COMPREHENSIVE SURGICAL CARE, INCLUDING SPECIALTIES IN GASTROINTESTINAL AND ABDOMINAL WALL SURGERY, TRAUMA AND SURGICAL CRITICAL CARE, BARIATRIC SURGERY, BURN AND RECONSTRUCTIVE SURGERY, SURGICAL ONCOLOGY, THORACIC SURGERY AND VASCULAR SURGERY. THE DEPARTMENT OF SURGERY FEATURES THE LATEST IN SURGICAL TECHNOLOGY, INCLUDING VIDEOSCOPIIC AND MINIMALLY-INVASIVE APPROACHES TO THE TREATMENT OF SURGICAL DISORDERS AND 24/7 EMERGENCY COVERAGE OF OUR LEVEL II TRAUMA CENTER.

4d Other program services (Describe in Schedule O.)  
(Expenses \$ 283,813,641. including grants of \$ 202,908. ) (Revenue \$ 351,410,900. )

4e Total program service expenses 528,090,502.

**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)?<br><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?<br><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  |

JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

**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? .....   |     | X  |
| <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? .....  |     | X  |
| <b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....   |     | X  |
| <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

|            |  | Yes        | No |
|------------|--|------------|----|
| <b>1a</b>  | Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable   |            |    |
|            | <b>1a</b> 402  |            |    |
| <b>b</b>   | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable  |            |    |
|            | <b>1b</b> 0  |            |    |
| <b>c</b>   | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?   | X          |    |
| <b>2a</b>  | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return  |            |    |
|            | <b>2a</b> 3953   |            |    |
| <b>b</b>   | If at least one is reported on line 2a, did the organization file all required federal employment tax returns?<br><b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)         | X          |    |
| <b>3a</b>  | Did the organization have unrelated business gross income of \$1,000 or more during the year?  | X          |    |
| <b>b</b>   | If "Yes," has it filed a Form 990-T for this year? If "No," to line 3b, provide an explanation in Schedule O   | X          |    |
| <b>4a</b>  | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? |            | X  |
| <b>b</b>   | If "Yes," enter the name of the foreign country:<br>See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).  |            |    |
| <b>5a</b>  | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?  |            | X  |
| <b>b</b>   | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?   |            | X  |
| <b>c</b>   | If "Yes," to line 5a or 5b, did the organization file Form 8886-T?   |            |    |
| <b>6a</b>  | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?                                    |            | X  |
| <b>b</b>   | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?  |            |    |
| <b>7</b>   | <b>Organizations that may receive deductible contributions under section 170(c).</b>   |            |    |
| <b>a</b>   | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?  |            | X  |
| <b>b</b>   | If "Yes," did the organization notify the donor of the value of the goods or services provided?  |            |    |
| <b>c</b>   | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?   |            | X  |
| <b>d</b>   | If "Yes," indicate the number of Forms 8282 filed during the year  |            |    |
|            | <b>7d</b>  |            |    |
| <b>e</b>   | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?  |            |    |
| <b>f</b>   | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?   |            |    |
| <b>g</b>   | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?   |            |    |
| <b>h</b>   | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?   |            |    |
| <b>8</b>   | <b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?   |            |    |
| <b>9</b>   | <b>Sponsoring organizations maintaining donor advised funds.</b>   |            |    |
| <b>a</b>   | Did the sponsoring organization make any taxable distributions under section 4966?   |            |    |
| <b>b</b>   | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?  |            |    |
| <b>10</b>  | <b>Section 501(c)(7) organizations.</b> Enter:   |            |    |
| <b>a</b>   | Initiation fees and capital contributions included on Part VIII, line 12   | <b>10a</b> |    |
| <b>b</b>   | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities  | <b>10b</b> |    |
| <b>11</b>  | <b>Section 501(c)(12) organizations.</b> Enter:  |            |    |
| <b>a</b>   | Gross income from members or shareholders  | <b>11a</b> |    |
| <b>b</b>   | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)   | <b>11b</b> |    |
| <b>12a</b> | <b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?  | <b>12a</b> |    |
| <b>b</b>   | If "Yes," enter the amount of tax-exempt interest received or accrued during the year  | <b>12b</b> |    |
| <b>13</b>  | <b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>  |            |    |
| <b>a</b>   | Is the organization licensed to issue qualified health plans in more than one state?<br><b>Note.</b> See the instructions for additional information the organization must report on Schedule O.   | <b>13a</b> |    |
| <b>b</b>   | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans  | <b>13b</b> |    |
| <b>c</b>   | Enter the amount of reserves on hand   | <b>13c</b> |    |
| <b>14a</b> | Did the organization receive any payments for indoor tanning services during the tax year?   | <b>14a</b> | X  |
| <b>b</b>   | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O  | <b>14b</b> |    |

**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<br>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> 14   |     |    |
| <b>b</b>  | Enter the number of voting members included in line 1a, above, who are independent   |     |    |
|           | <b>1b</b> 9  |     |    |
| <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)<br>Name and Title                               | (B)<br>Average hours per week (list any hours for related organizations below line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |          | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>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) FRANCIS X. KNOTT<br>TRUSTEE                     | 1.00<br>2.00  | X   |                       |         |              |                              |          | 0.   | 0.  | 0.  |
| (2) JAMES T. DRESHER, JR.<br>CHAIRMAN/TRUSTEE       | 1.00<br>1.00  | X   |                       | X       |              |                              |          | 0.   | 0.  | 0.  |
| (3) RICHARD BASTINELLI<br>TRUSTEE                   | 1.00  | X   |                       |         |              |                              |          | 0.   | 0.  | 0.  |
| (4) SAMUEL CHRISTOPHER DURSO, M.D.<br>TRUSTEE       | 1.00  | X   |                       |         |              |                              |          | 0.   | 0.  | 0.  |
| (5) DAVID B. HELLMANN, M.D.<br>VP RESEARCH/TRUSTEE  | 59.00<br>1.00   | X   |                       | X       |              |                              | 735,037. | 0.   | 69,991.   |   |
| (6) RONALD R. PETERSON<br>TRUSTEE/VICE CHAIRMAN     | 1.00<br>59.00   | X   |                       | X       |              |                              | 0.       | 2,263,048.   | 502,388.  |   |
| (7) JUDY A. REITZ, SC.D.<br>TRUSTEE                 | 1.00<br>59.00   | X   |                       |         |              |                              | 0.       | 955,506.   | 134,339.  |   |
| (8) MICHAEL SEAN BEATTY<br>TRUSTEE                  | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| (9) STEPHANIE COOPER GREENBERG<br>TRUSTEE           | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| (10) CHARLES SCHEELER<br>VICE CHAIRMAN/TRUSTEE      | 1.00  | X   |                       | X       |              |                              | 0.       | 0.   | 0.  |   |
| (11) SHERIDAN SMITH<br>TRUSTEE                      | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| (12) KENNETH M. STUZIN<br>TRUSTEE                   | 1.00  | X   |                       |         |              |                              | 0.       | 0.   | 0.  |   |
| (13) RONALD J. WERTHMAN<br>TRUSTEE                  | 1.00<br>59.00   | X   |                       |         |              |                              | 0.       | 2,286,146.   | 716,201.  |   |
| (14) RICHARD G. BENNETT, M.D.<br>PRESIDENT/TRUSTEE  | 60.00   | X   |                       | X       |              |                              | 0.       | 859,158.   | 48,350.   |   |
| (15) CRAIG R. BRODIAN<br>VP HUMAN RESOURCES         | 60.00   |   |                       | X       |              |                              | 0.       | 309,006.   | 73,955.   |   |
| (16) CARL FRANCIOLI<br>VP FINANCE                   | 60.00   |   |                       | X       |              |                              | 0.       | 381,165.   | 53,304.   |   |
| (17) CHERYL R. KOCH<br>VP OPERATIONS AND FACILITIES | 60.00   |   |                       | X       |              |                              | 0.       | 279,674.   | 78,593.   |   |



JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

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

| (A)<br>Name and title  | (B)<br>Average hours per week (list any hours for related organizations below line) | (C)<br>Position (do not check more than one box, unless person is both an officer and a director/trustee) |                       |         |              |                              |        | (D)<br>Reportable compensation from the organization (W-2/1099-MISC) | (E)<br>Reportable compensation from related organizations (W-2/1099-MISC) | (F)<br>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) MARIA V. KOSZALKA<br>VP PATIENT CARE SERVICES             | 60.00   |   |                       | X       |              |                              |        | 0.   | 418,096.  | 133,672.  |
| (19) CHARLES B. REULAND, SC.D.<br>VP & COO                     | 18.00<br>42.00  |   |                       | X       |              |                              |        | 0.   | 562,623.  | 52,269.   |
| (20) CAROL SYLVESTER<br>VP CARE MGMT & POP HLTH                | 60.00   |   |                       | X       |              |                              |        | 0.   | 266,762.  | 277,736.  |
| (21) RENEE J. BLANDING, M.D.<br>VP MEDICAL AFFAIRS             | 60.00   |   |                       | X       |              |                              |        | 421,020.   | 0.  | 45,245.   |
| (22) DANIELLE WHARTON<br>VP SUPPORT SERVICES                   | 60.00   |   |                       | X       |              |                              |        | 0.   | 157,208.  | 42,326.   |
| (23) THOMAS B. TRZCINSKI<br>TREASURER                          | 1.00<br>59.00   |   |                       | X       |              |                              |        | 0.   | 301,258.  | 109,427.  |
| (24) PETER MANCINO<br>SECRETARY                                | 1.00<br>59.00   |   |                       | X       |              |                              |        | 0.   | 409,104.  | 41,912.   |
| (25) JILL KEARNEY<br>MEDICAL ADMINISTRATOR                     | 60.00   |   |                       |         | X            |                              |        | 220,373.   | 0.  | 23,528.   |
| (26) KANIKA KHANNA<br>ADMINISTRATOR                            | 50.00   |   |                       |         |              | X                            |        | 208,896.   | 0.  | 40,235.   |
| <b>1b Sub-total</b>  |   |   |                       |         |              |                              |        | 1,585,326.   | 9,448,754.  | 2,443,471.  |
| <b>c Total from continuation sheets to Part VII, Section A</b> |   |   |                       |         |              |                              |        | 760,412.   | 833,719.  | 374,172.  |
| <b>d Total (add lines 1b and 1c)</b>                           |   |   |                       |         |              |                              |        | 2,345,738.   | 10,282,473.   | 2,817,643.  |

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 **273**

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

**Section B. Independent Contractors**

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

| (A)<br>Name and business address                                      | (B)<br>Description of services | (C)<br>Compensation |
|---|--------------------------------|---------------------|
| AMN HEALTHCARE INC.<br>PO BOX 910738, DALLAS, TX 75391                | HEALTHCARE STAFFING            | 12,524,938.         |
| BROADWAY SERVICES, INC., 3709 E. MONUMENT STREET, BALTIMORE, MD 21205 | MANAGMENT SERVICES             | 8,310,919.          |
| MCIC VERMONT, INC., 900 ASHWOOD PKWY, STE 400, ATLANTA, GA 30338      | INSURANCE                      | 3,425,463.          |
| ARAMARK CORPORATION<br>601 LIGHT STREET, BALTIMORE, MD 21230          | FOOD SERVICES                  | 2,951,186.          |
| FSK LAND, 3709 E. MONUMENT STREET, BALTIMORE, MD 21205                | RENT                           | 1,659,416.          |

