

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

2021

Open to Public Inspection

A For the 2021 calendar year, or tax year beginning 07/01/2021 **and ending** 06/30/2022

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			E Telephone number (410) 601-5653		
	2434 WEST BELVEDERE AVENUE					
	City or town, state or province, country, and ZIP or foreign postal code					
	BALTIMORE, MD 21215			G Gross receipts \$ 101,784,357.		
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			H(c) Group exemption number ▶
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 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	31
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	29
	5 Total number of individuals employed in calendar year 2021 (Part V, line 2a)	5	994
	6 Total number of volunteers (estimate if necessary)	6	NONE
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	28,738.
b Net unrelated business taxable income from Form 990-T, line 34	7b	NONE	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	1,150,259.	1,126,430.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	72,858,927.	90,254,338.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	1,896,715.	1,996,919.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	363,834.	422,022.
		76,269,735.	93,799,709.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	NONE	NONE
	14 Benefits paid to or for members (Part IX, column (A), line 4)	NONE	NONE
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	54,801,499.	53,302,137.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	NONE	NONE
	b Total fundraising expenses (Part IX, column (D), line 25) ▶	NONE	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	28,608,389.	31,126,404.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	83,409,888.	84,428,541.	
19 Revenue less expenses. Subtract line 18 from line 12	-7,140,153.	9,371,168.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	101,881,010.	89,301,544.
	22 Net assets or fund balances. Subtract line 21 from line 20.	50,853,156.	33,229,618.
	51,027,854.	56,071,926.	

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 Type or print name and title	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		5/7/2023		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** (2021)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

SEE SCHEDULE O

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

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

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

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

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

4a (Code:) (Expenses \$ 29,105,527. including grants of \$ NONE) (Revenue \$ 60,500,906.)

LEVINDALE OPERATES A 120-BED CHRONIC HOSPITAL, WHICH PROVIDES SPECIALTY LONG STAY HOSPITAL SERVICES, REHABILITATION CARE, AND BEHAVIORAL HEALTH CARE. LEVINDALE PROVIDED 31,295 INPATIENT DAYS: 7,626 IN THE HIGH-INTENSITY CARE UNIT (HICU); 3,843 IN THE REHABILITATION UNIT; AND 19,826 IN THE BRAIN HEALTH UNIT.

4b (Code:) (Expenses \$ 30,419,161. including grants of \$ NONE) (Revenue \$ 26,642,787.)

LEVINDALE OPERATES A 210-BED NURSING FACILITY, WHICH INCLUDES A 60-BED SUBACUTE UNIT. LEVINDALE PROVIDED 21,454 PATIENT DAYS OF SUBACUTE CARE AND 48,004 DAYS OF INTERMEDIATE NURSING CARE.

4c (Code:) (Expenses \$ 2,904,516. including grants of \$ NONE) (Revenue \$ 3,110,645.)

LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL PROVIDES ADULT DAY CARE, PARTIAL HOSPITALIZATION, CLINIC SERVICES, AND REHABILITATION SERVICES. LEVINDALE PROVIDED 9,076 DAYS IN ITS ADULT DAY CARE PROGRAM. THE PARTIAL HOSPITALIZATION PROGRAM HAD 1,707 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 62,429,204.

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>	<input checked="" type="checkbox"/>	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
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 Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III.</i>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
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>	<input checked="" type="checkbox"/>	
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>	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X.</i>	<input checked="" type="checkbox"/>	
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>	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>
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>	<input checked="" type="checkbox"/>	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i>		<input checked="" type="checkbox"/>
14a Did the organization maintain an office, employees, or agents outside of the United States?.		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
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>		<input checked="" type="checkbox"/>
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H.</i>	<input checked="" type="checkbox"/>	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<input checked="" type="checkbox"/>	
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>		<input checked="" type="checkbox"/>

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

	Yes	No
1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable		
1b Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable.		
1c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		

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 17 regarding employee reporting, tax shelter 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 (31), 1b (29), 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 NANCY KANE 10090 RED RUN BLVD. OWINGS MILLS, MD 21117

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
 - List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
 - List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
 - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.
- See the instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) NEIL M. MELTZER PRESIDENT/CEO/DIR, LIFEBRIDGE	1.00 40.00				X			NONE	3,103,147.	60,154.
(2) DAVID KRAJEWSKI ASSISTANT TREASURER	1.00 40.00			X				NONE	1,586,119.	227,190.
(3) LESLIE SIMMONS EXECUTIVE VP, COO LBH	1.00 40.00				X			NONE	1,404,398.	201,758.
(4) JASON WEINER ASSISTANT SECRETARY	1.00 40.00			X				NONE	908,657.	145,235.
(5) DEBORAH GRAVES DIR, PRES & COO, LEVINDALE	40.00 1.00	X		X				549,699.	NONE	65,752.
(6) HOLLY PHIPPS ADAMS VP, HUMAN RESOURCES, LEVINDALE	1.00 40.00						X	NONE	433,123.	81,130.
(7) JAMES ROBERGE VP CAPITAL IMPROV. & SUPPORT	1.00 40.00				X			NONE	433,348.	78,485.
(8) TERENCE CARNEY VP SUPPLY CHAIN	1.00 40.00				X			NONE	454,580.	21,228.
(9) NANCY KANE VP FINANCIAL REPORTING	1.00 40.00				X			NONE	368,542.	88,810.
(10) CRIS COLEMAN VP FIN CARROLL, CFO LEVINDALE	30.00 10.00			X				276,711.	92,236.	50,986.
(11) LOU DUNAWAY VP BUDGET & CAPITAL/CFO SINAI	1.00 40.00						X	NONE	328,277.	79,650.
(12) ROSS J. MAULTASCH AVP OPERATIONS	40.00 NONE					X		223,017.	NONE	33,946.
(13) ERNEST SHOCK VP - CHIEF NURSING OFFICER	40.00 NONE					X		248,241.	NONE	5,067.
(14) DIANN FERGUSON REGISTERED NURSE	40.00 NONE					X		220,611.	NONE	11,278.

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) OLUWATOYIN ADISA REGISTERED NURSE	40.00 NONE					X	197,439.	NONE	12,967.	
(16) PRISCILLA IZUCHUKWU REGISTERED NURSE	40.00 NONE					X	192,683.	NONE	14,764.	
(17) HOWARD PERLOW CHAIRMAN	1.00 NONE	X		X			NONE	NONE	NONE	
(18) MICHELE SHERMAK, M.D. VICE CHAIR	1.00 NONE	X		X			NONE	NONE	NONE	
(19) KEITH ATTMAN SECRETARY	1.00 NONE	X		X			NONE	NONE	NONE	
(20) ROBERT SMELKINSON TREASURER	1.00 NONE	X		X			NONE	NONE	NONE	
(21) ALLAN C. ALPERSTEIN DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(22) MARC A. COHEN DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(23) MARLENE DANIEL DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(24) GERALD B. FELDMAN, M.D. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(25) STACEY GOLDENBERG DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total							1,908,401.	9,112,427.	1,178,400.	
c Total from continuation sheets to Part VII, Section A							NONE	NONE	NONE	
d Total (add lines 1b and 1c)							1,908,401.	9,112,427.	1,178,400.	

