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| | | |
|--|--|---|
| 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/foim990 | OMB No 1545-0047 2015 Open to Public Inspection |
|--|--|---|

| | | | |
|---|---|---|--|
| A For the 2015 calendar year, or tax year beginning 07-01-2015 , and ending 06-30-2016 | | | |
| B Check if applicable <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | C Name of organization JOHN HEINZ INSTITUTE OF REHABILITATION MEDICINE | | D Employer identification number 23-2262852 |
| | Doing business as | | |
| | Number and street (or P.O. box if mail is not delivered to street address) 100 ABINGTON EXECUTIVE PARK | Room/suite | E Telephone number (570) 348-1300 |
| | City or town, state or province, country, and ZIP or foreign postal code CLARKS SUMMIT, PA 18411 | | G Gross receipts \$ 44,800,020 |
| | F Name and address of principal officer WILLIAM CONABOY 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 | | 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) H(c) Group exemption number ▶ |
| 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.ALLIED-SERVICES.ORG | |
| 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 1988 | M State of legal domicile PA |

Part I Summary

| | | | |
|---|---|---------------------------|--------------|
| Activities & Governance | 1 Briefly describe the organization's mission or most significant activities OPERATE A REHABILITATIVE HOSPITAL WHICH PROVIDES ALL TYPES OF REHABILITATIVE SERVICES | | |
| | | | |
| | | | |
| | 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 | 9 |
| | 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | 8 |
| | 5 Total number of individuals employed in calendar year 2015 (Part V, line 2a) | 5 | 549 |
| 6 Total number of volunteers (estimate if necessary) | 6 | 57 | |
| 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | 0 | |
| b Net unrelated business taxable income from Form 990-T, line 34 | 7b | 0 | |
| Revenue | | Prior Year | Current Year |
| | 8 Contributions and grants (Part VIII, line 1h) | 249,111 | 323,520 |
| | 9 Program service revenue (Part VIII, line 2g) | 36,313,776 | 36,409,018 |
| | 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | 727,767 | 529,534 |
| | 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 196,456 | 279,169 |
| | 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 37,487,110 | 37,541,241 |
| Expenses | 13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) | 0 | 0 |
| | 14 Benefits paid to or for members (Part IX, column (A), line 4) | 0 | 0 |
| | 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 22,392,145 | 23,340,993 |
| | 16a Professional fundraising fees (Part IX, column (A), line 11e) | 0 | 0 |
| | b Total fundraising expenses (Part IX, column (D), line 25) ▶ ⁰ | | |
| | 17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 15,175,467 | 14,823,847 |
| | 18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 37,567,612 | 38,164,840 |
| | 19 Revenue less expenses Subtract line 18 from line 12 | -80,502 | -623,599 |
| Net Assets or Fund Balances | | Beginning of Current Year | End of Year |
| | 20 Total assets (Part X, line 16) | 24,859,204 | 24,327,789 |
| | 21 Total liabilities (Part X, line 26) | 4,029,732 | 4,606,440 |
| | 22 Net assets or fund balances Subtract line 21 from line 20 | 20,829,472 | 19,721,349 |

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 | ***** | | 2017-05-03 | | |
| | Signature of officer | | Date | | |
| | WILLIAM CONABOY PRESIDENT/CEO Type or print name and title | | | | |
| Paid Preparer Use Only | Prnt/Type preparer's name JULIUS C GREEN CPA | Preparer's signature JULIUS C GREEN CPA | Date | Check <input type="checkbox"/> if self-employed | PTIN P00350393 |
| | Firm's name ▶ BAKER TILLY VIRCHOW KRAUSE LLP | | | Firm's EIN ▶ 39-0859910 | |
| | Firm's address ▶ 1650 MARKET STREET SUITE 4500 PHILADELPHIA, PA 19103 | | | Phone no (215) 972-0701 | |

Part III

Statement of Program Service Accomplishments

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

1

Briefly describe the organization's mission

OUR MISSION IS THAT WE ARE COMMITTED TO THE PEOPLE OF OUR COMMUNITY, TO HELP THEM OVERCOME CHALLENGES AND REACH THEIR GREATEST POTENTIAL BY PROVIDING QUALITY CARE, PEOPLE ORIENTED SERVICES, AND COMFORT

2

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

Yes

No

3

Did the organization cease conducting, or make significant changes in how it conducts, any program services?

Yes

No

4

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

4a

(Code) (Expenses \$ 23,569,319 including grants of \$) (Revenue \$ 36,409,018)

OPERATED A REHABILITATON HOSPITAL, LICENSED FOR 71 BEDS THAT PROVIDED VARIOUS TYPES OF REHABILITATION SERVICES. DURING 2016, THE HOSPITAL HAD 17,082 PATIENT DAYS, OF WHICH 66% WERE MEDICARE. THE TOTAL OCCUPANCY FOR THE REHABILITATION HOSPITAL WAS 51%. IN ADDITION, THE HOSPITAL HAD 304,989 OUTPATIENT VISITS. THE HOSPITAL ALSO OPERATED A 21-BED SKILLED NURSING TRANSITIONAL UNIT. DURING 2016, THE TRANSITIONAL UNIT HAD 7,715 PATIENT DAYS. TOTAL OCCUPANCY FOR THE TRANSITIONAL UNIT WAS 84.32%. SERVICES WERE PROVIDED TO PATIENTS WHO MET CERTAIN CRITERIA WITHOUT CHARGE OR AT AMOUNTS LESS THAN THE ESTABLISHED RATES. CHARGES FORGONE FOR SERVICES RENDERED AND SUPPLIES FURNISHED UNDER THE CHARITY CARE POLICY AMOUNTED TO \$73,081 DURING THE YEAR ENDED JUNE 30, 2016.

4b

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

4c

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

4d

Other program services (Describe in Schedule O)


















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

4e

Total program service expenses

23,569,319

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)? If "Yes," complete Schedule A  | 1 Yes | |
| 2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?  | 2 Yes | |
| 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I | 3 | No |
| 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? If "Yes," complete Schedule C, Part II | 4 | No |
| 5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III | 5 | No |
| 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? If "Yes," complete Schedule D, Part I  | 6 | No |
| 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II  | 7 | No |
| 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III  | 8 | No |
| 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? If "Yes," complete Schedule D, Part IV  | 9 | No |
| 10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V  | 10 | No |
| 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? If "Yes," complete Schedule D, Part VI  | 11a Yes | |
| 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? If "Yes," complete Schedule D, Part VII  | 11b | No |
| 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? If "Yes," complete Schedule D, Part VIII  | 11c | No |
| 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? If "Yes," complete Schedule D, Part IX  | 11d Yes | |
| e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X  | 11e Yes | |
| 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)? If "Yes," complete Schedule D, Part X  | 11f Yes | |
| 12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII  | 12a | No |
| b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional  | 12b Yes | |
| 13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E | 13 | No |
| 14a Did the organization maintain an office, employees, or agents outside of the United States? | 14a | No |
| 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? If "Yes," complete Schedule F, Parts I and IV | 14b | No |
| 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? If "Yes," complete Schedule F, Parts II and IV | 15 | No |
| 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? If "Yes," complete Schedule F, Parts III and IV | 16 | No |
| 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? If "Yes," complete Schedule G, Part I (see instructions) | 17 | No |
| 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II | 18 | No |
| 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III | 19 | No |
| 20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H  | 20a Yes | |
| b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?  | 20b Yes | |

Part IV Checklist of Required Schedules *(continued)*

| | | | | |
|------------|--|------------|-----|----|
| 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> | 21 | | 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> | 22 | | No |
| 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> | 23 | Yes | |
| 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> | 24a | | No |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | | |
| c | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | | |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | | |
| 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> | 25a | | No |
| b | Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> | 25b | | No |
| 26 | Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> | 26 | | No |
| 27 | Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> | 27 | | No |
| 28 | Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) | | | |
| a | A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | | No |
| b | A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28b | | No |
| c | An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <i>If "Yes," complete Schedule L, Part IV</i> | 28c | | No |
| 29 | Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | | No |
| 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> | 30 | | No |
| 31 | Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | | No |
| 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> | 32 | | No |
| 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> | 33 | | No |
| 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> | 34 | Yes | |
| 35a | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a | | No |
| b | If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35b | | |
| 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> | 36 | | No |
| 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> | 37 | | No |
| 38 | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O | 38 | Yes | |

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. | 1a39 | | |
| b | Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable. | 1b0 | | |
| c | Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | 1c | Yes | |
| 2a | Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. | 2a549 | | |
| b | If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions). | 2b | Yes | |
| 3a | Did the organization have unrelated business gross income of \$1,000 or more during the year? | 3a | | No |
| b | If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O. | 3b | | |
| 4a | At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | 4a | | No |
| b | If "Yes," enter the name of the foreign country: See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR). | | | |
| 5a | Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? | 5a | | No |
| b | Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | 5b | | No |
| c | If "Yes," to line 5a or 5b, did the organization file Form 8886-T? | 5c | | |
| 6a | Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? | 6a | | No |
| b | If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | 6b | | |
| 7 | Organizations that may receive deductible contributions under section 170(c). | | | |
| a | Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | 7a | | No |
| b | If "Yes," did the organization notify the donor of the value of the goods or services provided? | 7b | | |
| c | Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | 7c | | No |
| d | If "Yes," indicate the number of Forms 8282 filed during the year. | 7d | | |
| e | Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | 7e | | No |
| f | Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? | 7f | | No |
| g | If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? | 7g | | |
| h | If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? | 7h | | |
| 8 | Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? | 8 | | |
| 9a | Did the sponsoring organization make any taxable distributions under section 4966? | 9a | | |
| b | Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? | 9b | | |
| 10 | Section 501(c)(7) organizations. Enter | | | |
| a | Initiation fees and capital contributions included on Part VIII, line 12. | 10a | | |
| b | Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities. | 10b | | |
| 11 | Section 501(c)(12) organizations. Enter | | | |
| a | Gross income from members or shareholders. | 11a | | |
| b | Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them). | 11b | | |
| 12a | Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | 12a | | |
| b | If "Yes," enter the amount of tax-exempt interest received or accrued during the year. | 12b | | |
| 13 | Section 501(c)(29) qualified nonprofit health insurance issuers. | | | |
| a | Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O. | 13a | | |
| b | Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans. | 13b | | |
| c | Enter the amount of reserves on hand. | 13c | | |
| 14a | Did the organization receive any payments for indoor tanning services during the tax year? | 14a | | No |
| b | If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O. | 14b | | |

Part VI Governance, Management, and Disclosure

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed **PA**

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☒ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year

20 State the name, address, and telephone number of the person who possesses the organization's books and records
DAVID ARGUST 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 (570) 348-1335

Part VII

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

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

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

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

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

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) THOMAS J MELONE CPA CHAIRMAN | 1 00 5 00 | X | | X | | | | 0 | 0 | 0 |
| (2) WILLIAM P CONABOY ESQ VICE CHAIRMAN | 10 00 30 00 | X | | X | | | | 0 | 499,377 | 153,960 |
| (3) SHERRY DAVIDOWITZ TREASURER | 1 00 1 00 | X | | X | | | | 0 | 0 | 0 |
| (4) MICHAEL J ARONICA MD SECRETARY | 1 00 4 00 | X | | X | | | | 0 | 0 | 0 |
| (5) ROBERT POMENTO DIRECTOR | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (6) KENNETH KROGULSKI CFA DIRECTOR | 1 00 6 00 | X | | | | | | 0 | 0 | 0 |
| (7) JOSEPH SAVITZ ESQ DIRECTOR | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (8) RICHARD WEINBERGER DO DIRECTOR | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (9) THOMAS G SPEICHER DIRECTOR | 1 00 4 00 | X | | | | | | 0 | 0 | 0 |
| (10) MICHAEL AVVISATO ASSISTANT SECRETARY & TREASURER | 10 00 30 00 | | | X | | | | 0 | 292,334 | 68,804 |
| (11) GREGORY BASTING VICE PRESIDENT | 40 00 | | | | X | | | 371,616 | 0 | 17,226 |
| (12) KAREN KEARNEY ASSISTANT VICE PRESIDENT | 40 00 | | | | | X | | 175,780 | 0 | 13,398 |
| (13) MICHAEL RAYMOND STAFF PHYSICIAN | 40 00 | | | | | X | | 144,215 | 0 | 7,886 |
| (14) ANN SULLIVAN ASSISTANT VICE PRESIDENT | 40 00 | | | | | X | | 126,745 | 0 | 8,703 |
| | | | | | | | | | | |