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 **63**

SEE PART VII, SECTION A CONTINUATION SHEETS



JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

**Part VIII Statement of Revenue**

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

|  |   |   | (A)           | (B)                                | (C)                        | (D)  |  |
|--|---|---|---------------|------------------------------------|----------------------------|--|--|
|  |   |   | Total revenue | Related or exempt function revenue | Unrelated business revenue | 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>   |               |                                    |                            |  |  |
|  | <b>e</b> Government grants (contributions)  | <b>1e</b>   | 4,977,930.    |                                    |                            |  |  |
|  | <b>f</b> All other contributions, gifts, grants, and similar amounts not included above   | <b>1f</b>   | 997,531.      |                                    |                            |  |  |
|  | <b>g</b> Noncash contributions included in lines 1a-1f: \$  |   |               |                                    |                            |  |  |
|  | <b>h Total.</b> Add lines 1a-1f   |   |               | 5,975,461.                         |                            |  |  |
| <b>Program Service Revenue</b>                                       | <b>2 a</b> NET PATIENT SRVC   | <b>Business Code</b><br>621990                        | 554,641,438.  | 554,641,438.                       |                            |  |  |
|  | <b>b</b>  |   |               |                                    |                            |  |  |
|  | <b>c</b>  |   |               |                                    |                            |  |  |
|  | <b>d</b>  |   |               |                                    |                            |  |  |
|  | <b>e</b>  |   |               |                                    |                            |  |  |
|  | <b>f</b> All other program service revenue  |   |               |                                    |                            |  |  |
|  | <b>g Total.</b> Add lines 2a-2f   |   |               | 554,641,438.                       |                            |  |  |
| <b>Other Revenue</b>   | <b>3</b> Investment income (including dividends, interest, and other similar amounts)   |   | 2,082,978.    |                                    |                            | 2,082,978.   |  |
|  | <b>4</b> Income from investment of tax-exempt bond proceeds   |   |               |                                    |                            |  |  |
|  | <b>5</b> Royalties  |   |               |                                    |                            |  |  |
|  | <b>6 a</b> Gross rents  | (i) Real  | 3,606,899.    |                                    |                            |  |  |
|  |   | (ii) Personal   | 0.            |                                    |                            |  |  |
|  |   | <b>b</b> Less: rental expenses                        |               |                                    |                            |  |  |
|  | <b>c</b> Rental income or (loss)  |   | 3,606,899.    |                                    |                            |  |  |
|  | <b>d</b> Net rental income or (loss)  |   |               | 3,606,899.                         | 1,383.                     | 3,605,516.   |  |
|  | <b>7 a</b> Gross amount from sales of assets other than inventory   | (i) Securities  | 12,943,000.   |                                    |                            |  |  |
|  |   | (ii) Other  | 1,477.        |                                    |                            |  |  |
|  |   | <b>b</b> Less: cost or other basis and sales expenses |               | 12,647,597.                        | 0.                         |  |  |
|  |   | <b>c</b> Gain or (loss)                               |               | 295,403.                           | 1,477.                     |  |  |
|  | <b>d</b> Net gain or (loss)   |   |               | 296,880.                           | 296,880.                   |  |  |
|  | <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>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>c</b> Net income or (loss) from gaming activities  |   |               |                                    |                            |  |  |
| <b>10 a</b> Gross sales of inventory, less returns and allowances    | <b>a</b>  | 7,402,203.  |               |                                    |                            |  |  |
|  | <b>b</b> Less: cost of goods sold   |   |               |                                    |                            |  |  |
|  | <b>c</b> Net income or (loss) from sales of inventory   |   | 7,402,203.    |                                    | 7,402,203.                 |  |  |
| <b>Miscellaneous Revenue</b>   |   | <b>Business Code</b>                                  |               |                                    |                            |  |  |
| <b>11 a</b> RETAIL PHARMACY REVENUE                                  | 446110  |   | 18,054,586.   |                                    |                            | 18,054,586.  |  |
| <b>b</b> OTHER OPERATING REV   | 900099  |   | 16,023,750.   | 16,023,750.                        |                            |  |  |
| <b>c</b> ADMIN/MGMT FEES   | 900099  |   | 5,253,657.    |                                    |                            | 5,253,657.   |  |
| <b>d</b> All other revenue   | 900099  |   | 849,739.      | 836,670.                           |                            | 13,069.  |  |
| <b>e Total.</b> Add lines 11a-11d                                    |   |   | 40,181,732.   |                                    |                            |  |  |
| <b>12 Total revenue.</b> See instructions.                           |   |   | 614,187,591.  | 571,798,738.                       | 7,403,586.                 | 29,009,806.  |  |

**JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

**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

| <i>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</i>  | <b>(A)</b><br>Total expenses | <b>(B)</b><br>Program service expenses | <b>(C)</b><br>Management and general expenses | <b>(D)</b><br>Fundraising expenses |
|--|------------------------------|--|---|------------------------------------|
| <b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21  | 202,908.                     | 202,908.                               |   |                                    |
| <b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22   |                              |  |   |                                    |
| <b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16  |                              |  |   |                                    |
| <b>4</b> Benefits paid to or for members   |                              |  |   |                                    |
| <b>5</b> Compensation of current officers, directors, trustees, and key employees  | 243,901.                     |  | 243,901.                                      |                                    |
| <b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)   |                              |  |   |                                    |
| <b>7</b> Other salaries and wages  | 194,451,149.                 | 168,605,913.                           | 25,845,236.                                   |                                    |
| <b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)  | 15,094,997.                  | 13,072,267.                            | 2,022,730.                                    |                                    |
| <b>9</b> Other employee benefits   | 34,284,749.                  | 29,690,593.                            | 4,594,156.                                    |                                    |
| <b>10</b> Payroll taxes  | 14,311,880.                  | 12,394,088.                            | 1,917,792.                                    |                                    |
| <b>11</b> Fees for services (non-employees):   |                              |  |   |                                    |
| <b>a</b> Management  |                              |  |   |                                    |
| <b>b</b> Legal   | 1,582,234.                   | 1,370,215.                             | 212,019.                                      |                                    |
| <b>c</b> Accounting  | 570,730.                     | 494,252.                               | 76,478.                                       |                                    |
| <b>d</b> Lobbying  | 111,233.                     |  | 111,233.                                      |                                    |
| <b>e</b> Professional fundraising services. See Part IV, line 17   |                              |  |   |                                    |
| <b>f</b> Investment management fees  |                              |  |   |                                    |
| <b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch. O.)  | 51,835,846.                  | 47,801,880.                            | 4,033,966.                                    |                                    |
| <b>12</b> Advertising and promotion  | 570,572.                     | 494,115.                               | 76,457.                                       |                                    |
| <b>13</b> Office expenses  | 101,736,194.                 | 87,880,284.                            | 13,855,910.                                   |                                    |
| <b>14</b> Information technology   | 2,420,521.                   | 2,096,171.                             | 324,350.                                      |                                    |
| <b>15</b> Royalties  |                              |  |   |                                    |
| <b>16</b> Occupancy  | 7,238,507.                   | 6,268,547.                             | 969,960.                                      |                                    |
| <b>17</b> Travel   | 642,050.                     |  | 642,050.                                      |                                    |
| <b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials   |                              |  |   |                                    |
| <b>19</b> Conferences, conventions, and meetings   | 481,981.                     | 371,689.                               | 110,292.                                      |                                    |
| <b>20</b> Interest   | 5,051,727.                   | 4,374,796.                             | 676,931.                                      |                                    |
| <b>21</b> Payments to affiliates   |                              |  |   |                                    |
| <b>22</b> Depreciation, depletion, and amortization  | 28,568,248.                  | 24,740,103.                            | 3,828,145.                                    |                                    |
| <b>23</b> Insurance  | 5,946,856.                   | 5,859,950.                             | 86,906.                                       |                                    |
| <b>24</b> Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.) |                              |  |   |                                    |
| <b>a</b> <b>PURCHASED SERVICES - AF</b>  | 107,401,697.                 | 93,009,870.                            | 14,391,827.                                   |                                    |
| <b>b</b> <b>LAB SERVICES</b>   | 12,396,165.                  | 10,735,079.                            | 1,661,086.                                    |                                    |
| <b>c</b> <b>DIETARY (CATERING)</b>   | 4,064,368.                   | 4,059,645.                             | 4,723.  |                                    |
| <b>d</b> <b>PROVIDER CARE - PACE CL</b>  | 3,882,576.                   | 3,882,576.                             |   |                                    |
| <b>e</b> All other expenses  | 12,116,195.                  | 10,685,561.                            | 1,430,634.                                    |                                    |
| <b>25</b> <b>Total functional expenses.</b> Add lines 1 through 24e  | 605,207,284.                 | 528,090,502.                           | 77,116,782.                                   | 0.                                 |
| <b>26</b> <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.                              |                              |  |   |                                    |

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

**JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

Form 990 (2016)

52-1341890 Page **11**

**Part X Balance Sheet**

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

|   |  | (A)<br>Beginning of year |              | (B)<br>End of year |              |
|---|--|--------------------------|--------------|--------------------|--------------|
| <b>Assets</b>   | <b>1</b> Cash - non-interest-bearing .....   |                          | <b>1</b>     | 6,828,445.         |              |
|   | <b>2</b> Savings and temporary cash investments .....  | 27,789,698.              | <b>2</b>     |                    |              |
|   | <b>3</b> Pledges and grants receivable, net .....  | 8,046,933.               | <b>3</b>     | 7,910,877.         |              |
|   | <b>4</b> Accounts receivable, net .....  | 71,195,935.              | <b>4</b>     | 57,154,698.        |              |
|   | <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 .....   | 9,538,740.               | <b>8</b>     | 10,695,262.        |              |
|   | <b>9</b> Prepaid expenses and deferred charges .....   | 1,553,737.               | <b>9</b>     | 1,791,188.         |              |
|   | <b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....   | <b>10a</b> 513,157,475.  |              |                    |              |
|   | <b>b</b> Less: accumulated depreciation .....  | <b>10b</b> 303,156,717.  | 200,283,787. | <b>10c</b>         | 210,000,758. |
|   | <b>11</b> Investments - publicly traded securities .....   | 29,133,688.              | <b>11</b>    | 60,331,256.        |              |
|   | <b>12</b> Investments - other securities. See Part IV, line 11 .....   | 41,825,424.              | <b>12</b>    | 34,441,441.        |              |
|   | <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 .....   | 47,599,826.              | <b>15</b>    | 60,031,478.        |              |
| <b>16 Total assets.</b> Add lines 1 through 15 (must equal line 34) ..... | 436,967,768.   | <b>16</b>                | 449,185,403. |                    |              |
| <b>Liabilities</b>  | <b>17</b> Accounts payable and accrued expenses .....  | 62,770,977.              | <b>17</b>    | 59,244,094.        |              |
|   | <b>18</b> Grants payable .....   |                          | <b>18</b>    |                    |              |
|   | <b>19</b> Deferred revenue .....   |                          | <b>19</b>    |                    |              |
|   | <b>20</b> Tax-exempt bond liabilities .....  | 63,999,315.              | <b>20</b>    | 71,832,845.        |              |
|   | <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 .....  | 292,492,479.             | <b>25</b>    | 271,317,649.       |              |
|   | <b>26 Total liabilities.</b> Add lines 17 through 25 .....   | 419,262,771.             | <b>26</b>    | 402,394,588.       |              |
| <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 .....  | 9,658,064.               | <b>27</b>    | 38,877,317.        |              |
|   | <b>28</b> Temporarily restricted net assets .....  | 4,521,628.               | <b>28</b>    | 3,389,218.         |              |
|   | <b>29</b> Permanently restricted net assets .....  | 3,525,305.               | <b>29</b>    | 4,524,280.         |              |
|   | <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 .....                         | 17,704,997.  | <b>33</b>                | 46,790,815.  |                    |              |
| <b>34</b> Total liabilities and net assets/fund balances .....            | 436,967,768.   | <b>34</b>                | 449,185,403. |                    |              |