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 ▶ 120

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

Section B. Independent Contractors

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) BETH GOLDSMITH DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(27) DANIEL HENSON DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(28) ESTHER JACOBSON DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(29) KEVIN KEANE DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(30) JAYNE KLEIN DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(31) SHIMON MESSING DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(32) IRIS MILLER DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(33) BARRY J. NABOZNY DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(34) ABBA DAVID POLIAKOFF, ESQ. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(35) NANCY PRETTER DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(36) KANDACE SCHERR, ESQ. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

Section B. Independent Contractors

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(37) ETHAN SEIDEL, PH.D. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(38) LYNN SELBY DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(39) JUDI JANOSKI SHERWOOD, PHD. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(40) SHMUEL SILBER DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(41) MARC B. TERRILL DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(42) GILBERT TROUT DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(43) DAVID UHLFELDER, C.P.A. DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(44) STEVE VENICK DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(45) JAYSON WILLIAMS DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
(46) DIANE WIT DIRECTOR	1.00 NONE	X					NONE	NONE	NONE	
1b Sub-total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)										

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

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ▶ 9

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		589,502.				
	e Government grants (contributions) . .	1e		360,501.				
	f All other contributions, gifts, grants, and similar amounts not included above .	1f		176,427.				
	g Noncash contributions included in lines 1a-1f	1g	\$					
	h Total. Add lines 1a-1f				1,126,430.			
	Program Service Revenue				Business Code			
2a MEDICARE/MEDICAID PAYMENTS			623000	72,300,289.	72,300,289.			
b PATIENT SERVICE REVENUE			623000	17,954,049.	17,954,049.			
c								
d								
e								
f All other program service revenue								
g Total. Add lines 2a-2f				90,254,338.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			1,077,032.			1,077,032.	
	4 Income from investment of tax-exempt bond proceeds .			NONE				
	5 Royalties			NONE				
	6a Gross rents	6a	(i) Real	144,119.				
			(ii) Personal					
	b Less: rental expenses	6b						
	c Rental income or (loss)	6c		144,119.	NONE			
	d Net rental income or (loss)				144,119.		144,119.	
	7a Gross amount from sales of assets other than inventory	7a	(i) Securities	8,862,508.				
			(ii) Other					
	b Less: cost or other basis and sales expenses . .	7b		7,942,621.				
	c Gain or (loss)	7c		919,887.				
d Net gain or (loss)				919,887.		919,887.		
8a Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	8a			NONE				
		b Less: direct expenses	8b		NONE			
		c Net income or (loss) from fundraising events			NONE			
9a Gross income from gaming activities. See Part IV, line 19	9a			NONE				
		b Less: direct expenses	9b		NONE			
		c Net income or (loss) from gaming activities			NONE			
10a Gross sales of inventory, less returns and allowances	10a		66,295.					
		b Less: cost of goods sold	10b		42,027.			
		c Net income or (loss) from sales of inventory			24,268.	24,268.		
Miscellaneous Revenue				Business Code				
	11a CAFETERIA SALES		900099	101,739.	101,739.			
	b FEMA REIMBURSEMENT		900099	65,913.	65,913.			
	c PAY FOR PERFORMANCE		900099	61,897.	61,897.			
	d All other revenue		561000	24,086.		28,738.	-4,652.	
e Total. Add lines 11a-11d				253,635.				
12 Total revenue. See instructions				93,799,709.	90,508,155.	28,738.	2,136,386.	

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	NONE			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	NONE			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	NONE			
4 Benefits paid to or for members	NONE			
5 Compensation of current officers, directors, trustees, and key employees	10,750,625.	2,839,240.	7,911,385.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	NONE			
7 Other salaries and wages	34,194,177.	28,658,406.	5,535,771.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,128,365.	879,395.	248,970.	
9 Other employee benefits	4,048,381.	4,048,381.		
10 Payroll taxes	3,180,589.	2,478,802.	701,787.	
11 Fees for services (nonemployees):				
a Management	NONE			
b Legal	56,293.	55,318.	975.	
c Accounting	NONE			
d Lobbying	NONE			
e Professional fundraising services. See Part IV, line 17	NONE			
f Investment management fees	74,127.		74,127.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.)	SEE SCHE O 13,898,257.	11,082,245.	2,816,012.	NONE
12 Advertising and promotion	21,487.	5,786.	15,701.	
13 Office expenses	1,006,629.	272,579.	734,050.	
14 Information technology	NONE			
15 Royalties	NONE			
16 Occupancy	2,493,779.	1,645,116.	848,663.	
17 Travel	801.		801.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	NONE			
19 Conferences, conventions, and meetings	16,602.	5,564.	11,038.	
20 Interest	591,590.	165,645.	425,945.	
21 Payments to affiliates	NONE			
22 Depreciation, depletion, and amortization	4,038,201.	2,979,089.	1,059,112.	
23 Insurance	NONE			
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	6,929,055.	5,554,672.	1,374,383.	
b MEDICAID TAX ASSESSMENT	1,752,000.	1,752,000.		
c DUES AND MEMBERSHIPS	166,900.	6,849.	160,051.	
d EMPLOYEE EVENTS	75,470.	117.	75,353.	
e All other expenses	5,213.		5,213.	
25 Total functional expenses. Add lines 1 through 24e	84,428,541.	62,429,204.	21,999,337.	NONE
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A)		(B)
		Beginning of year		End of year
Assets	1 Cash - non-interest-bearing	18,427,706.	1	25,549,634.
	2 Savings and temporary cash investments	276,198.	2	274,906.
	3 Pledges and grants receivable, net	75,527.	3	30,630.
	4 Accounts receivable, net	9,605,518.	4	11,545,705.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	5	NONE
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	NONE	6	NONE
	7 Notes and loans receivable, net	NONE	7	NONE
	8 Inventories for sale or use	385,287.	8	344,188.
	9 Prepaid expenses and deferred charges	130,688.	9	158,432.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 88,100,032.		
	b Less: accumulated depreciation	10b 51,180,145.		
		38,292,424.	10c	36,919,887.
	11 Investments - publicly traded securities	NONE	11	NONE
	12 Investments - other securities. See Part IV, line 11	13,031,461.	12	10,826,316.
	13 Investments - program-related. See Part IV, line 11	NONE	13	NONE
	14 Intangible assets	NONE	14	NONE
15 Other assets. See Part IV, line 11	21,656,201.	15	3,651,846.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	101,881,010.	16	89,301,544.	
Liabilities	17 Accounts payable and accrued expenses	12,509,739.	17	11,719,679.
	18 Grants payable	NONE	18	NONE
	19 Deferred revenue	23,747,463.	19	8,652,628.
	20 Tax-exempt bond liabilities	1,000.	20	1,000.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	NONE	21	NONE
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	22	NONE
	23 Secured mortgages and notes payable to unrelated third parties	NONE	23	NONE
	24 Unsecured notes and loans payable to unrelated third parties	NONE	24	NONE
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	14,594,954.	25	12,856,311.
	26 Total liabilities. Add lines 17 through 25	50,853,156.	26	33,229,618.
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	41,027,606.	27	47,378,033.
	28 Net assets with donor restrictions	10,000,249.	28	8,693,893.
	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	51,027,854.	32	56,071,926.
33 Total liabilities and net assets/fund balances	101,881,010.	33	89,301,544.	

