

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

Do not enter social security numbers on this form as it may be made public.

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

OMB No. 1545-0047
2019
Open to Public Inspection

A For the **2019** calendar year, or tax year beginning **01-01-2019**, and ending **12-31-2019**

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

C Name of organization
 THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL
 % SCOTT EDELMAN
 Doing business as

D Employer identification number
 13-1739937

E Telephone number
 (914) 597-2277

G Gross receipts \$ 103,682,085

F Name and address of principal officer:
 JEFFREY MENKES
 785 MAMARONECK AVENUE
 WHITE PLAINS, NY 106052523

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.BURKE.ORG

K Form of organization: Corporation Trust Association Other ▶

L Year of formation: 1946 **M** State of legal domicile: NY

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
 To provide the highest quality medical care and rehabilitation services to ensure that each patient achieves the maximum functional recovery from illness, injury or disability.

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	23
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	18
5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	1,124
6 Total number of volunteers (estimate if necessary)	6	90
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	2,164,820
7b Net unrelated business taxable income from Form 990-T, line 39	7b	-74,461

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	1,293,076	1,650,519
9 Program service revenue (Part VIII, line 2g)	91,217,485	96,760,182
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,510,454	1,577,282
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,063,375	3,536,142
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	98,084,390	103,524,125

	Prior Year	Current Year
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)	64,037,456	71,719,532
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶ 631,551		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	25,866,169	25,181,367
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	89,903,625	96,900,899
19 Revenue less expenses. Subtract line 18 from line 12	8,180,765	6,623,226

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	119,356,108	128,873,061
21 Total liabilities (Part X, line 26)	68,468,532	76,416,154
22 Net assets or fund balances. Subtract line 21 from line 20	50,887,576	52,456,907

Part II Signature Block

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

Sign Here Signature of officer _____ Date 2020-10-27

SCOTT EDELMAN SVP & CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name _____ Preparer's signature _____ Date _____

Check if self-employed PTIN P01683199

Firm's name ▶ ERNST & YOUNG US LLP Firm's EIN ▶ _____

Firm's address ▶ 5 TIMES SQUARE Phone no. (212) 773-3000
 NEW YORK, NY 10036

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:

MISSION: TO PROVIDE THE HIGHEST QUALITY MEDICAL CARE AND REHABILITATION SERVICES TO ENSURE THAT EACH PATIENT ACHIEVES THE MAXIMUM FUNCTIONAL RECOVERY FROM ILLNESS, INJURY OR DISABILITY. VISION: TO LEAD THE FIELD AS THE MOST EFFECTIVE AND COMPASSIONATE PROVIDER OF MEDICAL REHABILITATION BY PRACTICING INNOVATIVE TREATMENT, PIONEERING CLINICAL RESEARCH AND INSPIRING EDUCATION.

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 \$ 78,420,341 including grants of \$ 0) (Revenue \$ 95,808,980)
See Additional Data

4b (Code:) (Expenses \$ 1,798,575 including grants of \$ 0) (Revenue \$ 951,202)
See Additional Data

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 ▶ 80,218,916

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, and Yes/No response. Rows include questions 1 through 21, covering various organizational requirements and reporting obligations.

Part IV Checklist of Required Schedules (continued)

Table with 3 main columns: Question, Yes, No. Rows include questions 22 through 38 regarding grants, compensation, tax-exempt bonds, excess benefit transactions, and related parties.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

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

Table with 16 main rows (2a-16) and multiple sub-rows. Includes questions about employee reporting, federal employment tax returns, unrelated business gross income, foreign country interests, prohibited tax shelter transactions, deductible contributions, and charitable trusts. Includes a grid for numerical answers.

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

Table with 5 columns: Question, 1a, 1b, Yes, No. Rows include questions about voting members, family relationships, management control, and governance decisions.

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

Table with 5 columns: Question, Yes, No. Rows include questions about local chapters, written policies, conflict of interest, whistleblower, and document retention policies.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NY
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.
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: SCOTT EDELMAN 785 MAMARONECK AVENUE WHITE PLAINS, NY 106052523 (914) 597-2240

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a			
	b Membership dues	1b			
	c Fundraising events	1c	480,352		
	d Related organizations	1d	20,000		
	e Government grants (contributions)	1e			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	1,150,167		
	g Noncash contributions included in lines 1a - 1f:\$	1g	7,925		
	h Total. Add lines 1a-1f		1,650,519		

Program Service Revenue			Business Code				
	2a INPATIENT REHABILITATION SERVICES		622310	77,970,730	77,970,730	0	0
b AMBULATORY REHABILITATION SERVICES		622310	14,748,802	14,748,802	0	0	0
c OTHER HEALTHCARE RELATED SERVICES		621999	4,020,640	1,855,820	2,164,820	0	0
d MEDICAL TRAINING		611430	20,010	20,010	0	0	0
e							
f All other program service revenue.							
g Total. Add lines 2a-2f.			96,760,182				