Form **990** (2016)

**Part XI Reconciliation of Net Assets**

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

|    |  |    |              |
|----|--|----|--------------|
| 1  | Total revenue (must equal Part VIII, column (A), line 12)  | 1  | 614,187,591. |
| 2  | Total expenses (must equal Part IX, column (A), line 25)   | 2  | 605,207,284. |
| 3  | Revenue less expenses. Subtract line 2 from line 1   | 3  | 8,980,307.   |
| 4  | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))                      | 4  | 17,704,997.  |
| 5  | Net unrealized gains (losses) on investments   | 5  |              |
| 6  | Donated services and use of facilities   | 6  |              |
| 7  | Investment expenses  | 7  |              |
| 8  | Prior period adjustments   | 8  |              |
| 9  | Other changes in net assets or fund balances (explain in Schedule O)   | 9  | 20,105,511.  |
| 10 | Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 46,790,815.  |

**Part XII Financial Statements and Reporting**

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

|   |  | Yes | No |
|---|--|-----|----|
| 1   | Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other   |     |    |
| If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.   |  |     |    |
| 2a  | Were the organization's financial statements compiled or reviewed by an independent accountant?  |     | 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                 |  |     |    |
| 2b  | 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      |  |     |    |
| 2c  | 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.   |  |     |    |
| 3a  | As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?   | X   |    |
| 3b  | 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 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 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> |   | (A) Prior Year | 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). |                |              |

JOHNS HOPKINS BAYVIEW

Schedule A (Form 990 or 990-EZ) 2016 MEDICAL CENTER, INC.

**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)<br>Excess Distributions | (ii)<br>Underdistributions<br>Pre-2016 | (iii)<br>Distributable<br>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

JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

Employer identification number

52-1341890

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<br><b>JOHNS HOPKINS BAYVIEW<br/>                 MEDICAL CENTER, INC.</b> | Employer identification number<br><b>52-1341890</b> |
|--|---|

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

| (a)<br>No. | (b)<br>Name, address, and ZIP + 4 | (c)<br>Total contributions | (d)<br>Type of contribution   |
|------------|-----------------------------------|----------------------------|---|
| 1          | <hr/> <hr/> <hr/>                 | \$ <u>20,000.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 2          | <hr/> <hr/> <hr/>                 | \$ <u>22,500.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 3          | <hr/> <hr/> <hr/>                 | \$ <u>50,000.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 4          | <hr/> <hr/> <hr/>                 | \$ <u>50,000.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 5          | <hr/> <hr/> <hr/>                 | \$ <u>6,000.</u>           | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 6          | <hr/> <hr/> <hr/>                 | \$ <u>10,000.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |



|  |  |
|--|--|
| Name of organization<br><b>JOHNS HOPKINS BAYVIEW<br/>                 MEDICAL CENTER, INC.</b> | Employer identification number<br>52-1341890 |
|--|--|

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

| (a)<br>No. | (b)<br>Name, address, and ZIP + 4 | (c)<br>Total contributions | (d)<br>Type of contribution   |
|------------|-----------------------------------|----------------------------|---|
| 7          | _____<br>_____<br>_____           | \$ 5,000.                  | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 8          | _____<br>_____<br>_____           | \$ 7,500.                  | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 9          | _____<br>_____<br>_____           | \$ 7,500.                  | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 10         | _____<br>_____<br>_____           | \$ 7,500.                  | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 11         | _____<br>_____<br>_____           | \$ 6,000.                  | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 12         | _____<br>_____<br>_____           | \$ 30,046.                 | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |

|  |   |
|--|---|
| Name of organization<br><b>JOHNS HOPKINS BAYVIEW<br/>                 MEDICAL CENTER, INC.</b> | Employer identification number<br><b>52-1341890</b> |
|--|---|

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

| (a)<br>No. | (b)<br>Name, address, and ZIP + 4 | (c)<br>Total contributions | (d)<br>Type of contribution   |
|------------|-----------------------------------|----------------------------|---|
| 13         | <hr/> <hr/> <hr/>                 | \$ <u>58,730.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 14         | <hr/> <hr/> <hr/>                 | \$ <u>50,000.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 15         | <hr/> <hr/> <hr/>                 | \$ <u>1,180,573.</u>       | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 16         | <hr/> <hr/> <hr/>                 | \$ <u>29,848.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 17         | <hr/> <hr/> <hr/>                 | \$ <u>72,152.</u>          | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 18         | <hr/> <hr/> <hr/>                 | \$ <u>1,375,668.</u>       | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |

|  |  |
|--|--|
| Name of organization<br><b>JOHNS HOPKINS BAYVIEW<br/>                 MEDICAL CENTER, INC.</b> | Employer identification number<br>52-1341890 |
|--|--|

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

| (a)<br>No. | (b)<br>Name, address, and ZIP + 4 | (c)<br>Total contributions | (d)<br>Type of contribution   |
|------------|-----------------------------------|----------------------------|---|
| 19         | _____<br>_____<br>_____           | \$ 299,564.                | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 20         | _____<br>_____<br>_____           | \$ 1,871,538.              | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| 21         | _____<br>_____<br>_____           | \$ 39,857.                 | Person <input checked="" type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.) |
| _____      | _____<br>_____<br>_____           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
| _____      | _____<br>_____<br>_____           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |
| _____      | _____<br>_____<br>_____           | \$ _____                   | Person <input type="checkbox"/><br>Payroll <input type="checkbox"/><br>Noncash <input type="checkbox"/><br>(Complete Part II for noncash contributions.)            |

|  |   |
|--|---|
| Name of organization<br><b>JOHNS HOPKINS BAYVIEW<br/>                 MEDICAL CENTER, INC.</b> | Employer identification number<br><b>52-1341890</b> |
|--|---|

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

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

|  |   |
|--|---|
| <b>Name of organization</b><br>JOHNS HOPKINS BAYVIEW<br>MEDICAL CENTER, INC. | <b>Employer identification number</b><br>52-1341890 |
|--|---|

**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>                    |                     |   |                                     |
| <b>Transferee's name, address, and ZIP + 4</b> |                     | <b>Relationship of transferor to transferee</b> |                                     |
|  |                     |   |                                     |
| (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>                    |                     |   |                                     |
| <b>Transferee's name, address, and ZIP + 4</b> |                     | <b>Relationship of transferor to transferee</b> |                                     |
|  |                     |   |                                     |
| (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>                    |                     |   |                                     |
| <b>Transferee's name, address, and ZIP + 4</b> |                     | <b>Relationship of transferor to transferee</b> |                                     |
|  |                     |   |                                     |
| (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>                    |                     |   |                                     |
| <b>Transferee's name, address, and ZIP + 4</b> |                     | <b>Relationship of transferor to transferee</b> |                                     |
|  |                     |   |                                     |

**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>JOHNS HOPKINS BAYVIEW<br/>MEDICAL CENTER, INC.</b> | Employer identification number<br><b>52-1341890</b> |
|--|---|

**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-. |
|----------|-------------|---------|---|--|
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |
|          |             |         |   |  |

JOHNS HOPKINS BAYVIEW

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

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

| Limits on Lobbying Expenditures<br>(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)   | 111,233.  |  |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>c</b>  | Total lobbying expenditures (add lines 1a and 1b)   | 111,233.  |  |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>d</b>  | Other exempt purpose expenditures   | 605,096,051.                                    |  |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>e</b>  | Total exempt purpose expenditures (add lines 1c and 1d)   | 605,207,284.                                    |  |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <b>f</b>  | Lobbying nontaxable amount. Enter the amount from the following table in both columns.  | 1,000,000.                                      |  |                    |                               |   |  |   |  |  |   |                   |              |  |  |
| <table border="1"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>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<br>(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<br>(150% of line 2a, column(e))    |            |            |            |            | 6,000,000. |
| <b>c</b> Total lobbying expenditures                                | 87,741.    | 88,778.    | 99,665.    | 111,233.   | 387,417.   |
| <b>d</b> Grassroots nontaxable amount                               | 250,000.   | 250,000.   | 250,000.   | 250,000.   | 1,000,000. |
| <b>e</b> Grassroots ceiling amount<br>(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)).**

|  | (a) |    | (b)    |
|--|-----|----|--------|
|  | Yes | No | Amount |
| <i>For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.</i>  |     |    |        |
| <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.

---



---



---



---



---



---



---



---



**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.**

OMB No. 1545-0047

**2016**

**Open to Public Inspection**

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

**Name of the organization** **JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.** **Employer identification number** **52-1341890**

**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:

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

|        | Yes | No |
|--------|-----|----|
| 3a(i)  |     |    |
| 3a(ii) |     |    |
| 3b     |     |    |

b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?