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	93,799,709.
2	Total expenses (must equal Part IX, column (A), line 25)	2	84,428,541.
3	Revenue less expenses. Subtract line 2 from line 1	3	9,371,168.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	51,027,854.
5	Net unrealized gains (losses) on investments	5	-4,743,269.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	416,173.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	56,071,926.

Part XII Financial Statements and Reporting

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

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

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

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

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

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

Schedule A (Form 990) 2021

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) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (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 (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f); 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (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, whether or not the business is regularly carried on; 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.); 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 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 3 columns: Line number, Description, and Percentage. Rows include: 14 Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f)); 15 Public support percentage from 2020 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2021; 16b 33 1/3% support test - 2020; 17a 10%-facts-and-circumstances test - 2021; 17b 10%-facts-and-circumstances test - 2020; 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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(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 2021 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2020 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2021 (line 10c, column (f), divided by line 13, column (f)),	17	%
18 Investment income percentage from 2020 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2021. 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 - 2020. 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).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

Section D - Distributions		Current Year
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 2021 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-2021	(iii) Distributable Amount for 2021
1	Distributable amount for 2021 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2021 (reasonable cause required - <i>explain in Part VI</i>). See instructions.			
3	Excess distributions carryover, if any, to 2021			
a	From 2016			
b	From 2017			
c	From 2018			
d	From 2019			
e	From 2020			
f	Total of lines 3a through 3e			
g	Applied to underdistributions of prior years			
h	Applied to 2021 distributable amount			
i	Carryover from 2016 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4	Distributions for 2021 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2021 distributable amount			
c	Remainder. Subtract lines 4a and 4b from line 4.			
5	Remaining underdistributions for years prior to 2021, 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 2021. 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 2022. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2017			
b	Excess from 2018			
c	Excess from 2019			
d	Excess from 2020			
e	Excess from 2021			

Schedule B (Form 990)

Schedule of Contributors

OMB No. 1545-0047

Department of the Treasury Internal Revenue Service

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

2021

Table with 2 columns: Name of the organization (LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL, INC.) and Employer identification number (52-0607913)

Organization type (check one):

Filers of:

Section:

- Form 990 or 990-EZ: [X] 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

- [X] 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...
[] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor...
[] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor...

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

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

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	\$ 589,502.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	N/A	\$ 360,501.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	N/A	\$ 50,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	N/A	\$ 15,745.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	N/A	\$ 12,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	N/A	\$ 10,068.	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/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	N/A <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	N/A <hr/> <hr/> <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.)

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)**

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2021

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) 2021

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="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a. If zero or less, enter -0-															
i Subtract line 1f from line 1c. If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?			<input type="checkbox"/> Yes <input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below.

See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(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		23,901.
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		15,330.
j Total. Add lines 1c through 1i			39,231.
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)

SCHEDULE C, 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, 2022 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

2021

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 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows 1-4 for values, 5-6 for Yes/No questions.

Part II Conservation Easements.

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

Form with multiple sections for conservation easements, including checkboxes for purposes, a table for held at end of tax year, and various questions.

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.

Form with questions 1a, 1b, 2, and 2a, 2b regarding art and historical treasures, including dollar amounts.

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

Schedule D (Form 990) 2021

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

- 3 Using the organization's acquisition, accession, and other records, check any of the following that make significant use of its collection items (check all that apply):
- a Public exhibition
 - b Scholarly research
 - c Preservation for future generations
 - d Loan or exchange program
 - e Other _____
- 4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	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	NONE	61,985,738.	33,612,352.	28,373,386.
c Leasehold improvements				
d Equipment	NONE	23,781,821.	16,423,310.	7,358,511.
e Other	NONE	2,332,473.	1,144,483.	1,187,990.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				36,919,887.

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	10,826,316.	FMV
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) . ▶	10,826,316.	

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)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	

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	9,196,189.
(3) ASSET RETIREMENT OBLIGATION	1,560,000.
(4) A/P - RELATED PARTIES	913,098.
(5) PENSION LIABILITY	892,239.
(6) CAPTIVE PROFESSIONAL LIABILITY	205,911.
(7) DEFERRED COMPENSATION	70,603.
(8) LEASE LIABILITY	18,271.
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	12,856,311.

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

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final total column.

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final total column.

Part XIII Supplemental Information.

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

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information (continued)

SCHEDULE D, PART III, LINE 4:

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

SCHEDULE D, 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.

SCHEDULE D, PART X, LINE 2:

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

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

Part XIII Supplemental Information *(continued)*

AND LIABILITIES OF A CHANGE IN TAX RATES IS RECOGNIZED IN THE PERIOD THAT INCLUDES THE ENACTMENT DATE. ANY CHANGES TO THE VALUATION ALLOWANCE ON THE DEFERRED TAX ASSET ARE REFLECTED IN THE YEAR OF THE CHANGE. THE CORPORATION ACCOUNTS FOR UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH ASC TOPIC 740.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2021

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	
1b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300.0000</u> %	X	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>500.0000</u> %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
5c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
6b If "Yes," did the organization make it available to the public?	X	

7 Financial Assistance and Certain Other Community Benefits at Cost

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			819,736.		819,736.	0.97
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			819,736.		819,736.	0.97
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			695,501.	63,993.	631,508.	0.75
f Health professions education (from Worksheet 5)			76,334.		76,334.	0.09
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			34,713.		34,713.	0.04
j Total. Other Benefits			806,548.	63,993.	742,555.	0.88
k Total. Add lines 7d and 7j			1,626,284.	63,993.	1,562,291.	1.85

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

Schedule H (Form 990) 2021

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			879,798.		879,798.	1.10
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			879,798.		879,798.	1.10

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	51,285,012.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	37,032,687.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	14,252,325.
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

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: <u>2020</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C		X
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SECTION C, LINE 7D</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>2020</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 10A</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? If "No," indicate why:		X
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)

		Yes	No
Name of hospital facility or letter of facility reporting group <u>LEVINDALE HEBREW GERIATRIC CENTER & H</u>			
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.	23		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.	24		X

Part V Facility Information (continued)

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

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

DURING THE FY 21 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, ASSOCIATIONS, AS WELL AS MEMBERS OF SPECIFIC DEMOGRAPHIC GROUPS—THOSE WITH DISABILITIES, RE-ENTRY RESIDENTS AND SPANISH SPEAKERS KNOWN TO HAVE PARTICULAR NEEDS.

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 LIFEBRIDGE 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 MEMBERS OF THE DEMOGRAPHIC GROUPS IDENTIFIED ABOVE.

