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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2020

Open to Public Inspection

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.

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

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

B Check if applicable:  
☐ Address change  
☐ Name change  
☐ Initial return  
☐ Final return/terminated  
☐ Amended return  
☐ Application pending

C Name of organization  
JOHN HEINZ INSTITUTE OF REHABILITATION  
MEDICINE  
  
Doing business as  
  
Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
100 ABINGTON EXECUTIVE PARK  
  
City or town, state or province, country, and ZIP or foreign postal code  
CLARKS SUMMIT, PA 18411

D Employer identification number  
23-2262852  
  
E Telephone number  
(570) 348-1300  
  
G Gross receipts \$ 30,455,116

F Name and address of principal officer:  
WILLIAM P CONABOY ESQ  
100 ABINGTON EXECUTIVE PARK  
CLARKS SUMMIT, PA 18411

H(a) Is this a group return for subordinates?  
☐ Yes ☒ No  
H(b) Are all subordinates included?  
☐ Yes ☐ No  
If "No," attach a list. (see instructions)  
H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) ▶ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.ALLIED-SERVICES.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ 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 ☐ 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 7

4 Number of independent voting members of the governing body (Part VI, line 1b) . . . . . 4 6

5 Total number of individuals employed in calendar year 2020 (Part V, line 2a) . . . . . 5 398

6 Total number of volunteers (estimate if necessary) . . . . . 6 60

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 39 . . . . . 7b 0

Revenue

8 Contributions and grants (Part VIII, line 1h) . . . . . 1,418,712 1,213,625

9 Program service revenue (Part VIII, line 2g) . . . . . 24,097,005 22,474,111

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d ) . . . . . -251,149 787,553

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) . . . . . 138,253 70,139

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) . . . . . 25,402,821 24,545,428

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) . . . . . 16,953,282 16,507,605

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) . . . . . 11,222,699 10,564,020

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) . . . . . 28,175,981 27,071,625

19 Revenue less expenses. Subtract line 18 from line 12 . . . . . -2,773,160 -2,526,197

Net Assets or Fund Balances

20 Total assets (Part X, line 16) . . . . . 20,925,878 23,653,118

21 Total liabilities (Part X, line 26) . . . . . 15,149,046 18,165,605

22 Net assets or fund balances. Subtract line 21 from line 20 . . . . . 5,776,832 5,487,513

Part II Signature Block

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

Sign Here

\*\*\*\*\*  
Signature of officer  
2022-05-04  
Date  
WILLIAM P CONABOY ESQ PRESIDENT/CEO  
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name Preparer's signature Date  
Firm's name ▶ BAKER TILLY US LLP Firm's EIN ▶ 39-0859910  
Firm's address ▶ 1570 FRUITVILLE PIKE SUITE 400  
LANCASTER, PA 17601 Phone no. (717) 740-4863

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

For Paperwork Reduction Act Notice, see the separate instructions. Cat. No. 11282Y Form 990 (2020)

**Part III Statement of Program Service Accomplishments**

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

**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

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

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

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

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

**4a** (Code: ) (Expenses \$ 17,148,315 including grants of \$ 0 ) (Revenue \$ 22,474,111 )  
See Additional Data













**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 ► 17,148,315

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	<b>2</b> Yes	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>4</b>	No
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	<b>5</b>	No
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I 	<b>6</b>	No
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II 	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	<b>8</b>	No
<b>9</b> Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV 	<b>9</b>	No
<b>10</b> 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	<b>10</b>	No
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	<b>11a</b> Yes	
<b>b</b> Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII 	<b>11b</b>	No
<b>c</b> Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII 	<b>11c</b>	No
<b>d</b> Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX 	<b>11d</b>	No
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	<b>11e</b> Yes	
<b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X 	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII 	<b>12a</b>	No
<b>b</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 	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	<b>14b</b>	No
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	<b>15</b>	No
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	<b>16</b>	No
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	<b>17</b>	No
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	<b>18</b>	No
<b>19</b> 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	<b>19</b>	No
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H 	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? 	<b>20b</b> Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	<b>21</b>	No

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

		Yes	No
<b>22</b>	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III.</i>		No
<b>23</b>	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J.</i>	Yes	
<b>24a</b>	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a.</i>		No
<b>24b</b>	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
<b>24c</b>	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
<b>24d</b>	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
<b>25a</b>	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I.</i>		No
<b>25b</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>		No
<b>26</b>	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part II.</i>		No
<b>27</b>	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III.</i>		No
<b>28</b>	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
<b>28a</b>	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV.</i>		No
<b>28b</b>	A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV.</i>		No
<b>28c</b>	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? <i>If "Yes," complete Schedule L, Part IV.</i>		No
<b>29</b>	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M.</i>		No
<b>30</b>	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M.</i>		No
<b>31</b>	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I.</i>		No
<b>32</b>	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II.</i>		No
<b>33</b>	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I.</i>		No
<b>34</b>	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1.</i>	Yes	
<b>35a</b>	Did the organization have a controlled entity within the meaning of section 512(b)(13)?		No
<b>35b</b>	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2.</i>		
<b>36</b>	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2.</i>		No
<b>37</b>	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI.</i>		No
<b>38</b>	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O.	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
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	33
<b>1b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0
<b>1c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		

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

Form **990** (2020)

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

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

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

See instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) THOMAS J MELONE CPA CHAIRMAN	1.00 ..... 5.00	X		X				0	0	0
(2) WILLIAM P CONABOY ESQ VICE CHAIRMAN/PRESIDENT/CEO	10.00 ..... 30.00	X		X				0	948,238	370,492
(3) RICHARD WEINBERGER DO SECRETARY	1.00 ..... 1.00	X		X				0	0	0
(4) JAY BRISLIN TREASURER	1.00 ..... 1.00	X		X				0	0	0
(5) MICHAEL J ARONICA MD TREASURER (UNTIL 12/20)	1.00 ..... 4.00	X		X				0	0	0
(6) WILLIAM SCRANTON DIRECTOR	1.00 ..... 3.00	X						0	0	0
(7) SHERRY DAVIDOWITZ DIRECTOR	1.00 ..... 1.00	X						0	0	0
(8) SANDRA KROKOS-KISLAN OD DIRECTOR	1.00 ..... 1.00	X						0	0	0
(9) MICHAEL AVVISATO ASST. TREASURER & SECRETARY	10.00 ..... 30.00			X				0	524,061	170,106
(10) ROSLYN ROWAN EXECUTIVE DIRECTOR	40.00 .....					X		115,971	0	18,865
(11) CHRIS MINCH SNC ADMIN.	40.00 .....					X		128,811	0	15,425
(12) JEAN FREDMUND ASST. DIRECTOR PT	40.00 .....					X		101,084	0	11,643

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
<b>1b Sub-Total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .								345,866	1,472,299	586,531

**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 ► **3**

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
US FOOD SERVICE 1200 HOOVER AVE ALLENTOWN, PA 18103 GEISINGER	FOOD SERVICES	207,424
100 NORTH ACADEMY AVE DANVILLE, PA 17822	LAB SERVICES	186,051
PARIS HEALTHCARE LINEN SERVICE PO BOX 103 DUBOIS, PA 15801	LINEN SERVICES	108,092

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► **3**



Form 990 (2020)		Page 9			
Part VIII		Statement of Revenue			
Check if Schedule O contains a response or note to any line in this Part VIII		<input type="checkbox"/>			
		(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	302,363		
	e Government grants (contributions)	1e	911,262		
	f All other contributions, gifts, grants, and similar amounts not included above	1f			
	g Noncash contributions included in lines 1a - 1f:\$	1g			
	h Total. Add lines 1a-1f		1,213,625		
Program Service Revenue	2a NET PATIENT SERVICE REV	Business Code 623000	21,531,425	21,531,425	
	b PA ASSESSMENT REVENUE	623000	942,686	942,686	
	c				
	d				
	e				
	f All other program service revenue.				
	g Total. Add lines 2a-2f.		22,474,111		
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		167,253		167,253
	4 Income from investment of tax-exempt bond proceeds				
	5 Royalties				
	6a Gross rents	(i) Real 18,626	(ii) Personal		
	b Less: rental expenses	20,860			
	c Rental income or (loss)	-2,234			
	d Net rental income or (loss)		-2,234		-2,234
	7a Gross amount from sales of assets other than inventory	(i) Securities 6,509,128	(ii) Other		
	b Less: cost or other basis and sales expenses	5,845,555	43,273		
	c Gain or (loss)	663,573	-43,273		
	d Net gain or (loss)		620,300		620,300
	8a Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	8a			
	b Less: direct expenses	8b			
	c Net income or (loss) from fundraising events				
	9a Gross income from gaming activities. See Part IV, line 19	9a			
	b Less: direct expenses	9b			
	c Net income or (loss) from gaming activities				
10a Gross sales of inventory, less returns and allowances	10a				
b Less: cost of goods sold	10b				
c Net income or (loss) from sales of inventory					
Miscellaneous Revenue	Business Code				
11a CAFETERIA SALES	722210	39,482		39,482	
b ABSTRACT REVENUE	561000	30,055		30,055	
c MISCELLANEOUS REVENUE	900099	2,836		2,836	
d All other revenue					
e Total. Add lines 11a-11d		72,373			
12 Total revenue. See instructions		24,545,428	22,474,111	0	857,692

