

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

OMB No. 1545-0047

2020

Open to Public Inspection

A For the 2020 calendar year, or tax year beginning 07/01, 2020, and ending 06/30, 2021

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC. Doing Business As			D Employer identification number 52-0607913		
	Number and street (or P.O. box if mail is not delivered to street address) Room/suite 2434 WEST BELVEDERE AVENUE		E Telephone number (410) 601-5653			
	City or town, state or province, country, and ZIP or foreign postal code BALTIMORE, MD 21215			G Gross receipts \$ 83,302,609.		
	F Name and address of principal officer: DEBORAH GRAVES SAME AS C ABOVE			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)		
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527						
J Website: ▶ WWW.LIFEBRIDGEHEALTH.ORG/LEVINDALE						
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶						
				L Year of formation: 1892		
				M State of legal domicile: MD		

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: LEVINDALE IS A GERIATRIC CENT. & HOSPITAL DEDICATED TO PROVIDING SUPERIOR SERVICE IN A COST EFFECTIVE MANNER FOR THE AGED, FRAIL AND ILL IN INSTITUTIONAL, COMMUNITY AND HOME SETTINGS			
	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 34.		
	4	Number of independent voting members of the governing body (Part VI, line 1b) 4 33.		
	5	Total number of individuals employed in calendar year 2020 (Part V, line 2a) 5 962.		
	6	Total number of volunteers (estimate if necessary) 6 0.		
	7a	Total unrelated business revenue from Part VIII, column (C), line 12 7a 18,294.		
7b	Net unrelated business taxable income from Form 990-T, line 34 7b 0.			
Revenue	8	Contributions and grants (Part VIII, line 1h) 5,351,502.	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g) 78,285,690.	5,351,502.	1,150,259.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d) 1,406,997.	78,285,690.	72,858,927.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 376,616.	1,406,997.	1,896,715.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) 85,420,805.	376,616.	363,834.
			85,420,805.	76,269,735.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3) 0.	0.	0.
	14	Benefits paid to or for members (Part IX, column (A), line 4) 0.	0.	0.
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) 51,826,095.	51,826,095.	54,801,499.
	16a	Professional fundraising fees (Part IX, column (A), line 11e) 0.	0.	0.
	16b	Total fundraising expenses (Part IX, column (D), line 25) 0.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 28,362,904.	28,362,904.	28,608,389.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) 80,188,999.	80,188,999.	83,409,888.	
19	Revenue less expenses. Subtract line 18 from line 12 5,231,806.	5,231,806.	-7,140,153.	
Net Assets or Fund Balances	20	Total assets (Part X, line 16) 99,789,143.	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26) 51,106,695.	99,789,143.	101,881,010.
	22	Net assets or fund balances. Subtract line 21 from line 20 48,682,448.	51,106,695.	50,853,156.

Part II Signature Block

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

Sign Here	Signature of officer		Date		
	DAVID KRAJEWSKI EXECUTIVE VP/CFO				
Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	MARC BERGER	<i>Marc Berger</i>	5/10/2022		P01871563
	Firm's name ▶ BDO USA, LLP	Firm's EIN ▶ 13-5381590		Phone no. 703-893-0600	

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2020)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

ATTACHMENT 1

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No

[] Yes [X] No

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

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

[] Yes [X] No

If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses \$ 30,200,149. including grants of \$) (Revenue \$ 26,403,981.)

LEVINDALE OPERATES A 120-BED CHRONIC HOSPITAL, WHICH PROVIDES SPECIALTY LONG STAY HOSPITAL SERVICES, REHABILITATION CARE, AND BEHAVIORAL HEALTH CARE. LEVINDALE PROVIDED 28,063 INPATIENT DAYS: 6,615 IN THE HICU UNIT; 2,633 IN THE REHABILITATION UNIT; AND 18,815 IN THE BRAIN HEALTH UNIT.

4b (Code:) (Expenses \$ 28,961,670. including grants of \$) (Revenue \$ 44,236,475.)

LEVINDALE OPERATES A 210-BED NURSING FACILITY, WHICH INCLUDES A 60-BED SUBACUTE UNIT. LEVINDALE PROVIDED 20,307 PATIENT DAYS OF SUBACUTE CARE AND 48,436 DAYS OF INTERMEDIATE NURSING CARE.

4c (Code:) (Expenses \$ 2,515,824. including grants of \$) (Revenue \$ 2,322,635.)

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL PROVIDES ADULT DAY CARE, PARTIAL HOSPITALIZATION, CLINIC SERVICES, AND REHABILITATION SERVICES. LEVINDALE HAS PROVIDED 11,148 DAYS IN ITS ADULT DAY CARE PROGRAM. THE PARTIAL HOSPITALIZATION PROGRAM HAD 1,654 DAYS. OTHER PROGRAM SERVICE EXPENSES INCLUDE CAFETERIA FOR RESIDENTS, VISITORS AND STAFF, AS WELL AS TRANSPORTATION FOR THE ELDERLY TO PROGRAMS RUN BY LEVINDALE.

4d Other program services (Describe on Schedule O.)

(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 61,677,643.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A.</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> See instructions?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I.</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II.</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I.</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	X	
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a 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
10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments-other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	X	
c Did the organization report an amount for investments-program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII.</i>		X
d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX.</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII.</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?.		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i> See instructions		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		X

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

Table with columns for question number, question text, and Yes/No response boxes. Includes questions 2a through 16 regarding employee counts, tax returns, business income, foreign accounts, prohibited transactions, and charitable trusts.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (34), 1b (33), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

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

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD,
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See 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.
- See instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) NEIL M. MELTZER PRESIDENT/CEO/DIR, LIFEBRIDGE	1.00 40.00			X				0.	3,250,231.	742,174.
(2) DAVID KRAJEWSKI EXEC VP/CFO	1.00 40.00			X				0.	1,637,764.	349,999.
(3) LESLIE SIMMONS EXECUTIVE VP	4.00 36.00			X				0.	1,426,322.	282,640.
(4) JASON WEINER SVP AND GENERAL COUNSEL	1.00 40.00			X				0.	875,971.	149,573.
(5) JAMES ROBERGE VP CAPITAL IMPV. & SUPPORT SE	1.00 40.00				X			0.	566,977.	83,753.
(6) DEBORAH GRAVES DIR, PRES & COO, LEVINDALE	40.00 1.00	X		X				545,779.	0.	58,185.
(7) HOLLY PHIPPS ADAMS VP HUMAN RESOURCES, LEVINDALE	1.00 40.00				X			0.	423,838.	83,953.
(8) NANCY KANE VP FINANCIAL REPORTING	1.00 40.00				X			0.	409,523.	93,200.
(9) TERENCE CARNEY VP SUPPLY CHAIN	1.00 40.00				X			0.	467,021.	19,689.
(10) LOU DUNAWAY VP BUDGET & CAPITAL PLANNING	1.00 40.00				X			0.	337,134.	78,944.
(11) ROSS J MAULTASCH AVP OF OPERATIONS	40.00 0.					X		225,794.	0.	32,456.
(12) CAROLINE NGAUJAH REGISTERED NURSE	40.00 0.					X		159,396.	0.	36,353.
(13) ANABELLE MAQUILING REGISTERED NURSE	40.00 0.					X		151,534.	0.	38,286.
(14) MARIA COHEN NURSE MANAGER	40.00 0.					X		153,684.	0.	29,427.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) DIANN FERGUSON REGISTERED NURSE	40.00 0.					X		160,470.	0.	16,466.
(16) LUANN HOLLENBERGER DIR OF PATIENT CARE SERVICES	1.00 40.00				X			21,859.	114,580.	22,014.
(17) KEITH ATTMAN TREASURER	1.00 0.	X		X				0.	240.	0.
(18) GERALD B. FELDMAN, M.D. DIRECTOR	1.00 0.	X						0.	240.	0.
(19) ESTHER JACOBSON DIRECTOR	1.00 0.	X						0.	240.	0.
(20) BRIAN MOFFET DIRECTOR	1.00 0.	X						0.	240.	0.
(21) RICHARD SHATZKIN DIRECTOR	1.00 0.	X						0.	240.	0.
(22) HOWARD PERLOW CHAIRMAN	1.00 0.	X		X				0.	0.	0.
(23) MICHELE SHERMAK, M.D. VICE CHAIR	1.00 0.	X		X				0.	0.	0.
(24) ROBERT SMELKINSON SECRETARY	1.00 0.	X		X				0.	0.	0.
(25) ALLAN C. ALPERSTEIN DIRECTOR	1.00 0.	X						0.	0.	0.
1b Sub-total								1,418,516.	9,510,561.	2,117,112.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								1,418,516.	9,510,561.	2,117,112.

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 ▶ 75

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 2		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 11

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) MARC A. COHEN ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(27) MARLENE DANIEL ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(28) JASON A. FRANK, ESQ. ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(29) STACEY GOLDENBERG ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(30) PERRI GOLDENHERSH ----- DIRECTOR (THRU 9/1/20)	1.00 ----- 0.	X					0.	0.	0.	
(31) BETH GOLDSMITH ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(32) DANIEL HENSON ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(33) JUDY SHERWOOD JANOSKI ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(34) KEVIN KEANE ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(35) JAYNE KLEIN ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
(36) SCOTT LONDON, ESQ. ----- DIRECTOR	1.00 ----- 0.	X					0.	0.	0.	
1b Sub-total							0.	0.	0.	
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **75**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(37) SHIMON MESSING ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(38) DR. RAYMOND MILLER ----- LEVINDALE MEDICAL DIRECTOR	1.00 ----- 40.00	X						0.	0.	0.
(39) IRIS MILLER ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(40) BARRY J. NABOZNY ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(41) ABBA DAVID POLIAKOFF, ESQ. ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(42) NANCY PRETTER ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(43) KANDACE SCHERR ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(44) ETHAN SEIDEL, PH.D. ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(45) LYNN SELBY ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(46) RABBI SHMUEL SILBER ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
(47) MARC B. TERRILL ----- DIRECTOR	1.00 ----- 0.	X						0.	0.	0.
1b Sub-total								0.	0.	0.
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 75

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(48) GILBERT TROUT ----- DIRECTOR	1.00 0.	X					0.	0.	0.	
(49) DAVID UHLFELDER, C.P.A. ----- DIRECTOR	1.00 0.	X					0.	0.	0.	
(50) STEVE VENICK ----- DIRECTOR	1.00 0.	X					0.	0.	0.	
(51) JAYSON WILLIAMS ----- DIRECTOR	1.00 0.	X					0.	0.	0.	
(52) DIANE WIT ----- DIRECTOR	1.00 0.	X					0.	0.	0.	
1b Sub-total							0.	0.	0.	
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 75