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

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

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

| Description of property  | (a) Cost or other basis (investment) | (b) Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|---------------------------------|------------------------------|----------------|
| 1a Land  |                                      | 3,150,000.                      |                              | 3,150,000.     |
| b Buildings  |                                      | 265,373,250.                    | 176,449,062.                 | 88,924,188.    |
| c Leasehold improvements   |                                      | 6,718,010.                      | 1,320,860.                   | 5,397,150.     |
| d Equipment  |                                      | 182,981,842.                    | 115,220,798.                 | 67,761,044.    |
| e Other  |                                      | 54,934,373.                     | 10,165,997.                  | 44,768,376.    |
| <b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) |                                      |                                 |                              | 210,000,758.   |

**JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

**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) MORTGAGE BACKED   |                    |   |
| (B) SECURITIES  | 9,107,630.         | END-OF-YEAR MARKET VALUE                                  |
| (C) EQUITY SECURITIES   | 25,333,811.        | END-OF-YEAR MARKET VALUE                                  |
| (D)   |                    |   |
| (E)   |                    |   |
| (F)   |                    |   |
| (G)   |                    |   |
| (H)   |                    |   |
| <b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶ | <b>34,441,441.</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) INERCOMPANY RECEIVABLES   | 3,476,863.         |
| (2) OTHER RECEIVABLES   | 5,991,583.         |
| (3) DUE FROM OTHERS   | 796,685.           |
| (4) MALPRACTICE FUNDING   | 929,682.           |
| (5) ASSETS-LIM-BY BOARD OF TRUSTEE  | 43,491,819.        |
| (6) INSURANCE RECOVERY  | 5,344,846.         |
| (7)   |                    |
| (8)   |                    |
| (9)   |                    |
| <b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶ | <b>60,031,478.</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) ADVANCES FROM THIRD PARTIES   | 21,044,560.         |
| (3) INTERCOMPANY PAYABLES   | 9,016,905.          |
| (4) MALPRACTICE LIABILITY   | 13,219,476.         |
| (5) WORKERS' COMP TAIL COVERAGE   | 3,188,424.          |
| (6) LONG-TERM PENSION LIABILITY   | 161,233,998.        |
| (7) LOSS ON MARKET VALUE SW   | 5,847,604.          |
| (8) LONG-TERM NOTES PAYABLE   | 57,766,682.         |
| (9)   |                     |
| <b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶ | <b>271,317,649.</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

**JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

**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>  | 610,284,000. |
| <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> |              |
| <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> | 0.           |
| <b>3</b> | Subtract line <b>2e</b> from line <b>1</b>   | <b>3</b>  | 610,284,000. |
| <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> | 3,903,591.   |
| <b>c</b> | Add lines <b>4a</b> and <b>4b</b>  | <b>4c</b> | 3,903,591.   |
| <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>  | 614,187,591. |

**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>  | 599,688,000. |
| <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> | 1,477.       |
| <b>e</b> | Add lines <b>2a</b> through <b>2d</b>   | <b>2e</b> | 1,477.       |
| <b>3</b> | Subtract line <b>2e</b> from line <b>1</b>  | <b>3</b>  | 599,686,523. |
| <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> | 5,520,761.   |
| <b>c</b> | Add lines <b>4a</b> and <b>4b</b>   | <b>4c</b> | 5,520,761.   |
| <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>  | 605,207,284. |

**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'S 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 JHBMC'S FINANCIAL STATEMENTS DURING THE YEARS ENDED JUNE 30, 2017 AND 2016.

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

**Part XIII** Supplemental Information (continued)

|                                       |            |
|---------------------------------------|------------|
| GAIN ON FIXED ASSET                   | 1,477.     |
| REALIZED GAIN ON INVESTMENTS          | 295,403.   |
| ROUNDING                              | -188.      |
| RENTAL REVENUE FROM EXPENSE           | 3,606,899. |
| TOTAL TO SCHEDULE D, PART XI, LINE 4B | 3,903,591. |

PART XII, LINE 2D - OTHER ADJUSTMENTS:

|                     |        |
|---------------------|--------|
| LOSS ON FIXED ASSET | 1,477. |
|---------------------|--------|

PART XII, LINE 4B - OTHER ADJUSTMENTS:

|  |            |
|--|------------|
| INTEREST EXPENSE ON SWAP               | 1,914,058. |
| ROUNDING                               | -196.      |
| REMOVE RENTAL CREDIT IN EXP TO REVENUE | 3,606,899. |
| TOTAL TO SCHEDULE D, PART XII, LINE 4B | 5,520,761. |

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2016**

Department of the Treasury  
Internal Revenue Service

▶ **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).**

**Open to Public Inspection**

**Name of the organization** **JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.** **Employer identification number** **52-1341890**

**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.<br><input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities<br><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.<br><b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care?<br>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) .....   |   |                               | 17,491,599.                         | 0.                            | 17,491,599.                       | 2.89%                        |
| <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 .....                           |   |                               | 17,491,599.                         |                               | 17,491,599.                       | 2.89%                        |
| <b>Other Benefits</b>  |   |                               |                                     |                               |                                   |                              |
| <b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) ..... |   |                               | 12,346,728.                         | 1,725,979.                    | 10,620,749.                       | 1.75%                        |
| <b>f</b> Health professions education (from Worksheet 5) .....   |   |                               | 28,079,897.                         | 0.                            | 28,079,897.                       | 4.64%                        |
| <b>g</b> Subsidized health services (from Worksheet 6) .....   |   |                               | 0.                                  | 0.                            |                                   |                              |
| <b>h</b> Research (from Worksheet 7) .....   |   |                               | 242,956.                            | 30,137.                       | 212,819.                          | .04%                         |
| <b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....                   |   |                               | 2,243,237.                          | 26,904.                       | 2,216,333.                        | .37%                         |
| <b>j Total.</b> Other Benefits .....   |   |                               | 42,912,818.                         | 1,783,020.                    | 41,129,798.                       | 6.80%                        |
| <b>k Total.</b> Add lines 7d and 7j .....  |   |                               | 60,404,417.                         | 1,783,020.                    | 58,621,397.                       | 9.69%                        |







**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 JOHNS HOPKINS BAYVIEW MEDICAL CENTER

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? .....   | 1   | 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 .....  | 2   | 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 .....   | 3   | 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 ..... | 5   | 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 .....  | 6a  | X  |
| b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C .....  | 6b  | X  |
| 7 Did the hospital facility make its CHNA report widely available to the public? .....   | 7   | 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/JOHNS_HOPKINS_BAY</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 .....  | 8   | 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? .....   | 10  | X  |
| a If "Yes," (list url): <u>WWW.HOPKINSMEDICINE.ORG/JOHNS_HOPKINS_BAYVIEW/COMMUN</u>  |     |    |
| b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....   | 10b |    |
| 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)? .....  | 12a | X  |
| b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....   | 12b |    |
| 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 JOHNS HOPKINS BAYVIEW MEDICAL CENTER

|  | 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> %<br>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 checked="" 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 JOHNS HOPKINS BAYVIEW MEDICAL CENTER

|   | 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? ..... | X   |    |
| <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? .....   |     | X  |
| 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? ..... | X |  |
| 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 JOHNS HOPKINS BAYVIEW MEDICAL CENTER

|           |   | 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? .....<br>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? .....<br>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.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER:

PART V, SECTION B, LINE 5: JOHNS HOPKINS BAYVIEW MEDICAL CENTER (JHBMC)

TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL THROUGH VARIOUS WAYS LISTED BELOW:

A) PUBLIC COMMENTS RELATED TO THE 2013 COMMUNITY HEALTH NEEDS ASSESSMENT

(CHNA) AND 2014 IMPLEMENTATION PLAN COMPLETED ON BEHALF OF THE JOHNS

HOPKINS INSTITUTIONS WERE OBTAINED VIA A SURVEY. THE SURVEY WAS

STRATEGICALLY PLACED AT THE MAIN HOSPITAL LOBBY AND IN THE COMMUNITY

RELATIONS OFFICE. THE COLLECTION PERIOD FOR THE PUBLIC COMMENTS BEGAN

AUGUST 2015 AND CONTINUED THROUGH EARLY SEPTEMBER 2015.

B) DURING SEPTEMBER AND OCTOBER 2015 PHONE INTERVIEWS WITH FIFTY-TWO

COMMUNITY STAKEHOLDERS. COMMUNITY STAKEHOLDERS TARGETED FOR INTERVIEWS

ENCOMPASSED A WIDE VARIETY OF PROFESSIONAL BACKGROUNDS INCLUDING: 1)

PUBLIC HEALTH EXPERTISE; 2) PROFESSIONALS WITH ACCESS TO COMMUNITY HEALTH

RELATED DATA; AND 3) REPRESENTATIVES OF UNDERSERVED POPULATIONS. A

DIVERSE REPRESENTATION OF COMMUNITY-BASED ORGANIZATIONS AND AGENCIES WERE

AMOUNT THE 52 STAKEHOLDERS INTERVIEWED.

C) BETWEEN THE MONTHS OF SEPTEMBER AND OCTOBER 2015, TRIPP UMBACH

FACILITATED SIX FOCUS GROUPS WITHIN THE STUDY AREA WITH AT-RISK

POPULATIONS. TARGETED UNDERSERVED FOCUS GROUP AUDIENCES WERE IDENTIFIED

AND SELECTED WITH THE DIRECTION FROM HOSPITAL LEADERSHIP BASED ON THEIR

KNOWLEDGE OF THEIR COMMUNITY BENEFITS SERVICES AREA (CBSA). TIPP UMBACH

WORKED CLOSELY WITH COMMUNITY-BASED ORGANIZATIONS AND THEIR

REPRESENTATIVES TO SCHEDULE, RECRUIT AND FACILITATE FOCUS GROUPS WITHIN

EACH OF THE AT-RISK COMMUNITIES.

D) TRIPP UMBACH EMPLOYED A HAND-DISTRIBUTION METHODOLOGY TO DISSEMINATE

**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.

SURVEYS TO INDIVIDUALS WITHIN THE CBSA. A HAND SURVEY WAS UTILIZED TO COLLECT INPUT, IN PARTICULAR, FROM UNDERSERVED POPULATIONS. THE HAND SURVEY, AVAILABLE IN BOTH ENGLISH AND SPANISH, WAS DESIGNED TO CAPTURE AND IDENTIFY THE HEALTH RISK FACTORS AND HEALTH NEEDS OF THOSE WITHIN THE STUDY AREA. THE HAND SURVEY COLLECTION PROCESS WAS IMPLEMENTED DURING SEPTEMBER AND OCTOBER 2015. TRIPP UMBACH WORKED WITH COMMUNITY-BASED ORGANIZATIONS TO COLLECT AND DISTRIBUTE THE SURVEYS TO END-USERS IN THE UNDERSERVED POPULATIONS. ENGAGEMENT OF LOCAL COMMUNITY ORGANIZATIONS WAS VITAL TO THE SURVEY DISTRIBUTION PROCESS.

E) A REGIONAL COMMUNITY PLANNING FORUM WAS HELD AT BREATH OF GOD LUTHERAN CHURCH IN BALTIMORE, MD ON DECEMBER 7, 2015. OVER 30 COMMUNITY LEADERS ATTENDED THE EVENT REPRESENTING A VARIETY OF COMMUNITY ORGANIZATIONS, HEALTH AND HUMAN SERVICES AGENCIES, HEALTH INSTITUTIONS AND ADDITIONAL COMMUNITY AGENCIES.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER:

PART V, SECTION B, LINE 6A: JHBMC CONDUCTED ITS CHNA WITH THE JOHNS HOPKINS HOSPITAL (JHH).

JOHNS HOPKINS BAYVIEW MEDICAL CENTER:

PART V, SECTION B, LINE 11: THE JHBMC IMPLEMENTATION STRATEGY FOR THE CHNA SPELLS OUT IN CONSIDERABLE DETAIL WAYS THAT JHBMC INTENDS TO ADDRESS THE MULTIPLE HEALTH NEEDS OF OUR COMMUNITY IN OUR TEN PRIORITY AREAS. AS THE HOSPITAL BEGINS TO USE THIS VALUABLE TOOL, THE IMPLEMENTATION STRATEGY ITSELF SHOULD BE CONSIDERED A DYNAMIC DOCUMENT AND MAY CHANGE AS JHH GAINS

**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.

**EXPERIENCE IN IMPLEMENTING PROGRAMS AND MEASURING OUTCOMES.**

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

PART V, LINE 16A, FAP WEBSITE:

WWW.HOPKINSMEDICINE.ORG/PATIENT\_CARE/PAY\_BILL/ASSISTANCE\_POLICIES.HTML

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

PART V, LINE 16B, FAP APPLICATION WEBSITE:

WWW.HOPKINSMEDICINE.ORG/PATIENT\_CARE/PAY\_BILL/PAYMENT\_ASSISTANCE.HTML

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

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

WWW.HOPKINSMEDICINE.ORG/PATIENT\_CARE/PAY\_BILL/PAYMENT\_ASSISTANCE.HTML

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.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

---

**PART I, LINE 7:**

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

---

**PART I, LINE 7G:**

JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC. DOES NOT HAVE ANY SUBSIDIZED HEALTH SERVICES.