FOUR STAKEHOLDER INTERVIEWS AND FOUR FOCUS GROUPS WERE CONDUCTED. 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 POPULATIONS THAT MADE UP THE FOCUS GROUPS AND THE DATES THE MEETINGS WERE HELD ARE LISTED BELOW:

OLDER ADULTS FOCUS GROUP - MEETING HELD AUGUST 11, 2020
 RE-ENTRY FOCUS GROUP - MEETING HELD SEPTEMBER 18, 2020
 DISABILITIES FOCUS GROUP - MEETING HELD SEPTEMBER 21, 2020
 SPANISH SPEAKING FOCUS GROUP - MEETING HELD NOVEMBER 20, 2020

THE STAKEHOLDER INTERVIEWS WERE CONDUCTED WITH REPRESENTATIVES FROM STEVENSWOOD COMMUNITY ASSOCIATION CENTRAL BAPTIST CHURCH, NEW SOLID ROCK FELLOWSHIP CHURCH, NORTH WEST FAITH BASED PARTNERSHIP, AND ROLLING OAKS COMMUNITY ASSOCIATION.

THE BALTIMORE CITY HEALTH DEPARTMENT AND THE RESIDENT HEALTH SYSTEMS PREVIOUSLY COLLABORATED ON A CHNA IN 2017-2018 AND SOUGHT TO DO 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, AS WELL AS THE BALTIMORE CITY

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.

HEALTH DEPARTMENT'S NEIGHBORHOOD HEALTH PROFILE.

SCHEDULE H, 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 2021 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, SAINT AGNES HOSPITAL AND MERCY HOSPITAL.

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

COPIES OF THE CHNA WERE DISTRIBUTED TO KEY COMMUNITY PARTNERS.
[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/MAIN/ABOUT/COMMUNITYHEALTHANDWELLBEING/LEVINDALECHNA.PDF](https://www.lifebridgehealth.org/uploads/public/main/about/communityhealthandwellbeing/levindalechna.pdf)

SCHEDULE H, PART V, SECTION B, LINE 10A:

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/MAIN/ABOUT/COMMUNITYHEALTHANDWELLBEING/LEVINDALEIP.PDF](https://www.lifebridgehealth.org/uploads/public/main/about/communityhealthandwellbeing/levindaleip.pdf)

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

LEVINDALE UTILIZED THE LIFEBRIDGE COMMUNITY HEALTH AND WELLNESS TEAM TO CONDUCT THE CHNA. TEAM MEMBERS IDENTIFIED FROM 3,170 PUBLIC SURVEYS THE MOST SIGNIFICANT NEEDS. THE LEVINDALE CEO AND CHNA LEADERSHIP MET WITH REPRESENTATIVES OF THE LEVINDALE HOSPITAL BOARD AND LEADERSHIP ON MARCH 19, 2021 TO REVIEW THE FINDINGS OF THE CHNA AND TO SEEK RECOMMENDATIONS TO PRIORITIZE THE HIGHEST NEEDS AND THOSE WITH THE HIGHEST FEASIBILITY. THE FOLLOWING NEEDS WERE SELECTED AS PRIORITIES:

HEART DISEASE

LEVINDALE WILL PROVIDE EDUCATION AND SCREENING DURING STROKE AWARENESS MONTH THROUGH VARIOUS EVENTS. WE PARTNERED WITH SEVERAL ORGANIZATIONS THROUGHOUT THE COMMUNITY INCLUDING THE AMERICAN HEART ASSOCIATION, BALTIMORE CITY HEALTH DEPARTMENT CARDIOVASCULAR DISPARITIES TASK FORCE AND THE PARK HEIGHTS COMMUNITY HEALTH ALLIANCE.

MENTAL HEALTH, DEPRESSION, AND SUBSTANCE USE DISORDER

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.

LEVINDALE HOSPITAL OPERATES 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 BEING DISCHARGED FROM AN INPATIENT STAY, WHO MAY NEED CONTINUED SUPPORT IN PROGRESSING TOWARDS THEIR TREATMENT GOALS.

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 CENTER(S) 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 INDIVIDUALS FIND AFFORDABLE, CONVENIENT HOUSING.

FOOD INSECURITY

LEVINDALE IN CONJUNCTION WITH SINAI IMPLEMENTED A FARMER'S MARKET WITH AFFORDABLE FRESH FOOD ON THE SINAI CAMPUS.

COMMUNITY SAFETY

LEVINDALE WORKS WITH THE CHANA-SAFE PROGRAM TO IDENTIFY AND PREVENT ELDER ABUSE AND NEGLECT.

NEEDS NOT ADDRESSED WITHIN IMPLEMENTATION STRATEGY

THE NEEDS LISTED BELOW WERE IDENTIFIED AS PRIORITIES DURING THE ASSESSMENT PROCESS, BUT ULTIMATELY WERE NOT CHOSEN AS PRIORITIES FOR ACTION, BECAUSE THE HOSPITAL OR ITS AFFILIATED ORGANIZATIONS HAVE BEEN ADDRESSING THEM IN OTHER WAYS, THE HOSPITAL DOES NOT HAVE SUFFICIENT RESOURCES TO ADDRESS THEM, OR OTHER ORGANIZATIONS ARE MORE CAPABLE OF MEETING THOSE NEEDS.

LACK OF TRANSPORTATION

LACK OF TRANSPORTATION AROSE IN THE SURVEYS AS AN IMPORTANT REASON FOR

Part V Facility Information (continued)

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

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.

ACCESS TO INSURANCE

LEVINDALE HOSPITAL PROVIDES SIGN-UP ASSISTANCE TO PATIENTS WITHOUT INSURANCE WHEN THEY PRESENT AT THE HOSPITAL. A STAFF PERSON OVERSEES THIS FUNCTION.

WORKFORCE DEVELOPMENT

LEVINDALE HOSPITAL REFERS RESIDENTS AND PATIENTS WITHOUT EMPLOYMENT TO PARTNER ORGANIZATIONS, PARTICULARLY BON SECOURS COMMUNITY WORKS IN SOUTH AND WEST BALTIMORE, TO ADDRESS THIS PRESSING SOCIAL NEED. SINAI HOSPITAL ALSO SUPPORTS VARIOUS AGENCIES IN ADDRESSING UNDERLYING FACTORS, E.G., FINANCIAL LITERACY AND EDUCATION TO MITIGATE CONDITIONS OF POVERTY.

ACCESS TO PHYSICIANS

A SYSTEM-WIDE EFFORT HAS BEEN DEVELOPED SINCE THE 2018 CHNA TO ADDRESS NEEDS OF VARIOUS PATIENTS. SPECIALISTS ARE READILY IDENTIFIED, AND REFERRALS ARE APPROPRIATELY MADE. DEPARTMENTS AND TEAM MEMEBERS 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 BOTH INTERNALLY AS WELL AS WITH COMMUNITY RESROUCES TO ENABLE PATIENTS TO ACCESS NECESSARY AND VALUABLE RESOURCES IN AS TIMELY A MANNER AS POSSIBLE. INCLUSION OF SOCIAL RESOURCES IN COORDINATION IS INTENDED TO REDUCE REOCCURENCE OF ACUTE HEALTH EPISODES THAT REQUIRE HOSPITALIZATIONS.