[illegible]

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 ► 6

Section B. Independent Contractors

| (A) | (B) | (C) |
|--|-------------------------|--------------|
| Name and business address | Description of services | Compensation |
| RAYMOND & SON INC 801 MUNROE AVENUE DUNMORE, PA 18510 | GENERAL CONTRACTOR | 424,900 |
| GEISINGER VIEWMONT HEALTH ASSOCIATES PO BOX 934 SCRANTON, PA 18501 | LAB SERVICES | 201,744 |
| TRANS MED AMBULANCE INC 14 MARION STREET LUZERNE, PA 18709 | AMBULANCE SERVICES | 165,633 |
| UNITED AMERICAN SECURITY LLC PO BOX 4582 CAROL STREAM, IL 60197 | SECURITY SERVICES | 138,445 |
| PARIS HEALTHCARE LINEN SERVICE PO BOX 103 DUBOIS, PA 15801 | LINEN SERVICE | 127,679 |

Form **990** (2015)

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 | 323,520 | | | |
| | e | Government grants (contributions) | 1e | | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | | | | |
| | g | Noncash contributions included in lines 1a-1f \$ | | | | | |
| | h | Total. Add lines 1a-1f | | | 323,520 | | |
| Program Service Revenue | 2a | NET PATIENT SERVICE REV | Business Code 623000 | 35,342,956 | 35,342,956 | | |
| | b | PA ASSESSMENT REVENUE | 623000 | 1,066,062 | 1,066,062 | | |
| | c | | | | | | |
| | d | | | | | | |
| | e | | | | | | |
| | f | All other program service revenue | | | | | |
| | g | Total. Add lines 2a-2f | | | 36,409,018 | | |
| | Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | | 154,567 | | |
| 4 | | Income from investment of tax-exempt bond proceeds . . | | | | | |
| 5 | | Royalties | | | | | |
| 6a | | Gross rents | (i) Real 23,326 | (ii) Personal | | | |
| b | | Less rental expenses | 0 | | | | |
| c | | Rental income or (loss) | 23,326 | | | | |
| d | | Net rental income or (loss) | | 23,326 | | | 23,326 |
| 7a | | Gross amount from sales of assets other than inventory | (i) Securities 7,633,746 | (ii) Other | | | |
| b | | Less cost or other basis and sales expenses | 7,258,779 | | | | |
| c | | Gain or (loss) | 374,967 | | | | |
| d | | Net gain or (loss) | | 374,967 | | | 374,967 |
| 8a | | Gross income from fundraising events (not including \$ of contributions reported on line 1c) See Part IV, line 18 | a | | | | |
| b | | Less direct expenses | b | | | | |
| c | | Net income or (loss) from fundraising events . . | | | | | |
| 9a | | Gross income from gaming activities See Part IV, line 19 | a | | | | |
| b | | Less direct expenses | b | | | | |
| c | | Net income or (loss) from gaming activities . . . | | | | | |
| 10a | | Gross sales of inventory, less returns and allowances | a | | | | |
| b | | Less cost of goods sold . . . | b | | | | |
| c | | Net income or (loss) from sales of inventory . . | | | | | |
| | | Miscellaneous Revenue | Business Code | | | | |
| 11a | | CAFETERIA SALES | 722210 | 155,056 | | | 155,056 |
| b | FITNESS MAINTENANCE INCOME | 900099 | 53,497 | | | 53,497 | |
| c | ABSTRACT REVENUE | 561000 | 42,876 | | | 42,876 | |
| d | All other revenue | | 4,414 | | | 4,414 | |
| e | Total. Add lines 11a-11d | | | 255,843 | | | |
| 12 | Total revenue. See Instructions | | | 37,541,241 | 36,409,018 | 0 | 808,703 |

Part IX Statement of Functional Expenses

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

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



| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|---|-----------------------|---------------------------------|--|-----------------------------|
| 1 | Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | | | | |
| 2 | Grants and other assistance to domestic individuals. See Part IV, line 22 | | | | |
| 3 | Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | | | | |
| 4 | Benefits paid to or for members | | | | |
| 5 | Compensation of current officers, directors, trustees, and key employees | 395,957 | 291,936 | 104,021 | |
| 6 | Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 | Other salaries and wages | 19,006,961 | 14,013,693 | 4,993,268 | |
| 8 | Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 509,455 | 375,617 | 133,838 | |
| 9 | Other employee benefits | 2,008,778 | 1,481,057 | 527,721 | |
| 10 | Payroll taxes | 1,419,842 | 1,046,839 | 373,003 | |
| 11 | Fees for services (non-employees) | | | | |
| a | Management | | | | |
| b | Legal | 5,561 | | 5,561 | |
| c | Accounting | 43,206 | | 43,206 | |
| d | Lobbying | | | | |
| e | Professional fundraising services. See Part IV, line 17 | | | | |
| f | Investment management fees | | | | |
| g | Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 5,386,204 | 872,326 | 4,513,878 | |
| 12 | Advertising and promotion | 1,050 | | 1,050 | |
| 13 | Office expenses | 540,995 | 191,877 | 349,118 | |
| 14 | Information technology | | | | |
| 15 | Royalties | | | | |
| 16 | Occupancy | 1,198,521 | 326,658 | 871,863 | |
| 17 | Travel | 13,763 | 6,424 | 7,339 | |
| 18 | Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 | Conferences, conventions, and meetings | 67,508 | 40,844 | 26,664 | |
| 20 | Interest | 5,155 | | 5,155 | |
| 21 | Payments to affiliates | | | | |
| 22 | Depreciation, depletion, and amortization | 848,200 | 848,200 | | |
| 23 | Insurance | 323,012 | | 323,012 | |
| 24 | Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O) | | | | |
| a | MEDICAL SUPPLIES | 1,632,244 | 1,632,244 | | |
| b | EQUIPMENT & REPAIRS | 1,611,384 | 147,465 | 1,463,919 | |
| c | PA MODERN ASSESSMENT | 1,066,062 | 1,066,062 | | |
| d | FOOD SERVICES | 561,633 | 518,858 | 42,775 | |
| e | All other expenses | 1,519,349 | 709,219 | 810,130 | |
| 25 | Total functional expenses. Add lines 1 through 24e | 38,164,840 | 23,569,319 | 14,595,521 | 0 |
| 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 | | 1,700 | 1 | 1,675 |
| | 2 | Savings and temporary cash investments | | 2,990,085 | 2 | 1,830,212 |
| | 3 | Pledges and grants receivable, net | | | 3 | |
| | 4 | Accounts receivable, net | | 3,140,585 | 4 | 3,238,539 |
| | 5 | Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | | 5 | |
| | 6 | Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L | | | 6 | |
| | 7 | Notes and loans receivable, net | | | 7 | |
| | 8 | Inventories for sale or use | | 61,522 | 8 | 58,058 |
| | 9 | Prepaid expenses and deferred charges | | 85,149 | 9 | 58,122 |
| | 10a | Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D | 10a 27,413,843 | | | |
| | b | Less: accumulated depreciation | 10b 20,561,270 | 6,818,868 | 10c | 6,852,573 |
| | 11 | Investments—publicly traded securities | | 9,816,059 | 11 | 9,848,752 |
| | 12 | Investments—other securities. See Part IV, line 11 | | | 12 | |
| | 13 | Investments—program-related. See Part IV, line 11 | | | 13 | |
| | 14 | Intangible assets | | | 14 | |
| | 15 | Other assets. See Part IV, line 11 | | 1,945,236 | 15 | 2,439,858 |
| | 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | 24,859,204 | 16 | 24,327,789 |
| Liabilities | 17 | Accounts payable and accrued expenses | | 2,196,641 | 17 | 2,670,901 |
| | 18 | Grants payable | | | 18 | |
| | 19 | Deferred revenue | | | 19 | |
| | 20 | Tax-exempt bond liabilities | | | 20 | |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | 21 | |
| | 22 | Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | | | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | 366,826 | 23 | 316,113 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | | 24 | |
| | 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 | | 1,466,265 | 25 | 1,619,426 |
| | 26 | Total liabilities. Add lines 17 through 25 | | 4,029,732 | 26 | 4,606,440 |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | | | |
| | 27 | Unrestricted net assets | | 20,829,472 | 27 | 19,721,349 |
| | 28 | Temporarily restricted net assets | | | 28 | |
| | 29 | Permanently restricted net assets | | | 29 | |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | | | |
| | 30 | Capital stock or trust principal, or current funds | | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | | 32 | |
| | 33 | Total net assets or fund balances | | 20,829,472 | 33 | 19,721,349 |
| | 34 | Total liabilities and net assets/fund balances | | 24,859,204 | 34 | 24,327,789 |

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 | 37,541,241 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 38,164,840 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | -623,599 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 20,829,472 |
| 5 | Net unrealized gains (losses) on investments | 5 | -484,524 |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | 0 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 19,721,349 |

Part XII

Financial Statements and Reporting

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

| | | Yes | No |
|----|--|-----|----|
| 1 | Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O | | |
| 2a | Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | | No |
| 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 <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | Yes | |
| 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 in Schedule O | Yes | |
| 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? | | No |
| b | If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits | | |

SCHEDULE A
(Form 990 or 990EZ)

Public Charity Status and Public Support

OMB No 1545-0047

2015

Open to Public Inspection

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

Department of the Treasury
Internal Revenue Service

| | |
|---|--|
| Name of the organization JOHN HEINZ INSTITUTE OF REHABILITATION MEDICINE | Employer identification number 23-2262852 |
|---|--|

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 11, check only one box)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).**(Attach Schedule E (Form 990 or 990-EZ))
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9 ☐ An 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)
- 10 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g
- 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- 9 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 | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Total | | | | | | |

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

| Section A. Public Support | | | | | | |
|---|---------|---------|---------|---------|---------|----------|
| Calendar year (or fiscal year beginning in) ► | (a)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (f)Total |
| 1 Gifts, grants, contributions, and membership fees received (Do not include any unusual grants) | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 Public support. Subtract line 5 from line 4 | | | | | | |

| Section B. Total Support | | | | | | |
|--|---------|---------|---------|---------|---------|----------|
| Calendar year (or fiscal year beginning in) ► | (a)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (f)Total |
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 11 Total support. Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc (see instructions) | | | | | 12 | |
| 13 First five years.If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/> | | | | | | |

| Section C. Computation of Public Support Percentage | | | | | | |
|---|--|--|--|--|----|--|
| 14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f)) | | | | | 14 | |
| 15 Public support percentage for 2014 Schedule A, Part II, line 14 | | | | | 15 | |
| 16a 33 1/3% support test—2015.If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/> | | | | | | |
| b 33 1/3% support test—2014.If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/> | | | | | | |
| 17a 10%-facts-and-circumstances test—2015.If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ► <input type="checkbox"/> | | | | | | |
| b 10%-facts-and-circumstances test—2014.If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ► <input type="checkbox"/> | | | | | | |
| 18 Private foundation.If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► <input type="checkbox"/> | | | | | | |

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

(Complete only if you checked the box on line 9 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)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (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)2011 | (b)2012 | (c)2013 | (d)2014 | (e)2015 | (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 five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ► <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2014 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2014 Schedule A, Part III, line 17 | 18 | |