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation

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

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514			
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a							
	b	Membership dues	1b							
	c	Fundraising events	1c							
	d	Related organizations	1d	490,667.						
	e	Government grants (contributions) . .	1e	474,922.						
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	184,670.						
	g	Noncash contributions included in lines 1a-1f.	1g	\$						
	h	Total. Add lines 1a-1f ▶			1,150,259.					
	Program Service Revenue	2a	MEDICARE/MEDICAID PAYMENTS	Business Code	623000	63,296,964.	63,296,964.			
b		PATIENT SERVICE REVENUE		623000	9,561,963.	9,561,963.				
c										
d										
e										
f		All other program service revenue								
g		Total. Add lines 2a-2f ▶			72,858,927.					
Other Revenue		3	Investment income (including dividends, interest, and other similar amounts). ▶			944,046.		944,046.		
	4	Income from investment of tax-exempt bond proceeds . ▶			0.					
	5	Royalties ▶			0.					
	6a	Gross rents	6a	(i) Real						
				(ii) Personal						
					175,149.					
	b	Less: rental expenses	6b							
	c	Rental income or (loss)	6c	175,149.						
	d	Net rental income or (loss) ▶			175,149.		175,149.			
	7a	Gross amount from sales of assets other than inventory	7a	(i) Securities						
				(ii) Other						
					7,942,621.					
	b	Less: cost or other basis and sales expenses . .	7b	6,989,952.						
	c	Gain or (loss)	7c	952,669.						
d	Net gain or (loss) ▶			952,669.		952,669.				
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a		0.						
			b	Less: direct expenses	8b	0.				
			c	Net income or (loss) from fundraising events. ▶		0.				
			9a	Gross income from gaming activities. See Part IV, line 19	9a		0.			
						b	Less: direct expenses	9b	0.	
						c	Net income or (loss) from gaming activities. ▶		0.	
			10a	Gross sales of inventory, less returns and allowances	10a		67,251.			
						b	Less: cost of goods sold	10b	42,922.	
						c	Net income or (loss) from sales of inventory. ▶		24,329.	24,329.
Miscellaneous Revenue	11a	CAFETERIA SALES	Business Code	900099	79,835.	79,835.				
	b	MEANINGFUL USE EHR INCENTIVE		900099	77,765.		77,765.			
	c	MANAGEMENT REVENUE		561000	18,294.	18,294.				
	d	All other revenue			-11,538.		-11,538.			
	e	Total. Add lines 11a-11d ▶			164,356.					
	12	Total revenue. See instructions ▶			76,269,735.	72,963,091.	18,294.	2,138,091.		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	0.			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	0.			
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	41,410,318.	30,746,832.	10,663,486.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	820,298.	650,214.	170,084.	
9 Other employee benefits	9,171,491.	6,853,173.	2,318,318.	
10 Payroll taxes	3,399,392.	2,694,549.	704,843.	
11 Fees for services (nonemployees):				
a Management	0.			
b Legal	74,918.	67,918.	7,000.	
c Accounting	0.			
d Lobbying	46,053.	34,054.	11,999.	
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	73,061.		73,061.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O). ATCH 3	12,025,765.	8,423,708.	3,602,057.	
12 Advertising and promotion	24,406.	9,339.	15,067.	
13 Office expenses	1,091,720.	295,541.	796,179.	
14 Information technology	0.			
15 Royalties	0.			
16 Occupancy	2,053,917.	1,235,369.	818,548.	
17 Travel	297.	122.	175.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	28,422.	6,651.	21,771.	
20 Interest	664,897.	191,879.	473,018.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	4,066,659.	3,000,368.	1,066,291.	
23 Insurance	0.			
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a SUPPLIES	6,734,801.	5,890,341.	844,460.	
b MEDICAID TAX ASSESSMENT	1,572,777.	1,572,777.		
c DUES AND MEMBERSHIPS	145,175.	4,808.	140,367.	
d UBIT	5,521.		5,521.	
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	83,409,888.	61,677,643.	21,732,245.	
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)	0.			

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	15,617,156.	1	18,427,706.
	2 Savings and temporary cash investments.	276,198.	2	276,198.
	3 Pledges and grants receivable, net	120,768.	3	75,527.
	4 Accounts receivable, net.	8,430,883.	4	9,605,518.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0.	5	0.
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B).	0.	6	0.
	7 Notes and loans receivable, net	0.	7	0.
	8 Inventories for sale or use	347,977.	8	385,287.
	9 Prepaid expenses and deferred charges	103,940.	9	130,688.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 87,661,971.		
	b Less: accumulated depreciation.	10b 49,369,547.	40,404,018.	10c 38,292,424.
	11 Investments - publicly traded securities.	0.	11	0.
	12 Investments - other securities. See Part IV, line 11	9,569,119.	12	13,031,461.
	13 Investments - program-related. See Part IV, line 11.	0.	13	0.
	14 Intangible assets	0.	14	0.
	15 Other assets. See Part IV, line 11	24,919,084.	15	21,656,201.
16 Total assets. Add lines 1 through 15 (must equal line 33)	99,789,143.	16	101,881,010.	
Liabilities	17 Accounts payable and accrued expenses.	9,195,026.	17	12,509,739.
	18 Grants payable	0.	18	0.
	19 Deferred revenue.	24,718,686.	19	23,747,463.
	20 Tax-exempt bond liabilities.	0.	20	1,000.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D.	0.	21	0.
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0.	22	0.
	23 Secured mortgages and notes payable to unrelated third parties	0.	23	0.
	24 Unsecured notes and loans payable to unrelated third parties.	0.	24	0.
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	17,192,983.	25	14,594,954.
	26 Total liabilities. Add lines 17 through 25.	51,106,695.	26	50,853,156.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions.	41,159,457.	27	41,027,606.
	28 Net assets with donor restrictions.	7,522,991.	28	10,000,249.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund.		30	
	31 Retained earnings, endowment, accumulated income, or other funds.		31	
32 Total net assets or fund balances	48,682,448.	32	51,027,854.	
33 Total liabilities and net assets/fund balances.	99,789,143.	33	101,881,010.	

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	76,269,735.
2	Total expenses (must equal Part IX, column (A), line 25)	2	83,409,888.
3	Revenue less expenses. Subtract line 2 from line 1	3	-7,140,153.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	48,682,448.
5	Net unrealized gains (losses) on investments	5	3,252,732.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain on Schedule O)	9	6,232,827.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	51,027,854.

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
 If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
 If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits . . .

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.**

Employer identification number
52-0607913

Part I Reason for Public Charity Status. (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

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

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

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

Schedule A (Form 990 or 990-EZ) 2020

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

Table with 7 columns: (a) 2016, (b) 2017, (c) 2018, (d) 2019, (e) 2020, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2016, (b) 2017, (c) 2018, (d) 2019, (e) 2020, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 9 Net income from unrelated business activities; 10 Other income; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities; 13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Percentage, %. Rows include: 14 Public support percentage for 2020; 15 Public support percentage from 2019 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2020; b 33 1/3% support test - 2019; 17a 10%-facts-and-circumstances test - 2020; b 10%-facts-and-circumstances test - 2019; 18 Private foundation.

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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2020 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2019 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f)).	17	%
18 Investment income percentage from 2019 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2020. 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 - 2019. 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 box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

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

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

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>)	5
6	Other distributions (<i>describe in Part VI</i>). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions.	8
9	Distributable amount for 2020 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2020	(iii) Distributable Amount for 2020
1	Distributable amount for 2020 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2020 (reasonable cause required - <i>explain in Part VI</i>). See instructions.			
3	Excess distributions carryover, if any, to 2020			
a	From 2015			
b	From 2016			
c	From 2017			
d	From 2018			
e	From 2019			
f	Total of lines 3a through 3e			
g	Applied to underdistributions of prior years			
h	Applied to 2020 distributable amount			
i	Carryover from 2015 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4	Distributions for 2020 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2020 distributable amount			
c	Remainder. Subtract lines 4a and 4b from line 4.			
5	Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
6	Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
7	Excess distributions carryover to 2021. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2016			
b	Excess from 2017			
c	Excess from 2018			
d	Excess from 2019			
e	Excess from 2020			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

Schedule of Contributors

2020

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

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
--	--

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 (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 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).

Name of organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	N/A <hr/> <hr/> <hr/>	\$ 490,667.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	N/A <hr/> <hr/> <hr/>	\$ 474,922.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	N/A <hr/> <hr/> <hr/>	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	N/A <hr/> <hr/> <hr/>	\$ 25,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	N/A <hr/> <hr/> <hr/>	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	N/A <hr/> <hr/> <hr/>	\$ 12,750.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	N/A <hr/> <hr/> <hr/>	\$ 10,038.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	N/A <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/>	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/>	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/>	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/>	<hr/> <hr/> <hr/>	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

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

Name of organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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Part III Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ► \$ _____
Use duplicate copies of Part III if additional space is needed.

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

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2020

Open to Public Inspection

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

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

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

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

Name of organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

Schedule C (Form 990 or 990-EZ) 2020

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

A Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).

B Check if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures															
e Total exempt purpose expenditures (add lines 1c and 1d)															
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.															
<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 50%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 50%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a. If zero or less, enter -0-															
i Subtract line 1f from line 1c. If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?	X		
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	X		
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?	X		11,408.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		34,645.
j Total. Add lines 1c through 1i			46,053.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV Supplemental Information *(continued)*

PART II-B, LINE 1, LOBBYING ACTIVITIES:

LOBBYING INCLUDES A PORTION OF MARYLAND HOSPITAL ASSOCIATION DUES RELATED TO LOBBYING ACTIVITIES DURING THE YEAR ENDED JUNE 30, 2021 AND OTHER LOBBYING ACTIVITIES PERFORMED ON BEHALF OF THE HOSPITAL REGARDING COMMUNITY STABILIZATION AND DEVELOPMENT, HEALTHCARE MALPRACTICE AND LONG TERM CARE.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.

Employer identification number 52-0607913

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

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

Table with 3 columns: Line number, Description, (a) Donor advised funds, (b) Funds and other accounts. Includes rows for total number at end of year, aggregate values, and Yes/No questions.

Part II Conservation Easements.

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

Table with 3 columns: Line number, Description, Held at the End of the Tax Year. Includes rows for purpose(s) of easements, total number, acreage, and monitoring expenses.

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

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

Table with 3 columns: Line number, Description, Amount. Includes rows for art collections, revenue, and assets.

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

Schedule D (Form 990) 2020

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

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

- a** Public exhibition
- b** Scholarly research
- c** Preservation for future generations
- d** Loan or exchange program
- e** Other _____

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

	Amount
1c Beginning balance	
1d Additions during the year	
1e Distributions during the year	
1f Ending balance	

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	4,223,234.	4,223,234.	4,223,234.	4,223,234.	4,223,234.
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	4,223,234.	4,223,234.	4,223,234.	4,223,234.	4,223,234.

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 100.0000 %
- c** Term endowment _____ %

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

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

- (i)** Unrelated organizations
- (ii)** Related organizations

	Yes	No
3a(i)		X
3a(ii)	X	
3b	X	

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				
b Buildings		61,573,884.	32,322,894.	29,250,990.
c Leasehold improvements				
d Equipment		23,811,267.	15,974,784.	7,836,483.
e Other		2,276,820.	1,071,869.	1,204,951.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				38,292,424.

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) ECONOMIC INTEREST IN FDN	13,031,461.	FMV
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) . ▶	13,031,461.	

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) INTERCOMPANY RECEIVABLES	21,302,558.
(2) LIMITED USE ASSETS	215,615.
(3) CAPITAL ACCUMULATED	112,178.
(4) RIGHT OF USE ASSET	25,850.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	21,656,201.

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) A/P DUE TO AFFILIATE BONDS	9,437,571.
(3) PENSION LIABILITY	2,043,580.
(4) ASSET RETIREMENT OBLIGATION	1,560,000.
(5) A/P - RELATED PARTIES	1,243,784.
(6) CAPTIVE PROFESSIONAL LIABILITY	205,911.
(7) DEFERRED COMPENSATION	78,257.
(8) LEASE LIABILITY	25,851.
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	14,594,954.

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

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-headers (2a-2d, 4a-4b), and totals (2e, 3, 4c, 5).

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include descriptions, sub-headers (2a-2d, 4a-4b), and totals (2e, 3, 4c, 5).

Part XIII Supplemental Information.

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

SEE PAGE 5

Multiple horizontal lines provided for entering supplemental information.

Part XIII Supplemental Information (continued)

PART III, LINE 4:

LEVINDALE OWNS AND DISPLAYS VARIOUS ARTWORKS, TO BRING HAPPINESS AND JOY TO LEVINDALE'S RESIDENTS AND PATIENTS.

PART V, LINE 4:

THE PERMANENTLY ENDOWED FUNDS HELD BY THE BALTIMORE JEWISH ELDERCARE FOUNDATION, INC. ARE USED TO SUPPORT LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.

PART X, LINE 2:

LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL, INC. HAS BEEN RECOGNIZED BY THE INTERNAL REVENUE SERVICE AS TAX-EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE.