---

**PART II, COMMUNITY BUILDING ACTIVITIES:**

JHBMC'S COMMUNITY BUILDING ACTIVITIES PROMOTE THE HEALTH OF THE COMMUNITY IT SERVES THROUGH THE WORK OF THE COMMUNITY RELATIONS DEPARTMENT. THE DEPARTMENT INTERFACES WITH A BROAD RANGE OF NON-PROFIT, BUSINESS AND COMMUNITY ORGANIZATIONS TO SUPPORT INITIATIVES THAT IMPROVE THE WELL-BEING OF THE COMMUNITY, ADDRESSING HEALTH, HOUSING, ECONOMIC DEVELOPMENT, TRANSPORTATION AND SAFETY ISSUES WITH THEIR COMMUNITY PARTNERS.

**Part VI** Supplemental Information

Provide the following information.

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

---



---

PART III, LINE 2:

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.

---



---

PART III, LINE 3:

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, JHBMC 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.

---



---

PART III, LINE 4:

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

**Part VI** Supplemental Information

Provide the following information.

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

---

**PART 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:**

THE CHNA WAS COORDINATED AND CONDUCTED PRIMARILY BY THE DIRECTOR OF COMMUNITY RELATIONS AND STAFF, GUIDED BY A STEERING COMMITTEE OF CAMPUS AND COMMUNITY LEADERS CO-CHAIRLED BY THE HOSPITAL PRESIDENT AND A TRUSTEE.

---

THE METHODOLOGY FOR THE CHNA INCLUDED THE COLLECTION OF DEMOGRAPHIC, HOSPITAL AND OTHER SECONDARY DATA, REVIEW OF BALTIMORE CITY, BALTIMORE COUNTY, MARYLAND, AND FEDERAL HEALTH PRIORITIES AND PLANS, A SURVEY OF COMMUNITY MEMBERS, A PUBLIC FORUM, INTERVIEWS WITH KEY STAKEHOLDERS AND

---

**Part VI Supplemental Information**

Provide the following information.

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

LEADERS, INFORMATION FROM THE JOHNS HOPKINS HOSPITAL'S LATINO FOCUS GROUP,  
AND A GROUP INTERVIEW WITH THE JOHNS HOPKINS BAYVIEW CHILDREN'S PRACTICE  
LATINO PATIENT AND FAMILY ADVISORY BOARD.

THE COMMUNITY SURVEYS AND INTERVIEW INFORMATION WERE COMPILED AND ANALYZED  
TO IDENTIFY KEY ISSUES.

TO ESTABLISH PRIORITIES, JHBMC SYNTHESIZED THE NEEDS ASSESSMENT DATA,  
HEAVILY WEIGHTED BY FEEDBACK FROM THE COMMUNITIES, AS WELL AS CONSIDERED  
THE HOSPITAL'S STRENGTHS AND ASSETS, LOCAL AND STATE PUBLIC HEALTH  
PRIORITIES, AND OTHER HOSPITALS' PLANS AFFECTING THE SPECIFIC CBSA  
POPULATION. IN ADDITION TO SURVEYS AND INTERVIEWS WITH COMMUNITY LEADERS,  
JHBMC WORKED WITH NUMEROUS COMMITTEES, COUNCILS AND COALITIONS TO  
DETERMINE THE SELECTION OF THE HEALTH PRIORITIES. OPPORTUNITIES TO  
COLLABORATE AND AVOID DUPLICATION OF EFFORT WERE KEY FACTORS.

THE CHNA STEERING COMMITTEE MET TO REVIEW THE SECONDARY DATA AND FEEDBACK  
FROM THE SURVEY, FOCUS GROUP AND INTERVIEWS. THE GROUP ALSO MET AT KEY  
POINTS IN THE NEEDS ASSESSMENT PROCESS TO GIVE DIRECTION, IDENTIFY  
RESOURCES, SET PRIORITIES AND RECOMMEND THE FINAL NEEDS ASSESSMENT AND  
IMPLEMENTATION STRATEGY TO THE BOARD OF TRUSTEES FOR APPROVAL.

**Part VI Supplemental Information**

Provide the following information.

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

---



---

**PART VI, LINE 3:**

JHBMCM 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 OFFICE AND AT THE EMERGENCY DEPARTMENT WITHIN JHBMCM. NOTICE OF AVAILABILITY 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. JHBMCM (FINANCIAL COUNSELORS/PATIENT FINANCIAL SERVICES REPRESENTATIVES, SOCIAL SERVICES DEPARTMENT PERSONNEL AND/OR MEDICAL ASSISTANCE/MEDICAID ELIGIBILITY TECHNICIAN) WILL PROVIDE PATIENTS WITH ASSISTANCE IN DETERMINING ELIGIBILITY FOR AND MAKING APPLICATION TO A VARIETY OF SPECIAL ENTITLEMENT PROGRAMS THAT PROVIDE FINANCIAL ASSISTANCE BOTH TOWARD PAYMENT OF MEDICAL BILLS AND GENERAL EXPENSES. THE FINANCE DEPARTMENT, IN CONJUNCTION WITH THE SOCIAL SERVICES DEPARTMENT, WILL INTERVIEW PATIENTS TO DETERMINE POTENTIAL ELIGIBILITY FOR MARYLAND MEDICAL ASSISTANCE AS WELL AS OTHER SPECIAL PROGRAMS.

**Part VI** Supplemental Information

Provide the following information.

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

---



---

**PART VI, LINE 4:**

JHBMC GEOGRAPHIC SERVICE AREA IS URBAN.

THE HOSPITAL CONSIDERS ITS COMMUNITY BENEFIT SERVICE AREA (CBSA) AS THE GEOGRAPHIC AREA CONTAINED WITHIN THE FOLLOWING NINE ZIP CODES: 21202,

21205, 21206, 21213, 21218, 21219, 21222, 21224, AND 21231. THIS AREA

REFLECTS THE POPULATION WITH THE LARGEST USAGE OF THE EMERGENCY

DEPARTMENTS AND THE MAJORITY OF RECIPIENTS OF COMMUNITY CONTRIBUTIONS AND

PROGRAMMING. WITHIN THE CBSA, JHBMC HAS FOCUSED ON CERTAIN TARGET

POPULATIONS SUCH AS THE ELDERLY, AT-RISK CHILDREN AND ADOLESCENTS,

UNINSURED INDIVIDUALS AND HOUSEHOLDS, AND UNDERINSURED AND LOW-INCOME

INDIVIDUALS AND HOUSEHOLDS.

THE GENERAL DATA FOR THIS COMMUNITY BENEFIT SERVICE AREA ARE AS FOLLOWS:

TOTAL POPULATION WAS 305,895 OF WHICH 48.8% WERE MALES AND 51.2% WERE

FEMALES, AVERAGE HOUSEHOLD INCOME WAS \$64,946, 10.3% OF RESIDENTS ARE

UNINSURED, 43.9% OF RESIDENTS ARE COVERED BY MEDICAID/MEDICARE, 19.0% OF

PEOPLE HAD INCOME BELOW THE FEDERAL POVERTY GUIDELINES.

NUMBER OF OTHER HOSPITALS SERVING THE COMMUNITY OR COMMUNITIES: 26

**Part VI Supplemental Information**

Provide the following information.

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

---

FEDERALLY-DESIGNATED MEDICALLY UNDERSERVED AREAS OR POPULATIONS ARE  
PRESENT IN THE COMMUNITY .

---



---

PART VI, LINE 5:

---

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.

---

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:

---

**Part VI Supplemental Information**

Provide the following information.

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

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

2. REVIEW AND APPROVE HOSPITAL RATES ;

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

4. 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 [HTTP://WWW.HSRC.STATE.MD.US/COMMUNITY\\_BENEFITS/DOCUMENTS/ CBR\\_FY2007\\_FINAL\\_REPORT.PDF](http://www.hsrc.state.md.us/community_benefits/documents/cbr_fy2007_final_report.pdf) .

BECAUSE OF THIS UNIQUE STRUCTURE MARYLAND HOSPITALS COMMUNITY BENEFITS NUMBERS WILL NOT COMPARE WITH THE REST OF THE NATIONS HOSPITALS . HOWEVER , MARYLAND HOSPITALS MEET OR EXCEED THE COMMUNITY BENEFIT STANDARD ESTABLISHED BY THE IRS IN 1969 . ADDITIONAL DETAIL ILLUSTRATING THIS CAN



**Part VI** Supplemental Information

Provide the following information.

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

---

BE FOUND WITHIN THIS SCHEDULE H REPORT.

---



---

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 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

**Part VI** Supplemental Information

Provide the following information.

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

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:

THE JOHNS HOPKINS HEALTH SYSTEM CORPORATION (JHHSC) IS INCORPORATED IN THE STATE OF MARYLAND TO, AMONG OTHER THINGS, FORMULATE POLICY AMONG AND PROVIDE CENTRALIZED MANAGEMENT FOR JHHSC AND AFFILIATES (JHHS). 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.

**Part VI** Supplemental Information

Provide the following information.

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

JHHSC 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 **JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.** Employer identification number  
**52-1341890**

**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 |
|--|----------------|--|---------------------------------|--|--|--|---|
| CHESAPEAKE GATEWAY CHAMBER OF COMMERCE - 405 WILLIAMS COURT SUITE 108 - BALTIMORE, MD 21220            | 52-0663241     | 501(C)(6)                              | 7,500.                          | 0.                                       |  |  | COMMUNITY OUTREACH                        |
| DUNDALK RENAISSANCE CORPORATION 11 CENTER PLACE 1ST FLOOR DUNDALK, MD 21222                            | 52-2306483     | 501(C)(3)                              | 35,000.                         | 0.                                       |  |  | COMMUNITY OUTREACH                        |
| SOUTHEAST COMMUNITY DEVELOPMENT CORPORATION - 3700 EASTERN AVENUE - BALTIMORE, MD 21224                | 52-1034460     | 501(C)(3)                              | 85,000.                         | 0.                                       |  |  | COMMUNITY OUTREACH                        |
| MERIT PROGRAM 5200 EASTERN AVENUE, SUITE 385 BALTIMORE, MD 21224                                       | 47-1139530     | 501(C)(3)                              | 33,000.                         | 0.                                       |  |  | COMMUNITY OUTREACH                        |
| BALTIMORE COUNTY CHAMBER OF COMMERCE - 102 W PENNSYLVANIA AVENUE #101 - TOWSON, MD 21204               | 52-0745702     | 501(C)(3)                              | 5,025.                          | 0.                                       |  |  | COMMUNITY OUTREACH                        |
| COMMUNITY COLLEGE OF BALTIMORE COUNTY FOUNDATION, INC. - 7200 SOLLERS POINT ROAD - BALTIMORE, MD 21222 | 20-3246676     | 501(C)(3)                              | 5,750.                          | 0.                                       |  |  | COMMUNITY OUTREACH                        |

- 2** Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 6.
- 3** Enter total number of other organizations listed in the line 1 table ▶ 1.