19a 33 1/3% support tests—2015. 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—2014. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ► ☐

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of 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? 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. | 1 | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2). | 2 | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below. | 3a | |
| 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)? If "Yes," describe in Part VI when and how the organization made the determination. | 3b | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use. | 3c | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below. | 4a | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? 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. | 4b | |
| 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)? 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. | 4c | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document). | 5a | |
| 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? | 5b | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | 5c | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI . | 6 | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990). | 7 | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990). | 8 | |
| 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))? If "Yes," provide detail in Part VI . | 9a | |
| b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI . | 9b | |
| c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI . | 9c | |
| 10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer b below. | 10a | |
| b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.) | 10b | |
| 11 Has the organization accepted a gift or contribution from any of the following persons? | | |
| a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization? | 11a | |
| b A family member of a person described in (a) above? | 11b | |
| c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI . | 11c | |

Part IV

Supporting Organizations (continued)

Section B. Type I Supporting Organizations

| | Yes | No |
|---|-----|----|
| <div>1</div> <div>Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <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 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></div> | | |
| <div>2</div> <div>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></div> | | |

Section C. Type II Supporting Organizations

| | Yes | No |
|--|-----|----|
| <div>1</div> <div>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></div> | | |

Section D. All Type III Supporting Organizations

| | Yes | No |
|---|-----|----|
| <div>1</div> <div>Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (1) a written notice describing the type and amount of support provided during the prior tax year, (2) a copy of the Form 990 that was most recently filed as of the date of notification, and (3) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?</div> | | |
| <div>2</div> <div>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></div> | | |
| <div>3</div> <div>By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i></div> | | |

Section E. Type III Functionally-Integrated Supporting Organizations

| | | |
|---|-----|----|
| <div>1</div> <div>Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)</div> <div><div>a</div><div><input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.</div></div> <div><div>b</div><div><input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.</div></div> <div><div>c</div><div><input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).</div></div> | | |
| <div>2</div> <div>Activities Test. Answer (a) and (b) below.</div> | Yes | No |
| <div>a</div> <div>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></div> | | |
| <div>b</div> <div>Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <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></div> | | |
| <div>3</div> <div>Parent of Supported Organizations. Answer (a) and (b) below.</div> | | |
| <div>a</div> <div>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>Provide details in Part VI.</i></div> | | |
| <div>b</div> <div>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></div> | | |

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 **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) | 1 | |
| 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 (explain in detail in Part VI) _____ | | |
| 2 | Acquisition indebtedness applicable to non-exempt use assets | 2 | |
| 3 | Subtract line 2 from line 1d | 3 | |
| 4 | Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions) | 4 | |
| 5 | Net value of non-exempt-use assets (subtract line 4 from line 3) | 5 | |
| 6 | Multiply line 5 by .035 | 6 | |
| 7 | Recoveries of prior-year distributions | 7 | |
| 8 | 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 85% of line 1 | 2 | |
| 3 | Minimum asset amount for prior year (from Section B, line 8, Column A) | 3 | |
| 4 | Enter greater of line 2 or line 3 | 4 | |
| 5 | Income tax imposed in prior year | 5 | |
| 6 | Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions) | 6 | |
| 7 | Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions) <input type="checkbox"/> | | |

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 | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI) See instructions | |
| 7 Total annual distributions. Add lines 1 through 6 | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | |
| 9 Distributable amount for 2015 from Section C, line 6 | |
| 10 Line 8 amount divided by Line 9 amount | |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2015 | (iii) Distributable Amount for 2015 |
|--|-------------------------------------|---|--|
| 1 Distributable amount for 2015 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2015 (reasonable cause required--see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2015 | | | |
| a | | | |
| b | | | |
| c | | | |
| d From 2013. | | | |
| e From 2014. | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2015 distributable amount | | | |
| i Carryover from 2010 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2015 from Section D, line 7 \$ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2015 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2016. Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a | | | |
| b | | | |
| c Excess from 2013. | | | |
| d From 2014. | | | |
| e From 2015. | | | |

Part VI Supplemental Information.

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

Facts And Circumstances Test

Return Reference

Explanation

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
► Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
JOHN HEINZ INSTITUTE OF REHABILITATION
MEDICINE

Employer identification number
23-2262852

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

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

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

1

Purpose(s) of conservation easements held by the organization (check all that apply)

☐ Preservation of land for public use (e g , recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space

☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2

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

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

3

Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►

4

Number of states where property subject to conservation easement is located ►

5

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

☐ Yes ☐ No

6

Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year
►

7

Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year
► \$

8

Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4) (B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9

In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a

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

b

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

(i)

Revenue included on Form 990, Part VIII, line 1
► \$

(ii)

Assets included in Form 990, Part X
► \$

2

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

a

Revenue included on Form 990, Part VIII, line 1
► \$

b

Assets included in Form 990, Part X
► \$

Part III

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

(continued)

3

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

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

Amount

1c

1d

1e

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 in Part XIII

☐

Part V

Endowment Funds.

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

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

2

Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Temporarily restricted endowment ▶

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

3a

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

(i) unrelated organizations

(ii) related organizations

3a(i)

3a(ii)

Yes

No

b

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

3b

4

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

Part VI

Land, Buildings, and Equipment.

Complete if the organization answered "Yes" to 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) | Accumulated (c)depreciation | (d)Book value |
|-------------------------|---|--------------------------------|-----------------------------|---------------|
| 1a | Land | 299,615 | | 299,615 |
| b | Buildings | 22,582,346 | 16,871,269 | 5,711,077 |
| c | Leasehold improvements | | | |
| d | Equipment | 4,531,882 | 3,690,001 | 841,881 |
| e | Other | | | |
| Total. | Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) | | | 6,852,573 |

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.

| | | | |
|---|---|----|------------|
| 1 | Total revenue, gains, and other support per audited financial statements | 1 | 37,056,717 |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12 | | |
| a | Net unrealized gains (losses) on investments | 2a | -484,524 |
| b | Donated services and use of facilities | 2b | |
| c | Recoveries of prior year grants | 2c | |
| d | Other (Describe in Part XIII) | 2d | |
| e | Add lines 2a through 2d | 2e | -484,524 |
| 3 | Subtract line 2e from line 1 | 3 | 37,541,241 |
| 4 | Amounts included on Form 990, Part VIII, line 12, but not on line 1 | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | |
| b | Other (Describe in Part XIII) | 4b | |
| c | Add lines 4a and 4b | 4c | 0 |
| 5 | Total revenue Add lines 3 and 4c.(This must equal Form 990, Part I, line 12) | 5 | 37,541,241 |

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.

| | | | |
|---|--|----|------------|
| 1 | Total expenses and losses per audited financial statements | 1 | 38,164,840 |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25 | | |
| a | Donated services and use of facilities | 2a | |
| b | Prior year adjustments | 2b | |
| c | Other losses | 2c | |
| d | Other (Describe in Part XIII) | 2d | |
| e | Add lines 2a through 2d | 2e | 0 |
| 3 | Subtract line 2e from line 1 | 3 | 38,164,840 |
| 4 | Amounts included on Form 990, Part IX, line 25, but not on line 1: | | |
| a | Investment expenses not included on Form 990, Part VIII, line 7b | 4a | |
| b | Other (Describe in Part XIII) | 4b | |
| c | Add lines 4a and 4b | 4c | 0 |
| 5 | Total expenses Add lines 3 and 4c.(This must equal Form 990, Part I, line 18) | 5 | 38,164,840 |

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.

| Return Reference | Explanation |
|------------------|--|
| PART X, LINE 2 | ALLIED ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES USING A RECOGNITION THRESHOLD OF MORE-LIKELY-THAN-NOT TO BE SUSTAINED UPON EXAMINATION BY THE APPROPRIATE TAXING AUTHORITY. MEASUREMENT OF THE TAX UNCERTAINTY OCCURS IF THE RECOGNITION THRESHOLD HAS BEEN MET. MANAGEMENT DETERMINED THAT THERE WERE NO TAX UNCERTAINTIES THAT MET THE RECOGNITION THRESHOLD IN 2016 AND 2015. |

Part XIII **Supplemental Information** *(continued)*

| Return Reference | Explanation |
|---------------------------------------|-----------------|
| PART XII, LINE 2D - OTHER ADJUSTMENTS | RENTAL EXPENSES |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

SCHEDULE H
(Form 990)

Department of the
Treasury
Internal Revenue
Service

Hospitals

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

▶ **Attach to Form 990.**

▶ **Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

2015

Open to Public
Inspection

| | |
|---|---|
| Name of the organization JOHN HEINZ INSTITUTE OF REHABILITATION MEDICINE | Employer identification number 23-2262852 |
|---|---|

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 | 1a | Yes | |
| b | If "Yes," was it a written policy? | 1b | Yes | |
| 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 checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities | | | |
| 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 <i>free</i> care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % | 3a | Yes | |
| b | Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input checked="" type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ % | 3b | Yes | |
| 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"? | 4 | Yes | |
| 5a | Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? | 5a | Yes | |
| b | If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? | 5b | Yes | |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | | No |
| 6a | Did the organization prepare a community benefit report during the tax year? | 6a | Yes | |
| b | If "Yes," did the organization make it available to the public? | 6b | Yes | |
| Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H. | | | | |

| 7 Financial Assistance and Certain Other Community Benefits at Cost | | | | | | |
|---|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Financial Assistance and Means-Tested Government Programs | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community benefit expense | (d) Direct offsetting revenue | (e) Net community benefit expense | (f) Percent of total expense |
| a Financial Assistance at cost (from Worksheet 1) | 1 | 200 | 198,123 | 0 | 198,123 | 0 530 % |
| b Medicaid (from Worksheet 3, column a) | | 750 | 2,079,834 | 941,233 | 1,138,601 | 3 030 % |
| c Costs of other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Financial Assistance and Means-Tested Government Programs | 1 | 950 | 2,277,957 | 941,233 | 1,336,724 | 3 560 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | | | | | | |
| f Health professions education (from Worksheet 5) | | | | | | |
| g Subsidized health services (from Worksheet 6) | | | | | | |
| h Research (from Worksheet 7) | | | | | | |
| i Cash and in-kind contributions for community benefit (from Worksheet 8) | | 100 | 83,335 | 0 | 83,335 | 0 220 % |
| j Total. Other Benefits | | 100 | 83,335 | | 83,335 | 0 220 % |
| k Total. Add lines 7d and 7j | 1 | 1,050 | 2,361,292 | 941,233 | 1,420,059 | 3 780 % |

Part IICommunity Building Activities

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

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

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1

Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?

1

Yes

No

2

Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

2

338,661

3

Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.

3

198,123

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

21,924,399

6

Enter Medicare allowable costs of care relating to payments on line 5.

6

20,671,134

7

Subtract line 6 from line 5. This is the surplus (or shortfall).

7

1,253,265

8

Describe in Part VI the extent to which any shortfall reported in 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.

☒ Cost accounting system

☐ Cost to charge ratio

☐ Other

9a

Did the organization have a written debt collection policy during the tax year?