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

Part XIII Supplemental Information *(continued)*

CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH ASC
TOPIC 740.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2020

Open to Public Inspection

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.**

Employer identification number
52-0607913

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free care</i> ? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300.0000</u> %	X	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted care</i> ? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500.0000</u> %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1,666,338.		1,666,338.	2.00
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			1,666,338.		1,666,338.	2.00
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			676,605.	49,395.	627,210.	.75
f Health professions education (from Worksheet 5)			43,503.	39.	43,464.	.05
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			30,757.		30,757.	.04
j Total. Other Benefits			750,865.	49,434.	701,431.	.84
k Total. Add lines 7d and 7j			2,417,203.	49,434.	2,367,769.	2.84

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			4,902.		4,902.	.01
9 Other						
10 Total			4,902.		4,902.	.01

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	46,284,240.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	39,646,096.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	6,638,144.
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 1

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

1 LEVINDALE HEBREW GERIATRIC CNTR & HOS
2434 WEST BELVEDERE AVENUE
BALTIMORE MD 21215
HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/LEVINDA
30088

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

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 LEVINDALE HEBREW GERIATRIC CENTER & H

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

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group LEVINDALE HEBREW GERIATRIC CENTER & H

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300.0000</u> % and FPG family income limit for eligibility for discounted care of <u>500.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance?	X	
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):			
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SCHEDULE C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SCHEDULE C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SCHEDULE C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group LEVINDALE HEBREW GERIATRIC CENTER & H

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group LEVINDALE HEBREW GERIATRIC CENTER & H

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

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 5:

DURING THE FY 2020 CHNA PROCESS, THE PROJECT TEAM USED A MULTI-PRONGED APPROACH TO SOLICIT INPUT FROM THE BALTIMORE COMMUNITY REGARDING THEIR HEALTH NEEDS. DATA COLLECTION METHODOLOGIES INCLUDED SURVEYS, STAKEHOLDER INTERVIEWS, AND FOCUS GROUPS. FOCUS GROUPS AND INTERVIEWS INCLUDED COMMUNITY LEADERS AND ASSOCIATIONS, AS WELL AS MEMBERS OF DEMOGRAPHIC GROUPS KNOWN TO HAVE PARTICULAR NEEDS: OLDER ADULTS, PERSONS WITH DISABILITIES, RE-ENTRY RESIDENTS, AND SPANISH SPEAKERS.

THE PROJECT TEAM PARTNERED WITH HEALTH SYSTEMS ACROSS BALTIMORE CITY IN DISSEMINATION OF A WEB-BASED AND HARDCOPY COMMUNITY SURVEY INSTRUMENT TO COLLECT INFORMATION FROM BALTIMORE CITY RESIDENTS REGARDING THEIR HEALTH AND SOCIAL NEEDS. THIS PROCESS RESULTED IN 3,170 SURVEY RESULTS.

IN ADDITION, LEVINDALE AND ITS COMPANION LIFE BRIDGE HEALTH FACILITIES CONDUCTED FOCUS GROUPS AS WELL AS CONVERSATIONS WITH KEY STAKEHOLDERS WITHIN THE PRIMARY SERVICE AREAS. REPRESENTATIVES INCLUDED COMMUNITY LEADERS, ASSOCIATIONS, AS WELL AS EXPRESSED DEMOGRAPHIC GROUPS. THE STAKEHOLDERS WERE SELECTED BECAUSE THEY HAD SPECIAL KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH OR REPRESENTED THE BROAD INTEREST OF THE COMMUNITY SERVED BY LEVINDALE, INCLUDING THE INTEREST OF MEDICALLY UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS WITH CHRONIC DISEASE NEEDS.

THE STAKEHOLDER INTERVIEWS WERE CONDUCTED WITH REPRESENTATIVES FROM

Part V Facility Information (continued)

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

STEVENSWOOD COMMUNITY ASSOCIATION CENTRAL BAPTIST CHURCH, NEW SOLID ROCK FELLOWSHIP CHURCH, NORTHWEST FAITH BASED PARTNERSHIP, AND ROLLING OAKS COMMUNITY ASSOCIATION.

THE BALTIMORE CITY HEALTH DEPARTMENT AND THE CITY-BASED HEALTH SYSTEMS PREVIOUSLY COLLABORATED ON A CHNA IN 2017-2018 AND HAVE SOUGHT TO SO AGAIN IN 2020-2021 THOUGH IN A MORE LIMITED MANNER DUE TO THE COVID-19 VIRUS. THE 2020-2021 CHNA INCORPORATES A VARIETY OF SECONDARY DATA SOURCED THROUGH THE BALTIMORE NEIGHBORHOOD INDICATORS ALLIANCE-JACOB FRANCE INSTITUTE (BNIA), THE CENTERS FOR DISEASE CONTROL, AND THE BALTIMORE CITY HEALTH DEPARTMENT'S NEIGHBORHOOD HEALTH PROFILE.

PART V, SECTION B, LINE 6A:

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC. CONDUCTED THE CHNA IN COLLABORATION WITH THE LIFEBRIDGE HEALTH SYSTEM'S SINAI HOSPITAL AND NORTHWEST HOSPITAL. FOR THE 2020 CHNA THE OTHER BALTIMORE AREA HOSPITALS THAT COLLABORATED WITH LEVINDALE IN GATHERING DATA FOR THE COMMUNITY NEEDS ASSESSMENT WERE JOHNS HOPKINS HOSPITAL, UNIVERSITY OF MARYLAND, MEDSTAR HEALTH, ST. AGNES HOSPITAL AND MERCY HOSPITAL.

PART V, SECTION B, LINE 7D:

COPIES OF THE CHNA WERE DISTRIBUTED TO KEY COMMUNITY PARTNERS.

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/DOCUMENTS/POPULATION%20HEALTH/LEVINDALE%20CHNA_FINAL_6%201%2021.PDF](https://www.lifebridgehealth.org/uploads/public/documents/population%20health/levindale%20chna_final_6%201%2021.pdf)

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 11:

THE LIFEBRIDGE COMMUNITY HEALTH AND WELLNESS TEAM REVIEWED THE SURVEY AND FOCUS GROUP RESULTS TO IDENTIFY THE MOST SIGNIFICANT NEEDS. THE LEVINDALE PRESIDENT AND CHNA LEADERSHIP TEAM THEN MET WITH REPRESENTATIVES OF THE LEVINDALE BOARD OF DIRECTORS AND EXECUTIVE LEADERSHIP TO REVIEW THE FINDINGS AND DEVELOP RECOMMENDATIONS FOR AREAS TO PURSUE, BASED ON THE AREAS OF GREATEST NEED AND THE HOSPITAL'S ABILITY TO HAVE THE MOST IMPACT. THE FOLLOWING AREAS WERE SELECTED AS PRIORITIES:

HEART DISEASE

LEVINDALE WILL PROVIDE EDUCATION AND SCREENING DURING STROKE AWARENESS MONTH THROUGH VARIOUS EVENTS. IN ADDITION, THE CHANGING HEARTS PROGRAM CONTINUED THROUGH JUNE 2019 TO MAINTAIN AND IMPROVE BEHAVIORAL AND BIOMETRIC OUTCOMES CONNECTED TO HEART DISEASE. VARIOUS ASPECTS OF THE PROGRAM CONTINUED FROM JUNE 2019 THROUGH MARCH 2020. COMPONENTS INCLUDED BUT WERE NOT LIMITED TO PROVIDING ON-GOING SUPPORT TO FACILITATE LIFESTYLE CHANGE; IMPROVE QUALITY OF LIFE, SMOKING STATUS, HEALTH EATING PRACTICES AND PHYSICAL ACTIVITY. THE PROGRAM ALSO HELD REGULAR EDUCATION SESSIONS AND SHARED MATERIALS TO IMPROVE BIOMETRIC ELEMENTS SUCH AS BLOOD PRESSURE, FASTING BLOOD SUGAR, BODY MASS INDEX, AND CHOLESTERAL LEVELS. WE PARTNERED WITH SEVERAL ORGANIZATION S THROUGHOUT THE COMMUNITY INCLUDING THE AMERICAN HEART ASSOCIATION, BALTIMORE CITY HEALTH DEPARTMENT CARDIOVASCULAR DISPARITIES TASK FORCE AND THE PARK HEIGHTS COMMUNITY HEALTH ALLIANCE.

Part V Facility Information (continued)

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

MENTAL HEALTH

BASED ON INFORMATION ABOUT THE IMPACT THAT COVID-19 AND OTHER FACTORS WERE HAVING ON THE HOSPITAL'S EMPLOYEES, IT WAS DECIDED TO GIVE INITIAL FOCUS TO THE MENTAL HEALTH OF THAT GROUP, AS WITHOUT A HEALTHY EMPLOYEE POPULATION THE HOSPITAL CANNOT EFFECTIVELY DELIVER CARE TO OTHERS.

LIFEBRIDGE HEALTH HAS ADOPTED A CARING FOR THE CAREGIVERS PROGRAM, WHICH WILL PROVIDE SUPPORT FOR OUR TEAM MEMBERS WHO ARE FACING MENTAL HEALTH ISSUES DUE TO THE INTENSITY OF THEIR JOBS. THERE ARE THREE COMPONENTS TO THIS PROGRAM. CABANA IS A PROGRAM DESIGNED TO CONNECT STAFF WITH VIRTUAL, ANONYMOUS SUPPORT GROUPS COMPRISED OF OTHER HEALTHCARE WORKERS FROM PEER ORGANIZATIONS ACROSS THE UNITED STATES. THE SECOND COMPONENT IS THE EMPLOYEE ASSISTANCE PROGRAM, WHICH PROVIDES RESOURCES THROUGH A THIRD-PARTY VENDOR, WITH A VAST OFFERING OF CONFIDENTIAL SUPPORT FOR MANY DIFFERENT NEEDS. THE THIRD COMPONENT IS THE RISE PROGRAM, WHICH WILL OFFER A PEER-TO-PEER SUPPORT SYSTEM TO PROVIDE TIMELY CONFIDENTIAL SUPPORT TO TEAM MEMBERS WHO ENCOUNTER A STRESSFUL PATIENT-RELATED EVENT.

IN ADDITION TO PROVIDING SUPPORT FOR EMPLOYEES, LEVINDALE OFFERS THE COMMUNITY A PARTIAL HOSPITALIZATION PROGRAM (PHP), WHICH IS A SHORT-TERM PSYCHIATRIC DAY PROGRAM FOR OLDER ADULTS WHO ARE EXPERIENCING BEHAVIORAL HEALTH SYMPTOMS THAT PUT THEM AT RISK OF INPATIENT HOSPITALIZATION. PHP IS ALSO USED AS A STEPDOWN FOR PEOPLE DISCHARGED FROM AN INPATIENT STAY WHO MAY NEED CONTINUED SUPPORT IN PROGRESSING TOWARD THEIR TREATMENT GOALS.

Part V Facility Information (continued)

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

COMMUNITY HEALTH AND WELLNESS EDUCATION

A PASTORAL OUTREACH COORDINATOR AND COMMUNITY EDUCATORS PROVIDE OUTREACH TO THE FAITH COMMUNITIES AND OFFER EDUCATIONAL TOPICS RELATED TO ILLNESS PREVENTION. IN ADDITION, INFORMATION WAS ADDED ON THE CONNECTION BETWEEN FAITH AND HEALTH; AND THE INCLUSION OF MORE INFORMATION ON COMMUNITY RESOURCES FACILITATED MORE ACCESS.

DIABETES

THE DIABETES WELLNESS SERIES WAS DEVELOPED TO ADDRESS THOSE AT RISK OF DEVELOPING CHRONIC DISEASES, IN ADDITION TO THOSE WHO LIVE WITH CHRONIC DISEASE ALREADY.

HEALTH DISPARITIES

LEVINDALE WILL EXPLORE PARTNERSHIPS WITH COMMUNITY RESOURCE CENTERS TO BETTER REACH COMMUNITY RESIDENTS WITH HEALTH EDUCATION AND HEALTH CARE ACCESS.

HOUSING

LEVINDALE WILL EXPLORE IMPLEMENTING THE PACE PROGRAM TO ENABLE INDIVIDUALS NEEDING HEALTH SERVICES TO BE ABLE TO STAY IN THEIR HOME. IN ADDITION, LEVINDALE WILL PARTICIPATE IN THE LIVE NEAR YOUR WORK PROGRAM TO HELP STRENGTHEN THE LOCAL HOUSING MARKET.

Part V Facility Information (continued)

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

FOOD INSECURITY

LEVINDALE WILL EXPLORE PARTNERSHIP WITH OR IMPLEMENTATION OF A FARMERS MARKET WITH AFFORDABLE FRESH FOOD ON OR NEAR THE LEVINDALE/SINAI CAMPUS.

COMMUNITY SAFETY

LEVINDALE WILL EXPLORE THE CHANA-SAFE PROGRAM TO IDENTIFY AND PREVENT ELDER ABUSE AND NEGLECT.