Form 990 (2020)

**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 ☐

<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>	<b>(A)</b> Total expenses	<b>(B)</b> Program service expenses	<b>(C)</b> Management and general expenses	<b>(D)</b> Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .				
<b>4</b> Benefits paid to or for members . . . . .				
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .				
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .				
<b>7</b> Other salaries and wages . . . . .	13,263,003	9,821,190	3,441,813	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	189,240	140,132	49,108	
<b>9</b> Other employee benefits . . . . .	2,104,349	1,558,266	546,083	
<b>10</b> Payroll taxes . . . . .	951,013	704,223	246,790	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .				
<b>b</b> Legal . . . . .	14,359		14,359	
<b>c</b> Accounting . . . . .	35,207		35,207	
<b>d</b> Lobbying . . . . .				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees . . . . .				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	2,515,817	689,028	1,826,789	
<b>12</b> Advertising and promotion . . . . .	642,696	16	642,680	
<b>13</b> Office expenses . . . . .	478,401	130,303	348,098	
<b>14</b> Information technology . . . . .				
<b>15</b> Royalties . . . . .				
<b>16</b> Occupancy . . . . .	982,482	271,523	710,959	
<b>17</b> Travel . . . . .	15,139	4,474	10,665	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .				
<b>19</b> Conferences, conventions, and meetings . . . . .	14,054	5,816	8,238	
<b>20</b> Interest . . . . .	1,208	1,208		
<b>21</b> Payments to affiliates . . . . .				
<b>22</b> Depreciation, depletion, and amortization . . . . .	1,028,995	1,028,995		
<b>23</b> Insurance . . . . .	332,546		332,546	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL SUPPLIES	1,232,542	1,223,219	9,323	
<b>b</b> EQUIPMENT & REPAIRS	1,084,694	145,687	939,007	
<b>c</b> PA NURSING HOME ASSESSM	945,654	945,654		
<b>d</b> CORPORATE ALLOCATION	490,512		490,512	
<b>e</b> All other expenses	749,714	478,581	271,133	
<b>25</b> Total functional expenses. Add lines 1 through 24e	27,071,625	17,148,315	9,923,310	0
<b>26</b> 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 IX ☐

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	1,650	<b>1</b>	1,650
	<b>2</b> Savings and temporary cash investments . . . . .		<b>2</b>	
	<b>3</b> Pledges and grants receivable, net . . . . .		<b>3</b>	
	<b>4</b> Accounts receivable, net . . . . .	1,639,367	<b>4</b>	1,889,283
	<b>5</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) . . . . .		<b>6</b>	
	<b>7</b> Notes and loans receivable, net . . . . .		<b>7</b>	
	<b>8</b> Inventories for sale or use . . . . .	44,440	<b>8</b>	35,877
	<b>9</b> Prepaid expenses and deferred charges . . . . .	56,319	<b>9</b>	48,976
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 27,404,953		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 21,810,713	6,307,257	<b>10c</b> 5,594,240
	<b>11</b> Investments—publicly traded securities . . . . .	12,671,832	<b>11</b>	15,776,190
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .		<b>12</b>	
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .		<b>13</b>	
	<b>14</b> Intangible assets . . . . .		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	205,013	<b>15</b>	306,902
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .	20,925,878	<b>16</b>	23,653,118	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	1,877,234	<b>17</b>	1,672,648
	<b>18</b> Grants payable . . . . .		<b>18</b>	
	<b>19</b> Deferred revenue . . . . .	110,012	<b>19</b>	37,185
	<b>20</b> Tax-exempt bond liabilities . . . . .		<b>20</b>	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons . . . . .		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	105,489	<b>23</b>	50,830
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .		<b>24</b>	3,473,665
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	13,056,311	<b>25</b>	12,931,277
	<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25 . . . . .	15,149,046	<b>26</b>	18,165,605
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions . . . . .	5,776,832	<b>27</b>	5,487,513
	<b>28</b> Net assets with donor restrictions . . . . .		<b>28</b>	
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds		<b>31</b>	
	<b>32</b> <b>Total net assets or fund balances</b> . . . . .	5,776,832	<b>32</b>	5,487,513
<b>33</b> <b>Total liabilities and net assets/fund balances</b> . . . . .	20,925,878	<b>33</b>	23,653,118	

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☐

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	24,545,428
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	27,071,625
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	-2,526,197
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	5,776,832
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	2,236,878
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	0
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	5,487,513

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? 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>b</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	
<b>c</b> If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	Yes	
<b>3a</b> As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		No
<b>b</b> If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		

# Additional Data

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

Form 990 (2020)

**Form 990, Part III, Line 4a:**

OPERATED A REHABILITATION HOSPITAL, LICENSED FOR 47 BEDS THAT PROVIDED VARIOUS TYPES OF REHABILITATION SERVICES. DURING THE FISCAL YEAR 2021, THE HOSPITAL HAD PATIENT DAYS, OF WHICH 69% WERE MEDICARE. THE TOTAL OCCUPANCY FOR THE REHABILITATION HOSPITAL WAS 40.65%. IN ADDITION, THE HOSPITAL HAD 219,252 OUTPATIENT VISITS. THE HOSPITAL ALSO OPERATED A 45 BED SKILLED NURSING TRANSITIONAL UNIT. DURING 2021, THE TRANSITIONAL UNIT HAD 8,354 PATIENT DAYS. TOTAL OCCUPANCY FOR THE TRANSITIONAL UNIT WAS 50.86%.CONTINUED ON SCHEDULE O.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 \$92,107 DURING THE YEAR ENDED JUNE 30, 2021.

SCHEDULE A  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

2020

Open to Public Inspection

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 12, check only one box.)

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

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
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 failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support							
	Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
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	<b>Total.</b> 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	<b>Public support.</b> Subtract line 5 from line 4.						

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(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	<b>Total support.</b> Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions) . . . . .					12	
13	<b>First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
14	Public support percentage for 2020 (line 6, column (f) divided by line 11, column (f)) . . . . .	14
15	Public support percentage for 2019 Schedule A, Part II, line 14 . . . . .	15
16a	<b>33 1/3% support test—2020.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
b	<b>33 1/3% support test—2019.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
17a	<b>10%-facts-and-circumstances test—2020.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
b	<b>10%-facts-and-circumstances test—2019.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . <input type="checkbox"/>	
18	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions . . . . . <input type="checkbox"/>	

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

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

**Section A. Public Support**

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

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>9</b> Amounts from line 6. . .						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
<b>c</b> Add lines 10a and 10b.						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.) . .						
<b>14 First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here.</b> . . . . . <input type="checkbox"/>						

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

<b>15</b> Public support percentage for 2020 (line 8, column (f) divided by line 13, column (f)) . . . . .	<b>15</b>	
<b>16</b> Public support percentage from 2019 Schedule A, Part III, line 15 . . . . .	<b>16</b>	

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

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

**19a 33 1/3% support tests—2020.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ☐

**b 33 1/3% support tests—2019.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ☐

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



**Part IV Supporting Organizations**

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

<b>Part V</b> <b>Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations</b>			
<b>1</b> <input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 ( <i>explain in Part VI</i> ). <b>See instructions.</b> All other Type III non-functionally integrated supporting organizations must complete Sections A through E.			
<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by 0.035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

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

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

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

Facts And Circumstances Test

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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.  
► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

2020

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? . . . . .