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.

Part V Facility Information (continued)

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

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

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/MAIN/FINANCIALASSISTANCE/FAP/LBH_FINANCIAL%20ASSISTANCE%20211001ENGLISH.PDF](https://www.lifebridgehealth.org/uploads/public/main/financialassistance/fap/lbh_financial%20assistance%20211001english.pdf)

SCHEDULE H, PART V, SECTION B, LINE 16B:

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/DOCUMENTS/FINANCIAL%20ASSISTANCE%20UNIFORM%20APPL.PDF](https://www.lifebridgehealth.org/uploads/public/documents/financial%20assistance%20uniform%20appl.pdf)

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

[HTTPS://WWW.LIFEBRIDGEHEALTH.ORG/UPLOADS/PUBLIC/MAIN/FINANCIALASSISTANCE/PLS/LBH%20HOSPITAL%20INFORMATION%20SHEET%20220302_ENGLISH.PDF](https://www.lifebridgehealth.org/uploads/public/main/financialassistance/pls/lbh%20hospital%20information%20sheet%20220302_english.pdf)

SCHEDULE H, 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 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 REIMBURSING UNCOMPENSATED CARE IN EACH PAYOR'S RATES, WHICH DOES NOT ENABLE MARYLAND HOSPITALS TO BREAK-OUT ANY OFFSETTING REVENUE RELATED TO UNCOMPENSATED CARE. IN RECENT YEARS, THE STATE OF MARYLAND HAS CLOSED FISCAL GAPS IN THE STATE MEDICAID BUDGET BY ASSESSING HOSPITALS THROUGH THE RATE-SETTING SYSTEM.

Part VI Supplemental Information

Provide the following information.

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

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

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

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

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 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.

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:

AS A LARGE EMPLOYER AND PROVIDER OF HEALTH SERVICES IN THE NORTHWEST
QUADRANT OF BALTIMORE CITY AND PARTS OF BALTIMORE COUNTY, LIFE BRIDGE
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.

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.
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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.

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.

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 AND WITH OTHER AREA EMPLOYERS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, LINE 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 VARIOUS OTHER MEANS SUCH AS ELIGIBLE FOR 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 EXPENSE, IT IS ESTIMATED THAT \$3,609,339 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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

AVAILABILITY OF FINANCIAL ASSISTANCE AND CHARITY CARE. THIS \$3,609,339
 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
 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.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART III, LINE 9B:

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.
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- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 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

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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. WE ALSO WORK WITH INTERNAL SPECIALTIES WITHIN LIFE BRIDGE HEALTH 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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

HOSPITAL. PATIENT FINANCIAL SERVICES BROCHURE 'FREEDOM TO CARE' IS 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

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.
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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.

FINANCIAL ASSISTANCE APPLICATION PROCESS. FINANCIAL ASSISTANCE

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

Part VI Supplemental Information

Provide the following 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.

MEDIAN HOUSEHOLD INCOME WAS \$26,015 AND \$32,410 RESPECTIVELY. THIS IS COMPARED TO BALTIMORE CITY'S MEDIAN HOUSEHOLD INCOME OF \$41,819. THE 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

Part VI Supplemental Information

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- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

REPRESENTATIVE OF BALTIMORE CITY. THIS IS IN CONTRAST TO THE NEIGHBORING
BALTIMORE COUNTY ZIP CODES (21208 & 21209) IN WHICH THE MEDIAN HOUSEHOLD
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 PEOPLE
WHO ARE LIVING IN THEIR OWN HOMES BUT ARE UNABLE TO PREPARE A MEAL FOR
THEMSELVES DUE TO AGE AND MEDICAL CONDITIONS. LEVINDALE ALSO PROVIDES
MEALS TO ADULT DAY CARE AND ASSISTED LIVING FACILITIES IN THE
NEIGHBORHOOD.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 6:

LEVINDALE HEBREW GERIATRIC CENTER & HOSPITAL IS A COMPONENT OF LIFE BRIDGE 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 LIFE BRIDGE 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.

ALL STATES WHICH ORGANIZATION FILES A 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.

2021

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) 2021

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
NEIL M. MELTZER 1 PRESIDENT/CEO/DIR, LIFEBRIDGE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	1,052,468.	1,442,162.	608,517.	34,349.	25,805.	3,163,301.	402,199.
LESLIE SIMMONS 2 EXECUTIVE VP, COO LBH	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	681,592.	459,362.	263,444.	176,752.	25,006.	1,606,156.	172,791.
DAVID KRAJEWSKI 3 ASSISTANT TREASURER	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	743,929.	505,741.	336,449.	197,271.	29,919.	1,813,309.	280,798.
JASON WEINER 4 ASSISTANT SECRETARY	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	436,068.	349,371.	123,218.	119,556.	25,679.	1,053,892.	NONE
DEBORAH GRAVES 5 DIR, PRES & COO, LEVINDALE	(i)	316,830.	181,844.	51,025.	41,007.	24,745.	615,451.	29,680.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
TERRENCE CARNEY 6 VP SUPPLY CHAIN	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	276,300.	96,129.	82,151.	19,147.	2,081.	475,808.	42,464.
JAMES ROBERGE 7 VP CAPITAL IMPROV. & SUPPORT	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	286,771.	74,413.	72,164.	48,087.	30,398.	511,833.	34,939.
HOLLY PHIPPS ADAMS 8 VP, HUMAN RESOURCES, LEVINDALE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	304,344.	67,501.	61,278.	49,956.	31,174.	514,253.	42,560.
NANCY KANE 9 VP FINANCIAL REPORTING	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	260,208.	65,626.	42,708.	61,651.	27,159.	457,352.	28,164.
LOU DUNAWAY 10 VP BUDGET & CAPITAL/CFO SINAI	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	261,431.	63,367.	3,479.	55,352.	24,298.	407,927.	NONE
ERNEST SHOCK 11 VP - CHIEF NURSING OFFICER	(i)	172,977.	48,330.	26,934.	4,064.	1,003.	253,308.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
ROSS J. MAULTASCH 12 AVP OPERATIONS	(i)	185,415.	37,451.	151.	4,038.	29,908.	256,963.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DIANN FERGUSON 13 REGISTERED NURSE	(i)	189,869.	30,564.	178.	NONE	11,278.	231,889.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
OLUWATOYIN ADISA 14 REGISTERED NURSE	(i)	166,574.	30,329.	536.	NONE	12,967.	210,406.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
PRISCILLA IZUCHUKWU 15 REGISTERED NURSE	(i)	162,560.	30,000.	123.	3,898.	10,866.	207,447.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
CRIS COLEMAN 16 VP FIN CARROLL, CFO LEVINDALE	(i)	232,035.	42,855.	1,821.	29,790.	8,450.	314,951.	NONE
	(ii)	77,345.	14,285.	606.	9,930.	2,816.	104,982.	NONE

Schedule J (Form 990) 2021

Part III Supplemental Information

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

SCHEDULE J, PART I, LINE 1A:

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

SCHEDULE J, 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.