NEEDS NOT ADDRESSED WITHIN IMPLEMENTATION STRATEGY

VARIOUS NEEDS WERE IDENTIFIED ON THE SURVEYS AND IN THE FOCUS GROUPS AS IMPORTANT, EITHER TO THE COMMUNITY AS A WHOLE OR TO PARTICULAR POPULATIONS, BUT WERE NOT CHOSEN AS PRIORITIES FOR IMPLEMENTATION UNDER THE CHNA BECAUSE THE HOSPITAL DOES NOT HAVE SUFFICIENT RESOURCES TO ADDRESS THEM, OTHER ORGANIZATIONS ARE MORE CAPABLE OF MEETING THE NEED, OR THEY ARE BEING ADDRESSED BY EXISTING LIFEBRIDGE HEALTH ACTIVITIES.

LACK OF TRANSPORTATION

LACK OF TRANSPORTATION AROSE IN THE SURVEYS AS AN IMPORTANT REASON FOR WHY PEOPLE DO NOT GET HEALTH CARE. THROUGH THE CARE MANAGEMENT DEPARTMENT AND OTHER PROGRAMS THAT WORK WITH PEOPLE IN THE COMMUNITY, TRANSPORTATION FUNDING IS PROVIDED FOR MANY PATIENTS WHO NEED HELP IN GETTING TO THEIR DOCTORS' APPOINTMENTS. SINCE PATIENTS AND CLIENTS ARE SERVED WELL BY THESE RESOURCES, THIS CONCERN WAS NOT PRIORITIZED FOR FURTHER INVESTMENT.

Part V Facility Information (continued)

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

ACCESS TO INSURANCE

LEVINDALE HOSPITAL PROVIDES SIGN-UP ASSISTANCE TO PATIENTS WITHOUT INSURANCE WHEN THEY PRESENT AT THE HOSPITAL. A STAFFER PERSON OVERSEES THIS FUNCTION. THUS, THIS GAP IS BEING ADDRESSED THROUGH OTHER MEANS.

WORKFORCE DEVELOPMENT

LEVINDALE HOSPITAL REFERS RESIDENTS AND PATIENTS WITHOUT EMPLOYMENT TO PARTNER ORGANIZATIONS, PARTICULARLY BON SECOURS COMMUNITYWORKS IN SOUTH AND WEST BALTIMORE, TO ADDRESS THIS PRESSING SOCIAL NEED.

ACCESS TO PHYSICIANS

A SYSTEM-WIDE EFFORT HAS BEEN DEVELOPED SINCE THE PREVIOUS CHNA TO ADDRESS NEEDS OF VARIOUS PATIENTS FOR ENHANCED ACCESS TO PHYSICIAN SERVICES. SPECIALISTS ARE READILY IDENTIFIED, AND REFERRALS ARE APPROPRIATELY MADE. DEPARTMENTS AND TEAM MEMBERS CONTINUE IN EFFORTS TO REDUCE APPOINTMENT WAIT TIME FOR HEALTH CARE SERVICES LACKING COMMUNITY CAPACITY SUCH AS MENTAL HEALTH THERAPY.

COORDINATION ACROSS SERVICES

SINCE THE LAST CHNA, LEVINDALE HOSPITAL DEPARTMENTS, INCLUDING SOCIAL SERVICES AND CARE MANAGEMENT, HAVE WORKED MORE CLOSELY INTERNALLY AS WELL AS WITH COMMUNITY RESOURCES TO ENABLE PATIENTS TO ACCESS NECESSARY AND VALUABLE RESOURCES IN AS TIMELY A MANNER AS POSSIBLE. INCLUSION OF SOCIAL SUPPORTS IN COORDINATION IS ALSO INTENDED TO REDUCE RECURRENCE OF ACUTE HEALTH EPISODES THAT REQUIRE HOSPITALIZATIONS.

Part V Facility Information (continued)

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

LANGUAGE BARRIERS

LEVINDALE HOSPITAL HAS INTERPRETIVE SERVICES AVAILABLE AND SIGNS IN MULTIPLE LANGUAGES AS WELL AS IN HARD COPY FORMS IN THE WELCOME PACKET PATIENTS RECEIVE. FORMS ARE AVAILABLE IN SPANISH AS WELL AS OTHER LANGUAGES, E.G., RUSSIAN. CONSENT FORMS ARE TRANSLATED INTO SEVERAL LANGUAGES AS WELL. PATIENTS RECEIVE. FORMS ARE AVAILABLE IN SPANISH AS WELL AS OTHER LANGUAGES, E.G., RUSSIAN. CONSENT FORMS ARE TRANSLATED INTO SEVERAL LANGUAGES AS WELL. WELL AS OTHER LANGUAGES, E.G., RUSSIAN. CONSENT FORMS ARE TRANSLATED INTO SEVERAL LANGUAGES AS WELL. INTO SEVERAL LANGUAGES AS WELL.

PART V, SECTION B, LINE 16A, 16B AND 16C:

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/MAIN/LIFEBRIDGEHEALTHFINANCIALASSISTANCE.ASPX](https://www.lifebridgehealth.org/main/lifebridgehealthfinancialassistance.aspx)

PART V, SECTION B, LINE 22C:

CHARGES FOR ALL HOSPITAL PATIENTS ARE STATE REGULATED. SERVICES ARE CHARGED TO ALL HOSPITAL PATIENTS AT THE SAME RATE. CHARGES FOR INDIVIDUALS FOUND ELIGIBLE FOR FAP BASED ON 300% OR LESS OF THE FEDERAL POVERTY LEVEL (FPL) ARE WRITTEN-OFF IN FULL TO FAP (THERE IS NO PATIENT LIABILITY). CHARGES FOR INDIVIDUALS FOUND ELIGIBLE FOR FAP BASED ON THE HSCRC'S FINANCIAL HARDSHIP CRITERIA OF 301%-500% OF FPL ARE CHARGED NO MORE THAN 25% OF THE ANNUAL HOUSEHOLD INCOME PER THE HSCRC'S FINANCIAL

Part V Facility Information *(continued)*

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

HARDSHIP CRITERIA. THE DIFFERENCE BETWEEN THE TOTAL CHARGES AND THE

CALCULATED 25% OF THE ANNUAL HOUSEHOLD INCOME IS WRITTEN OFF TO FAP.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
 (list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 2

Name and address	Type of Facility (describe)
1 LEVINDALE HEBREW GERIATRIC CENTER & HOSP 2434 WEST BELVEDERE AVENUE BALTIMORE MD 21215	NURSING HOME
2 LIFEBRIDGE ADULT DAY SERVICES 5400 OLD COURT ROAD RANDALLSTOWN MD 21133	ADULT DAY CARE
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART I, LINE 3C:

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

Part VI Supplemental Information

Provide the following information.

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

SCHEDULE H, PART I, LINE 7:

MARYLAND'S REGULATORY SYSTEM CREATES A UNIQUE PROCESS FOR HOSPITAL PAYMENT THAT DIFFERS FROM THE REST OF THE NATION. THE HEALTH SERVICES COST REVIEW COMMISSION (HSCRC) DETERMINES PAYMENT THROUGH A RATE-SETTING PROCESS AND ALL PAYORS, INCLUDING GOVERNMENTAL PAYORS, PAY THE SAME AMOUNT FOR THE SAME SERVICES DELIVERED AT THE SAME HOSPITAL. MARYLAND'S UNIQUE ALL-PAYOR SYSTEM INCLUDES A METHOD FOR REFERENCING UNCOMPENSATED CARE IN EACH PAYORS RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAK-OUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

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

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

OFFSETTING REVENUE - REVENUE FROM THE ACTIVITY DURING THE YEAR THAT OFFSETS THE TOTAL COMMUNITY BENEFIT EXPENSE OF THAT ACTIVITY. IT INCLUDES

Part VI Supplemental Information

Provide the following information.

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- 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.

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

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

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

PART II, COMMUNITY BUILDING ACTIVITIES:

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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AS A LARGE EMPLOYER AND PROVIDER OF HEALTH SERVICES IN THE NORTHWEST QUADRANT OF BALTIMORE CITY AND PARTS OF SOUTHERN BALTIMORE COUNTY, LIFEBRIDGE HEALTH PROVIDES COMMUNITY BENEFITS THAT ENHANCE THE OVERALL QUALITY OF LIFE IN OUR SURROUNDING COMMUNITIES. THIS IS ACCOMPLISHED THROUGH COALITION BUILDING AND WORKFORCE DEVELOPMENT. TO LIST A FEW EXAMPLES:

THE CHANGING HEARTS/HEALTHY HEARTS INITIATIVE HOLDS SCREENINGS FOR THE COMMUNITY TO IDENTIFY HEART HEALTHY LIFESTYLES, TO PROVIDE EDUCATION AND TO IDENTIFY INDIVIDUALS AT RISK FOR HEART DISEASE.

THE CAREER COACH WORKS WITH FRONT LINE EMPLOYEES TO PROVIDE SOCIAL, RETENTION AND CAREER DEVELOPMENT SERVICES. THIS POSITION PROMOTES THE HEALTH OF THE COMMUNITY BECAUSE MANY OF THE CLIENTS SERVED BY THE COACH LIVE IN THE SURROUNDING COMMUNITY. ONE SERVICE THAT THE COACH FOCUSES ON FOR MANY EMPLOYEES IS FINANCIAL HEALTH, PROVIDING THEM WITH RESOURCES AND TIPS TO ENSURE THEIR STABILITY.

Part VI Supplemental Information

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THE WORKFORCE DEVELOPMENT DEPARTMENT OFFERS EDUCATIONAL COURSES LIKE MEDICAL TERMINOLOGY THAT ARE OPEN TO THE COMMUNITY. PARTICIPATION IN THESE COURSES PROVIDES FOUNDATIONAL KNOWLEDGE NEEDED FOR MANY ENTRY LEVEL POSITIONS WITHIN OUR HEALTH SYSTEM.

SCHEDULE H, PART III, LINE 2:

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

SCHEDULE H, PART III, LINE 3:

LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL, INC. DETERMINES ELIGIBILITY FOR FINANCIAL ASSISTANCE THROUGH OTHER VARIOUS MEANS SUCH AS ELIGIBLE FOR NON-REIMBURSABLE MEDICAID PROGRAMS, OUT-OF STATE MEDICAID PROGRAMS, MARYLAND MEDICAID ELIGIBLE AFTER ADMISSION, APPROVED FINANCIAL ASSISTANCE UNDER PRESUMPTIVE ELIGIBILITY RULE AND IF THE PATIENT WAS DENIED MEDICAID FOR NOT MEETING DISABILITY REQUIREMENTS. OF THE REMAINING BAD DEBT

Part VI Supplemental Information

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EXPENSE, IT IS ESTIMATED THAT \$2,579,822 IN COST MAY BE ATTRIBUTABLE TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE/CHARITY CARE. AS DESCRIBED ELSEWHERE, THE HOSPITAL ENGAGES IN MULTIPLE EFFORTS TO INFORM PATIENTS OF THE AVAILABILITY OF FINANCIAL ASSISTANCE AND CHARITY CARE. THIS \$2,579,822 WAS BILLED TO PATIENTS ONLY BECAUSE THEY, DESPITE THE HOSPITAL'S EFFORTS, DID NOT REQUEST, OR DID NOT COOPERATE WITH THE HOSPITAL'S EFFORTS TO PROVIDE THEM WITH, THE AVAILABLE FINANCIAL ASSISTANCE.

SCHEDULE H, PART III, LINE 4:

ALL PATIENT ACCOUNTS ARE HANDLED CONSISTENTLY AND APPROPRIATELY TO MAXIMIZE CASH FLOW AND TO IDENTIFY BAD DEBT ACCOUNTS TIMELY. ACTIVE ACCOUNTS ARE CONSIDERED BAD DEBT ACCOUNTS WHEN THEY MEET SPECIFIC COLLECTION ACTIVITY GUIDELINES AND/OR ARE REVIEWED BY THE APPROPRIATE MANAGEMENT AND DEEMED TO BE UNCOLLECTIBLE. EVERY EFFORT IS MADE TO IDENTIFY AND PURSUE ALL ACCOUNT BALANCE LIQUIDATION OPTIONS, INCLUDING BUT NOT LIMITED TO THIRD PARTY PAYOR REIMBURSEMENT, PATIENT PAYMENT ARRANGEMENTS, MEDICAID ELIGIBILITY AND FINANCIAL ASSISTANCE. THIRD PARTY

Part VI Supplemental Information

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RECEIVABLE MANAGEMENT AGENCIES PROVIDE EXTENDED BUSINESS OFFICE SERVICES

AND INSURANCE OUTSOURCE SERVICES TO ENSURE MAXIMUM EFFORT IS TAKEN TO

RECOVER INSURANCE AND SELF-PAY DOLLARS BEFORE TRANSFER TO BAD DEBT.