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			1,335,483	0	0	1,335,483	
	4 Income from investment of tax-exempt bond proceeds			0				
	5 Royalties			0				
	6a Gross rents	6a	(i) Real	509,301				
			(ii) Personal					
		b Less: rental expenses	6b	62,027				
		c Rental income or (loss)	6c	447,274	0			
	d Net rental income or (loss)			447,274	0	0	447,274	
	7a Gross amount from sales of assets other than inventory	7a	(i) Securities	241,799				
			(ii) Other					
		b Less: cost or other basis and sales expenses	7b	0				
		c Gain or (loss)	7c	241,799				
	d Net gain or (loss)			241,799	0	0	241,799	
	8a Gross income from fundraising events (not including \$ 480,352 of contributions reported on line 1c). See Part IV, line 18	8a		71,929				
			8b	95,884				
		c Net income or (loss) from fundraising events			-23,955	0	0	-23,955
	9a Gross income from gaming activities. See Part IV, line 19	9a		981				
			9b	49				
		c Net income or (loss) from gaming activities			932	0	0	932
	10a Gross sales of inventory, less returns and allowances	10a		0				
10b			0					
c Net income or (loss) from sales of inventory				0				
Miscellaneous Revenue		Business Code						
11a EMPLOYEE BENEFIT CONTRIBUTIONS		900099	1,168,260	0	0	1,168,260		
	b RELATED PARTIES ADMINISTRATION SERVICES	561000	1,100,248	0	0	1,100,248		
	c FITNESS CENTER PROGRAM REVENUE	713940	691,430	0	0	691,430		
	d All other revenue		151,953	0	0	151,953		
	e Total. Add lines 11a-11d			3,111,891				
12 Total revenue. See instructions			103,524,125	94,595,362	2,164,820	5,113,424		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	0			
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	792,362	451,818	340,544	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	54,717,552	48,211,005	6,104,811	401,736
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	2,926,316	2,572,191	332,811	21,314
9 Other employee benefits	8,980,253	7,888,658	1,026,293	65,302
10 Payroll taxes	4,303,049	3,773,737	498,142	31,170
11 Fees for services (non-employees):				
a Management	0			
b Legal	105,125	0	105,125	0
c Accounting	76,000	0	76,000	0
d Lobbying	0			
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	0			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	6,059,649	4,629,673	1,401,348	28,628
12 Advertising and promotion	828,952	0	828,952	0
13 Office expenses	1,365,987	764,035	593,641	8,311
14 Information technology	1,405,350	24,458	1,376,358	4,534
15 Royalties	0			
16 Occupancy	2,637,871	2,416,061	221,810	0
17 Travel	292,966	224,865	62,721	5,380
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	0			
20 Interest	115,733	0	115,733	0
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	4,669,772	3,896,994	739,273	33,505
23 Insurance	969,375	738,591	230,784	0
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	2,737,165	2,725,331	11,828	6
b OUTSIDE DIETARY SERVICE	1,504,559	1,504,559	0	0
c INTERCOMP SHARED SERVICES	1,067,089	0	1,067,089	0
d PATIENT TRANSPORTATION	359,033	359,033	0	0
e All other expenses	986,741	37,907	917,169	31,665
25 Total functional expenses. Add lines 1 through 24e	96,900,899	80,218,916	16,050,432	631,551
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year	
Assets	1 Cash—non-interest-bearing	4,200	1	4,350	
	2 Savings and temporary cash investments	9,210,205	2	11,160,516	
	3 Pledges and grants receivable, net	0	3	0	
	4 Accounts receivable, net	14,044,328	4	15,101,727	
	5 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0	5	0	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	0	6	0	
	7 Notes and loans receivable, net	0	7	0	
	8 Inventories for sale or use	660,464	8	547,392	
	9 Prepaid expenses and deferred charges	1,062,470	9	1,632,338	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 150,486,105			
	b Less: accumulated depreciation	10b 108,039,494	41,399,323	10c	42,446,611
	11 Investments—publicly traded securities	5,489,213	11	5,147,261	
	12 Investments—other securities. See Part IV, line 11	25,957,000	12	27,936,000	
	13 Investments—program-related. See Part IV, line 11	0	13	0	
	14 Intangible assets	20,790,433	14	20,573,866	
	15 Other assets. See Part IV, line 11	738,472	15	4,323,000	
16 Total assets. Add lines 1 through 15 (must equal line 34)	119,356,108	16	128,873,061		
Liabilities	17 Accounts payable and accrued expenses	5,564,582	17	6,198,524	
	18 Grants payable	0	18	0	
	19 Deferred revenue	0	19	251,437	
	20 Tax-exempt bond liabilities	0	20	0	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	40,199	21	32,578	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0	22	0	
	23 Secured mortgages and notes payable to unrelated third parties	2,667,000	23	2,317,000	
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	60,196,751	25	67,616,615	
	26 Total liabilities. Add lines 17 through 25	68,468,532	26	76,416,154	
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.				
	27 Net assets without donor restrictions	46,434,538	27	48,739,295	
	28 Net assets with donor restrictions	4,453,038	28	3,717,612	
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.				
	29 Capital stock or trust principal, or current funds		29		
	30 Paid-in or capital surplus, or land, building or equipment fund		30		
	31 Retained earnings, endowment, accumulated income, or other funds		31		
32 Total net assets or fund balances	50,887,576	32	52,456,907		
33 Total liabilities and net assets/fund balances	119,356,108	33	128,873,061		