SCHEDULE J, PART I, LINE 4B:

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

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.

AMOUNTS REPORTED BELOW REPRESENT EMPLOYER CONTRIBUTIONS TO THE SECTION

457(F) PLAN MADE DURING THE YEAR:

DAVID KRAJEWSKI	\$159,849
LESLIE SIMMONS	\$145,191
JASON WEINER	\$ 93,461
DEBORAH GRAVES	\$ 35,589
JAMES ROBERGE	\$ 34,837
HOLLY PHIPPS ADAMS	\$ 34,709
NANCY KANE	\$ 29,558
CRIS COLEMAN	\$ 29,727
LOU DUNAWAY	\$ 29,120

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	\$550,299
--------------	-----------

Part III Supplemental Information

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

DAVID KRAJEWSKI	\$ 299,687
LESLIE SIMMONS	\$ 239,743
JASON WEINER	\$ 93,008
HOLLY PHIPPS ADAMS	\$ 57,184
JAMES ROBERGE	\$ 44,830
DEBORAH GRAVES	\$ 42,979
TERRENCE CARNEY	\$ 42,464
NANCY KANE	\$ 36,030
ERNEST SHOCK	\$ 20,134

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

MR. WEINER RECEIVED COMPENSATION AS SENIOR VICE PRESIDENT AND GENERAL COUNSEL OF LIFEBRIDGE HEALTH, NOT AS AN OFFICER.

**SCHEDULE L
(Form 990)**

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

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

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

OMB No. 1545-0047

2021

**Open To Public
Inspection**

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.

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

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) ACME PAPER & SUPPLY CO., INC.	INDIRECT BUSINESS	227,599.	SEE PART V		X
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

SCHEDULE L, PART IV, COLUMN (D)

ACME PAPER & SUPPLY CO., INC.
 LEVINDALE HEBREW GERIATRIC CENTER, INC. AND OTHER LIFEBRIDGE SUBSIDIARIES
 PURCHASED APPROXIMATELY \$227,599 IN PAPER SUPPLIES CLEANING AND FOOD
 SERVICE DISPOSABLE PRODUCTS 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.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

LEVINDALE HEBREW GERIATRIC CENTER AND

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

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
MEETING IS THEN SCHEDULED WITH THE CHIEF FINANCIAL OFFICER, VICE

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

LEVINDALE HEBREW GERIATRIC CENTER AND

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

52-0607913

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 DOMESTIC PARTNER, PARENTS, BROTHERS AND SISTERS, CHILDREN (WHETHER NATURAL OR ADOPTED), GRANDPARENTS, GRANDCHILDREN, GREAT-GRANDCHILDREN,

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

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

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 15A:

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

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

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

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.

2021

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization

Employer identification number

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

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

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

FORM 990, PART XI, LINE 9:

ADJUSTMENT TO PENSION BENEFIT	\$ 1,476,219
TRANSFER FROM AFFILIATES	\$ 728,209
DONATED PROPERTY	\$ 245,476
NON-UNION PENSION NON-SERVICE COST	\$ 181,388
CHANGE IN THE NET ASSETS OF BALTIMORE	
JEWISH ELDERCARE FOUNDATION	\$(2,205,145)
LOSS ON REFINANCING OF DEBT	\$(9,974)

TOTAL	\$ 416,173

Name of the organization

Employer identification number

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

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.

Name of the organization

Employer identification number

LEVINDALE HEBREW GERIATRIC CENTER AND52-0607913

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
METZ CULINARY MANAGEMENT TWO WOODLAND DRIVE DALLAS, PA 18612	FOOD SERVICE	1,767,692.
CORNERSTONE HEALTHCARE 5 ENGLEFIELD SQUARE OWINGS MILLS, MD 21117	AGENCY NURSING	1,328,808.
HEALTH CAROUSEL TRAVEL 3805 EDWARDS ROAD, SUITE 700 CINCINNATI, OH 45209	AGENCY NURSING	674,169.
DAVITA OWINGS MILLS P.O. BOX 403008 ATLANTA, GA 30384	RENAL DIALYSIS	390,187.
CROTHALL HEALTHCARE 1500 LIBERTY RIDGE DRIVE, SUITE 210 WAYNE, PA 19087	CONTRACT CLEANING	281,589.

Name of the organization

Employer identification number

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

FORM 990, PART IX - OTHER FEES

=====

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
-----	-----	-----	-----	-----
FOOD SERVICE CONTRACT	4,157,440.	4,157,440.	NONE	NONE
AGENCY NURSES	3,847,649.	3,836,528.	11,121.	NONE
PROF. & TECHNICAL EXPENSE	663,335.	537,935.	125,400.	NONE
CONTRACT RENAL DIALYSIS	354,527.	354,527.	NONE	NONE
MISC. PURCHASED SERVICES	343,108.	280,996.	62,112.	NONE
CONTRACT CLEANING	298,605.	30,064.	268,541.	NONE
LABORATORY SERVICE	286,448.	282,314.	4,134.	NONE
OTHER SUBSIDY	250,009.	225,000.	25,009.	NONE
LAUNDRY SERVICE	216,420.	216,420.	NONE	NONE
PURCHASED TEMP HELP	214,292.	194,648.	19,644.	NONE
CONTRACT PICC LINE	166,465.	166,465.	NONE	NONE
BUNDLE BILLING SERVICE FE	148,065.	148,065.	NONE	NONE
SPECIAL PATIENT TRANSPORT	138,095.	104,935.	33,160.	NONE
AMBULANCE SERVICE	117,528.	117,528.	NONE	NONE
COLLECTION SERVICE FEES	104,395.	NONE	104,395.	NONE
CONTRACT SNOW REMOVAL	95,477.	NONE	95,477.	NONE
PURCHASED PAYROLL SERVICE	84,449.	84,449.	NONE	NONE
OTHER EXPENSES	2,411,950.	344,931.	2,067,019.	NONE
TOTALS	----- 13,898,257. =====	----- 11,082,245. =====	----- 2,816,012. =====	----- NONE =====

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization
HOSPITAL, INC.