CONTRACTUAL ARRANGEMENTS WITH THIRD PARTY COLLECTION AGENCIES ARE USED TO

ASSIST IN THE RECOVERY OF BAD DEBT DOLLARS AFTER ALL INTERNAL COLLECTION

EFFORTS HAVE BEEN EXHAUSTED. IN SO DOING, THE COLLECTION AGENCIES MUST

OPERATE CONSISTENTLY WITH LEVINDALE HEBREW GERIATRIC CENTER AND

HOSPITAL'S GOAL OF MAXIMUM BAD DEBT RECOVERY AND STRICT ADHERENCE WITH

FAIR DEBT COLLECTIONS PRACTICES ACT (FDCPA) RULES AND REGULATIONS, WHILE

MAINTAINING POSITIVE PATIENT RELATIONS. SEE AUDITED FINANCIAL STATEMENTS

PAGE 17.

SCHEDULE H, PART III, LINE 8:

TOTAL REVENUE RECEIVED FROM MEDICARE (DSH & IME) AND MEDICARE ALLOWABLE

COSTS ARE DERIVED FROM THE ANNUAL MEDICARE COST REPORT. THE INPATIENT

ROUTINE COSTS ARE DERIVED FROM THE STEP-DOWN METHODOLOGY BASED ON

ACCEPTED STATISTICAL ALLOCATION WITH A UNIFORM PER DIEM COST FOR EACH

PAYOR TYPE. THE ANCILLARY MEDICARE ALLOWABLE COSTS ARE INITIALLY DERIVED

Part VI Supplemental Information

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FROM THE STEP-DOWN METHODOLOGY BUT ARE ALLOCATED TO THE PAYOR TYPES BASED
ON THE RATIO OF COST TO CHARGE FOR EACH PAYOR.

SCHEDULE H, PART III, LINE 9B:

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

Part VI Supplemental Information

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 2:

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

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

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

Part VI Supplemental Information

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

SCHEDULE H, PART VI, LINE 3:

LEVINDALE USES THE FOLLOWING MEANS TO INFORM AND ASSIST PATIENTS REGARDING ELIGIBILITY FOR FINANCIAL ASSISTANCE UNDER GOVERNMENTAL PROGRAMS AND THE HOSPITAL'S CHARITY CARE PROGRAM. FINANCIAL ASSISTANCE NOTICES, INCLUDING CONTACT INFORMATION, ARE POSTED IN THE BUSINESS OFFICE AND ADMITTING, AS WELL AS POINTS OF ENTRY AND REGISTRATION THROUGHOUT THE HOSPITAL. PATIENT FINANCIAL SERVICES BROCHURE 'FREEDOM TO CARE' IS

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AVAILABLE TO ALL INPATIENTS. BROCHURES ARE ALSO AVAILABLE IN ALL
 OUTPATIENT REGISTRATION AND SERVICE AREAS. LEVINDALE EMPLOYS A FINANCIAL
 ASSISTANCE LIAISON WHO IS AVAILABLE TO ANSWER QUESTIONS AND TO ASSIST
 PATIENTS AND FAMILY MEMBERS WITH THE PROCESS OF APPLYING FOR FINANCIAL
 ASSISTANCE. A PATIENT INFORMATION SHEET IS GIVEN TO ALL INPATIENTS PRIOR
 TO DISCHARGE AND MAILED TO ALL INPATIENTS. LEVINDALE'S UNINSURED
 (SELF-PAY) AND UNDER-INSURED (MEDICARE BENEFICIARY WITH NO SECONDARY)
 MEDICAL ASSISTANCE ELIGIBILITY PROGRAM SCREENS, ASSISTS WITH THE
 APPLICATION PROCESS AND ULTIMATELY CONVERTS PATIENTS TO VARIOUS MEDICAL
 ASSISTANCE COVERAGE AND INCLUDES ELIGIBILITY SCREENING AND ASSISTANCE
 WITH COMPLETING THE FINANCIAL ASSISTANCE APPLICATION AS PART OF THAT
 PROCESS. ALL HOSPITAL STATEMENTS INCLUDE A MESSAGE REFERENCING THE
 AVAILABILITY OF FINANCIAL ASSISTANCE FOR THOSE WHO ARE EXPERIENCING
 FINANCIAL DIFFICULTY AND PROVIDES CONTACT INFORMATION TO DISCUSS
 LEVINDALE'S FINANCIAL ASSISTANCE PROGRAM. ALL HOSPITAL PATIENT FINANCIAL
 SERVICES STAFF, AND MEDICAID ELIGIBILITY VENDORS ARE TRAINED TO IDENTIFY
 POTENTIAL FINANCIAL ASSISTANCE ELIGIBILITY AND ASSIST PATIENTS WITH THE
 FINANCIAL ASSISTANCE APPLICATION PROCESS. FINANCIAL ASSISTANCE

Part VI Supplemental Information

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APPLICATION AND INSTRUCTIONS COVER SHEET ARE

AVAILABLE IN RUSSIAN AND SPANISH.

SCHEDULE H, PART VI, LINE 4:

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL IS LOCATED IN THE NORTHWEST QUADRANT OF BALTIMORE CITY. IT DRAWS MANY PATIENTS FROM THE NEIGHBORHOODS PROXIMATE TO THE FACILITY. CONSISTENT WITH ITS MISSION TO SERVE THE JEWISH COMMUNITY, LEVINDALE ALSO SERVES PATIENTS FROM THROUGHOUT THE BALTIMORE METROPOLITAN AREA. IN ADDITION, AS ONE OF A SMALL NUMBER OF CHRONIC HOSPITALS IN THE STATE, LEVINDALE DRAWS PATIENTS FROM ACROSS CENTRAL MARYLAND. THE NEIGHBORHOODS SURROUNDING LEVINDALE ARE IDENTIFIED BY THE BALTIMORE NEIGHBORHOOD INDICATORS ALLIANCE (BNIA) AS SOUTHERN PARK HEIGHTS (SPH) AND PIMLICO/ARLINGTON/HILLTOP (PAH). TOGETHER THEY CONSTITUTE AN AREA THAT IS PREDOMINANTLY AFRICAN AMERICAN WITH A BELOW AVERAGE MEDIAN FAMILY INCOME, BUT ABOVE AVERAGE RATES FOR UNEMPLOYMENT AND OTHER SOCIAL DETERMINANTS OF POOR HEALTH. SPH AND PAH'S MEDIAN HOUSEHOLD INCOME WAS \$26,015 AND \$32,410 RESPECTIVELY. THIS IS COMPARED TO BALTIMORE CITY'S MEDIAN HOUSEHOLD INCOME OF \$41,819. THE

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PERCENTAGE OF FAMILIES WITH INCOMES BELOW THE FEDERAL POVERTY GUIDELINES IN SPH WAS 46.4% AND IN PAH, 28.4%. THE UNEMPLOYMENT RATE FOR BALTIMORE CITY WAS 13.1%. SPH AND PAH HAD UNEMPLOYMENT RATES OF 23.6% AND 17.1% RESPECTIVELY. THE NINE ZIP CODES THAT REPRESENT THE PRIMARY SERVICE AREA IN FISCAL YEAR 2017 WERE 21215, 21207, 21208, 21209, 21117, 21216, 21133, 21234 AND 21228. THE BALTIMORE CITY HEALTH DEPARTMENT USES COMMUNITY STATISTICAL AREAS (CSA) WHEN ANALYZING HEALTH OUTCOMES AND RISK FACTORS. THE DATA PROVIDED FOR THE PRIMARY RACIAL COMPOSITION, MEDIAN INCOME AND HOUSEHOLD BELOW POVERTY LEVEL WAS OBTAINED FROM THE BALTIMORE CITY HEALTH DEPARTMENT'S 2017 NEIGHBORHOOD HEALTH PROFILES. THE LIFE EXPECTANCY DATA WAS OBTAINED FROM THE BALTIMORE CITY HEALTH DEPARTMENT. THE RACIAL COMPOSITION AND INCOME DISTRIBUTION OF THESE ZIP CODES REFLECT THE SEGREGATION AND INCOME DISPARITY CHARACTERISTICS OF THE BALTIMORE METROPOLITAN REGION. AS INDICATED ABOVE, THOSE ZIP CODES THAT HAVE A PREDOMINANTLY AFRICAN AMERICAN POPULATION, INCLUDING 21215, IN WHICH THE HOSPITAL IS LOCATED, REFLECT THE RACIAL SEGREGATION AND POVERTY REPRESENTATIVE OF BALTIMORE CITY. THIS IS IN CONTRAST TO THE NEIGHBORING BALTIMORE COUNTY ZIP CODES (21208 & 21209) IN WHICH THE MEDIAN HOUSEHOLD

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

INCOME WAS MUCH HIGHER, AND IN WHICH THE POPULATION IS PREDOMINANTLY
WHITE.

SCHEDULE H, PART VI, LINE 5:

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL PROVIDES MEALS TO
RESIDENTS WHO ARE UNABLE TO PREPARE A MEAL FOR THEMSELVES DUE TO AGE AND
MEDICAL CONDITIONS. LEVINDALE PROVIDES MEALS TO ADULT DAY CARE AND
ASSISTED LIVING FACILITIES IN THE NEIGHBORHOOD.

SCHEDULE H, PART VI, LINE 6:

LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL IS A COMPONENT OF LIFEBRIDGE
HEALTH, A NONPROFIT HEALTH SYSTEM THAT PROVIDES A WIDE VARIETY OF HEALTH
CARE AND RELATED SERVICES TO THE RESIDENTS OF CENTRAL MARYLAND. THE
COMPONENTS OF THE LIFEBRIDGE SYSTEM WORK TOGETHER CLOSELY TO ENSURE THAT
AS MANY AS POSSIBLE OF THE COMMUNITY'S NEEDS ARE MET IN AN INTEGRATED,
NONDUPLICATIVE MANNER. SINAI HOSPITAL OF BALTIMORE AND NORTHWEST HOSPITAL
ARE AFFILIATES AND DISCHARGED PATIENTS REQUIRING CHRONIC HOSPITAL AND
SUB-ACUTE CARE ARE OFTEN ADMITTED TO LEVINDALE FOR FURTHER CARE.

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.

STATE FILING OF COMMUNITY BENEFIT REPORT

MD,

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

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

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

▶ Attach to Form 990.

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

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.**

Employer identification number
52-0607913

Part I Questions Regarding Compensation

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

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

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

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

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

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

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

- a** Receive a severance payment or change-of-control payment?
- b** Participate in or receive payment from a supplemental nonqualified retirement plan?
- c** Participate in or receive payment from an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) 2020

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	DEBORAH GRAVES DIR, PRES & COO, LEVINDALE	(i)	344,012.	194,138.	7,629.	34,720.	23,465.	603,964.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
2	NEIL M. MELTZER PRESIDENT/CEO/DIR, LIFEBRIDGE	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	1,250,601.	1,531,535.	468,095.	717,490.	24,684.	3,992,405.	370,304.
3	DAVID KRAJEWSKI EXEC VP/CFO	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	860,277.	546,969.	230,518.	316,293.	33,706.	1,987,763.	188,569.
4	LESLIE SIMMONS EXECUTIVE VP	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	758,321.	496,810.	171,191.	258,913.	23,727.	1,708,962.	124,690.
5	JASON WEINER SVP AND GENERAL COUNSEL	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	483,984.	362,377.	29,610.	124,233.	25,340.	1,025,544.	0.
6	TERRENCE CARNEY VP SUPPLY CHAIN	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	307,803.	81,367.	77,851.	18,469.	1,220.	486,710.	30,624.
7	JAMES ROBERGE VP CAPITAL IMPV. & SUPPORT SE	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	314,316.	184,434.	68,227.	55,003.	28,750.	650,730.	33,854.
8	HOLLY PHIPPS ADAMS VP HUMAN RESOURCES, LEVINDALE	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	340,878.	78,913.	4,047.	54,426.	29,527.	507,791.	0.
9	NANCY KANE VP FINANCIAL REPORTING	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	299,669.	66,353.	43,501.	67,592.	25,608.	502,723.	29,204.
10	LOU DUNAWAY VP BUDGET & CAPITAL PLANNING	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	276,709.	58,377.	2,048.	54,939.	24,005.	416,078.	0.
11	ROSS J MAULTASCH AVP OF OPERATIONS	(i)	187,325.	38,324.	145.	4,065.	28,391.	258,250.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
12	CAROLINE NGAUJAH REGISTERED NURSE	(i)	158,136.	1,000.	260.	12,842.	23,511.	195,749.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
13	DIANN FERGUSON REGISTERED NURSE	(i)	159,504.	800.	166.	5,624.	10,842.	176,936.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
14	MARIA COHEN NURSE MANAGER	(i)	152,641.	1,000.	43.	10,266.	19,161.	183,111.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
15	LUANN HOLLENBERGER DIR OF PATIENT CARE SERVICES	(i)	21,859.	0.	0.	0.	0.	21,859.	0.
		(ii)	92,823.	21,542.	215.	2,388.	19,626.	136,594.	0.
16	ANABELLE MAQUILING REGISTERED NURSE	(i)	150,945.	500.	89.	9,858.	28,428.	189,820.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.