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? . . . . .

☐ Yes ☐ No

Part II

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

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

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

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

	Held at the End of the Year
a Total number of conservation easements . . . . .	2a
b Total acreage restricted by conservation easements . . . . .	2b
c Number of conservation easements on a certified historic structure included in (a) . . . . .	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register . . . . .	2d

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

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

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

☐ 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 FASB 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 FASB 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 FASB ASC 958 relating to these items:

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

b Assets included in Form 990, Part X . . . . . ► \$

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

Cat. No. 52283D

Schedule D (Form 990) 2020

Part III

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

3

Using the organization's acquisition, accession, and other records, check any of the following that 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" on Form 990, Part IV, line 10.

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

2

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

a

Board designated or quasi-endowment ▶ .....

b

Permanent endowment ▶ .....

c

Term endowment ▶ .....

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

3a

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

(i) Unrelated organizations . . . . .

(ii) Related organizations . . . . .

b

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

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

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land . . . . .		299,615		299,615
b Buildings . . . . .		24,487,079	20,129,629	4,357,450
c Leasehold improvements				
d Equipment . . . . .		2,479,335	1,681,084	798,251
e Other . . . . .		138,924		138,924
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				5,594,240

Part VII

Investments—Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII

Investments—Program Related.

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Column (b) must equal Form 990, Part X, col.(B) line 13.) ▶		

Part IX

Other Assets.

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

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) . . . . . ▶	

Part X

Other Liabilities.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) INTERCOMPANY PAYABLES, NET	1,082,223
(3) ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	953,505
(4) AMOUNTS DUE TO AFFILIATES FOR WORKING CAPITAL	7,904,353
(5) MEDICARE ADVANCE PAYMENTS	2,991,196
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	12,931,277

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



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

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

<b>1</b>	Total revenue, gains, and other support per audited financial statements . . . . .	<b>1</b>	26,702,319
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
<b>a</b>	Net unrealized gains (losses) on investments . . . . .	<b>2a</b>	2,236,878
<b>b</b>	Donated services and use of facilities . . . . .	<b>2b</b>	
<b>c</b>	Recoveries of prior year grants . . . . .	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII.) . . . . .	<b>2d</b>	-100,847
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .	<b>2e</b>	2,136,031
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .	<b>3</b>	24,566,288
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line <b>1</b> :		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII.) . . . . .	<b>4b</b>	-20,860
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .	<b>4c</b>	-20,860
<b>5</b>	Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12.) . . . . .	<b>5</b>	24,545,428

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

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

<b>1</b>	Total expenses and losses per audited financial statements . . . . .	<b>1</b>	26,991,638
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
<b>a</b>	Donated services and use of facilities . . . . .	<b>2a</b>	
<b>b</b>	Prior year adjustments . . . . .	<b>2b</b>	
<b>c</b>	Other losses . . . . .	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII.) . . . . .	<b>2d</b>	20,860
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .	<b>2e</b>	20,860
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .	<b>3</b>	26,970,778
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line <b>1</b> :		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII.) . . . . .	<b>4b</b>	100,847
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .	<b>4c</b>	100,847
<b>5</b>	Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18.) . . . . .	<b>5</b>	27,071,625

**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
See Additional Data Table	

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

Return Reference	Explanation

**Additional Data**

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

**Supplemental Information**

Return Reference	Explanation
PART X, LINE 2:	ALLIED ACCOUNTS FOR UNCERTAINTY IN INCOME TAXES USING A RECOGNITION THRESHOLD OF MORE-LIKE LY-THAN-NOT TO BE SUSTAINED UPON EXAMINATION BY THE APPROPRIATE TAXING AUTHORITY. MEASUREM ENT OF THE TAX UNCERTAINTY OCCURS IF THE RECOGNITION THRESHOLD HAS BEEN MET. MANAGEMENT DE TERMINED THAT THERE WERE NO TAX UNCERTAINTIES THAT MET THE RECOGNITION THRESHOLD IN 2021 A ND 2020.

Supplemental Information	
Return Reference	Explanation
PART XI, LINE 2D - OTHER ADJUSTMENTS:	BAD DEBT EXPENSE NETTED AGAINST REVENUE ON FINANCIALS -100,847.

Supplemental Information	
Return Reference	Explanation
PART XI, LINE 4B - OTHER ADJUSTMENTS:	RENTAL EXPENSES -20,860.

Supplemental Information	
Return Reference	Explanation
PART XII, LINE 2D - OTHER ADJUSTMENTS:	RENTAL EXPENSES 20,860.

Supplemental Information	
Return Reference	Explanation
PART XII, LINE 4B - OTHER ADJUSTMENTS:	BAD DEBT EXPENSE NETTED AGAINST REVENUE ON FINANCIALS 100,847.

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.  
► Go to [www.irs.gov/Form990EZ](http://www.irs.gov/Form990EZ) for instructions and the latest information.

OMB No. 1545-0047

2020

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 . . . . .	Yes	
b	If "Yes," was it a written policy? . . . . .	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 free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ % b Did the organization use FPG as a factor in determining eligibility for providing discounted 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 _____ % 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"? . . . . . 5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? . . . . . b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . . 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? . . . . . 6a Did the organization prepare a community benefit report during the tax year? . . . . . b If "Yes," did the organization make it available to the public? . . . . . Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.	Yes	No
1a		Yes	
1b		Yes	
3a		Yes	
3b		Yes	
4		Yes	
5a		Yes	
5b		Yes	
5c			No
6a		Yes	
6b		Yes	

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	100,004		100,004	0.370 %
b Medicaid (from Worksheet 3, column a) . . . . .		750	2,282,494	807,978	1,474,516	5.470 %
c Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .						
d Total Financial Assistance and Means-Tested Government Programs . . . . .	1	950	2,382,498	807,978	1,574,520	5.840 %
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				
j Total. Other Benefits . . . . .		100				
k Total. Add lines 7d and 7j . . . . .	1	1,050	2,382,498	807,978	1,574,520	5.840 %



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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development						
<b>9</b> Other			21,257		21,257	0.080 %
<b>10 Total</b>			21,257		21,257	0.080 %

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. . . . .	<b>2</b>	143,402	
<b>3</b> 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. . . . .	<b>3</b>	100,004	
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME) . . . . .	<b>5</b>	12,231,751	
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	<b>6</b>	15,362,445	
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	<b>7</b>	-3,130,694	
<b>8</b> 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:			
<input checked="" type="checkbox"/> Cost accounting system			
<input type="checkbox"/> Cost to charge ratio			
<input type="checkbox"/> Other			

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year? . . . . .	<b>9a</b>	Yes	
<b>b</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 . . . . .	<b>9b</b>	Yes	

**Part IV Management Companies and Joint Ventures**

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(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 %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

**Part V Facility Information****Section A. Hospital Facilities**

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

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

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

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

**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****Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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. . . . .	<b>2</b>	No
<b>3</b> 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):	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <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		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>20</u>		
<b>5</b> 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 . . . . .	<b>5</b>	No
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</b> Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C . . . . .	<b>6b</b>	No
<b>7</b> 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): WWW.ALLIED-SERVICES.ORG/ABOUT-US/COMMUNITY-HEALTH-NEEDS-	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>ASSESSMENT/</u>		
<b>b</b> <input type="checkbox"/> Other website (list url): _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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. . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>20</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . WWW.ALLIED-SERVICES.ORG/ABOUT-US/COMMUNITY-HEALTH-NEEDS-	<b>10</b>	Yes
<b>a</b> If "Yes" (list url): <u>ASSESSMENT/</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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.		
<b>12a</b> 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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	<b>13</b> Yes	
<b>a</b> <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>b</b> <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input type="checkbox"/> Asset level		
<b>d</b> <input type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount		
<b>g</b> <input type="checkbox"/> Residency		
<b>h</b> <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients?	<b>14</b> Yes	
<b>15</b> 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):	<b>15</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b> <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	<b>16</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.ALLIED-SERVICES.ORG/RESOURCES/UNCOMPENSATED-FINANCIAL-AID-PROGRAM/		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.ALLIED-SERVICES.ORG/RESOURCES/UNCOMPENSATED-FINANCIAL-AID-PROGRAM/		
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.ALLIED-SERVICES.ORG/RESOURCES/UNCOMPENSATED-FINANCIAL-AID-PROGRAM/		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b> <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)**Billing and Collections**

JOHN HEINZ INSTITUTE OF REHABILITATION

**Name of hospital facility or letter of facility reporting group**

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

**Policy Relating to Emergency Medical Care**

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

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

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

JOHN HEINZ INSTITUTE OF REHABILITATION

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

**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** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☒ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C.