9a

Yes

No

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

Yes

No

Part IVManagement 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 | | | | |

Section A. Hospital Facilities

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

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)

Schedule H (Form 990) 2015

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)

JOHN HEINZ INSTITUTE OF REHABILITATION

Name of hospital facility or letter of facility reporting group

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? | 1 | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | 2 | No |
| 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) 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"/> Information gaps that limit the hospital facility's ability to assess the community's health needs j <input type="checkbox"/> Other (describe in Section C) 4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>15</u> 5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | 3 | Yes |
| 6a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | 6a | Yes |
| 6b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | 6b | Yes |
| 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) a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.ALLIED-SERVICES.ORG/ABOUT-US</u> b <input type="checkbox"/> Other website (list url) _____ c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility d <input type="checkbox"/> Other (describe in Section C) 8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | 7 | Yes |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>15</u> | 8 | Yes |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | 10 | Yes |
| 10b | If "Yes" (list url) <u>WWW.ALLIED-SERVICES.ORG/ABOUT-US</u> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | 10b | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed 12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | |
| 12a | | 12a | No |
| 12b | If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | 12b | |
| c | If "Yes" on 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)

JOHN HEINZ INSTITUTE OF REHABILITATION

Name of hospital facility or letter of facility reporting group

| | | Yes | No | |
|----|---|-----|-----|--|
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that 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 a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 000000000000 % and FPG family income limit for eligibility for discounted care of 200 000000000000 % b <input checked="" 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 checked="" type="checkbox"/> Insurance status f <input checked="" type="checkbox"/> Underinsurance discount g <input type="checkbox"/> Residency h <input type="checkbox"/> Other (describe in Section C) | 13 | Yes | |
| 14 | Explained the basis for calculating amounts charged to patients? | 14 | Yes | |
| 15 | Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) 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 checked="" 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) | 15 | Yes | |
| 16 | Included measures to publicize the policy within the community served by the hospital facility? 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) WWW ALLIED-SERVICES ORG b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW ALLIED-SERVICES ORG c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW ALLIED-SERVICES ORG 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 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"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility h <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP i <input type="checkbox"/> Other (describe in Section C) | 16 | Yes | |

Billing and Collections

| | | | | |
|----|--|----|-----|--|
| 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 non-payment? | 17 | Yes | |
| 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"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) e <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | | |

Part V

Facility Information (continued)

JOHN HEINZ INSTITUTE OF REHABILITATION

| Name of hospital facility or letter of facility reporting group | | | Yes | No |
|---|--|----|-----|----|
| 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 | 19 | | No |
| 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"/> Actions that require a legal or judicial process | | | |
| d | <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"/> Notified individuals of the financial assistance policy on admission | | | |
| b | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | | |
| e | <input checked="" 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 | 21 | | No |
| 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) | | | |
| Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals) | | | | |
| 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 its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | | |
| d | <input checked="" type="checkbox"/> Other (describe in Section C) | | | |
| 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 | | No |
| 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 | | No |

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, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 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.

| Form and Line Reference | Explanation |
|-------------------------|-------------|
| | |
| | |
| | |
| | |
| | |
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| | |
| | |
| | |
| | |
| | |

Part V **Facility Information** *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

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

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

Part VI **Supplemental Information**

Provide the following information

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

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART I, LINE 7 | THE MAJORITY OF THE NET COMMUNITY BENEFIT EXPENSES, UNREIMBURSED MEDICAID, WERE CALCULATED USING OUR INTERNAL COST ACCOUNTING SYSTEM, WHICH ADDRESSES ALL PATIENT SEGMENTS CHARITY CARE WAS CALCULATED USING A COST-TO-CHARGE RATIO ALL OTHER AMOUNTS ARE CALCULATED AS DIRECT EXPENSE AND REVENUE AS RECORDED ON THE GENERAL LEDGER |

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART I, LN 7 COL(F) | COMMUNITY BENEFIT PERCENTAGE IS NET COMMUNITY BENEFIT EXPENSE DIVIDED BY TOTAL EXPENSE LESS PROVISION FOR DOUBTFUL COLLECTIONS THE AMOUNT OF BAD DEBT EXPENSE WAS \$557,093 |

| Form and Line Reference | Explanation |
|--|---|
| PART II, COMMUNITY BUILDING ACTIVITIES | <p>BEYOND PROVIDING INPATIENT AND OUTPATIENT MEDICAL REHABILITATION, ALLIED REHAB HOSPITAL AND THE JOHN HEINZ REHAB HOSPITAL CONTRIBUTE TO THE HEALTH AND WELFARE OF NORTHEASTERN AND CENTRAL PENNSYLVANIANS THROUGH HEALTH EDUCATION, CLINICAL MENTORING AND INTERNSHIPS, FINANCIAL AND IN-KIND SUPPORT TO INDIVIDUALS, COMMUNITY SERVICE ORGANIZATIONS, COMMUNITY WELLNESS AND MEDICAL/CLINICAL EDUCATION PROVIDERS SOME EXAMPLES OF ALLIED REHAB AND JOHN HEINZ REHAB HOSPITAL FOR COMMUNITY BUILDING ACTIVITIES DURING THE YEAR - USE OF FACILITY SPACE AND/OR PRINTING SERVICES BY NONPROFIT ORGANIZATIONS SUCH AS ASSOCIATION OF FUNDRAISING PROFESSIONALS, BOYS & GIRLS CLUB OF SCRANTON, CATHOLIC SOCIAL SERVICES, FAMILIES CARING FOR CHILDREN, FRIENDS OF THE POOR, KEYSTONE COMMUNITY RESOURCES, LEADERSHIP LACKAWANNA, NORTHEAST REGIONAL CANCER INSTITUTE, ST JOSEPH'S CENTER, THE SUSAN G KOMEN NEPA AFFILIATE, THE UNICO CHARITABLE FOUNDATION, THE VOLUNTARY ACTION CENTER AND THE WOMEN'S RESOURCE CENTER - THE HOSPITALS ALSO SUPPORTED THE EDUCATION AND TRAINING OF HEALTH CARE PROFESSIONALS THROUGH COOPERATION WITH THE COMMONWEALTH MEDICAL COLLEGE, OCCUPATIONAL THERAPY AND PHYSICAL THERAPY PROFESSIONALS, THE REGIONAL LONG TERM CARE ASSOCIATION, THE NEPA AGING NETWORK ALLIANCE, FORTIS INSTITUTE, THE UNIVERSITY OF SCRANTON, LACKAWANNA COLLEGE AND THE ACADEMY OF THE AMERICAN ASSOCIATION FOR PSYCHIATRIC REHABILITATION - THE HOSPITALS HOSTED AND FACILITATED REGULARLY SCHEDULED MEETINGS OF SUPPORT GROUPS FOR STROKE, LIMB AMPUTATION, PARKINSON'S DISEASE, MYASTHENIA GRAVIS, BRAIN INJURY, AND MULTIPLE SCLEROSIS - ALLIED SERVICES CLINICIANS ALSO PARTICIPATED IN TELEVISED HEALTH EDUCATION PROGRAMS ON FITNESS AND CONDITIONING, BREAST CANCER AND LYMPHEDEMA, ALZHEIMER'S DISEASE/AGE-ASSOCIATED DEMENTIA, MENTAL HEALTH PROGRAMS, HEART HEALTH, AND ARTHRITIS COMMUNITY OUTREACH STAFF ALSO PROVIDED INFORMATIONAL PRESENTATIONS TO SENIOR CENTERS AND HEALTH GROUPS ON TOPICS BALANCE/FALL PREVENTION, ADVANCE HEALTH DIRECTIVES, FITNESS FOR RUNNERS, HOSPICE CARE, AND MEDICAL REHABILITATION - IN MAY, 2016, ALLIED SERVICES HOSTED A FREE CONFERENCE ON LIFE AFTER SPINAL CORD INJURY, WITH INSPIRATIONAL KEYNOTE SPEAKER MIA SCHAIKOWITZ, STAR OF THE REALITY TV SHOW "PUSH GIRLS " THE CONFERENCE FOCUSED ON OVERCOMING BARRIERS TO ACCESS, CAREER AND PERSONAL SUCCESS IT WAS HOSTED IN COOPERATION WITH IAM - INDIVIDUAL ABILITIES IN MOTION---A REGIONAL ADVOCACY GROUP FOR ADULTS WITH SPINAL CORD INJURY MS SCHAIKOWITZ ALSO SPOKE TO AREA HIGH SCHOOL AND COLLEGE STUDENTS IN ALL, SOME 100 INDIVIDUALS HEARD THE PRESENTATION - HOSPITAL STAFF DELIVERED HEALTH EDUCATION PRESENTATIONS AND SCREENINGS DURING THE YEAR, IN CONJUNCTION WITH PUBLIC HEALTH FAIRS, COMMUNITY SERVICE AND SCHOOL EVENTS IN ALL, STAFF TOOK PART IN 42 COMMUNITY HEALTH EDUCATION EVENTS INVOLVING OVER 255 CONSUMER PARTICIPANTS WE ALSO PROVIDED SCREENINGS AND/OR INFORMATIONAL TALKS REGARDING BALANCE/FALL PREVENTION, HEAD INJURY PREVENTION, PULMONARY REHABILITATION, LYMPHEDEMA MANAGEMENT, SPORTS FITNESS AND INJURY PREVENTION, INFANT TORTICOLLIS AWARENESS AND THERAPIES - IN OCTOBER, 2015, HEINZ REHAB HOSPITAL SPONSORED AN ON-SITE PASTORAL CARE CONFERENCE ENTITLED "DEMYSTIFYING AUTISM EXPLORING PHYSICAL, BEHAVIORAL, AND SPIRITUAL NEEDS" FOR AREA SOCIAL WORKERS, CASEWORKERS, NURSES, CLERGY, AND CONSUMERS THE PROGRAM EXPLORED NEW APPROACHES TO INCLUSION, ACCEPTANCE AND SERVICES FOR INDIVIDUALS WITH AUTISM AND THEIR FAMILIES - SPONSORSHIP OF COMMUNITY HEALTH EDUCATION EVENTS INCLUDED THE THE UNIVERSITY OF SCRANTON DISABILITY CONFERENCE, OCTOBER, 2015, WHICH FOCUSED ON VOCATIONAL REHABILITATION FOR INDIVIDUALS WITH DISABILITIES, THE SCRANTON HALF-MARATHON, APRIL, 2016, AND THE ALL ABILITIES 5K RUN/WALK, OCTOBER, 2015 - PEDIATRIC SERVICES PROVIDED THROUGH EACH REHAB HOSPITAL INCLUDES A SIGNIFICANT PERCENTAGE OF CHARITY CARE FOR THE UNDERINSURED THE REHAB HOSPITALS ALSO HAVE CREATED AND SUPPORTED DEVELOPMENTAL PROGRAMS THROUGHOUT THE YEAR FOR CHILDREN WITH A VARIETY OF DISABILITIES, WITH SPECIAL EMPHASIS ON CHILDREN WITH AUTISM SPECTRUM (ASD) DIAGNOSES, MUSCULO-SKELETAL DISABILITIES AND INJURIES, LEARNING/MEMORY AND ATTENTION DISORDERS, AND DEVELOPMENTAL DISABILITIES - THE DEPAUL SCHOOL FOR CHILDREN WITH LEARNING DISABILITIES IS A EXAMPLE OF A NECESSARY EDUCATION-BASED PROGRAM WHICH BECAME PART OF THE ALLIED SERVICES REHABILITATION HOSPITAL IN 1991 THIS PRIMARY SCHOOL SERVED OVER 76 LOCAL CHILDREN WITH DYSLEXIA AND RELATED LEARNING DISABILITIES THE COST TO ALLIED SERVICES INSTITUTE FOR REHAB MEDICINE IN 2015-16 WAS \$171,205</p> |

| Form and Line Reference | Explanation |
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| PART III, LINE 2 | BAD DEBT EXPENSE IS CALCULATED BASED ON ACTUAL WRITE-OFFS THROUGHOUT THE YEAR AND IS ESTIMATED AT COST USING THE COST TO CHARGE RATIO |

| Form and Line Reference | Explanation |
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| PART III, LINE 3 | THE ORGANIZATION APPLIES THE COST TO CHARGE RATIO TO THE GROSS CHARITY CARE WRITE-OFFS TO ESTIMATE THE AMOUNT OF THE COST OF BAD DEBT |