LEVINDALE HEBREW GERIATRIC CENTER AND

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

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

Schedule R (Form 990) 2021

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

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

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

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

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

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

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

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

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

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

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

LEVINDALE HEBREW GERIATRIC CENTER AND

52-0607913

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

(A) NAME/ADDRESS/EIN	(B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) ENTITY TYPE	(F) SHARE OF TOT INCOME	(G) SHARE OF EOY	(H) % OWNERSHIP	(I) SEC 512(B)(13) YES NO
CARROLL COUNTY MED-SERVICES, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157 52-1891102	MEDICAL SERVICES	MD	CCMS INC	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE INVESTMENTS, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-1483166	INVESTMENT	MD	LBH	C CORP	NONE	NONE	NONE	X
HEALTHSTAR MEDICAL SERVICES, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 52-1829098	HEALTHCARE	MD	LB INV INC	C CORP	NONE	NONE	NONE	X
PRACTICE DYNAMICS, INC 124 BUSINESS CENTER DRIVE REISTERSTOWN, MD 21136 52-1960319	MANAGEMENT	MD	LB INV INC	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE INSURANCE COMPANY, LTD PO BOX 1109 GRAND CAYMAN, CJ KY1-1102 98-0415396	INSURANCE	CJ	LBH	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE COMMUNITY PHYSICIANS, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 80-0719005	HEALTHCARE	MD	LB INV INC	C CORP	NONE	NONE	NONE	X
CARROLL BILLING SERVICES, INC 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 30-0026598	BILLING SERVICES	MD	CHC INC	C CORP	NONE	NONE	NONE	X
CARROLL COUNTY GEN. HOSP. SOUTH CARROLL 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	REAL ESTATE	MD	N/A	C CORP	NONE	NONE	NONE	X
MED-SERVICES HOLDINGS, INC 200 MEMORIAL AVENUE WESTMINSTER, MD 21157	MEDICAL SERVICES	MD	CCMS INC	C CORP	NONE	NONE	NONE	X
LIFEBRIDGE HEALTH ISRAEL, LTD 16 ABBA HILLEL ROAD RAHMAT GAN, IS 5250608 46-5739154	HEALTHCARE	IS	LB INV INC	C CORP	NONE	NONE	NONE	X

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

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

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

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

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

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

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

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

Part VII Supplemental Information

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

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
CARROLL HOSPITAL CENTER INC 200 MEMORIAL AVENUE	52-1452024 WESTMINSTER, MD 21157 HOSPITAL	MD	501(C)(3)	3	CCHS		X
BRIDGINGLIFE INC 292 STONER AVENUE	52-1565870 WESTMINSTER, MD 21157 HOSPICE	MD	501(C)(3)	7	CHC		X
CARROLL HOSPITAL CENTER FOUNDATION INC 200 MEMORIAL AVENUE	52-1115038 WESTMINSTER, MD 21157 FOUNDATION	MD	501(C)(3)	12A, I	CHC		X
PARTNERSHIP FOR A HEALTHIER CARROLL CTY 535 OLD WESTMINSTER PIKE, #102	52-2156892 WESTMINSTER, MD 21157 HEALTH SVCS	MD	501(C)(3)	7	CHC		X
SINAI HOSPITAL OF BALTIMORE INC 2401 WEST BELVEDERE AVENUE	52-0486540 BALTIMORE, MD 21215 HOSPITAL	MD	501(C)(3)	3	LBH		X
COURTLAND GARDENS NURSING AND REHAB CTR 2434 WEST BELVEDERE AVENUE	52-0607907 BALTIMORE, MD 21215 NURSING	MD	501(C)(3)	10	LBH		X
NORTHWEST HOSPITAL CENTER INC 5401 OLD COURT ROAD	52-1372665 RANDALLSTOWN, MD 21133 HOSPITAL	MD	501(C)(3)	3	LBH		X
CHILDRENS HOSPITAL OF BALTIMORE CITY INC 2401 WEST BELVEDERE AVENUE	52-0591592 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
THE BALTIMORE JEWISH HEALTH FDN INC 2401 WEST BELVEDERE AVENUE	52-2111541 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
CHILDRENS HOSPITAL AT SINAI FOUNDATION 2401 WEST BELVEDERE AVENUE	52-2167587 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X

Part VII Supplemental Information

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

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
THE BALTIMORE JEWISH ELDERCARE FDN 2401 WEST BELVEDERE AVENUE	52-2337669 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
CENTER FOR HOPE INC 5400 PREAKNESS WAY	52-1681279 BALTIMORE, MD 21215 CHILD SVCS	MD	501(C)(3)	7	LBH		X
GRACE MEDICAL CENTER INC 2000 W BALTIMORE STREET	52-0591555 BALTIMORE, MD 21223 HOSPITAL	MD	501(C)(3)	3	LBH		X
WEST BALTIMORE RENAISSANCE FDN INC 2401 WEST BELVEDERE AVENUE	84-3355332 BALTIMORE, MD 21215 COMMUNITY CTR	MD	501(C)(3)	7	LBH		X
CARROLL COUNTY HEALTH SERVICES CORP 200 MEMORIAL AVENUE	52-0691413 WESTMINSTER, MD 21157 HOSPITAL SUPP	MD	501(C)(3)	12B, II	LBH		X
LIFEBRIDGE CENTER FOR HOPE INC 2401 WEST BELVEDERE AVENUE	85-3920012 BALTIMORE, MD 21215 REAL ESTATE	MD	501(C)(3)	12A, I	SHB		X
LIFEBRIDGE HEALTH INC 2401 WEST BELVEDERE AVENUE	52-1402373 BALTIMORE, MD 21215 SUPPORT	MD	501(C)(3)	12C, III	N/A		X
THE LEVINDALE AUXILIARY, INC. 2434 WEST BELVEDERE AVENUE	52-1788224 BALTIMORE, MD 21215 HOSPITAL SUPP	MD	501(C)(3)	7	N/A		X

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

For calendar year 2021 or other tax year beginning 07/01, 2021, and ending 06/30, 2022

2021

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	D Employer identification number 52-0607913
B Exempt under section <input checked="" type="checkbox"/> 501(C)(3) <input type="checkbox"/> 408(e) 220(e) <input type="checkbox"/> 408A 530(a) <input type="checkbox"/> 529(a) 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 ▶ 89301544.	
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			
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 ▶ LIFEBRIDGE HEALTH, INC.; 52-1402373			
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	-39,317.
2 Reserved	2	
3 Add lines 1 and 2	3	-39,317.
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	-39,317.
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	-39,317.
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	NONE

Part II Tax Computation

1 Organizations taxable as corporations. Multiply Part I, line 11 by 21% (0.21) ▶	1	NONE
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	NONE

For Paperwork Reduction Act Notice, see instructions. Form **990-T** (2021)

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		NONE
3 Other amounts due. Check if from: <input type="checkbox"/> Form 4255 <input type="checkbox"/> Form 8611 <input type="checkbox"/> Form 8697 <input type="checkbox"/> Form 8866 <input type="checkbox"/> Other (attach statement)	3		
4 Total tax. Add lines 2 and 3 (see instructions). <input type="checkbox"/> Check if includes tax previously deferred under section 1294. Enter tax amount here	4		NONE
5 Current net 965 tax liability paid from Form 965-A, Part II, column (k)	5		
6 a Payments: A 2020 overpayment credited to 2021	6a		
b 2021 estimated tax payments. Check if section 643(g) election applies <input type="checkbox"/>	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: <input type="checkbox"/> Form 2439 _____ <input type="checkbox"/> Form 4136 _____ <input type="checkbox"/> Other _____ Total ▶	6g		
7 Total payments. Add lines 6a through 6g	7		
8 Estimated tax penalty (see instructions). Check if Form 2220 is attached <input type="checkbox"/>	8		
9 Tax due. If line 7 is smaller than the total of lines 4, 5, and 8, enter amount owed ▶	9		NONE
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 2022 estimated tax ▶ _____ Refunded ▶ _____	11		