Part III Supplemental Information

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

PART I, LINE 1A:

ALL BOARD MEMBERS ARE ELIGIBLE FOR COMPLIMENTARY HEALTH CLUB MEMBERSHIPS.

THE BOARD MEMBERS WHO SIGN UP AND RECEIVE THE COMPLIMENTARY MEMBERSHIP

ARE REPORTED ON FORM 990, PART VII.

PART I, LINE 3:

THE COMPENSATION OF LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL,
INC.'S PRESIDENT IS DETERMINED AT THE PARENT LEVEL BY LIFEBRIDGE HEALTH,
INC. THE METHODS USED AT LIFEBRIDGE HEALTH, INC. INCLUDE COMPENSATION
COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT
CONTRACT, COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR
COMPENSATION COMMITTEE.

PART I, LINE 4B:

DURING THE YEAR, THE FOLLOWING DIRECTORS AND OFFICERS PARTICIPATED IN A
LIFEBRIDGE HEALTH SPONSORED SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN:

NEIL MELTZER \$685,526

DAVID KREJEWSKI \$279,355

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.

LESLIE SIMMONS	\$227,561
JAMES ROBERGE	\$ 40,501
NANCY KANE	\$ 35,641
DEBORAH GRAVES	\$ 34,720
LOU DUNAWAY	\$ 29,001
HOLLY PHIPPS ADAMS	\$ 39,153
JASON WEINER	\$105,764

DURING THE YEAR, THE FOLLOWING DIRECTORS AND OFFICERS RECEIVED PAYMENTS
AS PART OF THEIR PARTICIPATION IN A LIFEBRIDGE HEALTH SPONSORED
SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN:

NEIL MELTZER	\$425,633
DAVID KREJEWSKI	\$193,756
LESLIE SIMMONS	\$147,274
JAMES ROBERGE	\$ 41,265
NANCY KANE	\$ 37,094
TERRENCE CARNEY	\$ 38,830

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 VII, LINE 5 - DISCLOSURE INFORMATION

THE ORGANIZATION AND ITS AFFILIATED PAID POST ACUTE PHYSICANS PARTNERS

\$48,000 DURING FISCAL YEAR 2021 FOR DR. RAYMOND MILLER'S SERVICES.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2020

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Department of the Treasury
Internal Revenue Service

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

▶ **Attach to Form 990 or Form 990-EZ.**

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

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.**

Employer identification number
52-0607913

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

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

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

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

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

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

Part III Grants or Assistance Benefiting Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

1	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ACME PAPER & SUPPLY CO., INC.	INDIRECT BUSINESS	4,067,462.	SEE PART V		X
(2) LONDON ELIGIBILITY, INC.	INDIRECT BUSINESS	935,537.	SEE PART V		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

PART IV, COLUMN (D)

ACME PAPER & SUPPLY CO., INC.

LEVINDALE HEBREW GERIATRIC CENTER, INC. AND OTHER LIFEBRIDGE SUBSIDIARIES PURCHASED APPROXIMATELY \$4,067,462 IN PAPER SUPPLIES FROM ACME PAPER & SUPPLY CO. ONE OF THE DIRECTORS OF LEVINDALE, MR. KEITH ATTMAN, IS THE DIRECTOR OF PURCHASING FOR ACME PAPER & SUPPLY CO. MR. ATTMAN'S FAMILY ALSO OWNS ACME PAPER & SUPPLY CO. ALL TRANSACTIONS WERE AT FAIR MARKET VALUE AND NEGOTIATED AT ARM'S LENGTH.

LONDON ELIGIBILITY, INC.

LIFEBRIDGE HEALTH SUBSIDIARIES PAID APPROXIMATELY \$935,537 FOR LEGAL SERVICES FROM LONDON ELIGIBILITY, INC. ONE OF THE DIRECTORS OF LEVINDALE, SCOTT LONDON, IS PRESIDENT OF THE FIRM. ALL TRANSACTIONS WERE AT FAIR MARKET VALUE AND NEGOTIATED AT ARM'S LENGTH.

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

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

2020

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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.

Name of the organization
LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.

Employer identification number
52-0607913

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

THE CORPORATION SHALL HAVE ONE MEMBER: LIFEBRIDGE HEALTH INC., (THE
"MEMBER") A MARYLAND NONSTOCK CORPORATION. MEMBERSHIP IN THE CORPORATION
SHALL NOT BE TRANSFERABLE.

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

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

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

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

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

THE LIFEBRIDGE EXEMPT ENTITIES 990'S ARE INITIALLY REVIEWED BY THE
ASSISTANT VICE PRESIDENT OF FINANCIAL REPORTING. IN ADDITION, AN
INDEPENDENT ACCOUNTING FIRM ALSO REVIEWS ALL THE 990 RETURNS. A FORMAL

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.

Employer identification number
52-0607913

MEETING IS THEN SCHEDULED WITH THE CHIEF FINANCIAL OFFICER, VICE
PRESIDENT OF FINANCIAL REPORTING, GENERAL COUNSEL, AND THE ASSISTANT VICE
PRESIDENT OF FINANCIAL REPORTING TO REVIEW IN THEIR ENTIRETY ALL THE
LIFEBRIDGE EXEMPT ENTITIES 990'S. MANAGEMENT THEN PROVIDES A COPY OF THE
990'S TO THE AUDIT AND COMPLIANCE COMMITTEE OF THE LIFEBRIDGE HEALTH
BOARD AND TO EACH INDIVIDUAL BOARD DIRECTOR PRIOR TO THE FILING DATE FOR
REVIEW.

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

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

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

LIFEBRIDGE AND ALL OF ITS SUBSIDIARIES SHALL REQUIRE ALL EMPLOYEES,
MEDICAL STAFF, AND MEMBERS OF THE BOARD TO DISCLOSE ANY ACTIVITIES THAT
COULD RESULT IN A POSSIBLE CONFLICT OF INTEREST. IF A CONFLICT IS
IDENTIFIED, THE PERSON INVOLVED WOULD RECUSE HIM/HERSELF FROM
DELIBERATIONS REGARDING THE TRANSACTIONS. AN INDIVIDUAL IS CONSIDERED TO
HAVE A CONFLICT OF INTEREST WITH REGARD TO A MATTER OR TRANSACTION IF THE

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.

Employer identification number
52-0607913

INDIVIDUAL HAS A PERSONAL OR FINANCIAL INTEREST THAT HAS THE POTENTIAL TO INFLUENCE THE ACTION TAKEN BY THE INDIVIDUAL ON BEHALF OF LIFEBRIDGE OR ANY OF ITS SUBSIDIARIES.

AN INDIVIDUAL IS CONSIDERED TO HAVE A "PERSONAL INTEREST" IN A MATTER IF IT IS LIKELY TO HAVE A DIRECT AND MATERIAL IMPACT ON THE INDIVIDUAL'S RELATIONSHIP WITH LIFEBRIDGE OR ANY OF ITS SUBSIDIARIES (E.G., THE INDIVIDUAL'S CONTINUED MEMBERSHIP ON A SUBSIDIARY HOSPITAL'S MEDICAL STAFF), OR ON THE INDIVIDUAL'S OWN HEALTH CARE, OR THE INDIVIDUAL IS PERSONALLY INVOLVED IN A SUBSTANTIAL WAY (E.G., SERVES AS AN OFFICER, DIRECTOR, TRUSTEE, OR KEY EMPLOYEE) WITH ANOTHER ORGANIZATION THAT HAS A SIGNIFICANT INTEREST IN THE MATTER.

AN INDIVIDUAL IS CONSIDERED TO HAVE A "FINANCIAL INTEREST" IN A TRANSACTION IF THE INDIVIDUAL, OR THEIR FAMILY MEMBER, (I) IS A PARTY TO THE TRANSACTION, (II) WILL BENEFIT PERSONALLY FROM THE TRANSACTION, OR (III) HAS, DIRECTLY OR INDIRECTLY, A CURRENT OR ANTICIPATED OWNERSHIP OR INVESTMENT IN, OR COMPENSATION ARRANGEMENT WITH, A PARTY TO THE TRANSACTION. AN OWNERSHIP INTEREST OF LESS THAN 5% IN AN ENTITY WILL NOT, IN AND OF ITSELF, GENERALLY BE CONSIDERED A FINANCIAL INTEREST; HOWEVER, TO THE EXTENT THE INDIVIDUAL'S COMPENSATION FROM THE ENTITY IS DIRECTLY LINKED TO THE ENTITY'S BUSINESS WITH LIFEBRIDGE HEALTH, SUCH COMPENSATION WILL CONSTITUTE A FINANCIAL INTEREST.

FOR THE PURPOSES OF THIS POLICY, A "FAMILY MEMBER" INCLUDES SPOUSE OR

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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DOMESTIC PARTNER, PARENTS, BROTHERS AND SISTERS, CHILDREN (WHETHER NATURAL OR ADOPTED), GRANDPARENTS, GRANDCHILDREN, GREAT-GRANDCHILDREN, AND IN-LAWS, SPOUSES OF BROTHERS, SISTERS, CHILDREN, GRANDCHILDREN, AND GREAT-GRANDCHILDREN, AND ANY OTHER MEMBER OF A HOUSEHOLD OF THE INDIVIDUAL.

CONFLICTS OF INTEREST ARE TO BE REPORTED BY EMPLOYEES TO THEIR SUPERVISOR, WHO WILL BE RESPONSIBLE FOR DETERMINING WHETHER FURTHER DISSEMINATION IS NECESSARY.

MEMBERS OF THE MEDICAL STAFF SHOULD REPORT CONFLICTS TO THE CHIEF OF THEIR DEPARTMENT, AND MEMBERS OF THE BOARD SHOULD REPORT THEM TO THE CHIEF COMPLIANCE OFFICER.

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

NOTHING IN THIS DEFINITION IS INTENDED TO RELIEVE ANY PERSON OF ANY ADDITIONAL OBLIGATIONS THAT MAY BE IMPOSED BY STATE OR FEDERAL LAW.

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

IT IS THE POLICY OF LIFEBRIDGE HEALTH INC. AND ITS SUBSIDIARIES TO MAKE AVAILABLE UPON REQUEST THE AUDITED FINANCIAL STATEMENTS TO THE GENERAL PUBLIC. THE LIFEBRIDGE HEALTH INC. AND SUBSIDIARY GOVERNING DOCUMENTS ARE NOT MADE AVAILABLE TO THE GENERAL PUBLIC UPON REQUEST OR VIA A WEBSITE.

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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THE CONFLICT OF INTEREST POLICY IS INCLUDED ON SCHEDULE O.

FORM 990, PART IX, LINE 9:

CHANGE IN THE NET ASSETS OF BALTIMORE

JEWISH ELDERCARE FOUNDATION	\$3,462,642
ADJUSTMENT TO PENSION BENEFIT	3,266,889
NON-UNION PENSION NON SERVICE COST	(496,220)
UNLOCATED	(184)

TOTAL	\$6,232,827

ATTACHMENT 1

FORM 990, PART III, LINE 1 - ORGANIZATION'S MISSION

LEVINDALE IS A GERIATRIC CENTER AND HOSPITAL DEDICATED TO PROVIDING SERVICE IN A COST-EFFECTIVE MANNER FOR THE AGED, FRAIL AND ILL IN INSTITUTIONAL, COMMUNITY AND HOME SETTINGS. AS AN ADVOCATE FOR THE ELDERLY, LEVINDALE ACCEPTS A LEADERSHIP ROLE IN DEFINING AND DEVELOPING, IN COLLABORATION WITH OTHER AGENCIES, A COMPREHENSIVE CONTINUUM OF NURSING, MEDICAL, AND SOCIAL SERVICES WITHIN THE JEWISH COMMUNITY OF THE BALTIMORE METROPOLITAN AREA. PROGRAMS ARE OPERATED WITHIN THE VALUES INHERENT IN JUDAISM PURSUANT TO LEVINDALE'S CHARTER.