| Form and Line Reference | Explanation |
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| PART III, LINE 4 | ACCOUNTS RECEIVABLE ARE REPORTED AT NET REALIZABLE VALUE ACCOUNTS ARE WRITTEN OFF WHEN THEY ARE DETERMINED TO BE UNCOLLECTABLE BASED ON MANAGEMENT'S ASSESSMENT OF INDIVIDUAL ACCOUNTS THE ALLOWANCE FOR DOUBTFUL COLLECTIONS IS ESTIMATED BASED UPON A PERIODIC REVIEW OF THE ACCOUNTS RECEIVABLE AGING, PAYOR CLASSIFICATIONS AND APPLICATION OF HISTORICAL WRITE-OFF PERCENTAGES |

| Form and Line Reference | Explanation |
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| PART III, LINE 8 | DUE TO OUR STATUS AS A REHABILITATION HOSPITAL, THERE IS NO SHORTFALL FOR MEDICARE REIMBURSEMENT PURPOSES |

| Form and Line Reference | Explanation |
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| PART III, LINE 9B | ELIGIBILITY FOR CHARITY IS DETERMINED PRIOR TO COLLECTION AND AT ANY TIME DURING THE COLLECTION PROCESS COLLECTIONS ARE PURSUED UP TO THE POINT THAT A PATIENT COMPLETES AND IS APPROVED FOR CHARITY CARE ONCE CHARITY CARE IS APPROVED, NO FURTHER COLLECTION EFFORTS ARE MADE IF A PATIENT QUALIFIES FOR FULL CHARITY CARE, THERE ARE NO FURTHER COLLECTION EFFORTS IF A PATIENT QUALIFIES FOR PARTIAL CHARITY CARE, REGULAR COLLECTION PRACTICES ARE FOLLOWED THERE IS A STANDARD TIMELINE FOR THE COLLECTION PROCESS BASED UPON THE DOLLAR VALUE OF THE ACCOUNT IT BEGINS WITH MONTHLY STATEMENTS TO COLLECTION CALLS AND COLLECTION LETTERS TO SENDING ACCOUNTS TO COLLECTION AGENCIES TO LEGAL ACTION (BASED UPON THE DOLLAR VALUE) THIS PROCESS IS SUSPENDED WHEN A PATIENT INDICATES THEY ARE UNABLE TO PAY THE INVOICE BASED UPON FINANCIAL ISSUES |

| Form and Line Reference | Explanation |
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| PART VI, LINE 2 | <p>TRIPP UMBACH FACILITATED AND MANAGED A COMPREHENSIVE COMMUNITY HEALTH NEEDS ASSESSMENT ON BEHALF OF ALLIED SERVICES REHABILITATION HOSPITAL AND JOHN HEINZ REHABILITATION HOSPITAL, WHICH RESULTED IN THE IDENTIFICATION OF COMMUNITY HEALTH NEEDS. THE ASSESSMENT PROCESS INCLUDED INPUT FROM PERSONS WHO REPRESENT THE BROAD INTERESTS OF THE COMMUNITY SERVED BY THE HOSPITAL FACILITIES, INCLUDING THOSE WITH SPECIAL KNOWLEDGE AND EXPERTISE OF PUBLIC HEALTH ISSUES. A SERIES OF MEETINGS WAS FACILITATED BY THE CONSULTANTS AND THE CHNA OVERSIGHT COMMITTEE CONSISTING OF LEADERSHIP FROM SERVICES REHABILITATION HOSPITAL AND REHABILITATION HOSPITAL AND OTHER PARTICIPATING HOSPITALS AND ORGANIZATIONS (I.E., GEISINGER COMMUNITY MEDICAL CENTER, GEISINGER WYOMING VALLEY MEDICAL CENTER). THIS PROCESS LASTED FROM OCTOBER 2014 UNTIL MARCH 2015. THE HEALTH OF A COMMUNITY IS LARGELY RELATED TO THE CHARACTERISTICS OF ITS RESIDENTS. AN INDIVIDUAL'S AGE, RACE, GENDER, EDUCATION AND ETHNICITY OFTEN DIRECTLY OR INDIRECTLY IMPACT HEALTH STATUS AND ACCESS TO CARE. TRIPP UMBACH COMPLETED A COMPREHENSIVE ANALYSIS OF HEALTH STATUS AND SOCIO-ECONOMIC ENVIRONMENTAL FACTORS RELATED TO THE HEALTH OF RESIDENTS OF THE ALLIED SERVICES REHABILITATION HOSPITAL AND JOHN HEINZ REHABILITATION HOSPITAL COMMUNITY FROM EXISTING DATA SOURCES SUCH AS STATE AND COUNTY PUBLIC HEALTH AGENCIES, THE CENTERS FOR DISEASE CONTROL AND PREVENTION, COUNTY HEALTH RANKINGS, THOMPSON REUTERS, CNI, HEALTHY PEOPLE 2020, AND OTHER DATA SOURCES. THIS PROCESS LASTED FROM OCTOBER 2014 UNTIL MARCH 2015. TRIPP UMBACH WORKED COLLABORATIVELY WITH THE ALLIED SERVICES REHABILITATION HOSPITAL AND JOHN HEINZ REHABILITATION HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT OVERSIGHT COMMITTEE TO DEVELOP A SECONDARY DATA PROCESS FOCUSED ON THREE PHASES: COLLECTION, ANALYSIS AND EVALUATION. TRIPP UMBACH OBTAINED INFORMATION ON THE DEMOGRAPHICS, HEALTH STATUS AND SOCIO-ECONOMIC AND ENVIRONMENTAL FACTORS RELATED TO THE HEALTH AND NEEDS OF RESIDENTS FROM THE MULTICOMMUNITY SERVICE AREA OF ALLIED SERVICES REHABILITATION HOSPITAL AND JOHN HEINZ REHABILITATION HOSPITAL. THE PROCESS DEVELOPED ACCURATE COMPARISONS TO THE STATE BASELINE OF HEALTH MEASURES UTILIZING THE MOST CURRENT VALIDATED DATA. IN ADDITION TO DEMOGRAPHIC DATA, SPECIFIC ATTENTION WAS FOCUSED ON TWO KEY COMMUNITY HEALTH INDEX FACTORS: COMMUNITY NEED INDEX (CNI) AND PREVENTION QUALITY INDICATORS INDEX (PQI). TRIPP UMBACH PROVIDED ADDITIONAL COMPARISONS AND TREND ANALYSIS FOR COUNTY HEALTH RANKINGS, PREVENTION QUALITY INDICATORS AND CNI DATA FROM 2012 TO PRESENT. THERE WERE INTERVIEWS WITH KEY COMMUNITY STAKEHOLDERS AND SURVEYS OF THE VULNERABLE POPULATION THAT WERE CONDUCTED. ONCE ALL THE INFORMATION WAS COLLECTED, THE CONSULTANTS PRESENTED TO COMMUNITY LEADERS THE CHNA FINDINGS FROM ANALYZING THE SECONDARY DATA, KEY STAKEHOLDER INTERVIEWS AND SURVEYS. COMMUNITY LEADERS DISCUSSED THE DATA PRESENTED, SHARED THEIR VISIONS AND PLANS FOR COMMUNITY HEALTH IMPROVEMENT IN THEIR COMMUNITIES, AND IDENTIFIED AND PRIORITIZED THE TOP COMMUNITY HEALTH NEEDS IN THE ALLIED SERVICES REHABILITATION HOSPITAL AND JOHN HEINZ REHABILITATION HOSPITAL COMMUNITY. FROM THIS MEETING A FINAL REPORT WAS DEVELOPED THAT SUMMARIZED THE KEY FINDINGS FROM THE ASSESSMENT PROCESS, INCLUDING THE PRIORITIES SET BY COMMUNITY LEADERS IN THE IMPLEMENTATION PLAN.</p> |

| Form and Line Reference | Explanation |
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| PART VI, LINE 3 | <p>UPON REGISTRATION OR ADMISSION, PATIENTS WHO MAY HAVE A SELF PAY BALANCE ARE ADVISED ABOUT ALLIED'S FINANCIAL ASSISTANCE PROGRAM AS AN OPTION THE APPLICATION PROCESS TO QUALIFY, ALONG WITH ALL OF THE REQUIREMENTS NECESSARY TO APPLY ARE EXPLAINED APPLICATIONS ARE HANDED TO THESE PATIENTS IN PERSON OR THEY ARE ADVISED THAT THE APPLICATION MAY BE DOWNLOADED VIA ALLIED'S WEBSITE ADDITIONALLY, WHEN PATIENTS ARE CONTACTED ABOUT NON PAYMENT OF THEIR SELF PAY BY THE PATIENT FINANCE DEPARTMENT, THEY ARE AGAIN ADVISED OF THE AVAILABILITY OF THE FINANCIAL ASSISTANCE PROGRAM AS A VIABLE OPTION AND ENCOURAGED TO APPLY IF THEY ARE UNABLE TO AFFORD THEIR MEDICAL BILL</p> <p>INTREPRETER SERVICES ARE MADE AVAILABLE TO NON ENGLISH SPEAKING PATIENTS VIA TELEPHONE OR IN PERSON ALL PATIENTS DURING THE ADMISSION PROCESS ARE OFFERED EDUCATION AND ASSISTANCE WITH REGARD TO THEIR ELIGIBILITY FOR VARIOUS FEDERAL, STATE OR LOCAL GOVERNMENTAL PROGRAMS, AS WELL AS OUR CHARITY CARE PROGRAM COPIES OF OUR CHARITY CARE GUIDELINES AND UNCOMPENSATED CARE APPLICATION ARE AVAILABLE UPON REQUEST</p> |

| Form and Line Reference | Explanation |
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| PART VI, LINE 4 | <p>THE COMMUNITY SERVED BY ALLIED SERVICES REHABILITATION HOSPITAL AND HEINZ REHABILITATION HOSPITAL (ALLIED RH / HEINZ RH) INCLUDES 43 POPULATED ZIP CODE AREAS MOSTLY IN LACKAWANNA AND LUZERNE COUNTIES. LACKAWANNA COUNTY IS PROJECTED TO EXPERIENCE A SLIGHT DECLINE IN POPULATION OVER THE NEXT FIVE YEARS (2014-2019) AT A RATE OF 0.1% (APPROXIMATELY 118 RESIDENTS). LUZERNE COUNTY, ON THE OTHER HAND, IS PROJECTED TO EXPERIENCE A SLIGHT RISE IN POPULATION OVER THE NEXT FIVE YEARS AT A RATE OF 0.1%, APPROXIMATELY 450 NEW RESIDENTS. BOTH LACKAWANNA AND LUZERNE COUNTIES REPORT HIGHER RATES OF ELDERLY RESIDENTS (18.9% AND 19.1% RESPECTIVELY) AS COMPARED WITH STATE AND NATIONAL NORMS (16.6% AND 14.2% RESPECTIVELY). AND THIS POPULATION IS PROJECTED TO INCREASE IN THE NEXT FIVE YEARS. BOTH LACKAWANNA AND LUZERNE COUNTIES SHOW LOWER AVERAGE ANNUAL HOUSEHOLD INCOME LEVELS AS COMPARED WITH THE STATE (\$69,931) AND NATION (\$71,320). LUZERNE COUNTY REPORTS THE LOWER AVERAGE ANNUAL HOUSEHOLD INCOME LEVEL (\$60,432) COMPARED TO LACKAWANNA COUNTY (\$63,150). LACKAWANNA AND LUZERNE COUNTIES REPORT HIGHER RATES OF HOUSEHOLDS THAT EARN LESS THAN \$25K PER YEAR THAN THE STATE AND NATIONAL NORMS (26.4% FOR LACKAWANNA COUNTY, 27.8% FOR LUZERNE COUNTY, 24% FOR PA, 24.5% FOR U.S.). LUZERNE COUNTY REPORTS THE HIGHEST RATE OF DIVERSITY WITH 14.3% OF THE POPULATION SELF-REPORTING AS A RACE OTHER THAN "WHITE, NON-HISPANIC," 8.5% OF WHICH REPORT BEING HISPANIC (HIGHER RATE THAN THE STATE AT 6.5%). 12.1% OF THE LACKAWANNA COUNTY POPULATION IDENTIFIES AS A RACE OTHER THAN "WHITE, NON-HISPANIC," WITH 5.9% OF THIS POPULATION IDENTIFYING AS HISPANIC. BOTH LACKAWANNA AND LUZERNE COUNTIES REPORT HIGHER RATES OF RESIDENTS UNDER THE AGE OF 65 WITH A DISABILITY (9.8% AND 10.6% RESPECTIVELY) AS COMPARED WITH THE STATE AND NATION (9.2% AND 8.4% RESPECTIVELY). LACKAWANNA AND LUZERNE COUNTIES REPORT LOWER RATES OF RESIDENTS HAVING NO INSURANCE (11.8% AND 12.7% RESPECTIVELY) AS COMPARED WITH THE COUNTRY (15.3%), BUT HIGHER RATES AS COMPARED WITH THE STATE (11.5%). ROUGHLY ONE IN EVERY SIX RESIDENTS OF LUZERNE COUNTY REPORTS LIVING IN POVERTY (16.1%), THIS RATE IS HIGHER THAN THE RATES SEEN FOR LUZERNE COUNTY (14.6%), THE STATE (13.7%) OR THE NATION (14.5%).</p> |