**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.

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No



**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)
<b>1</b>	
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	



**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.

**990 Schedule H, Supplemental Information**

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.

# 990 Schedule H, Supplemental Information

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 \$100,847.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES:	<p>SOME EXAMPLES OF OUR COMMUNITY-BUILDING ACTIVITIES DURING THE YEAR:- THE DEPAUL SCHOOL FOR CHILDREN WITH LEARNING DISABILITIES PROVIDES A FULL DAY EDUCATIONAL PROGRAM FOR CHILDREN WITH DYSLEXIA AND RELATED LEARNING CHALLENGES. DURING THE 2021 SCHOOL YEAR, DEPAUL SERVED 48 STUDENTS, AGES 7 THROUGH 14. COSTS TO ALLIED SERVICES INSTITUTE OF REHAB MEDICINE TOTALED \$334,421.- CONTRIBUTIONS OF PRINTING SERVICES VALUED AT \$42,513 WERE PROVIDED TO THE FOLLOWING NOT-FOR-PROFIT ORGANIZATIONS DURING THE YEAR: BOYS &amp; GIRLS CLUB OF SCRANTON, BRIGHTER JOURNEYS, CHILDREN'S ADVOCACY ALLIANCE, COUNTRYSIDE CONSERVANCY, HELPING HEROES, JEWISH COMMUNITY CENTER, LACKAWANNA HISTORICAL SOCIETY, LEADERSHIP WILKES-BARRE, NEPA LONG TERM CARE ASSOCIATION, PA INTERSCHOLASTIC ATHLETIC ASSOCIATION DISTRICT 2, SCRANTON BALLET THEATER, SCRANTON CULTURAL CENTER, AND UNICO WILKES-BARRE.- FINANCIAL SUPPORT WAS PROVIDED TO COMMUNITY HEALTH EDUCATION AND AWARENESS PROJECTS, INCLUDING THE AMERICAN HEART &amp; STROKE ASSOCIATION'S F.A.S.T. STROKE RESPONSE AND STROKE PREVENTION INITIATIVES, THE KIEL EIGEN FOUNDATION FOR ADAPTIVE AIDS AND SERVICES FOR ADULTS WITH SPINAL CORD INJURIES, THE AHA'S "GO RED" CAMPAIGN (HEART DISEASE PREVENTION), SEVERAL AUTISM SPECTRUM DISORDER AWARENESS/INCLUSION PROGRAMS, AND LOCAL PUBLIC SCHOOLS FOR EQUIPMENT/SUPPLIES FOR IN-SCHOOL CPR TRAINING PROGRAMS. - AS COVID-19 SAFETY PROTOCOLS CONTINUED TO LIMIT OUR OPPORTUNITIES FOR IN-PERSON HEALTH EDUCATION SERVICES, ALLIED SERVICES RELIED MORE HEAVILY ON SOCIAL MEDIA (FACEBOOK, TWITTER, INSTAGRAM) PLATFORMS AND CONVENTIONAL PRINT/BROADCAST MEDIA TO PROMOTE PUBLIC HEALTH. TOPICS INCLUDED STROKE SYMPTOM RECOGNITION AND PREVENTION; NEW THERAPIES FOR MANAGEMENT OF PARKINSON'S AND MS SYMPTOMS; BALANCE DISORDERS AND FALL PREVENTION; LYMPHEDEMA THERAPIES; AND COORDINATION OF POST-ACUTE HEALTHCARE SERVICES.</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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.

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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.

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8:	THE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT. THE FISCAL YEAR MEDICARE COST REPORT WAS UTILIZED TO CALCULATE THE COST. SERVING PATIENTS WITH GOVERNMENT BENEFITS, SUCH AS MEDICARE, IS A COMPONENT OF THE COMMUNITY BENEFIT STANDARD THAT TAX EXEMPT HOSPITALS ARE HELD TO. THIS IMPLIES THAT SERVING MEDICARE PATIENTS IS A COMMUNITY BENEFIT AND THAT THE HOSPITAL OPERATES TO PROMOTE THE HEALTH OF THE COMMUNITY.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B:	<p>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.</p>



## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2:	THE COMMUNITY HEALTH NEEDS ASSESSMENT [DESCRIBED IN PART V, SECTION B] PROVIDES AN UPDATED PICTURE OF POPULATION HEALTH, DEMOGRAPHICS, SOCIAL DETERMINANTS OF HEALTH AND BARRIERS TO ACCESSING HEALTH SERVICES.THE HOSPITALS MONITOR LOCAL HEALTH NEEDS AND TRENDS BY REVIEWING PUBLICATIONS ISSUED BY THE PENNSYLVANIA'S DEPARTMENTS OF HEALTH, HUMAN SERVICES, AGING (OFFICE OF LONG-TERM LIVING), AND HEALTH CARE COST CONTAINMENT COUNCIL. DATA FROM U.S. CENSUS REPORTS (AGE, INCOME, DISABILITY STATUS) AND HHS' CENTER FOR MEDICARE & MEDICAID SERVICES REPORTS ARE USEFUL IN TRACKING CHANGES IN POPULATION HEALTH AND PUBLIC HEALTH. FINALLY, THE HOSPITALS' CHNA PROCESS REFERENCES ADDITIONAL INFORMATION SOURCES: HHS HEALTHY PEOPLE BENCHMARK REPORTS, DATA FROM THE CENTER FOR DISEASE CONTROL & PREVENTION, HHS HRSA, AND U.S. BUREAU OF LABOR STATISTICS.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
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. INTERPRETER 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>

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4:	THE HOSPITALS' PRIMARY INPATIENT SERVICE AREA CONSISTS OF LACKAWANNA AND LUZERNE COUNTIES IN NORTHEASTERN PENNSYLVANIA. THE TWO COUNTIES TOGETHER COVER AN AREA OF 827.5 SQUARE MILES. ACCORDING TO U.S. CENSUS ESTIMATES FOR 2021, THESE COUNTIES HAD POPULATIONS OF 215,863 AND 326,053, RESPECTIVELY. WHEN COMPARED TO THE COMMONWEALTH AS A WHOLE, THE AREA FAR LESS DIVERSE IN ETHNIC AND RACIAL COMPOSITION.% OF POPULATION LACKAWANNA LUZERNE PENNSYLVANIAWHITE/CAUCASIAN 90.4 89.3 81.6BLACK/AFRICAN-AMERICAN 4.2 6.6 12.0AMERICAN INDIAN/ALASKAN NAT. .3 .7 .4ASIAN 3.1 1.4 3.8NATIVE HAWAIIAN/OTHER PACIFIC .1 .1 .1TWO OR MORE RACES 1.9 2.0 2.1HISPANIC OR LATINO ORIGIN 8.4 13.8 7.8LACKAWANNA AND LUZERNE COUNTY RESIDENTS HAVE LOWER INCOMES THAN THEIR PENNSYLVANIA COUNTERPARTS. MEDIAN INCOME FOR PENNSYLVANIANS OVERALL (2021) WAS \$63,627, COMPARED WITH \$54,064 FOR LACKAWANNA AND \$53,194 FOR LUZERNE RESIDENTS. PERSONS IN POVERTY CONSTITUTED 10.9% OF ALL PENNSYLVANIANS, COMPARED TO 12.2% AND 15.1% OF THE POPULATIONS OF LACKAWANNA AND LUZERNE COUNTIES, RESPECTIVELY.A SIGNIFICANT PERCENT OF THE AREA'S POPULATION IS MADE UP OF OLDER ADULTS, AGE 65 OR OLDER. OLDER ADULTS REPRESENT 20.3% OF LACKAWANNA COUNTY RESIDENTS AND 20.2% OF LUZERNE COUNTY RESIDENTS, COMPARED TO 8.7% FOR PENNSYLVANIA OVERALL. PERSONS WITH DISABILITIES BELOW THE AGE OF 65 MADE UP SOME 11.3% OF LACKAWANNA COUNTY'S AND 11.1% OF LUZERNE COUNTY'S POPULATION, COMPARED WITH 9.8% OF THE COMMONWEALTH AS A WHOLE.