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

Schedule I (Form 990) (2016)



**JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

**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 JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 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 **JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

Employer identification number  
**52-1341890**

**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 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

JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

Schedule J (Form 990) 2016

52-1341890

Page 2

**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) DAVID B. HELLMANN, M.D.<br>VP RESEARCH/TRUSTEE | (i)  | 422,691.   | 216,500.                            | 95,846.                             | 51,706.  | 18,285.                 | 805,028.                        | 95,846.   |
|  | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (2) RONALD R. PETERSON<br>TRUSTEE/VICE CHAIRMAN    | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 1,409,062.   | 705,810.                            | 148,176.                            | 477,286.                                       | 25,102.                 | 2,765,436.                      | 0.  |
| (3) JUDY A. REITZ, SC.D.<br>TRUSTEE                | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 327,369.   | 217,436.                            | 410,701.                            | 121,832.                                       | 12,507.                 | 1,089,845.                      | 292,653.  |
| (4) RONALD J. WERTHMAN<br>TRUSTEE                  | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 773,591.   | 387,036.                            | 1,125,519.                          | 691,805.                                       | 24,396.                 | 3,002,347.                      | 528,741.  |
| (5) RICHARD G. BENNETT, M.D.<br>PRESIDENT/TRUSTEE  | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 561,190.   | 189,586.                            | 108,382.                            | 37,107.  | 11,243.                 | 907,508.                        | 0.  |
| (6) CRAIG R. BRODIAN<br>VP HUMAN RESOURCES         | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 232,863.   | 54,195.                             | 21,948.                             | 47,440.  | 26,515.                 | 382,961.                        | 0.  |
| (7) CARL FRANCIOLI<br>VP FINANCE                   | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 292,361.   | 67,194.                             | 21,610.                             | 26,228.  | 27,076.                 | 434,469.                        | 0.  |
| (8) CHERYL R. KOCH<br>VP OPERATIONS AND FACILITIES | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 209,665.   | 51,024.                             | 18,985.                             | 51,439.  | 27,154.                 | 358,267.                        | 0.  |
| (9) MARIA V. KOSZALKA<br>VP PATIENT CARE SERVICES  | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 263,022.   | 62,618.                             | 92,456.                             | 114,958.                                       | 18,714.                 | 551,768.                        | 53,176.   |
| (10) CHARLES B. REULAND, SC.D.<br>VP & COO         | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 407,210.   | 112,542.                            | 42,871.                             | 26,064.  | 26,205.                 | 614,892.                        | 0.  |
| (11) CAROL SYLVESTER<br>VP CARE MGMT & POP HLTH    | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 208,861.   | 46,675.                             | 11,226.                             | 254,898.                                       | 22,838.                 | 544,498.                        | 0.  |
| (12) RENEE J. BLANDING, M.D.<br>VP MEDICAL AFFAIRS | (i)  | 343,232.   | 77,288.                             | 500.                                | 41,571.  | 3,674.                  | 466,265.                        | 0.  |
|  | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (13) DANIELLE WHARTON<br>VP SUPPORT SERVICES       | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 142,600.   | 0.                                  | 14,608.                             | 15,768.  | 26,558.                 | 199,534.                        | 0.  |
| (14) THOMAS B. TRZCINSKI<br>TREASURER              | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 232,316.   | 58,151.                             | 10,791.                             | 83,509.  | 25,918.                 | 410,685.                        | 8,422.  |
| (15) PETER MANCINO<br>SECRETARY                    | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|  | (ii) | 265,642.   | 51,625.                             | 91,837.                             | 19,521.  | 22,391.                 | 451,016.                        | 38,992.   |
| (16) JILL KEARNEY<br>MEDICAL ADMINISTRATOR         | (i)  | 174,230.   | 30,100.                             | 16,043.                             | 13,436.  | 10,092.                 | 243,901.                        | 0.  |
|  | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |



JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

**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) KANIKA KHANNA<br>ADMINISTRATOR             | (i)  | 168,931.   | 0.                                  | 39,965.                             | 19,858.  | 20,377.                 | 249,131.                        | 0.  |
|   | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (18) WILLIAM HALE<br>SPECIAL ADVISOR            | (i)  | 183,330.   | 0.                                  | 18,800.                             | 38,935.  | 11,614.                 | 252,679.                        | 0.  |
|   | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (19) JANET MCINTYRE<br>SR DIR PATIENT SAFETY    | (i)  | 166,740.   | 0.                                  | 15,222.                             | 51,409.  | 10,410.                 | 243,781.                        | 0.  |
|   | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (20) ROBERT BARTLETT<br>PSYCHIATRY ADMINISTATOR | (i)  | 137,483.   | 0.                                  | 61,804.                             | 23,137.  | 2,864.                  | 225,288.                        | 0.  |
|   | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (21) BRUCE BLAYLOCK<br>SR ADMINISTRATOR         | (i)  | 155,012.   | 0.                                  | 22,021.                             | 20,659.  | 28,417.                 | 226,109.                        | 0.  |
|   | (ii) | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
| (22) DAN SHEALER<br>FORMER OFFICER              | (i)  | 0.   | 0.                                  | 0.                                  | 0.   | 0.                      | 0.                              | 0.  |
|   | (ii) | 515,473.   | 156,663.                            | 161,583.                            | 172,782.                                       | 13,945.                 | 1,020,446.                      | 113,292.  |
|   | (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, LINE 4B:**

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 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

**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.

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.

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 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

**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 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 DEFERRED COMPENSATION THAT IS REPORTED ON SCHEDULE J, PART II, COLUMN (C):  
JUDY REITZ \$95,699; G. DANIEL SHEALER, JR. \$140,205; RONALD WERTHMAN \$641,448; MARIA KOSZALKA \$68,096; CAROL SYLVESTER \$4,280; AND RONALD PETERSON \$473,624.

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

**Part III Supplemental Information**

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

SCHEDULE J, PART II, COLUMN (F) IF THEY WERE REQUIRED TO BE DISCLOSED ON  
PRIOR YEAR'S FORMS 990:

MARIA KOSZALKA \$73,212; JUDY RETIZ \$366,930; G. DANIEL SHEALER, JR.

\$138,732; RONALD WERTHMAN \$1,094,157; RICHARD BENNETT \$85,512; CARL

FRANCIOLI \$6,100; CHERYL KOCH \$6,280; PETER MANCINO \$43,971; AND CHARLES

REULAND \$14,180.

PART I, LINE 7:

BONUSES: THE BONUSES ARE ISSUED 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.

DEPENDENT TUITION REIMBURSEMENT: THE DEPENDENT TUITION REIMBURSEMENT

PROGRAM REIMBURSES EMPLOYEES FOR 50% LESS TAXES OF EACH DEPENDENT CHILD'S

FULL TIME UNDERGRADUATION TUITION AND MANDATORY ACADEMIC FEES, UP TO A

MAXIMUM OF 50% OF THE JOHNS HOPKINS UNIVERSITY'S FRESHMAN UNDERGRADUATE

TUITION FOR EACH ELIGIBLE DEPENDENT. EMPLOYEES WHO HAVE A MINIMUM OF TWO

YEARS OF CONTINUOUS SERVICE ARE ELIGIBLE. THE DEPENDENT MUST BE ENROLLED

**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.

FULL TIME AT AN APPROVED, ACCREDITED COLLEGE OR UNIVERSITY AND IN GOOD  
ACADEMIC STANDING. PAYMENT IS LIMITED TO FOUR YEARS OF FULL TIME,  
UNDERGRADUATE STUDY PER DEPENDENT CHILD.

PART VII, SECTION A, QUESTION 5

THE FOLLOWING OFFICERS OF JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.  
ARE PAID AND REPORTED BY THE JOHNS HOPKINS UNIVERSITY (EIN 52-0595110).  
THE JOHNS HOPKINS UNIVERSITY (JHU) IS A 501(C)(3) NOT DIRECTLY RELATED  
TO JHBMC. JHBMC REIMBURSES JOHNS HOPKINS UNIVERSITY FOR THE  
COMPENSATION AND THE AMOUNTS ARE REPORTED ON THE 990 AS PURCHASED  
SERVICES IN FUNCTIONAL EXPENSE. THE SERVICES PROVIDED TO THE FILING  
ORGANIZATION ARE PAID THROUGH A CHARGEBACK BETWEEN THE FILING  
ORGANIZATION AND JHU.

RENEE BLANDING - BASE COMPENSATION \$343,232, BONUS & INCENTIVE  
COMPENSATION \$77,288, OTHER REPORTABLE COMPENSATION \$500, DEFERRED  
COMPENSATION \$41,571 AND NON TAXABLE BENEFITS \$3,674 AND DAVID HELLMANN  
- BASE COMPENSATION \$422,691, BONUS & INCENTIVE COMPENSATION \$216,500,  
OTHER REPORTABLE COMPENSATION \$95,846.00, DEFERRED COMPENSATION \$51,706  
AND NON TAXABLE BENEFITS \$18,285.



**Supplemental Information on Tax-Exempt Bonds**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

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

Name of the organization **JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.** Employer identification number **52-1341890**

| Part I | Bond Issues       | SEE PART VI FOR COLUMN (F) CONTINUATIONS |                |             |                 |                                 |                            |              |    |                         |    |                      |    |
|--------|-------------------|--|----------------|-------------|-----------------|---------------------------------|----------------------------|--------------|----|-------------------------|----|----------------------|----|
|        |                   | (a) Issuer name                          | (b) Issuer EIN | (c) CUSIP # | (d) Date issued | (e) Issue price                 | (f) Description of purpose | (g) Defeased |    | (h) On behalf of issuer |    | (i) Pooled financing |    |
|        |                   |  |                |             |                 |                                 |                            | Yes          | No | Yes                     | No | Yes                  | No |
| A      | MHHEFA - 2004B CP | 52-0936091                               | 57421V3AA      | 02/09/04    | 101,990,000.    | REFUND PRIOR ISSUES (7/21/1993) |                            | X            |    | X                       |    | X                    |    |
| B      |                   |  |                |             |                 |                                 |                            |              |    |                         |    |                      |    |
| C      |                   |  |                |             |                 |                                 |                            |              |    |                         |    |                      |    |
| D      |                   |  |                |             |                 |                                 |                            |              |    |                         |    |                      |    |

| Part II | Proceeds   | A            |    | B   |    | C   |    | D   |    |
|---------|--|--------------|----|-----|----|-----|----|-----|----|
| 1       | Amount of bonds retired  | 43,995,000.  |    |     |    |     |    |     |    |
| 2       | Amount of bonds legally defeased   |              |    |     |    |     |    |     |    |
| 3       | Total proceeds of issue  | 101,990,000. |    |     |    |     |    |     |    |
| 4       | Gross proceeds in reserve funds  |              |    |     |    |     |    |     |    |
| 5       | Capitalized interest from proceeds   |              |    |     |    |     |    |     |    |
| 6       | Proceeds in refunding escrows  |              |    |     |    |     |    |     |    |
| 7       | Issuance costs from proceeds   |              |    |     |    |     |    |     |    |
| 8       | Credit enhancement from proceeds   |              |    |     |    |     |    |     |    |
| 9       | Working capital expenditures from proceeds   |              |    |     |    |     |    |     |    |
| 10      | Capital expenditures from proceeds   |              |    |     |    |     |    |     |    |
| 11      | Other spent proceeds   | 101,990,000. |    |     |    |     |    |     |    |
| 12      | Other unspent proceeds   |              |    |     |    |     |    |     |    |
| 13      | Year of substantial completion   |              |    |     |    |     |    |     |    |
|         |  | Yes          | No | Yes | No | Yes | No | Yes | No |
| 14      | Were the bonds issued as part of a current refunding issue?  | X            |    |     |    |     |    |     |    |
| 15      | Were the bonds issued as part of an advance refunding issue?   |              | X  |     |    |     |    |     |    |
| 16      | Has the final allocation of proceeds been made?  | X            |    |     |    |     |    |     |    |
| 17      | Does the organization maintain adequate books and records to support the final allocation of proceeds? | X            |    |     |    |     |    |     |    |

| Part III | Private Business Use   | A   |    | B   |    | C   |    | D   |    |
|----------|--|-----|----|-----|----|-----|----|-----|----|
|          |  | Yes | No | Yes | No | Yes | No | Yes | No |
| 1        | Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? |     |    |     |    |     |    |     |    |
| 2        | Are there any lease arrangements that may result in private business use of bond-financed property?                        |     |    |     |    |     |    |     |    |



JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

**Part III Private Business Use** (Continued)

|   | A   |    | B   |    | C   |    | D   |    |
|---|-----|----|-----|----|-----|----|-----|----|
|   | Yes | No | Yes | No | Yes | No | Yes | No |
| <b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? .....  |     |    |     |    |     |    |     |    |
| <b>b</b> If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?   |     |    |     |    |     |    |     |    |
| <b>c</b> Are there any research agreements that may result in private business use of bond-financed property?   |     |    |     |    |     |    |     |    |
| <b>d</b> If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? .....   |     |    |     |    |     |    |     |    |
| <b>4</b> Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government .....  |     | %  |     | %  |     | %  |     | %  |
| <b>5</b> Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ..... |     | %  |     | %  |     | %  |     | %  |
| <b>6</b> Total of lines 4 and 5 .....   |     | %  |     | %  |     | %  |     | %  |
| <b>7</b> Does the bond issue meet the private security or payment test? .....   |     |    |     |    |     |    |     |    |
| <b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?   |     |    |     |    |     |    |     |    |
| <b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of .....  |     | %  |     | %  |     | %  |     | %  |
| <b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? .....  |     |    |     |    |     |    |     |    |
| <b>9</b> Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2? .....                           |     |    |     |    |     |    |     |    |

**Part IV Arbitrage**

|  | A   |    | B   |    | C   |    | D   |    |
|--|-----|----|-----|----|-----|----|-----|----|
|  | Yes | No | Yes | No | Yes | No | Yes | No |
| <b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? .....    |     | X  |     |    |     |    |     |    |
| <b>2</b> If "No" to line 1, did the following apply? .....   |     |    |     |    |     |    |     |    |
| <b>a</b> Rebate not due yet? .....   |     | X  |     |    |     |    |     |    |
| <b>b</b> Exception to rebate? .....  | X   |    |     |    |     |    |     |    |
| <b>c</b> No rebate due? .....  |     | X  |     |    |     |    |     |    |
| If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed .....                                    |     |    |     |    |     |    |     |    |
| <b>3</b> Is the bond issue a variable rate issue? .....  | X   |    |     |    |     |    |     |    |
| <b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? ..... |     | X  |     |    |     |    |     |    |
| <b>b</b> Name of provider .....  |     |    |     |    |     |    |     |    |
| <b>c</b> Term of hedge .....   |     |    |     |    |     |    |     |    |
| <b>d</b> Was the hedge superintegrated? .....  |     |    |     |    |     |    |     |    |
| <b>e</b> Was the hedge terminated? .....   |     |    |     |    |     |    |     |    |

JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

**Part IV Arbitrage** (Continued)

|   | A   |    | B   |    | C   |    | D   |    |
|---|-----|----|-----|----|-----|----|-----|----|
|   | Yes | No | Yes | No | Yes | No | Yes | No |
| 5a Were gross proceeds invested in a guaranteed investment contract (GIC)?                        |     | X  |     |    |     |    |     |    |
| b Name of provider  |     |    |     |    |     |    |     |    |
| c Term of GIC   |     |    |     |    |     |    |     |    |
| d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?     |     |    |     |    |     |    |     |    |
| 6 Were any gross proceeds invested beyond an available temporary period?                          |     | X  |     |    |     |    |     |    |
| 7 Has the organization established written procedures to monitor the requirements of section 148? | X   |    |     |    |     |    |     |    |

**Part V Procedures To Undertake Corrective Action**

|   | A   |    | B   |    | C   |    | D   |    |
|---|-----|----|-----|----|-----|----|-----|----|
|   | Yes | No | Yes | No | Yes | No | Yes | No |
| Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations? | X   |    |     |    |     |    |     |    |

**Part VI Supplemental Information.** Provide additional information for responses to questions on Schedule K. See instructions

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: MHHEFA - 2004B CP

(F) DESCRIPTION OF PURPOSE: REFUND PRIOR ISSUES (7/21/1993)

SCHEDULE K, PART II, COLUMN A, LINE 11

THE OTHER SPENT PROCEEDS ARE THE REFUNDING PROCEEDS OF THE ISSUE THAT ARE NO LONGER IN ESCROW

SCHEDULE K, PART III, COLUMN A

THE SOLE PURPOSE OF THE 2004B COMMERCIAL PAPER WAS THE REFUNDING OF AN ISSUE DATED PRIOR TO 12/31/2002 AND THEREFORE IS NOT REQUIRED TO COMPLETE PART III OF SCHEDULE K

**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

JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

Employer identification number  
52-1341890

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

HEALTH CARE THAT IS FOCUSED ON THE UNIQUENESS AND DIGNITY OF EACH  
PERSON WE SERVE. WE OFFER THIS CARE IN AN ENVIRONMENT THAT PROMOTES,  
EMBRACES AND HONORS THE DIVERSITY OF OUR GLOBAL COMMUNITY. WITH A RICH  
AND LONG TRADITION OF MEDICAL CARE, EDUCATION AND RESEARCH, WE ARE  
DEDICATED TO PROVIDING AND ADVANCING MEDICINE THAT IS RESPECTFUL AND  
NURTURING OF THE LIVES OF THOSE WE TOUCH.

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

SCIENCE, CLINICAL CARE, HEALTH SERVICES DELIVERY, AND MEDICAL  
EDUCATION, ADMINISTRATION OF MEDICAL ACTIVITIES.

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

NATIONAL LEADERS IN MANY AREAS, INCLUDING GERIATRIC MEDICINE. IN  
ADDITION TO THE EXPERT CARE PROVIDED BY OUR OWN STAFF, ACCESS TO THE  
SPECIALIZED STAFF, SERVICES AND FACILITIES OF THE ADJACENT JOHNS  
HOPKINS BAYVIEW MEDICAL CENTER ENSURES CONTINUITY OF CARE FOR PATIENTS  
AND CONVENIENCE FOR FAMILIES. THE SHP'S INTERDISCIPLINARY TEAM  
INCLUDES PHYSICIANS, NURSING STAFF, RESPIRATORY THERAPISTS, DIETITIANS,  
RECREATIONAL THERAPISTS, SOCIAL WORKERS, CASE MANAGERS, CARE  
COORDINATORS AND REHABILITATION THERAPISTS. INDIVIDUALIZED TEAMS  
DEVELOP AND CARRY OUT CARE PLANS DESIGNED SPECIFICALLY TO ADDRESS EACH  
PATIENT'S PSYCHOLOGICAL, SOCIAL, PHYSICAL AND SPIRITUAL NEEDS.

FORM 990, PART III, LINE 4D, OTHER PROGRAM SERVICES:

AMONG THE OTHER PROGRAM SERVICES PROVIDED AT JOHNS HOPKINS BAYVIEW

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 | JOHNS HOPKINS BAYVIEW<br>MEDICAL CENTER, INC. | Employer identification number | 52-1341890 |
|--------------------------|---|--------------------------------|------------|

MEDICAL CENTER ANOTHER CRITICAL SERVICE PROVIDED IS THE BURN CENTER.

MARYLAND'S REGIONAL BURN CENTER PROVIDES AN INTERNATIONALLY RECOGNIZED

COMPREHENSIVE PROGRAM OF CARE FOR PATIENTS WITH BURNS AND WOUNDS. OUR

GOAL FOCUSES ON RETURNING PATIENTS TO THEIR HIGHEST LEVEL OF FUNCTION

BY ATTENDING TO THE PHYSICAL, PSYCHOLOGICAL, SOCIAL AND VOCATIONAL

ASPECTS OF THEIR LIVES. OUR SPECIALTY SERVICES INCORPORATE ACUTE ADULT

AND PEDIATRIC BURN TREATMENT, PLASTIC AND RECONSTRUCTIVE BURN SURGERY,

REPAIR OF COMPLEX SURGICAL WOUNDS. THE COMPLEX NATURE OF BURNS AND

THEIR UNIQUE PHYSICAL AND PSYCHOLOGICAL ASPECTS REQUIRE THE EXPERTISE

OF A MULTIDISCIPLINARY TEAM OF PROVIDERS. OUR HEALTH CARE TEAM

CONSISTS OF SPECIALIST SURGEONS, INTENSIVISTS, NURSES, PHYSICAL AND

OCCUPATIONAL THERAPISTS, NUTRITIONISTS, PHARMACISTS, PSYCHOLOGISTS,

SOCIAL WORKERS AND CASE COORDINATORS, AS WELL AS OTHER SUPPORT

SERVICES. WE ARE RECOGNIZED AS A STATE-OF-THE-ART FACILITY, PROVIDING

INDIVIDUALIZED COORDINATED CARE FOR BURN PATIENTS.

EXPENSES \$ 283,813,641. INCL GRANTS OF \$ 202,908. REVENUE \$ 351,410,900.

OTHER PROGRAMS OF JHBMC

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 JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.

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

JOHNS HOPKINS HEALTH SYSTEM CORPORATION, A IRC 501C (3) TAX EXEMPT PARENT

ORGANIZATION OF JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC. ELECTS THE BOARD

OF TRUSTEES.

Name of the organization **JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

Employer identification number  
**52-1341890**

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

THE GOVERNING BODY OF JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 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 WAS PROVIDED 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.