| Form and Line Reference | Explanation |
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| PART VI, LINE 5 | <p>ALLIED SERVICES WAS FOUNDED OVER 50 YEARS AGO WHEN A GROUP OF SCRANTON AREA CHARITIES BEGAN COLLABORATING TO CREATE NEW OPPORTUNITIES AND BETTER SERVICES FOR NORTHEASTERN PENNSYLVANIANS WITH DISABILITIES. TODAY, WITH OVER 3200 EMPLOYEES IN 23 COUNTIES, ALLIED SERVICES IS THE REGION'S LEADING PROVIDER OF POST-ACUTE CARE AND RESIDENTIAL CARE TO PERSONS WITH DISABILITIES AND CHRONIC ILLNESSES. ALLIED SERVICES IS A CONTINUUM OF POST-ACUTE AND COMMUNITY-BASED PROGRAMS UNITED BY A COMMON AIM: TO IMPROVE THE HEALTH, INDEPENDENCE AND LIFE QUALITY OF OUR CONSUMERS. OUR PROGRAMS INCLUDE INPATIENT AND OUTPATIENT MEDICAL REHABILITATION, SKILLED NURSING CARE, TRANSITIONAL REHABILITATION, HOME HEALTH CARE, IN-HOME SERVICES, HOSPICE, VOCATIONAL REHABILITATION, RESIDENTIAL PROGRAMS FOR ADULTS WITH DEVELOPMENTAL OR BEHAVIORAL DISABILITIES AND SENIOR ASSISTED LIVING. EACH DAY, THESE SERVICES TOUCH THE LIVES OF SOME 5,000 PERSONS. MEDICAL REHABILITATION HOSPITALS IN SCRANTON AND WILKES-BARRE ARE THE CORE AND MOST WIDELY RECOGNIZED COMPONENT OF THE ALLIED SYSTEM, COMPLEMENTED BY A NETWORK OF 13 OUTPATIENT CLINICS IN A FOUR-COUNTY AREA. OUR HOSPITALS PROVIDE COMPREHENSIVE REHABILITATION SERVICES FOR SPINAL CORD AND NEUROLOGICAL INJURIES/DISEASE, STROKE, TRAUMATIC BRAIN INJURY, AND OTHER LIFE-CHANGING ILLNESSES AND INJURIES. BEYOND PROVIDING DIRECT CARE AND SUPPORT SERVICES TO ADULTS AND CHILDREN, ALLIED'S RESOURCES (CLINICIANS, FACILITIES, EXPERTISE, MANAGEMENT) SERVE THE LARGER REGION THROUGH -THE EDUCATION AND TRAINING OF HEALTH PROFESSIONALS---THROUGH SYMPOSIA, INTERNSHIP AND EDUCATIONAL OPPORTUNITIES OFFERED TO PHYSICIANS, PHARMACISTS, NURSES AND OTHER HEALTH CAREERS -ORGANIZED PEER SUPPORT AND HEALTH EDUCATION FOR PERSONS AFFECTED BY TRAUMATIC BRAIN INJURY, SPINAL CORD INJURY, PEDIATRIC DISABILITIES, PARKINSON'S DISEASE AND OTHER CONDITIONS -ACCREDITED, IN-SCHOOL INJURY PREVENTION PROGRAMS FOR SCHOOL CHILDREN, TEACHERS AND COACHES-AFFORDABLE WELLNESS/EXERCISE PROGRAMS AND FACILITIES FOR PERSONS WITH DISABILITIES, CHRONIC ILLNESS, LIMITED MOBILITY-EXTRAMURAL SOCIAL AND RECREATIONAL PROGRAMS FOR KIDS WITH AUTISM SPECTRUM DISORDERS AND FOR THEIR FAMILIES -LEADERSHIP, VOLUNTEER SERVICE AND IN-KIND SUPPORT FOR LOCAL HEALTH CARE CHARITIES---E G , NORTHEAST REGIONAL CANCER INSTITUTE, AMERICAN HEART ASSOCIATION, ALZHEIMER'S ASSOCIATION, MUSCULAR DYSTROPHY ASSOCIATION, LEUKEMIA & LYMPHOMA SOCIETY, PARKINSON'S FOUNDATION, RONALD MCDONALD HOUSE CHARITIES OF NORTHEASTERN PENNSYLVANIA, THE COMMONWEALTH MEDICAL COLLEGE AND MANY OTHERS -THE DEPAUL SCHOOL, AN ACCREDITED, YEAR-ROUND EDUCATIONAL PROGRAM FOR CHILDREN WITH DYSLEXIA AND OTHER LEARNING DISABILITIES-OPENING OUR FACILITIES---E G , MEETING AND DINING FACILITIES, GROUNDS, AND PEDIATRIC GYMS--TO AREA NONPROFIT AND VOLUNTEER GROUPS THAT SERVE OUR COMMUNITY. THE NEIGHBORS, BUSINESSES AND GRANT-MAKERS THAT SUPPORT ALLIED ARE CRUCIAL TO ITS SUCCESS. THEIR GENEROSITY ALLOWS US TO PROVIDE CARE TO THE UNINSURED AND UNDER-INSURED, CORRECT DEFICIENCIES AND FILL GAPS IN THE REGION'S HEALTH AND HUMAN SERVICE SYSTEMS, ENSURE CONTINUITY OF CARE WHEN PROGRAM FUNDING (E G , FROM PUBLIC GRANTS OR THIRD-PARTY PAYERS) IS INTERRUPTED, AND OFFER PATIENTS THE LATEST, MOST EFFECTIVE MEDICAL AND REHAB TECHNOLOGIES.</p> |

| Form and Line Reference | Explanation |
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| PART VI, LINE 6 | <p>WITHOUT EXCEPTION, OUR AFFILIATE ORGANIZATIONS/PROGRAMS EACH PLAY UNIQUE AND CRITICAL FUNCTIONS IN OUR REGION'S CONTINUUM OF CARE FOR PERSONS WITH DISABILITIES AND THE AGED. THESE INCLUDE ALLIED SKILLED NURSING & REHABILITATION CENTER, SCRANTON. THE CENTER IS HOME TO SOME 340 PERSONS WHOSE CHRONIC ILLNESS AND/OR SEVERE DISABILITIES DEMAND ROUND-THE-CLOCK, SKILLED CARE. THE CENTER IS RECOGNIZED FOR ITS SERVICES TO MEDICALLY-COMPLEX, TECHNOLOGY-DEPENDENT PATIENTS, INCLUDING THOSE WHO NEED RESPIRATORS, HEMODIALYSIS OR SPECIALIZED PROGRAMS FOR DEMENTIA. ABOUT 70% TO 80% OF SNRC RESIDENTS ARE ECONOMICALLY DISADVANTAGED (MEDICALLY-ELIGIBLE). A FAR HIGHER PERCENTAGE THAN MOST LONG-TERM CARE ORGANIZATIONS IN THE REGION AND STATE. THESE ATTRIBUTES MAKE THE CENTER AN ESSENTIAL HEALTH CARE RESOURCE FOR A GROWING POPULATION OF SENIORS IN NORTHEASTERN AND CENTRAL PENNSYLVANIA, AS WELL AS THEIR PHYSICIANS, CAREGIVERS AND FAMILIES. ALLIED TERRACE. THE TERRACE IS A MODERN, WELL-APPOINTED, FULL SERVICE ASSISTED LIVING FACILITY FOR SENIORS WHO ARE ABLE TO LIVE INDEPENDENTLY IF PROVIDED WITH HELP FOR MEALS, HOUSEKEEPING, LAUNDRY AND PERSONAL CARE. CONSISTENT WITH NATIONAL AND REGIONAL TRENDS, THE TERRACE IS SERVING THE FAST-GROWING COMMUNITY OF SENIORS WHO ARE SUCCESSFULLY "AGING IN PLACE", THANKS TO INTENSIVE, HIGH-QUALITY SUPPORT SERVICES---E.G., MEDICATION MANAGEMENT, IN-HOME HEALTH AND PERSONAL CARE---TO ENSURE THEIR CONTINUED HEALTH AND SAFETY. IN THIS WAY, ALLIED TERRACE IS EXTENDING AND ENRICHING THE LIVES OF ITS 60 RESIDENTS, WHILE REDUCING THEIR RISK (AND POTENTIAL COSTS) OF INJURY, DEBILITATION, ACUTE ILLNESS, HOSPITALIZATION OR INSTITUTIONALIZATION. ALLIED CONTINUING CARE RETIREMENT COMMUNITY. ALLIED CCRC WAS FORMED IN 2006 FOR THE PURPOSES OF PROVIDING INDEPENDENT LIVING SERVICES. IN SPACE LEASED FROM ALLIED TERRACE, SENIORS WHO ARE CAPABLE OF INDEPENDENTLY MANAGING ACTIVITIES OF DAILY LIVING---MEAL PREPARATION, LIGHT HOUSEKEEPING, SELF-CARE, ETC---OCCUPY THESE UNITS, WHILE ENJOYING FULL ACCESS TO THE TERRACE'S SOCIAL AND RECREATIONAL OPPORTUNITIES. TWO INDIVIDUALS OCCUPIED CCRC UNITS DURING THIS PERIOD. VOCATIONAL SERVICES. FOR OVER 50 YEARS, ALLIED'S VOCATIONAL SERVICES PROGRAMS HAVE PROVIDED TRAINING AND GAINFUL EMPLOYMENT TO TEENS AND ADULTS WITH PHYSICAL, INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. EACH YEAR, OVER 500 PARTICIPANTS ARE INVOLVED IN PROJECTS THAT ENHANCE THEIR SKILLS, EMPLOYABILITY AND SELF-RELIANCE. WHILE OUR VOCATIONAL PROGRAMS DRAW UPON STATE AND FEDERAL TRAINING DOLLARS, THE JOBS THEMSELVES DEPEND UPON A CONTINUAL SUPPLY OF WORK FROM BUSINESS AND INDUSTRY PARTNERS, FOR SERVICES SUCH AS PACKAGING, LIGHT ASSEMBLY, SORTING, SCANNING, MAILING, CLEANING AND LANDSCAPING. ONGOING COMMUNITY FUNDRAISING ENSURES THAT ALLIED MAINTAINS THE SKILLED STAFF, SPECIALIZED EQUIPMENT AND FACILITIES TO KEEP THIS DIVERSE "ENTERPRISE" PRODUCTIVE AND GROWING. THE RESULT: TRAINING, JOB, EDUCATIONAL AND SOCIAL OPPORTUNITIES FOR DISABLED INDIVIDUALS WHO MIGHT OTHERWISE BE ISOLATED AND IDLE AT HOME. DEVELOPMENTAL SERVICES. FOR ADULTS WHO HAVE BOTH INTELLECTUAL AND PHYSICAL DISABILITIES/ILLNESSES, ALLIED'S INTERMEDIATE CARE FACILITY IS A COMFORTABLE, SAFE RESIDENTIAL ENVIRONMENT WHERE SKILLED NURSING AND PERSONAL SUPERVISION ARE AVAILABLE. "24-7" RESIDENTS RECEIVE MEALS, PERSONAL CARE (DRESSING, BATHING, GROOMING, ETC.), MEDICAL AND MEDICATION MANAGEMENT, SOCIAL AND RECREATIONAL PROGRAMS IN A HOME-LIKE SETTING. FOR CONSUMERS WHO ARE ABLE TO LIVE MORE INDEPENDENTLY, ALLIED OFFERS A RANGE OF COMMUNITY LIVING OPTIONS IN SMALL GROUP HOMES THROUGHOUT THE REGION. IN ALL PROGRAM SETTINGS, HOWEVER, OUR DEVELOPMENTAL PROGRAMS HAVE MET A GROWING REGIONAL DEMAND FOR RESIDENTIAL CARE FOR OLDER ADULTS WHOSE INTELLECTUAL AND COMPLEX PHYSICAL DISABILITIES/MEDICAL CONDITIONS DEMAND MORE INTENSIVE, SPECIALIZED LEVELS OF CARE. AT THE URGING OF LOCAL AND REGIONAL AUTHORITIES, ALLIED HAS ASSUMED THIS ROLE. WITH A LONG AND SUCCESSFUL TRACK RECORD IN MEDICAL REHAB, LONG-TERM CARE, SKILLED NURSING AND PROGRAM MANAGEMENT, ALLIED SERVICES IS UNIQUELY QUALIFIED TO MEET THE NEED. BEHAVIORAL SERVICES. SIMILARLY, OUR BEHAVIORAL SERVICES HAVE EXPANDED BOTH GEOGRAPHICALLY AND PROGRAMMATICALLY IN RECENT YEARS, PROVIDING SPECIALIZED RESIDENTIAL AND COMMUNITY-BASED SERVICES TO THE CHRONICALLY MENTALLY ILL. STAFF MEMBERS WORK WITH CONSUMERS AS THEY RE-CONNECT WITH JOBS, FAMILIES, PEER AND COMMUNITY RESOURCES. AS THEY PURSUE SOBRIETY, PHYSICAL AND MENTAL HEALTH, AND INDEPENDENT LIVING. THROUGH AN INTENSIVE PROGRAM OF COUNSELING AND BEHAVIORAL SUPPORTS, THE PROGRAM ATTACKS LONGSTANDING PATTERNS OF MENTAL HEALTH CRISES, HOSPITALIZATION AND/OR INSTITUTIONALIZATION (AND RELATED "COSTS" TO INDIVIDUALS AND COMMUNITIES). ALLIED PROJECT OPPORTUNITY. LOCATED IN JERMYN, (LACKAWANNA COUNTY) PA, THE SIX UNITS OF HOUSING ARE MANAGED BY ALLIED'S BEHAVIORAL HEALTH DIVISION. INDIVIDUALS WHO ARE RECOVERING FROM CHRONIC MENTAL HEALTH PROBLEMS FIND SAFE, PLEASANT, AFFORDABLE A</p> |