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	103,524,125
2	Total expenses (must equal Part IX, column (A), line 25)	2	96,900,899
3	Revenue less expenses. Subtract line 2 from line 1	3	6,623,226
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	50,887,576
5	Net unrealized gains (losses) on investments	5	2,916,283
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-7,970,178
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	52,456,907

Part XII Financial Statements and Reporting

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

1 Accounting method used to prepare the Form 990: Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.

2a Were the organization's financial statements compiled or reviewed by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis

b Were the organization's financial statements audited by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis

c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.

3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?

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.

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

Additional Data

Software ID:

Software Version:

EIN: 13-1739937

Name: THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

Form 990 (2019)

Form 990, Part III, Line 4a:

Patient services: BURKE IS A 150 BED ACUTE CARE HOSPITAL ENTIRELY DEDICATED TO REHABILITATION MEDICINE AND A LEADER IN THE FIELD OF MEDICAL REHABILITATION. WE PROVIDE INPATIENT AND AMBULATORY CARE FOR A BROAD RANGE OF NEUROLOGICAL, MUSCULOSKELETAL, CARDIAC AND PULMONARY DISABILITIES CAUSED BY DISEASE OR INJURY. Our programs targets those WHO HAVE SUFFERED A STROKE, SPINAL CORD or brain INJURY, underwent COMPLICATED ORTHOPEDIC SURGERY or are afflicted with CARDIAC or PULMONARY DISEASE or other NEUROLOGICAL DISORDERS SUCH AS PARKINSON'S DISEASE or MULTIPLE SCLEROSIS. Most of our patients are referrals that were transferred to Burke from other acute care facilities once their condition had stabilized AND THEY were ABLE TO PARTICIPATE IN INTENSE PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY. THE GOAL OF THE INTENSIVE INPATIENT REHABILITATION PROGRAM AT BURKE IS TO MAXIMIZE OUR PATIENT'S RECOVERY. OUR EXPERT REHABILITATION TEAM IS COMMITTED TO HELPING OUR PATIENT'S RETURN TO AS ACTIVE AND PRODUCTIVE LIFE AS POSSIBLE. EACH PATIENT'S PROGRAM IS TAILORED TO MEET HIS OR HER NEEDS BY INTEGATING SEVERAL DISCIPLINES, INCLUDING PHYSICAL, OCCUPATIONAL, RESPIRATORY, SPEECH LANGUAGE AND RECREATIONAL THERAPIES WITH SPECIALTY MEDICINE, NURSING, CASE MANAGEMENT, SOCIAL WORK AND THE APPROPRIATE SPECIALTY SERVICES AS NEEDED. GROUP DISCUSSIONS AND INDIVIDUAL COUNSELING SESSIONS HELP PATIENTS AND FAMILY MEMBERS ADJUST TO CIRCUMSTANCES RESULTING FROM PHYSICAL DISABILITY AND PREPARE them for the possibility of A NEW WAY OF LIFE. THE MAJORITY OF our patients RETURN TO THEIR HOME OR COMMUNITIES after their hospital stay is completed. In 2019, the hospital provided 47,789 patient days based on 2,895 admissions and 144,283 clinical visits. At Burke Rehabilitation Hospital, we strive to create lifelong relationships with our patients even after their therapy has been completed. We also invite community members to the Burke campus to utilize and enjoy all of our programs and services. Burke offers many community programs from support groups to educational events to our Adult Fitness Center and related health programs. All of our programs offer individuals the opportunity to learn, exercise and share with others.