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

1 At any time during the 2021 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 ▶ _____	Yes	No
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 Enter available pre-2018 NOL carryovers here ▶ \$ <u>NONE</u> . Do not include any post-2017 NOL carryover shown on Schedule A (Form 990-T). Don't reduce the NOL carryover shown here by any deduction reported on Part I, line 6.		
5 Post-2017 NOL carryovers. Enter available Business Activity Code and post-2017 NOL carryovers. Don't reduce the amounts shown below by any NOL claimed on any Schedule A, Part II, line 17 for the tax year. See instructions.		
Business Activity Code	Available post-2017 NOL carryover	
561000	\$ 8,436.	
_____	\$ _____	
_____	\$ _____	
_____	\$ _____	
6a Did the organization change its method of accounting? (see instructions)		X
b If 6a is "Yes," has the organization described the change on Form 990, 990-EZ, 990-PF, or Form 1122? If "No," explain in Part V.		

Part V Supplemental Information

Provide the explanation required by Part IV, line 6b. Also, provide any other additional information. See instructions.

Sign Here	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 taxpayer) is based on all information of which preparer has any knowledge.		May the IRS discuss this return with the preparer shown below (see instructions)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	DAVID KRAJEWSKI Signature of officer	_____ Date		EXECUTIVE VP/CFO Title	
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>	5/7/2023		P01871563
	Firm's name ▶ BDO USA, LLP	Firm's EIN ▶ 13-5381590		Phone no. 703-893-0600	
Firm's address ▶ 8401 GREENSBORO DRIVE, #800, MCLEAN, VA 22102					

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

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

OMB No. 1545-0074

2021

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, I	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 ▶			
1c				
2 Cost of goods sold (Part III, line 8)	2			
3 Gross profit. Subtract line 2 from line 1c	3			
4a Capital gain net income (attach Sch D (Form 1041 or Form 1120)). See instructions	4a			
b Net gain (loss) (Form 4797) (attach Form 4797). See instructions	4b			
c Capital loss deduction for trusts	4c			
5 Income (loss) from a partnership or an S corporation (attach statement)	5			
6 Rent income (Part IV)	6			
7 Unrelated debt-financed income (Part V)	7			
8 Interest, annuities, royalties, and rents from a controlled organization (Part VI)	8			
9 Investment income of section 501(c)(7), (9), or (17) organizations (Part VII)	9			
10 Exploited exempt activity income (Part VIII)	10			
11 Advertising income (Part IX)	11			
12 Other income (see instructions; attach statement) . . . STMT. 1	12	28,738.		28,738.
13 Total. Combine lines 3 through 12	13	28,738.		28,738.

Part II Deductions Not Taken Elsewhere See instructions for limitations on deductions. Deductions must be directly connected with the unrelated business income				
1 Compensation of officers, directors, and trustees (Part X)	1			
2 Salaries and wages	2			67,905.
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			
8b				
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) . . . STMT. 2	14			150.
15 Total deductions. Add lines 1 through 14	15			68,055.
16 Unrelated business income before net operating loss deduction. Subtract line 15 from Part I, line 13, column (C)	16			-39,317.
17 Deduction for net operating loss. See instructions	17			
18 Unrelated business taxable income. Subtract line 17 from line 16.	18			-39,317.

For Paperwork Reduction Act Notice, see instructions.

Schedule A (Form 990-T) 2021

Part III Cost of Goods Sold

Enter method of inventory valuation ▶

1	Inventory at beginning of year	1	
2	Purchases	2	
3	Cost of labor	3	
4	Additional section 263A costs (attach statement)	4	
5	Other costs (attach statement)	5	
6	Total. Add lines 1 through 5	6	
7	Inventory at end of year	7	
8	Cost of goods sold. Subtract line 7 from line 6. Enter here and in Part I, line 2	8	

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)

1 Description of property (property street address, city, state, ZIP code). Check if a dual-use. See instructions.
 A _____
 B _____
 C _____
 D _____

	A	B	C	D
2 Rent received or accrued				
a From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)				
b 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)				
c 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) ▶ _____

4 Deductions directly connected with the income in lines 2(a) and 2(b) (attach statement)

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)

1 Description of debt-financed property (street address, city, state, ZIP code). Check if a dual-use. See instructions.
 A _____
 B _____
 C _____
 D _____

	A	B	C	D
2 Gross income from or allocable to debt-financed property				
3 Deductions directly connected with or allocable to debt-financed property				
a Straight line depreciation (attach statement)				
b Other deductions (attach statement)				
c Total deductions (add lines 3a and 3b, columns A through D)				
4 Amount of average acquisition debt on or allocable to debt-financed property (attach statement)				
5 Average adjusted basis of or allocable to debt-financed property (attach statement)				
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) ▶ _____

9 Allocable deductions. Multiply line 3c by line 6

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)

		Exempt Controlled Organizations			
1. Name of controlled organization	2. Employer identification number	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)					
				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)
Totals					

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)				
		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)
Totals				

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

Part IX Advertising Income

1 Name(s) of periodical(s). Check box if reporting two or more periodicals on a consolidated basis.

A	<input type="checkbox"/>
B	<input type="checkbox"/>
C	<input type="checkbox"/>
D	<input type="checkbox"/>

Enter amounts for each periodical listed above in the corresponding column.

	A	B	C	D
2 Gross advertising income				

a Add columns A through D. Enter here and on Part I, line 11, column (A), **▶** _____

3 Direct advertising costs by periodical				
---	--	--	--	--

a Add columns A through D. Enter here and on Part I, line 11, column (B), **▶** _____

4 Advertising gain (loss). Subtract line 3 from line 2. For any column in line 4 showing a gain, complete lines 5 through 8. For any column in line 4 showing a loss or zero, do not complete lines 5 through 7, and enter zero on line 8				
5 Readership costs				
6 Circulation income				
7 Excess readership costs. If line 6 is less than line 5, subtract line 6 from line 5. If line 5 is less than line 6, enter zero				
8 Excess readership costs allowed as a deduction. For each column showing a gain on line 4, enter the lesser of line 4 or line 7				

a Add line 8, columns A through D. Enter the greater of the line 8a, columns total or zero here and on Part II, line 13 **▶** _____

Part X Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percentage of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	

Total. Enter here and on Part II, line 1 **▶** _____

Part XI Supplemental Information (see instructions)

SCHEDULE A:MANAGEMENT FEE INCOME
PART I - LINE 12 - OTHER INCOME
=====

BILLING FEE INCOME 28,738.

TOTAL OTHER INCOME -----
28,738.
=====

SCHEDULE A:MANAGEMENT FEE INCOME
PART II - LINE 14 - OTHER DEDUCTIONS
=====

ENVELOPES	150.

TOTAL OTHER DEDUCTIONS	150.
	=====