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 6 | <p>CCOMMODATIONS AT PROJECT OPPORTUNITY, SUBSIDIZED BY THE HUD SECTION 8 PROGRAM HOME HEALTH & IN-HOME SERVICES THESE PROGRAMS PROVIDE ESSENTIAL MEDICAL AND SUPPORT SERVICES TO PERSONS WITH DISABILITIES THROUGHOUT A 23-COUNTY AREA OF NORTHEASTERN/CENTRAL PENNSYLVANIA REGISTERED NURSES, PHYSICAL AND OCCUPATIONAL THERAPISTS, PERSONAL CARE AND HOME CARE WORKERS HELP KEEP THEM HEALTHY AND SAFE AT HOME ACTIVITIES RANGE FROM MAKING MEALS OR DOING HOUSEHOLD CHORES, OR MONITORING THE PATIENT'S PHYSICAL AND MENTAL HEALTH, TO ADDRESSING MEDICAL OR POST-SURGICAL NEEDS SUCH AS WOUND DRESSING, MEDICATION MANAGEMENT, ETC THE HEALTH EDUCATION, MEDICAL SUPPORT, PRACTICAL ASSISTANCE AND CASE MANAGEMENT PROVIDED BY IN-HOME AND HOME HEALTH PROFESSIONALS ARE ESSENTIAL TO THE HEALTH, LIFE QUALITY AND INDEPENDENCE OF THEIR CONSUMERS ABSENT SUCH PROGRAMS, EXTENDED HOSPITALIZATIONS, RE-HOSPITALIZATION AND/OR INSTITUTIONALIZATION WOULD BE UNAVOIDABLE ALLIED HOSPICE ALLIED HOSPICE WAS ESTABLISHED IN 2015 TO EXTEND THE ASIHS CONTINUUM TO INDIVIDUALS WHO HAVE LIFE-LIMITING ILLNESSES THE PROGRAM WILL DELIVER PALLIATIVE CARE AND A FULL COMPLEMENT OF SUPPORTIVE/COUNSELING SERVICES CORE SERVICES INCLUDE MEDICAL DIRECTION BY THE HOSPICE PHYSICIAN, NURSING SERVICES UNDER SUPERVISION OF A REGISTERED NURSE FUNCTIONING WITHIN A PLAN OF CARE DEVELOPED BY THE HOSPICE INTERDISCIPLINARY TEAM IN CONSULTATION WITH THE PHYSICIAN, MEDICAL SOCIAL SERVICES BY A QUALIFIED SOCIAL WORKER UNDER THE DIRECTION OF A PHYSICIAN, COUNSELING INCLUDING SPIRITUAL, BEREAVEMENT, AND DIETARY BEREAVEMENT SERVICES ARE AVAILABLE TO FAMILY MEMBERS AND OTHERS IDENTIFIED IN THE PLAN OF CARE FOR UP TO ONE YEAR FOLLOWING THE DEATH OF THE PATIENT ALLIED SERVICES FOUNDATION THE FOUNDATION IS THE COMMUNITY RELATIONS AND FUNDRAISING ARM OF ALLIED SERVICES THE FOUNDATION'S FUNDRAISING APPEALS, SPONSORSHIP AND GRANT SOLICITATIONS GENERATE SUPPORT FOR ALLIED'S PEDIATRIC PROGRAMS, DEPAUL SCHOOL, VOCATIONAL PROGRAMS AND OTHER COMMUNITY SERVICES THIS DEPARTMENT ALSO COORDINATES THE COMMUNITY VOLUNTEERS AND EMPLOYEE VOLUNTEERS WHO HELP TO RAISE FUNDS AND PROVIDE IN-KIND, NON-MEDICAL SERVICES TO OUR RESIDENTS, PATIENTS AND CONSUMERS PUBLIC RELATIONS, OUTREACH, INTERNAL COMMUNICATIONS, CHARITABLE FUND COMPLIANCE AND ACCOUNTABILITY ARE ALSO AMONG THE FOUNDATION'S DUTIES</p> |

| Form and Line Reference | Explanation |
|---|-------------|
| PART VI, LINE 7, REPORTS FILED WITH STATES | P A |

Schedule H (Form 990) 2015

Additional Data

Software ID:
Software Version:
EIN: 23-2262852
Name: JOHN HEINZ INSTITUTE OF REHABILITATION
MEDICINE

Form 990 Schedule H, Part V Section A. Hospital Facilities

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

| | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (Describe) | Facility reporting group |
|---|--|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|-----------------------|--------------------------|
| 1 | JOHN HEINZ INSTITUTE OF REHABILITATION 100 ABINGTON EXECUTIVE PARK DRIVE CLARKS SUMMIT, PA 18411 013701 | | | | | | | | REHABILITATION CENTER | |

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

2015

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
JOHN HEINZ INSTITUTE OF REHABILITATION
MEDICINE

Employer identification number
23-2262852

Part I

Questions Regarding Compensation

| | Yes | No |
|---|-----|----|
| 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. <div><input type="checkbox"/> First-class or charter travel</div> <div><input type="checkbox"/> Travel for companions</div> <div><input type="checkbox"/> Tax indemnification and gross-up payments</div> <div><input type="checkbox"/> Discretionary spending account</div> <div><input type="checkbox"/> Housing allowance or residence for personal use</div> <div><input type="checkbox"/> Payments for business use of personal residence</div> <div><input type="checkbox"/> Health or social club dues or initiation fees</div> <div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div> | | |
| b If any of the boxes in 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, officers, including the CEO/Executive Director, regarding the items checked in line 1a? | | |
| 3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <div><input type="checkbox"/> Compensation committee</div> <div><input type="checkbox"/> Independent compensation consultant</div> <div><input type="checkbox"/> Form 990 of other organizations</div> <div><input type="checkbox"/> Written employment contract</div> <div><input type="checkbox"/> Compensation survey or study</div> <div><input type="checkbox"/> Approval by the board or compensation committee</div> | | |
| 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? | | No |
| b Participate in, or receive payment from, a supplemental nonqualified retirement plan? | Yes | |
| 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. | | No |
| Only 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? | | No |
| b Any related organization? If "Yes," on line 5a or 5b, describe in Part III. | | No |
| 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? | | No |
| b Any related organization? If "Yes," on line 6a or 6b, describe in Part III. | | No |
| 7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III. | | No |
| 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. | | No |
| 9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)? | | |

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 are not listed on Form 990, Part VII

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column(B) reported as deferred on prior Form 990 |
|--|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|--|
| | | Base (i) compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 WILLIAM P CONABOY ESQ VICE CHAIRMAN | (i) | 0 ----- | 0 ----- | 0 ----- | 0 ----- | 0 ----- | 0 ----- | 0 ----- |
| | (ii) | 499,377 | 0 | 0 | 145,200 | 8,760 | 653,337 | 0 |
| 2 MICHAEL AWVISATO ASSISTANT SECRETARY & TREASURER | (i) | 0 ----- | 0 ----- | 0 ----- | 0 ----- | 0 ----- | 0 ----- | 0 ----- |
| | (ii) | 292,334 | 0 | 0 | 57,264 | 11,540 | 361,138 | 0 |
| 3 GREGORY BASTING VICE PRESIDENT | (i) | 371,616 ----- | 0 ----- | 0 ----- | 5,300 ----- | 11,926 ----- | 388,842 ----- | 0 ----- |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 KAREN KEARNEY ASSISTANT VICE PRESIDENT | (i) | 175,780 ----- | 0 ----- | 0 ----- | 3,620 ----- | 9,778 ----- | 189,178 ----- | 0 ----- |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 MICHAEL RAYMOND STAFF PHYSICIAN | (i) | 144,215 ----- | 0 ----- | 0 ----- | 2,904 ----- | 4,982 ----- | 152,101 ----- | 0 ----- |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Part III **Supplemental Information**

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

| Return Reference | Explanation |
|------------------|--|
| PART I, LINE 3 | THE PRESIDENT, WILLIAM CONABOY, IS COMPENSATED BY ALLIED HEALTH CARE SERVICES (AHCS), A RELATED TAX-EXEMPT ORGANIZATION. AHCS USES THE FOLLOWING METHODS TO DETERMINE HIS COMPENSATION: COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT CONTRACT, COMPENSATION SURVEY OR STUDY, AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE. |
| PART I, LINE 4B | WILLIAM CONABOY, ESQ. AND MICHAEL AVVISATO PARTICIPATE IN A RABBI TRUST NON-QUALIFIED DEFERRED COMPENSATION PLAN. THERE WERE NO DISTRIBUTIONS FROM THE TRUST TO THE INDIVIDUALS DURING CALENDAR YEAR 2015. |