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 5:	<p>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 THOSE WE SERVE. OUR PROGRAMS INCLUDE INPATIENT AND OUTPATIENT MEDICAL REHABILITATION, SKILLED NURSING CARE, TRANSITIONAL REHABILITATION, HOME HEALTH CARE, IN-HOME SERVICES, PERSONAL CARE, HOSPICE CARE, PALLIATIVE CARE, VOCATIONAL REHABILITATION, AND RESIDENTIAL PROGRAMS FOR ADULTS WITH INTELLECTUAL, DEVELOPMENTAL OR BEHAVIORAL/MENTAL HEALTH DISABILITIES. EACH DAY, THESE SERVICES TOUCH THE LIVES OF SOME 5,000 PERSONS IN COMMUNITIES THROUGHOUT NORTHEASTERN AND CENTRAL PENNSYLVANIA.OUR HOSPITALS IN SCRANTON AND WILKES-BARRE TOWNSHIP ARE THE CORE AND MOST WIDELY RECOGNIZED COMPONENT OF THE ALLIED SERVICES SYSTEM. COMPLEMENTED BY A NETWORK OF OUTPATIENT CLINICS, THEY 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, HOSPITAL RESOURCES (CLINICIANS, FACILITIES, EXPERTISE, MANAGEMENT) SERVE THE LARGER REGION THROUGH:- THE EDUCATION AND TRAINING OF HEALTH PROFESSIONALS: THROUGH SYMPOSIA, INTERNSHIP AND CLINICAL EXPERIENCES OFFERED TO PHYSICIANS, PHARMACISTS, NURSES AND OTHER HEALTH CAREERS.- FACILITATING AND HOSTING PEER SUPPORT AND HEALTH EDUCATION FOR PERSONS AFFECTED BY LIFE: CHANGING BRAIN OR SPINAL CORD INJURIES, PARKINSON'S DISEASE AND OTHER CONDITIONS.- OFFERING AFFORDABLE WELLNESS/EXERCISE PROGRAMS AND FACILITIES FOR PERSONS WITH DISABILITIES, CHRONIC ILLNESS, LIMITED MOBILITY- LEADERSHIP, VOLUNTEER SERVICE AND IN-KIND SUPPORT FOR LOCAL HEALTH CARE CHARITIES- SUPPORTING THE DEPAUL SCHOOL: AN ACCREDITED, YEAR-ROUND, FULL-DAY EDUCATIONAL PROGRAM FOR CHILDREN (AGES 7 14) WITH DYSLEXIA AND RELATED LEARNING DISABILITIES- OPENING OUR FACILITIES: E.G., MEETING AND DINING FACILITIES, GROUNDS, AND PEDIATRIC GYMS--TO NONPROFIT AND VOLUNTEER GROUPS THAT SERVE OUR COMMUNITY.</p>

Form and Line Reference	Explanation
PART VI, LINE 6:	<p>ALLIED SKILLED NURSING &amp; REHABILITATION CENTER, SCRANTON; CENTER CITY SKILLED NURSING CENT ER, WILKES-BARRE; MEADE STREET SKILLED NURSING CENTER, WILKES-BARRE: SKILLED NURSING CENTE RS ARE HOME TO PERSONS WHOSE CHRONIC ILLNESS AND/OR SEVERE DISABILITIES DEMAND ROUND-THE-C LOCK, SKILLED CARE. THESE FACILITIES MEET A WIDE RANGE OF SKILLED CARE NEEDS, E.G., SUPPOR TIVE/RESTORATIVE CARE FOLLOWING AN EXTENDED ILLNESS OR MAJOR SURGERY; LONG-TERM CARE FOR M EDICALLY FRAGILE/COMPLEX OLDER ADULTS WHO NEED 24/7 MONITORING AND MEDICAL MANAGEMENT; CAR E AND SUPPORTIVE SERVICES FOR PEOPLE WITH CHRONIC ILLNESSES (ALZHEIMER'S OR OTHER DEMENTIA , PARKINSON'S, CARDIOPULMONARY DISEASE, ETC.) ABOUT 70% TO 80% OF SKILLED NURSING RESIDENT S ARE ECONOMICALLY DISADVANTAGED (MEDICAID-ELIGIBLE).PERSONAL CARE: ALLIED TERRACE (SCRANT ON) &amp; ALLIED SERVICES MEADE STREET RESIDENCE (WILKES-BARRE): OUR SENIOR LIVING COMMUNITIES OFFER MODERN, WELL-APPOINTED, FULL SERVICE ASSISTED LIVING FOR OLDER ADULTS WHO ARE ENJOY LIVING INDEPENDENTLY, WITH HELP FOR HOUSEKEEPING, LAUNDRY, MEALS/DINING SERVICES. SUPPORT SERVICES, E.G., MEDICATION MANAGEMENT, IN-HOME HEALTH AND PERSONAL CARE, ARE AVAILABLE TO ENSURE RESIDENTS' CONTINUED HEALTH, SAFETY, AND QUALITY OF LIFE.ALLIED CONTINUING CARE RE TIREMENT COMMUNITY: ALLIED CCRC WAS FORMED IN 2006 FOR THE PURPOSES OF PROVIDING INDEPENDE NT LIVING SERVICES. IN SPACE LEASED FROM ALLIED TERRACE, SENIORS WHO ARE CAPABLE OF INDEPE NDENTLY MANAGING ACTIVITIES OF DAILY LIVING, MEAL PREPARATION, LIGHT HOUSEKEEPING, SELF-CA RE, ETC., OCCUPY THESE UNITS, WHILE ENJOYING FULL ACCESS TO THE TERRACE'S SOCIAL AND RECRE ATIONAL OPPORTUNITIES.VOCATIONAL SERVICES: FOR OVER 60 YEARS, ALLIED'S VOCATIONAL SERVICES PROGRAMS HAVE PROVIDED TRAINING AND GAINFUL EMPLOYMENT TO TEENS AND ADULTS WITH PHYSICAL, INTELLECTUAL AND DEVELOPMENTAL DISABILITIES. PARTICIPANTS ARE INVOLVED IN PROJECTS THAT E NHANCE THEIR SKILLS, EMPLOYABILITY, SELF-RELIANCE AND PARTICIPATION IN THE COMMUNITY. OUR VOCATIONAL PROGRAMS DRAW UPON STATE AND FEDERAL GRANT DOLLARS, AS WELL AS COMPETITIVELY AW ARDED CONTRACTS FROM GOVERNMENT AND BUSINESS PARTNERS.DEVELOPMENTAL SERVICES: FOR ADULTS W HO HAVE BOTH INTELLECTUAL AND PHYSICAL DISABILITIES/ILLNESSES, ALLIED SERVICES' INTERMEDIA TE CARE FACILITY IS A COMFORTABLE, SAFE RESIDENTIAL ENVIRONMENT WHERE SKILLED NURSING AND PERSONAL SUPERVISION ARE AVAILABLE "24-7". RESIDENTS RECEIVE MEALS, PERSONAL CARE (DRESSIN G, BATHING, GROOMING, ETC.), MEDICAL AND MEDICATION MANAGEMENT, SOCIAL AND RECREATIONAL PR OGRAMS IN A HOME-LIKE SETTING. FOR CONSUMERS WHO ARE ABLE TO LIVE MORE INDEPENDENTLY, ALLI ED OFFERS A RANGE OF COMMUNITY LIVING OPTIONS IN SMALL GROUP HOMES THROUGHOUT THE REGION. THESE PROGRAMS MEET A GROWING NEED FOR RESIDENTIAL CARE FOR OLDER ADULTS WHOSE INTELLECTUA L AND COMPLEX PHYSICAL DISABILITIES/MEDICAL CONDITIONS DEMAND MORE INTENSIVE, SPECIALIZED LEVELS OF CARE. BEHAVIORAL SERVICES: BEHAVIORAL SERVICES PROVIDE RESIDENTIAL AND COMMUNITY -BASED SUPPORT TO ADULTS WITH CHRONIC MENTAL ILLNESS. STAFF MEMBERS WORK WITH CONSUMERS AS THEY RE-CONNECT WITH JOBS, FAMILIES, PEER AND COMMUNITY RESOURCES. THROUGH AN INTENSIVE P ROGRAM OF COUNSELING AND BEHAVIORAL SUPPORTS, THE PROGRAM ATTACKS LONGSTANDING PATTERNS OF MENTAL HEALTH CRISES, SUBSTANCE ABUSE, HOSPITALIZATION AND/OR INSTITUTIONALIZATION.ALLIED PROJECT OPPORTUNITY: LOCATED IN JERMYN, (LACKAWANNA COUNTY) PA., THE SIX UNITS OF HOUSING ARE MANAGED BY THE BEHAVIORAL HEALTH DIVISION. INDIVIDUALS WHO ARE RECOVERING FROM CHRONI C MENTAL HEALTH PROBLEMS FIND SAFE, PLEASANT, AFFORDABLE ACCOMMO/DATIONS AT PROJECT OPPORTUNITY, SUBSIDIZED BY THE HUD SECTION 8 PROGRAM.HOME HEALTH &amp; IN-HOME SERVICES: THESE PROGR AMS PROVIDE ESSENTIAL MEDICAL AND SUPPORT SERVICES TO PERSONS WITH DISABILITIES. HOME HEAL TH CARE ADDRESSES THE MEDICAL NEEDS OF ADULTS WHO ARE RECOVERING FROM SURGERIES, EXTENDED ILLNESSES, FALL INJURIES AND OTHER HEALTH CRISES. RNS, LPNS, PHYSICAL AND OCCUPATIONAL THE RAPISTS MONITOR PATIENTS' HEALTH, FUNCTIONING AND SAFETY AT HOME, ASSISTING THEM WITH MEDI CAL NEEDS SUCH AS WOUND CARE, MEDICATION MANAGEMENT, MEDICAL EQUIPMENT OR ASSISTIVE DEVICE S, AND REHABILITATION. IN-HOME SERVICES PROVIDES PERSONAL/SUPPORTIVE CARE FOR COMMUNITY-DW ELLING ADULTS WHO HAVE SERIOUS DISABILITIES OR CHRONIC ILLNESSES. PERSONAL CARE AIDES/DIRE CT CARE WORKERS HELP WITH MEAL PREPARATION, HOUSEKEEPING CHORES, LAUNDRY, GROCERY/PHARMACY SHOPPING, AND OTHER TASKS. THE ABOVE SERVICES ENABLE THEIR PATIENTS/CLIENTS TO MAINTAIN I NDEPENDENT LIVING BY HELPING THEM TO AVOID PREVENTABLE ILLNESSES, INJURIES, HOSPITALIZATIO NS AND INSTITUTIONALIZATION. ALLIED SERVICES HOSPICE (SCRANTON &amp; WILKES-BARRE): ALLIED SER VICES IN-HOME HOSPICE PROGRAM WAS ESTABLISHED IN 2015 TO EXTEND THE ASIHS CONTINUUM TO IND IVIDUALS WHO HAVE LIFE-LIMITING ILLNESSES. THE PROGRAM PROVIDES PALLIATIVE CARE AND A FULL COMPLEMENT OF SUPPORTIVE/COUNSELING SERVICES. CORE SERVICES INCLUDE MEDICAL DIRECTION BY THE HOSPICE PHYSICIAN; NURSING SERVICES UNDER SUPE</p>