ATTACHMENT 2

Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	Employer identification number 52-0607913
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ATTACHMENT 2 (CONT'D)990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
METZ CULINARY MANAGEMENT TWO WOODLAND DRIVE DALLAS, PA 18612	FOOD SERVICE	2,159,036.
HEALTH CAROUSEL TRAVEL 3805 EDWARDS ROAD, SUITE 700 CINCINNATI, OH 45209	AGENCY NURSING	1,263,709.
CORNERSTONE HEALTHCARE 5 ENGLEFIELD SQUARE OWINGS MILLS, MD 21117	AGENCY NURSING	606,727.
CHESAPEAKE VASCULAR 4725 DORSEY HALL DRIVE, SUITE A ELLICOTT CITY, MD 21042	CONT PICC LINE INSR	328,300.
HANDCRAFT LINEN SERVICES 2810 COFER ROAD RICHMOND, VA 23224	CONT LAUNDRY SERVICE	287,972.

ATTACHMENT 3FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
FOOD SERVICE CONTRACT	3,763,395.	3,763,395.	0.	0.
AGENCY NURSES	2,327,437.	2,314,002.	13,435.	0.
OTHER EXPENSES	2,164,343.	220,518.	1,943,825.	0.
LABORATORY SERVICE	1,280,558.	209,698.	1,070,860.	0.
PROF. & TECHNICAL EXPENSE	364,549.	310,192.	54,357.	0.
CONTRACT RENAL DIALYSIS	314,046.	314,046.	0.	0.
MISC. PURCHASED SERVICES	311,584.	243,086.	68,498.	0.
LAUNDRY SERVICE	262,047.	262,047.	0.	0.
CONTRACT CLEANING	251,017.	0.	251,017.	0.

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.**Employer identification number
52-0607913ATTACHMENT 3 (CONT'D)FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	<u>(A) TOTAL FEES</u>	<u>(B) PROGRAM SERVICE EXP.</u>	<u>(C) MANAGEMENT AND GENERAL</u>	<u>(D) FUNDRAISING EXPENSES</u>
OTHER SUBSIDY	231,405.	225,200.	6,205.	0.
CONTRACT PICC LINE	218,455.	218,455.	0.	0.
SPECIAL PATIENT TRANSPORTATION	178,633.	178,633.	0.	0.
COLLECTION SERVICE FEES	101,336.	0.	101,336.	0.
CONTRACT SNOW REMOVAL	92,524.	0.	92,524.	0.
BUNDLE BILLING SERVICE FEES	83,173.	83,173.	0.	0.
PURCHASED PAYROLL SERVICES	81,263.	81,263.	0.	0.
TOTALS	<u>12,025,765.</u>	<u>8,423,708.</u>	<u>3,602,057.</u>	<u>0.</u>

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2020

**Open to Public
Inspection**

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

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.**

Employer identification number
52-0607913

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CARROLL HOSPITAL CENTER, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157 52-1452024	HOSPITAL	MD	501(C)(3)	3	CCHS		X
(2) BRIDGEINGLIFE, INC 292 STONER AVENUE WESTMINSTER, MD 21157 52-1565870	HOSPICE	MD	501(C)(3)	7	CHC		X
(3) CARROLL HOSPITAL CENTER FOUNDATION, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157 52-1115038	FOUNDATION	MD	501(C)(3)	12A, I	CHC		X
(4) PARTNERSHIP FOR A HEALTHIER CARROLL CTY 535 OLD WESTMINSTER PIKE, # 10 WESTMINSTER, MD 21157 52-2156892	HEALTH SVCS	MD	501(C)(3)	7	CHC		X
(5) SINAI HOSPITAL OF BALTIMORE INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-0486540	HOSPITAL	MD	501(C)(3)	3	LBH		X
(6) COURTLAND GARDENS NURSING AND REHAB CTR 2434 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-0607907	NURSING	MD	501(C)(3)	10	LBH		X
(7) NORTHWEST HOSPITAL CENTER INC 5401 OLD COURT ROAD RANDALLSTOWN, MD 21133 52-1372665	HOSPITAL	MD	501(C)(3)	3	LBH		X

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

Schedule R (Form 990) 2020

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2020

**Open to Public
Inspection**

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

▶ **Attach to Form 990.**

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Department of the Treasury
Internal Revenue Service

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.**

Employer identification number
52-0607913

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CHILDRENS HOSPITAL OF BALTIMORE CITY INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-0591592	HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
(2) THE BALTIMORE JEWISH HEALTH FDN, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-2111541	HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
(3) CHILDRENS HOSPITAL AT SINAI FOUNDATION 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-2167587	HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
(4) THE BALTIMORE JEWISH ELDERCARE FDN 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-2337669	HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
(5) LIFEBRIDGE HEALTH, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-1402373	SUPPORT	MD	501(C)(3)	12C, III	N/A		X
(6) CENTER FOR HOPE, INC 2300 NORTH CHARLES STREET BALTIMORE, MD 21218 52-1681279	CHILD SVCS	MD	501(C)(3)	7	LBH		X
(7) GRACE MEDICAL CENTER, INC 2000 W BALTIMORE STREET BALTIMORE, MD 21223 52-0591555	HOSPITAL	MD	501(C)(3)	3	LBH		X

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

Schedule R (Form 990) 2020

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2020

**Open to Public
Inspection**

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

▶ Attach to Form 990.

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

Department of the Treasury
Internal Revenue Service

Name of the organization **LEVINDALE HEBREW GERIATRIC CENTER AND
HOSPITAL, INC.**

Employer identification number
52-0607913

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) WEST BALTIMORE RENAISSANCE FDN, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 84-3355332	COMMUNITY CTR	MD	501(C)(3)	7	LBH		X
(2) CARROLL COUNTY HEALTH SERVICES CORP 200 MEMORIAL AVENUE WESTMINSTER, MD 21157 52-0691413	HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
(3) LIFEBRIDGE CENTER FOR HOPE, LLC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 85-3920012	REAL ESTATE	MD	501(C)(3)	12A, I	SHB		X
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) 2020

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) CARROLL COUNTY RADIOLOGY, LLC 7253 AMBASSADOR ROAD BALTIMORE	RADIOLOGY	MD	N/A	N/A	0.	0.		X	0.		X	
(2) CARROLL OCCUPATIONAL HEALTH, L 7001 CORPORATE CENTER COURT WE	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(3) CARDIOVASCULAR ASSOCIATES OF M 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(4) LIFEBRIDGE CARDIOLOGY OF PARKV 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(5) LIFEBRIDGE COMMUNITY GASTROENT 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(6) LIFEBRIDGE COMMUNITY PEDIATRIC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(7) LIFEBRIDGE COMMUNITY PULMONOLO 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) CARROLL COUNTY MED-SERVICES, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	MEDICAL SERVICES	52-1891102 MD	N/A	C CORP	0.	0.			X
(2) LIFEBRIDGE INVESTMENTS, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	INVESTMENT	52-1483166 MD	N/A	C CORP	0.	0.			X
(3) HEALTHSTAR MEDICAL SERVICES, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	HEALTHCARE	52-1829098 MD	N/A	C CORP	0.	0.			X
(4) PRACTICE DYNAMICS, INC 124 BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136	MANAGEMENT	52-1960319 MD	N/A	C CORP	0.	0.			X
(5) LIFEBRIDGE INSURANCE COMPANY, LTD PO BOX 1109 GRAND CAYMAN, CJ KY1-1102	INSURANCE	98-0415396 CJ	N/A	C CORP	0.	0.			X
(6) LIFEBRIDGE COMMUNITY PHYSICIANS, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215	HEALTHCARE	80-0719005 MD	N/A	C CORP	0.	0.			X
(7) CARROLL BILLING SERVICES, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	HEALTHCARE	30-0026598 MD	N/A	C CORP	0.	0.			X

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) LIFEBRIDGE GYNECOLOGY OF PIKES 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(2) LIFEBRIDGE MEDICAL ASSOCIATES, 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(3) LIFEBRIDGE NEUROSCIENCES, LLC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(4) LIFEBRIDGE PRIMARY CARE OF ELD 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(5) LIFEBRIDGE PRIMARY CARE OF NOR 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(6) HOMECARE MARYLAND, LLC 26-1378 8028 RITCHIE HIGHWAY, SUITE 21	HOME HEALTH SRVC	MD	N/A	N/A	0.	0.		X	0.		X	
(7) LIFEBRIDGE REHABILITATION SERV 2401 WEST BELVEDERE AVENUE BAL	REHAB SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) CARROLL COUNTY GEN. HOSP. SOUTH CARROLL 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	REAL ESTATE	MD	N/A	C CORP	0.	0.			X
(2) MED-SERVICES HOLDINGS, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	N/A	C CORP	0.	0.			X
(3) CARROLL URGENT CARE, LLC 46-5739154 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	HEALTHCARE	MD	N/A	C CORP	0.	0.			X
(4) CARROLL HEALTH GROUP, LLC 27-1956453 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	HEALTHCARE	MD	N/A	C CORP	0.	0.			X
(5) LIFEBRIDGE HEALTH ISRAEL, LTD 51-5804516 16 ABBA HILLEL ROAD RAHMAT GAN, IS 5250608	HEALTHCARE	IS	N/A	C CORP	0.	0.			X
(6)									
(7)									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) ELLICOTT CITY ASC MANAGEMENT, 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(2) SURGICENTER OF BALTIMORE, LLC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(3) MOUNT AIRY MED-SERVICES, LLC 4 200 MEMORIAL AVENUE WESTMINSTE	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(4) SPRINGWELL PARTNERS, LLC 27-19 2200 PINE HILL FARMS LANE HUNT	ASSISTED LIVING	MD	N/A	N/A	0.	0.		X	0.		X	
(5) LIFEBRIDGE SUBURBAN PHYSICIAN 5401 OLD COURT ROAD RANDALLSTO	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(6) LIFEBRIDGE LAB MANAGEMENT, LLC 2401 WEST BELVEDERE AVENUE BAL	LAB SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(7) LIFEBRIDGE METROPOLITAN PHYSIC 2401 WEST BELVEDERE AVENUE BAL	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) LIFEBRIDGE MULTI-SPECIALTY, LL 41 MAGNA WAY, SUITE 100 WESTMI	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(2) ELLICOTT CITY AMBULATORY SURGE 2850 N RIDGE ROAD ELLICOTT CIT	MEDICAL SERVICES	MD	N/A	N/A	0.	0.		X	0.		X	
(3) OAK FARM SOLUTIONS, LLC 47-494 1122 KENILWORTH DRIVE, SUITE 3	HOME HEALTH SRVC	MD	N/A	N/A	0.	0.		X	0.		X	
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

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

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)		X
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)		X
k Lease of facilities, equipment, or other assets from related organization(s)		X
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)		X
p Reimbursement paid to related organization(s) for expenses	X	
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)	X	
s Other transfer of cash or property from related organization(s)	X	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

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

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

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

**Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))**

For calendar year 2020 or other tax year beginning 07/01, 2020, and ending 06/30, 2021

2020

Department of the Treasury
Internal Revenue Service

▶ Go to www.irs.gov/Form990T for instructions and the latest information.

▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

Open to Public Inspection for
501(c)(3) Organizations Only

A <input type="checkbox"/> Check box if address changed.		Name of organization (<input type="checkbox"/> Check box if name changed and see instructions.) LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	D Employer identification number 52-0607913
B Exempt under section <input checked="" type="checkbox"/> 501(C)(3) <input type="checkbox"/> 408(e) <input type="checkbox"/> 220(e) <input type="checkbox"/> 408A <input type="checkbox"/> 530(a) <input type="checkbox"/> 529(a) <input type="checkbox"/> 529A	Print or Type	Number, street, and room or suite no. If a P.O. box, see instructions. 2434 WEST BELVEDERE AVENUE	E Group exemption number (see instructions)
		City or town, state or province, country, and ZIP or foreign postal code BALTIMORE, MD 21215	
		C Book value of all assets at end of year ▶ 101,881,010.	
G Check organization type ▶ <input checked="" type="checkbox"/> 501(c) corporation <input type="checkbox"/> 501(c) trust <input type="checkbox"/> 401(a) trust <input type="checkbox"/> Other trust <input type="checkbox"/> Applicable reinsurance entity			
H Check if filing only to ▶ <input type="checkbox"/> Claim credit from Form 8941 <input type="checkbox"/> Claim a refund shown on Form 2439			
I Check if a 501(c)(3) organization filing a consolidated return with a 501(c)(2) titleholding corporation ▶ <input type="checkbox"/>			
J Enter the number of attached Schedules A (Form 990-T) ▶ 1			
K During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," enter the name and identifying number of the parent corporation ▶ ATCH 1			
L The books are in care of ▶ NANCY KANE		Telephone number ▶ 410-601-5653	

10090 RED RUN BLVD.
OWINGS MILLS MD 21117

Part I Total Unrelated Business Taxable Income

1 Total of unrelated business taxable income computed from all unrelated trades or businesses (see instructions).	1	-4,218.
2 Reserved	2	
3 Add lines 1 and 2	3	-4,218.
4 Charitable contributions (see instructions for limitation rules)	4	
5 Total unrelated business taxable income before net operating losses. Subtract line 4 from line 3	5	-4,218.
6 Deduction for net operating loss. See instructions.	6	
7 Total of unrelated business taxable income before specific deduction and section 199A deduction. Subtract line 6 from line 5	7	-4,218.
8 Specific deduction (generally \$1,000, but see instructions for exceptions)	8	
9 Trusts. Section 199A deduction. See instructions.	9	
10 Total deductions. Add lines 8 and 9	10	
11 Unrelated business taxable income. Subtract line 10 from line 7. If line 10 is greater than line 7, enter zero.	11	0.

Part II Tax Computation

1 Organizations taxable as corporations. Multiply Part I, line 11 by 21% (0.21) ▶	1	
2 Trusts taxable at trust rates. See instructions for tax computation. Income tax on the amount on Part I, line 11 from: <input type="checkbox"/> Tax rate schedule or <input type="checkbox"/> Schedule D (Form 1041). ▶	2	
3 Proxy tax. See instructions ▶	3	
4 Other tax amounts. See instructions	4	
5 Alternative minimum tax (trusts only)	5	
6 Tax on noncompliant facility income. See instructions	6	
7 Total. Add lines 3 through 6 to line 1 or 2, whichever applies	7	

For Paperwork Reduction Act Notice, see instructions.

Part III Tax and Payments

1 a Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116). 1a
b Other credits (see instructions). 1b
c General business credit. Attach Form 3800 (see instructions) 1c
d Credit for prior year minimum tax (attach Form 8801 or 8827). 1d
e Total credits. Add lines 1a through 1d. 1e
2 Subtract line 1e from Part II, line 7 2
3 Other taxes. Check if from: Form 4255 Form 8611 Form 8697 Form 8866
Other (attach statement) 3
4 Total tax. Add lines 2 and 3 (see instructions). Check if includes tax previously deferred under section 1294. Enter tax amount here. 4 0.
5 2020 net 965 tax liability paid from Form 965-A or Form 965-B, Part II, column (k), line 4 5
6 a Payments: A 2019 overpayment credited to 2020 6a
b 2020 estimated tax payments. Check if section 643(g) election applies Form 6b
c Tax deposited with Form 8868. 6c
d Foreign organizations: Tax paid or withheld at source (see instructions) 6d
e Backup withholding (see instructions) 6e
f Credit for small employer health insurance premiums (attach Form 8941) 6f
g Other credits, adjustments, and payments: Form 2439 Other Total Form 4136 Other Total Form 6g
7 Total payments. Add lines 6a through 6g 7
8 Estimated tax penalty (see instructions). Check if Form 2220 is attached. 8
9 Tax due. If line 7 is smaller than the total of lines 4, 5, and 8, enter amount owed 9
10 Overpayment. If line 7 is larger than the total of lines 4, 5, and 8, enter amount overpaid. 10
11 Enter the amount of line 10 you want: Credited to 2021 estimated tax Refunded 11

Part IV Statements Regarding Certain Activities and Other Information (see instructions)

1 At any time during the 2020 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If "Yes," the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If "Yes," enter the name of the foreign country here X
2 During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If "Yes," see instructions for other forms the organization may have to file. X
3 Enter the amount of tax-exempt interest received or accrued during the tax year \$
4 a Did the organization change its method of accounting? (see instructions) X
b If 4a is "Yes," has the organization described the change on Form 990, 990-EZ, 990-PF, or Form 1128? If "No," explain in Part V

Part V Supplemental Information

Provide the explanation required by Part IV, line 4b. Also, provide any other additional information. See instructions.

Sign Here DAVID KRAJEWSKI 05/06/2022 EXECUTIVE VP/CFO
Signature of officer Date Title
May the IRS discuss this return with the preparer shown below (see instructions)? X Yes No
Paid Preparer Use Only Print/Type preparer's name Preparer's signature Date
MARC BERGER 5/10/2022
Firm's name BDO USA, LLP Firm's EIN 13-5381590
Firm's address 8401 GREENSBORO DRIVE, #800, MCLAN, VA 22102 Phone no. 703-893-0600

**SCHEDULE A
(Form 990-T)**

**Unrelated Business Taxable Income
From an Unrelated Trade or Business**

OMB No. 1545-0074

2020

Department of the Treasury
Internal Revenue Service

▶ Go to www.irs.gov/Form990T for instructions and the latest information.

▶ Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).

**Open to Public Inspection for
501(c)(3) Organizations Only**

A Name of the organization LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.	B Employer identification number 52-0607913
C Unrelated business activity code (see instructions) ▶ 561000	D Sequence: 1 of 1

E Describe the unrelated trade or business ▶ MANAGEMENT FEE INCOME

Part I Unrelated Trade or Business Income	(A) Income	(B) Expenses	(C) Net
1a Gross receipts or sales			
b Less returns and allowances c Balance ▶			
2 Cost of goods sold (Part III, line 8)			
3 Gross profit. Subtract line 2 from line 1c			
4a Capital gain net income (attach Sch D (Form 1041 or Form 1120)) (see instructions)			
b Net gain (loss) (Form 4797) (attach Form 4797) (see instructions)			
c Capital loss deduction for trusts			
5 Income (loss) from a partnership or an S corporation (attach statement)			
6 Rent income (Part IV)			
7 Unrelated debt-financed income (Part V)			
8 Interest, annuities, royalties, and rents from a controlled organization (Part VI)			
9 Investment income of section 501(c)(7), (9), or (17) organizations (Part VII)			
10 Exploited exempt activity income (Part VIII)			
11 Advertising income (Part IX)			
12 Other income (see instructions; attach statement) . . . ATCH 2	4,179.		4,179.
13 Total. Combine lines 3 through 12	4,179.		4,179.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions) Deductions must be directly connected with the unrelated business income		(A) Income	(B) Expenses	(C) Net
1 Compensation of officers, directors, and trustees (Part X)	1			
2 Salaries and wages	2			8,360.
3 Repairs and maintenance	3			
4 Bad debts	4			
5 Interest (attach statement) (see instructions)	5			
6 Taxes and licenses	6			
7 Depreciation (attach Form 4562) (see instructions)	7			
8 Less depreciation claimed in Part III and elsewhere on return	8a			
9 Depletion	9			
10 Contributions to deferred compensation plans	10			
11 Employee benefit programs	11			
12 Excess exempt expenses (Part VIII)	12			
13 Excess readership costs (Part IX)	13			
14 Other deductions (attach statement) . . . ATCH 3	14			37.
15 Total deductions. Add lines 1 through 14	15			8,397.
16 Unrelated business income before net operating loss deduction. Subtract line 15 from Part I, line 13, column (C)	16			-4,218.
17 Deduction for net operating loss (see instructions)	17			
18 Unrelated business taxable income. Subtract line 17 from line 16	18			-4,218.

For Paperwork Reduction Act Notice, see instructions.

Schedule A (Form 990-T) 2020

Part III Cost of Goods Sold

Enter method of inventory valuation

Table with 8 rows for Cost of Goods Sold: 1 Inventory at beginning of year, 2 Purchases, 3 Cost of labor, 4 Additional section 263A costs, 5 Other costs, 6 Total, 7 Inventory at end of year, 8 Cost of goods sold.

9 Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization? Yes No

Part IV Rent Income (From Real Property and Personal Property Leased with Real Property)

Table with 1 row for Description of property (property street address, city, state, ZIP code). Check if a dual-use (see instructions). Columns A, B, C, D.

Table with 2 rows for Rent received or accrued. Row 2a: From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%). Row 2b: From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income). Row 2c: Total rents received or accrued by property. Add lines 2a and 2b, columns A through D.

3 Total rents received or accrued. Add line 2c columns A through D. Enter here and on Part I, line 6, column (A)

Table with 1 row for Deductions directly connected with the income in lines 2(a) and 2(b) (attach statement). Columns A, B, C, D.

5 Total deductions. Add line 4 columns A through D. Enter here and on Part I, line 6, column (B)

Part V Unrelated Debt-Financed Income (see instructions)

Table with 1 row for Description of debt-financed property (street address, city, state, ZIP code). Check if a dual-use (see instructions). Columns A, B, C, D.

Table with 4 rows for Unrelated Debt-Financed Income: 2 Gross income from or allocable to debt-financed property, 3 Deductions directly connected with or allocable to debt-financed property (3a Straight line depreciation, 3b Other deductions, 3c Total deductions), 4 Amount of average acquisition debt on or allocable to debt-financed property, 5 Average adjusted basis of or allocable to debt-financed property, 6 Divide line 4 by line 5, 7 Gross income reportable. Multiply line 2 by line 6.

8 Total gross income (add line 7, columns A through D). Enter here and on Part I, line 7, column (A)

Table with 1 row for Allocable deductions. Multiply line 3c by line 6. Columns A, B, C, D.

10 Total allocable deductions. Add line 9, columns A through D. Enter here and on Part I, line 7, column (B)

11 Total dividends-received deductions included in line 10.

Part VI Interest, Annuities, Royalties, and Rents from Controlled Organizations (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations			
		3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

Nonexempt Controlled Organizations

7. Taxable income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
Totals			Add columns 5 and 10. Enter here and on Part I, line 8, column (A)	Add columns 6 and 11. Enter here and on Part I, line 8, column (B)

Part VII Investment Income of a Section 501(c)(7), (9), or (17) Organization (see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach statement)	4. Set-asides (attach statement)	5. Total deductions and set-asides (add columns 3 and 4)
(1)				
(2)				
(3)				
(4)				
Totals		Add amounts in column 2. Enter here and on Part I, line 9, column (A)		Add amounts in column 5. Enter here and on Part I, line 9, column (B)

Part VIII Exploited Exempt Activity Income, Other Than Advertising Income (see instructions)

1 Description of exploited activity: _____	
2 Gross unrelated business income from trade or business. Enter here and on Part I, line 10, column (A)	2
3 Expenses directly connected with production of unrelated business income. Enter here and on Part I, line 10, column (B)	3
4 Net income (loss) from unrelated trade or business. Subtract line 3 from line 2. If a gain, complete lines 5 through 7	4
5 Gross income from activity that is not unrelated business income	5
6 Expenses attributable to income entered on line 5	6
7 Excess exempt expenses. Subtract line 5 from line 6, but do not enter more than the amount on line 4. Enter here and on Part II, line 12	7

990-T: ITEM K - NAME AND FEIN OF PARENT CORPORATION

LIFEBRIDGE HEALTH, INC.
52-1402373

SCHEDULE A: MANAGEMENT FEE INCOME

PART I LINE 12 - OTHER INCOME

BILLING FEE INCOME	4,179.
TOTAL	<u>4,179.</u>

SCHEDULE A: MANAGEMENT FEE INCOME

PART II LINE 14 - OTHER DEDUCTIONS DETAIL

ENVELOPES	37.
TOTAL OTHER DEDUCTIONS	<u>37.</u>