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

Department of the
Treasury
Internal Revenue
Service

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

2015

**Open to Public
Inspection**

Name of the organization
JOHN HEINZ INSTITUTE OF REHABILITATION
MEDICINE

Employer identification number

23-2262852

**Return
Reference**

Explanation

FORM 990,
PART V, LINE 2

JOHN HEINZ INSTITUTE OF REHABILITATION MEDICINE (JOHN HEINZ) DOES NOT HAVE ANY OF ITS OWN EMPLOYEES PROVIDING SERVICES TO THE ORGANIZATION THE ORGANIZATION DOES NOT FILE ITS OWN FORM W-3 THE EMPLOYEES PROVIDING SERVICES TO JOHN HEINZ ARE EMPLOYED BY ALLIED HEALTH CARE SERVICES, A RELATED TAX EXEMPT ORGANIZATION THESE EMPLOYEES RECEIVE A W-2 FROM ALLIED HEALTH CARE SERVICES

| Return Reference | Explanation |
|--------------------------------------|--|
| FORM 990, PART VI, SECTION A, LINE 6 | THE MEMBERS OF JOHN HEINZ INSTITUTE OF REHABILITATION MEDICINE (THE "HOSPITAL") SHALL BE THOSE PERSONS WHO SERVE FROM TIME TO TIME AS MEMBERS OF THE EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS OF ALLIED SERVICES FOUNDATION (THE "FOUNDATION"), IN EACH CASE TO SERVE IN SUCH CAPACITY AT THE DISCRETION OF THE FOUNDATION, AND SUBJECT TO REMOVAL BY THE FOUNDATION AT ANY TIME, WITH OR WITHOUT CAUSE |

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION A, LINE 7A | AS DOCUMENTED IN THE HOSPITAL'S BY LAWS, THE MEMBERS, AT THEIR ANNUAL MEETING, SHALL ELECT THE PRESIDENT OF THE BOARD FROM AMONG THE NOMINEES FOR SUCH OFFICE SUBMITTED TO THE MEMBERS BY THE PRESIDENT OF THE FOUNDATION |

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION B, LINE 11 | THE FORM 990 WAS REVIEWED IN DETAIL BY THE CHAIRMAN OF THE BOARD AND THE CHAIRMAN OF THE AUDIT COMMITTEE THE BOARD OF DIRECTORS IS NOTIFIED AND GIVEN ACCESS TO THE 990 VIA A WEBLINK PRIOR TO FILING WITH THE IRS |

| Return Reference | Explanation |
|---|---|
| FORM 990, PART VI, SECTION B, LINE 12C | <p>ALLIED SERVICES CONFLICT OF INTEREST POLICY COVERS BOARD MEMBERS DOWN TO DEPARTMENT HEADS AS WELL AS ANY STAFF THAT ARE INVOLVED IN THE PURCHASING PROCESS ALL COVERED PERSONS MUST COMPLETE AN ANNUAL CONFLICT STATEMENT IF A TRANSACTION IS PROPOSED INVOLVING A CONFLICT, THE BOARD INVESTIGATES ALTERNATIVES FOR THE TRANSACTION AND MAKES A DETERMINATION IF A MORE ADVANTAGEOUS ARRANGEMENT CAN BE MADE MEMBERS INVOLVED IN THE CONFLICT MUST ABSTAIN FROM VOTING ON SUCH MATTERS ANY VIOLATIONS OF THE POLICY ARE HANDLED AS NECESSARY FROM REPRIMAND TO TERMINATION FROM THE BOARD OR EMPLOYMENT, DEPENDING ON THE SEVERITY OF THE OFFENSE COMPLIANCE WITH THIS POLICY IS MONITORED BY THE VICE PRESIDENT OF HUMAN RESOURCES</p> |

| Return Reference | Explanation |
|--|--|
| FORM 990, PART VI, SECTION B, LINE 15 | <p>ALLIED PARTICIPATES IN MULTIPLE REGIONAL SALARY SURVEYS, TWO OF WHICH ARE THE SOCIETY OF HEALTHCARE HUMAN RESOURCES OF PENNSYLVANIA AND THE APPALACHIAN HEALTHCARE HUMAN RESOURCES SOCIETY , TO DETERMINE MARKET COMPETITIVENESS, AND CONSIDERS THE EXTERNAL MARKET AS A FACTOR IN THE JOB EVALUATION PROCESS. COMPENSATION FOR OFFICERS AND KEY EMPLOYEES IS REVIEWED BY A COMPENSATION COMMITTEE OF THE BOARD. INCREASES ARE RECOMMENDED BY THE COMMITTEE AND APPROVED BY THE BOARD OF DIRECTORS BASED ON THE EXTERNAL SURVEYS AND INTERNAL REVIEWS. THIS PROCESS IS DOCUMENTED BY THE COMPENSATION COMMITTEE AND THE BOARD OF DIRECTORS. FOR ALL OTHER EMPLOYEES, ALLIED SERVICES FOLLOWS AN INTERNAL JOB EVALUATION PROCESS, ADMINISTERED BY A CROSS DIVISIONAL JOB EVALUATION TEAM COMPRISED OF DIRECTORS AND ASSISTANT VICE PRESIDENTS. THE JOB EVALUATION PROCESS IS BASED ON A FOURTEEN POINT FACTOR SYSTEM AND INTERNAL ALIGNMENT WITHIN JOB CLASSIFICATION. THE PROCESS IS DOCUMENTED AND LABOR GRADE RECOMMENDATIONS BASED ON BOTH INTERNAL AND EXTERNAL RESULTS ARE MADE TO THE DIVISIONAL VICE PRESIDENT AND VICE PRESIDENT OF HUMAN RESOURCES FOR FINAL APPROVAL.</p> |

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION C, LINE 19 | THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST |

| Return Reference | Explanation |
|-----------------------------------|--|
| FORM 990, PART IX, LINE 11G | <p> NURSING PATIENT CARE PROGRAM SERVICE EXPENSES 7,573 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 7,573 CORPORATE PURCHASED SERVICES PROGRAM SERVICE EXPENSES 0 MANAGEMENT AND GENERAL EXPENSES 4,452,912 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 4,452,912 OTHER PROFESSIONAL FEES PROGRAM SERVICE EXPENSES 247,722 MANAGEMENT AND GENERAL EXPENSES 60,966 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 308,688 PHARMACY FEES PROGRAM SERVICE EXPENSES 122,312 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 122,312 LAB FEES PROGRAM SERVICE EXPENSES 228,668 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 228,668 RADIOLOGY FEES PROGRAM SERVICE EXPENSES 127,704 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 127,704 OUTSIDE MEDICAL SERVICES & AMBULANCE FEES PROGRAM SERVICE EXPENSES 138,347 MANAGEMENT AND GENERAL EXPENSES 0 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 138,347 </p> |

SCHEDULE R
(Form 990)

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2015

Open to Public Inspection

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

▶ Attach to Form 990. ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury
Internal Revenue Service

Name of the organization
JOHN HEINZ INSTITUTE OF REHABILITATION
MEDICINE

Employer identification number

23-2262852

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 |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
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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 Additional Data Table | | | | | | | |
| | | | | | | | |
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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 | |
| | | | | | | | | | | | | |
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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 |
| | | | | | | | | | |
| | | | | | | | | | |
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Part V

Transactions With Related Organizations

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

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

1

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

a

Receipt of (i) interest, (ii)annuities, (iii)royalties, or(iv)rent from a controlled entity

b

Gift, grant, or capital contribution to related organization(s)

c

Gift, grant, or capital contribution from related organization(s)

d

Loans or loan guarantees to or for related organization(s)

e

Loans or loan guarantees by related organization(s)

f

Dividends from related organization(s)

g

Sale of assets to related organization(s)

h

Purchase of assets from related organization(s)

i

Exchange of assets with related organization(s)

j

Lease of facilities, equipment, or other assets to related organization(s)

k

Lease of facilities, equipment, or other assets from related organization(s)

l

Performance of services or membership or fundraising solicitations for related organization(s)
.

m

Performance of services or membership or fundraising solicitations by related organization(s)

n

Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

o

Sharing of paid employees with related organization(s)

p

Reimbursement paid to related organization(s) for expenses

q

Reimbursement paid by related organization(s) for expenses

r

Other transfer of cash or property to related organization(s)

s

Other transfer of cash or property from related organization(s)

Yes

No

1a

No

1b

No

1c

Yes

1d

Yes

1e

Yes

1f

No

1g

No

1h

No

1i

No

1j

No

1k

No

1l

No

1m

No

1n

No

1o

Yes

1p

Yes

1q

No

1r

No

1s

No

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 |
|-------------------------------------|----------------------------------|------------------------|--|
| | | | |
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Schedule R (Form 990) 2015

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.

[illegible]

Part VII **Supplemental Information**

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

| Return Reference | Explanation |
|------------------|-------------|
|------------------|-------------|

Additional Data

Software ID:

Software Version:

EIN: 23-2262852

Name: JOHN HEINZ INSTITUTE OF REHABILITATION MEDICINE

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c) (3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|---|---|---|-------------------------------|---|-------------------------------------|--|----|
| | | | | | | Yes | No |
| ALLIED SERVICES CONTINUING CARE 100 TERRACE LANE SCRANTON, PA 18508 20-4472148 | PROVIDE INDEPENDENT LIVING SERVICES | PA | 501(C)(3) | 11A | ALLIED SERVICES FOUNDATION | | No |
| ALLIED HEALTH CARE SERVICES 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 24-0860110 | PROVIDE HEALTH CARE SERVICES TO ELDERLY AND MENTALLY CHALLENGED | PA | 501(C)(3) | 3 | ALLIED SERVICES FOUNDATION | | No |
| ALLIED SERVICES FOUNDATION 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523682 | INVESTED FUNDS FOR RELATED ENTITIES TO SUPPORT THEIR MISSIONS | PA | 501(C)(3) | 7 | N/A | | No |
| ALLIED PROJECT OPPORTUNITY 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523680 | PROVIDE LOW INCOME HOUSING | PA | 501(C)(3) | 9 | ALLIED HEALTH CARE SERVICES | | No |
| ALLIED NORTHEAST APARTMENTS 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523679 | INACTIVE | PA | 501(C)(3) | 9 | ALLIED HEALTH CARE SERVICES | | No |
| ALLIED SERVICES INSTITUTE OF REHABILITATION MEDICINE 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523395 | PROVIDE REHABILITATIVE SERVICES | PA | 501(C)(3) | 3 | ALLIED SERVICES FOUNDATION | | No |
| ALLIED SERVICES PERSONAL CARE INC 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2862231 | OPERATE A PERSONAL CARE FACILITY | PA | 501(C)(3) | 3 | ALLIED SERVICES FOUNDATION | | No |
| ALLIED SERVICES SKILLED NURSING CENTER 100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523688 | OPERATE A SKILLED AND INTERMEDIATE NURSING FACILITY | PA | 501(C)(3) | 3 | ALLIED SERVICES FOUNDATION | | No |
| THE BURNLEY WORKSHOP OF THE POCONOS INC 4219 MANOR DRIVE STROUDSBURG, PA 18360 23-1642528 | OPERATE A VOCATIONAL REHABILITATION FACILITY | PA | 501(C)(3) | 7 | ALLIED HEALTH CARE SERVICES | | No |
| RISK RETENTION GROUP 1327 ASHLEY RIVER ROAD BLDG C SUITE CHARLESTON, SC 29407 20-1177431 | PROVIDE INSURANCE, CLAIMS DEFENSE, ADMINISTRATION & INDEMNITY TO AFFILIATES | SC | 501(C)(3) | 11C | ALLIED SERVICES FOUNDATION | | No |