Form and Line Reference	Explanation
PART VI, LINE 6:	<p>VISION 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; SPIRITUAL, BEREAVEMENT, AND DIETARY COUNSELING. IN 2018, ALLIED SERVICES OPENED AN 8-BED INPATIENT HOSPICE FACILITY IN SCRANTON FOR END-OF-LIFE PATIENTS WHO CANNOT BE ADEQUATELY SERVED IN THE HOME ENVIRONMENT. IN FEBRUARY OF 2021, A SECOND 8-BED INPATIENT HOSPICE UNIT WAS ESTABLISHED AT 200 MEADE STREET IN WILKES-BARRE. ALLIED SERVICES PALLIATIVE CARE: COMMUNITY-BASED PALLIATIVE CARE SERVICES FILL A GAP IN CARE AND SUPPORT SERVICES FOR THE CHRONICALLY-ILL, PROVIDING AN "EXTRA LAYER" OF CARE AND SAFETY. PALLIATIVE CARE IS SPECIALIZED, INTERDISCIPLINARY CARE THAT ATTENDS TO THE PHYSICAL, EMOTIONAL AND SPIRITUAL NEEDS OF PEOPLE WITH CHRONIC ILLNESS AND TO THE RELATED EMOTIONAL AND EDUCATIONAL NEEDS OF CAREGIVERS. PC HAS BEEN DEMONSTRATED TO SIGNIFICANTLY REDUCE BOTH HUMAN SUFFERING AND HEALTHCARE COSTS BY ACHIEVING BETTER SYMPTOM/PAIN CONTROL, BETTER CARE PLANNING AND COORDINATION, AND GREATER ENGAGEMENT OF PATIENTS IN THEIR OWN CARE. IT IS PARTICULARLY BENEFICIAL FOR PEOPLE WHOSE SOCIAL CHARACTERISTICS, ISOLATION, HEALTH LITERACY OR GENERAL LITERACY DEFICITS, LANGUAGE BARRIERS, POOR HEALTH HABITS, ETC., INCREASE THE RISK OF ADVERSE HEALTH OUTCOMES. 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. FOUNDATION ALSO MANAGES GENERAL PUBLIC RELATIONS, OUTREACH, INTERNAL COMMUNICATIONS, CHARITABLE FUND COMPLIANCE/ACCOUNTABILITY.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	PA

## 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

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		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	



**Section C. Supplemental Information for Part V, Section B.**Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
JOHN HEINZ INSTITUTE OF REHABILITATION	PART V, SECTION B, LINE 5: THE 2021 CHNA WAS UNDERTAKEN BY ALLIED SERVICES REHAB HOSPITAL, HEINZ REHAB HOSPITAL, AND GEISINGER HEALTH SYSTEM HOSPITALS THROUGHOUT EASTERN AND CENTRAL PENNSYLVANIA. THE CHNA PROCESS TOOK PLACE FROM JULY TO DECEMBER 2020, WITH APPROVAL OF A FINAL CHNA REPORT & IMPLEMENTATION PLAN IN MAY OF 2021. THE COLLABORATIVE CHNA PROCESS WAS ADMINISTERED BY BAKER TILLY, A NATIONALLY RECOGNIZED AUTHORITY IN PUBLIC HEALTH RESEARCH AND COMMUNITY NEEDS ASSESSMENT. REGIONAL REPORTS FOR EACH HOSPITAL'S UNIQUE SERVICE AREA WERE DEVELOPED USING HEALTH AND SOCIOECONOMIC STATISTICS AND KEY STAKEHOLDER SURVEYS.THE CHNA PROCESS SOLICITED INPUT FROM PERSONS FROM A BROAD RANGE OF COMMUNITY STAKEHOLDERS, AND INCORPORATED RESPONSES FROM PUBLIC HEALTH EXPERTS AND INDIVIDUALS REPRESENTING THE MEDICALLY-UNDERSERVED, LOW-INCOME AND MINORITY POPULATIONS. WHILE COVID-19 SAFETY CONCERNS PREVENTED MOST IN-PERSON MEETINGS AND GROUP EVENTS, ONLINE SURVEYS, VIRTUAL MEETINGS, AND WEBINAR PRESENTATIONS WERE UTILIZED TO MAXIMIZE ENGAGEMENT AND GATHER INPUT. IN ALL, SOME 61 INDIVIDUALS FROM EASTERN AND CENTRAL PENNSYLVANIA KEY STAKEHOLDER ORGANIZATIONS COMPLETED SURVEYS, INCLUDING REPRESENTATIVES FROM THESE NORTHEASTERN PENNSYLVANIA ORGANIZATIONS/GROUPS : - HEALTHCARE & HEALTH EDUCATION PROVIDERS: ALZHEIMER'S ASSOCIATION, GEISINGER COMMUNITY MEDICAL CENTER SCRANTON, GEISINGER WYOMING VALLEY PLAINS, GEISINGER HEALTH SYSTEM, LACKAWANNA & LUZERNE COUNTY MEDICAL SOCIETIES, PEDIATRICS OF NORTHEASTERN PA, THE WRIGHT CENTER FOR COMMUNITY HEALTH, VOLUNTEERS IN MEDICINE, WYOMING VALLEY ALCOHOL & DRUG SERVICES- HUMAN SERVICE AGENCIES: CAMP VICTORY, CATHOLIC SOCIAL SERVICES, COMMUNITY INTERVENTION CENTER, FAMILY SERVICES ASSOCIATION, GOODWILL INDUSTRIES OF NEPA, NATIONAL ALLIANCE ON MENTAL ILLNESS-NORTHEAST PA REGION, NEPA YOUTH SHELTER, NORTHEAST SUICIDE PREVENTION INITIATIVE, ST. JOSEPH'S CENTER, UNITED WAY OF LACKAWANNA & WAYNE COUNTIES, UNITED WAY OF WYOMING VALLEY- PUBLIC/GOVERNMENTAL ORGANIZATIONS: LACKAWANNA COUNTY MENTAL HEALTH COURT, PA OFFICE OF RURAL HEALTH-CIVIC AND PHILANTHROPIC ORGANIZATIONS: BERWICK INDUSTRIAL DEVELOPMENT, ASSOCIATION, GREATER PITTSBURGH CHAMBER OF COMMERCE, GREATER SCRANTON CHAMBER OF COMMERCE, THE LUZERNE FOUNDATION, MOSES TAYLOR FOUNDATION, SCRANTON AREA COMMUNITY FOUNDATION, VALLEY IN MOTION- HIGHER EDUCATION, EDUCATION ORGANIZATIONS: HANOVER AREA SCHOOL DISTRICT, PENN STATE EXTENSION-NUTRITION LINKS COMMUNITY ENGAGEMENT WAS AN INTEGRAL PART OF THE 2021 CHNA. A VIRTUAL TOWN HALL WAS HELD IN AUGUST 2020 TO ANNOUNCE THE ONSET OF THE CHNA AND ENCOURAGE BROAD STAKEHOLDER PARTICIPATION. A KEY INFORMANT SURVEY WAS SENT TO NEARLY 1,000 COMMUNITY STAKEHOLDERS TO SOLICIT INPUT ON HEALTH DISPARITIES, OPPORTUNITIES FOR COLLABORATION, COVID-19 RESPONSE, COMMUNITY HEALTH PRIORITIES, AMONG OTHER INSIGHTS. CONTINUED COMMUNITY ENGAGEMENT ACTIVITIES WERE PLANNED TO ENSURE ONGOING DIALOGUE AND A FORUM FOR ADDRESSING COMMUNITY HEALTH NEEDS.COMMENTS, OBSER