**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 **JOHNS HOPKINS BAYVIEW MEDICAL CENTER, INC.** Employer identification number **52-1341890**

**Part I Identification of Disregarded Entities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

| (a)<br>Name, address, and EIN (if applicable)<br>of disregarded entity | (b)<br>Primary activity | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Total income | (e)<br>End-of-year assets | (f)<br>Direct controlling<br>entity |
|--|-------------------------|---|---------------------|---------------------------|-------------------------------------|
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |
|  |                         |   |                     |                           |                                     |

**Part II Identification of Related Tax-Exempt Organizations.** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

| (a)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity             | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity           | (g)<br>Section 512(b)(13)<br>controlled<br>entity? |    |
|--|-------------------------------------|---|-------------------------------|---|---|--|----|
|  |                                     |   |                               |   |   | Yes  | No |
| JOHNS HOPKINS HEALTH SYSTEM CORPORATION -<br>52-1465301, 3910 KESWICK RD, SOUTH BLDG, 4TH<br>FL, STE. 4300A, BALTIMORE, MD 21211 | SUPPORTING ORGANIZATION             | MARYLAND  | 501(C)(3)                     | 11 TYPE 3 FI  | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| HOWARD COUNTY GENERAL HOSPITAL - 52-2093120<br>5755 CEDAR LANE<br>COLUMBIA, MD 21044   | HOSPITAL                            | MARYLAND  | 501(C)(3)                     | 3   | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| HOWARD COUNTY LIQUIDATION CORPORATION -<br>52-0892284, 5755 CEDAR LANE, COLUMBIA, MD<br>21044                                    | INACTIVE TAX EXEMPT<br>ORGANIZATION | MARYLAND  | 501(C)(3)                     | 3   | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| JOHNS HOPKINS COMMUNITY PHYSICIANS -<br>52-1467441, 3910 KESWICK RD, SOUTH BLDG, 4TH<br>FL, STE. 4300A, BALTIMORE, MD 21211      | HEALTHCARE SERVICES                 | MARYLAND  | 501(C)(3)                     | 11 TYPE 3 FI  | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |

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

Schedule R (Form 990) 2016

SEE PART VII FOR CONTINUATIONS

JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

Schedule R (Form 990)

52-1341890

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

| (a)<br>Name, address, and EIN<br>of related organization  | (b)<br>Primary activity    | (c)<br>Legal domicile (state or<br>foreign country) | (d)<br>Exempt Code<br>section | (e)<br>Public charity<br>status (if section<br>501(c)(3)) | (f)<br>Direct controlling<br>entity           | (g)<br>Section 512(b)(13)<br>controlled<br>organization? |    |
|---|----------------------------|---|-------------------------------|---|---|--|----|
|   |                            |   |                               |   |   | Yes  | No |
| JOHNS HOPKINS HOSPITAL ENDOWMENT CORPORATION<br>- 23-7252596, 3910 KESWICK RD, SOUTH BLDG,<br>4TH FL, STE. 4300A, BALTIMORE, MD 21211 | SUPPORTING ORGANIZATION    | MARYLAND  | 501(C)(3)                     | 11 TYPE 3 FI  | JOHNS HOPKINS<br>HOSPITAL<br>ENDOWMENT        |  | X  |
| JOHNS HOPKINS MEDICAL SERVICES CORPORATION -<br>52-1232569, 3910 KESWICK RD, SOUTH BLDG, 4TH<br>FL, STE. 4300A, BALTIMORE, MD 21211   | HOSPITAL                   | MARYLAND  | 501(C)(3)                     | 3   | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| THE JOHNS HOPKINS HOSPITAL - 52-0591656<br>3910 KESWICK RD, SOUTH BLDG, 4TH FL, STE. 43<br>BALTIMORE, MD 21211                        | HOSPITAL                   | MARYLAND  | 501(C)(3)                     | 3   | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| SUBURBAN HOSPITAL HEALTHCARE SYSTEM, INC. -<br>52-2052354, 8600 OLD GEORGETOWN ROAD,<br>BETHESDA, MD 20814                            | SUPPORTING ORGANIZATION    | MARYLAND  | 501(C)(3)                     | 11 TYPE 3 FI  | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| SUBURBAN HOSPITAL, INC. - 52-0610545<br>8600 OLD GEORGETOWN ROAD<br>BETHESDA, MD 20814  | HOSPITAL                   | MARYLAND  | 501(C)(3)                     | 3   | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| POTOMAC HOME SUPPORT, INC. - 52-1750383<br>6001 MONTROSE ROAD NO 1020<br>ROCKVILLE, MD 20852  | HOME HEALTH CARE           | MARYLAND  | 501(C)(3)                     | 9   | N/A   |  | X  |
| SIBLEY SUBURBAN HOME HEALTH AGENCY -<br>52-1450142, 6001 MONTROSE ROAD NO 307,<br>ROCKVILLE, MD 20852                                 | HOME HEALTH CARE           | MARYLAND  | 501(C)(3)                     | 9   | N/A   |  | X  |
| PEDIATRIC PHYSICIAN SERVICES, INC. -<br>59-3425191, 501 SIXTH AVENUE SOUTH, ST.<br>PETERSBURG, FL 33701                               | PEDIATRIC MEDICAL SERVICES | FLORIDA   | 501(C)(3)                     | 9   | ALL CHILDREN'S<br>HEALTH SYSTEM,<br>INC.      |  | X  |
| ALL CHILDREN'S HOSPITAL FOUNDATION -<br>59-2481738, 501 SIXTH AVENUE SOUTH, ST.<br>PETERSBURG, FL 33701                               | FOUNDATION                 | FLORIDA   | 501(C)(3)                     | 7   | ALL CHILDREN'S<br>HEALTH SYSTEM,<br>INC.      |  | X  |
| ALL CHILDREN'S HOSPITAL - 59-0683252<br>501 SIXTH AVENUE SOUTH<br>ST. PETERSBURG, FL 33701  | HOSPITAL                   | FLORIDA   | 501(C)(3)                     | 3   | JOHNS HOPKINS<br>HEALTH SYSTEM<br>CORPORATION |  | X  |
| ALL CHILDREN'S RESEARCH INSTITUTE, INC. -<br>59-2481742, 501 SIXTH AVENUE SOUTH, ST.<br>PETERSBURG, FL 33701                          | RESEARCH                   | FLORIDA   | 501(C)(3)                     | 4   | ALL CHILDREN'S<br>HEALTH SYSTEM,<br>INC.      |  | X  |
| SURGIKID OF FLORIDA, INC. - 59-3441883<br>501 SIXTH AVENUE SOUTH<br>ST. PETERSBURG, FL 33701  | MEDICAL SERVICES           | FLORIDA   | 501(C)(3)                     | 9   | ALL CHILDREN'S<br>HEALTH SYSTEM,<br>INC.      |  | X  |





JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.

**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)<br>Name, address, and EIN<br>of related organization  | (b)<br>Primary activity   | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Predominant income<br>(related, unrelated,<br>excluded from tax under<br>sections 512-514) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Disproportionate<br>allocations? |    | (i)<br>Code V-UBI<br>amount in box<br>20 of Schedule<br>K-1 (Form 1065) | (j)<br>General or<br>managing<br>partner? |    | (k)<br>Percentage<br>ownership |
|---|---------------------------|---|-------------------------------------|---|---------------------------------|--|---|----|---|---|----|--------------------------------|
|   |                           |   |                                     |   |                                 |  | Yes                                     | No |   | Yes                                       | No |                                |
| OPHTHALMOLOGY ASSOCIATES, LLC<br>- 52-1890957, 3910 KESWICK<br>RD, SOUTH BLDG, 4TH FL, STE.<br>4300A, BALTIMORE, MD 21211 | OPHTHALMOLOGY<br>SERVICES | MD  | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                     |    | N/A   | N/A                                       |    | N/A                            |
| SUBURBAN WELLNESS CENTER, LLC<br>- 56-2296930, 20500 GOLDENROD<br>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 -<br>52-2326237, 1201 SEVEN LOCKS<br>ROAD, STE. 200, ROCKVILLE, MD<br>20854                     | OUTPATIENT<br>RADIOLOGY   | MD  | N/A                                 | N/A   | N/A                             | N/A                                      | N/A                                     |    | N/A   | N/A                                       |    | N/A                            |
| CHEVY CHASE IMAGING, LLC -<br>14-1944126, 1201 SEVEN LOCKS<br>ROAD, STE. 200, ROCKVILLE, MD<br>20854                      | RADIOLOGY<br>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)<br>Name, address, and EIN<br>of related organization   | (b)<br>Primary activity           | (c)<br>Legal domicile<br>(state or<br>foreign<br>country) | (d)<br>Direct controlling<br>entity | (e)<br>Type of entity<br>(C corp, S corp,<br>or trust) | (f)<br>Share of total<br>income | (g)<br>Share of<br>end-of-year<br>assets | (h)<br>Percentage<br>ownership | (i)<br>Section<br>512(b)(13)<br>controlled<br>entity? |    |
|--|-----------------------------------|---|-------------------------------------|--|---------------------------------|--|--------------------------------|---|----|
|  |                                   |   |                                     |  |                                 |  |                                | Yes   | No |
| HOWARD COUNTY HEALTH SERVICES, INC. -<br>52-1434783, 3910 KESWICK RD, SOUTH BLDG, 4TH<br>FL, STE 4300A, BALTIMORE, MD 21211          | HEALTHCARE MANAGEMENT             | MD  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| HSI MEDICAL SERVICES CORPORATION -<br>52-1847705, 3910 KESWICK RD, SOUTH BLDG, 4TH<br>FL, STE 4300A, BALTIMORE, MD 21211             | HEALTHCARE - SLEEP<br>DIAGNOSTICS | MD  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| JOHNS HOPKINS MEDICAL MANAGEMENT CORPORATION<br>- 52-1250028, 3910 KESWICK RD, SOUTH BLDG,<br>4TH FL, STE 4300A, BALTIMORE, MD 21211 | NURSING SERVICES                  | MD  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| JOHNS HOPKINS EMPLOYER HEALTH PROGRAMS, INC.<br>- 52-1947678, 3910 KESWICK RD, SOUTH BLDG,<br>4TH FL, STE 4300A, BALTIMORE, MD 21211 | BENEFIT PLANS                     | MD  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |
| TCAS, INC. - 52-1979344<br>5755 CEDAR LANE<br>COLUMBIA, MD 21044   | NURSING SERVICES                  | MD  | N/A                                 | C CORP   | N/A                             | N/A                                      | N/A                            |   | X  |





**JOHNS HOPKINS BAYVIEW  
MEDICAL CENTER, INC.**

**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)<br>Name of related organization | (b)<br>Transaction<br>type (a-s) | (c)<br>Amount involved | (d)<br>Method of determining amount involved |
|-------------------------------------|----------------------------------|------------------------|--|
| <b>(1)</b>                          |                                  |                        |  |
| <b>(2)</b>                          |                                  |                        |  |
| <b>(3)</b>                          |                                  |                        |  |
| <b>(4)</b>                          |                                  |                        |  |
| <b>(5)</b>                          |                                  |                        |  |
| <b>(6)</b>                          |                                  |                        |  |



**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 CORPORATION

**DIRECT CONTROLLING ENTITY:** JOHNS HOPKINS HOSPITAL ENDOWMENT CORPORATION

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

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

HEALTHCARE SUPPLY CHAIN INNOVATIONS, LLC

**EIN:** 47-2509307

3910 KESWICK RD, SOUTH 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, SOUTH BLDG, 4TH FL, STE. 4300A

BALTIMORE, MD 21211

**DIRECT CONTROLLING ENTITY:** JOHNS HOPKINS MEDICAL MANAGEMENT CORPORATION