**Section C. Supplemental Information for Part V, Section B.**Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
JOHN HEINZ INSTITUTE OF REHABILITATION	VATIONS AND RECOMMENDATIONS FROM THE ABOVE GROUPS (KEY INFORMANTS, PARTNER FORUM PARTICIPANTS AND MEETING PARTICIPANTS) WERE COMBINED WITH SECONDARY (STATISTICAL) DATA TO DEVELOP THE CHNA ACTION PLAN.

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</b> Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
JOHN HEINZ INSTITUTE OF REHABILITATION	PART V, SECTION B, LINE 6A: THE CHNA WAS A COLLABORATIVE EFFORT WITH GEISINGER HOSPITALS, INCLUDING GEISINGER WYOMING VALLEY (WILKES-BARRE/PLAINS) AND GEISINGER COMMUNITY MEDICAL CENTER (SCRANTON), AND OTHER GEISINGER HOSPITALS IN NORTHEASTERN AND CENTRAL PENNSYLVANIA.

**Section C. Supplemental Information for Part V, Section B.**Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
JOHN HEINZ INSTITUTE OF REHABILITATION	<p>PART V, SECTION B, LINE 11: THE FOLLOWING IMPLEMENTATION STRATEGIES WERE ADOPTED TO ADDRESS THE PRIORITY HEALTH NEEDS THAT WERE IDENTIFIED BY THE CHNA. THEY REFLECT OUR ASSESSMENT OF EACH AREA'S RELEVANCE TO OUR CORE COMPETENCIES AND MISSION, THE POTENTIAL IMPACT AND EFFECTIVENESS OF POSSIBLE INTERVENTION(S), AND THE FEASIBILITY OF ADDRESSING THE NEED BASED ON OUR RESOURCES, CAPACITY AND CAPABILITIES. PRIORITY 1: ACCESS TO CAREGOAL: REDUCE IDENTIFIED BARRIERS TO HEALTHCARE, INCLUDING HEALTHCARE PROFESSIONAL SHORTAGES, LANGUAGE BARRIER S, AND TRANSPORTATION FOR DAILY LIVING, HEALTHCARE AND EMPLOYMENT NEEDS1. CONTRIBUTE TO THE TRAINING, EDUCATION AND DEVELOPMENT OF HEALTHCARE PROFESSIONALS TO SERVE THE REGION- RESUME CLINICAL EXPERIENCES, INTERNSHIPS, MENTORING TO STUDENTS OF PHYSICAL, OCCUPATIONAL OR SPEECH THERAPIES, NURSING, MEDICINE, SOCIAL WORK AND OTHER CRITICAL HEALTHCARE POSITIONS2. MAINTAIN DIVERSE ADMISSION AND CARE DELIVERY OPTIONS FOR CONSUMERS WHO FACE CARE BARRIERS E.G., ADVANCED CHRONIC ILLNESS, LIMITED MOBILITY, THE LACK OF SOCIAL/FAMILY SUPPORTS OR TRANSPORTATION.- CONTINUE ADMIT FROM HOME, REHAB YOUR WAY, TELEHEALTH, IN-HOME THERAPIES, ON SITE CLINIC AND OTHER INITIATIVES THAT DIVERSIFY ACCESS TO CARE3. CONTINUE PARTICIPATION IN REGIONAL TRANSPORTATION IMPROVEMENT EFFORTS- CONTINUE COORDINATION WITH COUNTIES' IN PARATRANSIT/SHARED RIDE PROGRAMS4. CONTINUE DEVELOPMENT OF HUMAN RESOURCES INITIATIVES TO ENSURE FULL COMPLEMENTS OF CAPABLE, COMPASSIONATE, WELL-QUALIFIED STAFF- CONTINUE INNOVATIVE RECRUITMENT/RETENTION, TRAINING/PROFESSIONAL DEVELOPMENT AND SCHOLARSHIP PROGRAMS FOR HEALTHCARE WORKFORCEPRIORITY 2: PREVENTION AND MANAGEMENT OF CHRONIC ILLNESSGOAL: IMPROVE GENERAL HEALTH LITERACY, HEALTH AND WELLNESS BEHAVIORS, WITH SPECIAL EMPHASIS ON PERSONS ALREADY AFFECTED OR AT HIGH RISK OF CHRONIC DISEASE1. RESUME HOSPITAL-BASED HEALTH EDUCATION, WELLNESS AND FITNESS PROGRAMS BY PERSONS DIAGNOSED OR AT-RISK OF CHRONIC ILLNESS. - INVOLVE NEW PARTICIPANTS IN HEALTH EDUCATION AND WELLNESS PROGRAMS FOR ADULTS WITH PARKINSON'S, MS, ARTHRITIS, IMPAIRED BALANCE/MOBILITY, STROKE OR CANCER SURVIVORS2. EXPAND HEALTH EDUCATION OUTREACH TO INDIVIDUALS WITH CHRONIC AND AGE-ASSOCIATED ILLNESSES- CONTINUE PRINT, BROADCAST AND ELECTRONIC MEDIA OUTREACH TO CONSUMERS WITH CHRONIC AND AGE-ASSOCIATED ILLNESS 3. RESUME OFF-CAMPUS HEALTH EDUCATION, WELLNESS AND FITNESS PROGRAMS- RESUME/EXPAND OUTREACH IN COOPERATION WITH LOCAL FITNESS/RECREATION CENTERS, SENIOR CENTERS, HEALTH ADVOCACY AND COMMUNITY SERVICE ORGANIZATIONS</p> <p>PRIORITY 3: BEHAVIORAL HEALTH &amp; SUBSTANCE ABUSE DISORDERNO IMPLEMENTATION PLAN IS PROPOSED. THE DELIVERY OF COMMUNITY-BASED MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT PROGRAMS IS BEYOND OUR SCOPE OF WORK AS A MEDICAL REHABILITATION ORGANIZATION. ALLIED SERVICES BEHAVIORAL HEALTH (A PART OF ALLIED SERVICES INTEGRATED HEALTH SYSTEM) IS ONE OF THE REGION'S LEADING PROVIDERS OF POST-ACUTE BEHAVIORAL HEALTH RESIDENTIAL SERVICES, COUNSELING AND</p>

**Section C. Supplemental Information for Part V, Section B.**Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
JOHN HEINZ INSTITUTE OF REHABILITATION	PSYCHIATRIC REHAB FOR PERSONS WHO HAVE EXPERIENCED CHRONIC MENTAL ILLNESS. POPULATIONS SER VED INCLUDE ADULTS, SENIORS AND YOUNG ADULTS. PRIORITY 4: MATERNAL & CHILD HEALTHNO IMPLEM ENTATION PLAN IS PROPOSED. ALLIED SERVICES IS A LEADING PROVIDER OF PEDIATRIC MEDICAL REHA BILITATION SERVICES (OUTPATIENT PHYSICAL, OCCUPATIONAL, SPEECH THERAPIES AND PRAGMATIC SOC IAL PROGRAMS) FOR CHILDREN WITH DISABILITIES. HOWEVER, OUR REHABILITATION HOSPITALS DO NOT PROVIDE MATERNITY CARE OR RELATED COUNSELING.

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
JOHN HEINZ INSTITUTE OF REHABILITATION	PART V, SECTION B, LINE 20E: PATIENTS ARE NOTIFIED OF ALLIED'S FINANCIAL ASSISTANCE PROGRAM UPON REGISTRATION WHEN THE PATIENT'S INSURANCE BENEFITS ARE BEING DISCUSSED. FINANCIAL ASSISTANCE APPLICATIONS ARE AVAILABLE IN ALL OUTPATIENT CLINICS AND ON ALLIED'S WEBSITE. EACH INVOICE SENT TO PATIENTS HAS A NOTE STATING THAT WE OFFER FINANCIAL ASSISTANCE AND A PHONE NUMBER TO CALL. ALSO, WHEN PATIENTS CALL THIS OFFICE ABOUT THEIR BILL AND INDICATE IT IS A FINANCIAL HARDSHIP, FINANCIAL ASSISTANCE IS OFFERED. DURING THE COLLECTION PROCESS, FINANCIAL ASSISTANCE IS OFFERED IF THE PATIENT INDICATES A HARDSHIP.

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2020
		Open to Public Inspection
Department of the Treasury Internal Revenue Service	For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23. ▶ Attach to Form 990. ▶ Go to <a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a> for instructions and the latest information.	
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><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification 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></div>			
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
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 on Line 1a?	2		
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><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></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: <div><div>a Receive a severance payment or change-of-control payment?</div><div>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div><div>c Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.	4a 4b 4c		No Yes 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: <div><div>a The organization?</div><div>b Any related organization?</div></div> If "Yes," on line 5a or 5b, describe in Part III.	5a 5b		No 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: <div><div>a The organization?</div><div>b Any related organization?</div></div> If "Yes," on line 6a or 6b, describe in Part III.	6a 6b		No No
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7		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.	8		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

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.

[illegible]



**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	EXECUTIVES ARE COMPENSATED BY ALLIED HEALTH CARE SERVICES (AHCS), A RELATED TAX-EXEMPT ORGANIZATION. AHCS USES THE FOLLOWING METHODS TO DETERMINE COMPENSATION: COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, 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. CONTRIBUTIONS OF \$350,640 AND \$147,521 WERE MADE ON THEIR BEHALF, RESPECTIVELY. THEY RECEIVED THE FOLLOWING DISTRIBUTIONS IN CALENDAR YEAR 2020: - WILLIAM CONABOY, ESQ. (\$388,747) - MICHAEL AVVISATO (\$174,099)

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

Department of the Treasury

Internal Revenue Service

Name of the organization  
JOHN HEINZ INSTITUTE OF REHABILITATION  
MEDICINE**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.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2020****Open to Public  
Inspection****Employer identification number**

23-2262852

**990 Schedule O, Supplemental Information**

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.

**990 Schedule O, Supplemental Information**

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.

# 990 Schedule O, Supplemental Information

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.

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	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.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>THE ALLIED SERVICES CONFLICT OF INTEREST POLICY COVERS BOARD MEMBERS DOWN TO DEPARTMENT HEADS AS WELL AS ANY STAFF WHO ARE INVOLVED IN THE PURCHASING PROCESS. ALL COVERED PERSONS MUST COMPLETE AN ANNUAL CONFLICT STATEMENT. A COVERED PERSON MAY HAVE A DIRECT OR INDIRECT FINANCIAL INTEREST WHICH WOULD INCLUDE FAMILY AND BUSINESS RELATIONSHIPS AS POTENTIAL SOURCES OF CONFLICT. 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, ALTHOUGH CONFLICTED INDIVIDUALS MAY PRESENT FACTS TO THE BOARD. 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>

**990 Schedule O, Supplemental Information**

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 H EALTHCARE HUMAN RESOURCES OF PENNSYLVANIA AND THE APPALACHIAN HEALTHCARE HUMAN RESOURCES S OCIETY, 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 APP ROVED BY THE BOARD OF DIRECTORS BASED ON THE EXTERNAL SURVEYS AND INTERNAL REVIEWS. THIS P ROCESS IS DOCUMENTED BY THE COMPENSATION COMMITTEE AND THE BOARD OF DIRECTORS. FOR ALL OTH ER EMPLOYEES, ALLIED SERVICES FOLLOWS AN INTERNAL JOB EVALUATION PROCESS, ADMINISTERED BY A CROSS DIVISIONAL JOB EVALUATION TEAM COMPRISED OF DIRECTORS AND ASSISTANT VICE PRESIDENT S. THE JOB EVALUATION PROCESS IS BASED ON A FOURTEEN POINT FACTOR SYSTEM AND INTERNAL ALIG NMENT 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>

# 990 Schedule O, Supplemental Information

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.



SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

2020

Open to Public Inspection

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

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.

See Additional Data Table

(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

**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	

**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

**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

Yes

1k

No

1l

No

1m

No

1n

No

1o

Yes

1p

Yes

1q

Yes

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

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
100 TERRACE LANE SCRANTON, PA 18508 20-4472148	PROVIDE INDEPENDENT LIVING SERVICES	PA	501(C)(3)	LINE 12A, I	ALLIED SERVICES FOUNDATION		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 24-0860110	PROVIDE HEALTH CARE SERVICES TO ELDERLY AND MENTALLY CHALLENGED	PA	501(C)(3)	LINE 3	ALLIED SERVICES FOUNDATION		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523682	INVESTED FUNDS FOR RELATED ENTITIES TO SUPPORT THEIR MISSIONS	PA	501(C)(3)	LINE 7	N/A		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523680	PROVIDE LOW INCOME HOUSING	PA	501(C)(3)	LINE 10	ALLIED HEALTH CARE SERVICES		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523679	INACTIVE	PA	501(C)(3)	LINE 10	ALLIED HEALTH CARE SERVICES		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523395	PROVIDE REHABILITATIVE SERVICES	PA	501(C)(3)	LINE 3	ALLIED SERVICES FOUNDATION		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2862231	OPERATE A PERSONAL CARE FACILITY	PA	501(C)(3)	LINE 3	ALLIED SERVICES FOUNDATION		No
100 ABINGTON EXECUTIVE PARK CLARKS SUMMIT, PA 18411 23-2523688	OPERATE A SKILLED AND INTERMEDIATE NURSING FACILITY	PA	501(C)(3)	LINE 3	ALLIED SERVICES FOUNDATION		No
4219 MANOR DRIVE STROUDSBURG, PA 18360 23-1642528	OPERATE A VOCATIONAL REHABILITATION FACILITY	PA	501(C)(3)	LINE 7	ALLIED HEALTH CARE SERVICES		No
1327 ASHLEY RIVER ROAD BLDG C SUITE CHARLESTON, SC 29407 20-1177431	PROVIDE INSURANCE, CLAIMS DEFENSE, ADMINISTRATION & INDEMNITY TO AFFILIATES	SC	501(C)(3)	LINE 12A, I	ALLIED SERVICES FOUNDATION		No