Form 990, Part III, Line 4b:

Medical Education: The Winifred Masterson Burke Rehabilitation Hospital has been a longstanding leader in clinical care, research and innovation and is now home to a nationally recognized Physical Medicine and Rehabilitation residency program. The Accreditation Council for Graduate Medical Education (ACGME)-approved program envisions being the future benchmark for all Physical Medicine and Rehabilitation residency programs in the country. Burke's goal is to produce healthcare leaders known for innovation in all branches of physiatry. This is accomplished by rigorous training and development of highly skilled clinical and academic physiatrists. Our residents receive a unique training experience working directly with neurologists, physiatrists, rheumatologists, internists, cardiologists and pulmonologists on Burkes rehabilitation units. They also have the opportunity to work closely with research scientists from the world-renowned Burke Medical Research Institute, which is located on Burkes 61-acre campus in White Plains. Burke aims to teach residents who will go on to utilize their training to improve patient care, advance the field of Physical Medicine and Rehabilitation and enhance healthcare in the communities they serve. We offer a 3-year Physical Medicine and Rehabilitation residency program, which is affiliated with Albert Einstein College of Medicine (AECOM). We also offer a one-year neurorehabilitation fellowship under the AECOM Department of Neurology. In the future, we plan to expand the program by including fellowships in traumatic brain injury, sports concussion and spinal cord injury.

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
Andrew Racine MD P Trustee	1.0 59.0	X						0	2,211,370	46,446
Michael J Palumbo M Trustee	1.0 49.0	X						0	1,168,432	155,688
Christopher Panczner Trustee	1.0 59.0	X						0	1,270,367	26,913
Jeffrey Menkes Executive Director/President	58.0 2.0	X		X				0	1,034,428	17,000
Matthew Bartels MD Trustee	1.0 49.0	X						0	475,811	17,940
Mooyeon Oh-Park MD SVP, Chief Medical Officer	50.0 0.0				X			421,773	0	30,045
Scott A Edelman SVP & CFO	50.0 0.0			X				310,937	0	29,608
Catherine Dwyer VP, Information Tech/CIO	40.0 0.0				X			200,463	0	30,157
Annette Bucci VP, Human Resources	40.0 0.0				X			193,726	0	26,984
Janet Herbold VP, Outpatient Services	40.0 0.0				X			189,822	0	29,824

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
Steven Tisser VP, Outpatient Services	40.0 0.0					X		186,150	0	27,911
Valerie Vermiglio-Kohn VP, Nursing/CNO	40.0 0.0					X		208,042	0	0
Christopher C Allen trustee	1.0 0.0	X						0	0	0
Robert Baldoni Vice Chair (Resigned 5/16/19)	4.0 0.0	X						0	0	0
Richard T Celiberti Trustee	1.0 0.0	X						0	0	0
Michael J Daly Vice Chair	4.0 0.0	X						0	0	0
Wilfred A Finnegan Treasurer	4.0 0.0	X						0	0	0
Anthony Gioffre III Secretary (Resigned 5/16/19)	4.0 0.0	X						0	0	0
Charles V Glennon Secretary	4.0 0.0	X						0	0	0
Bernadette Kingham-Bez Trustee	1.0 0.0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
Kevin A Knight Trustee	1.0 0.0	X						0	0	0
J David Lynn Trustee	1.0 0.0	X						0	0	0
John R McCarthy Chair	4.0 0.0	X						0	0	0
Barbara Z Monahan Trustee	1.0 0.0	X						0	0	0
Pamela B Rosenthal M Trustee	1.0 0.0	X						0	0	0
Kenneth J Sweeney Trustee	1.0 0.0	X						0	0	0
Jason Wong Trustee	1.0 0.0	X						0	0	0
Richard Ahearn Trustee	1.0 0.0	X						0	0	0
Steven Kessler Trustee	1.0 0.0	X						0	0	0
Mark Bronzo Trustee (Effective 4/17/19)	1.0 0.0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
James E Cain Trustee (Effective 4/17/19)	1.0 0.0	X						0	0	0
Anna Linda Marciano Trustee (Effective 4/17/19)	1.0 0.0	X						0	0	0

SCHEDULE A
(Form 990 or 990-EZ)

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

OMB No. 1545-0047
2019
Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

Employer identification number
13-1739937

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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f). . .						
6	Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7	Amounts from line 4. . .						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9	Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc. (see instructions)					12	
13	First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

14	Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2018 Schedule A, Part II, line 14	15	
16a	33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
b	33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
17a	10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
b	10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
18	Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>		

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

(Complete only if you checked the box on line 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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.						
c	Add lines 7a and 7b.						
8	Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9	Amounts from line 6.						
10a	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
b	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c	Add lines 10a and 10b.						
11	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15	Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for 2019 (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from 2018 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2019. 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—2018. 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 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<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	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	
9 Distributable amount for 2019 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2019	(iii) Distributable Amount for 2019
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7:			
\$			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, 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 2019. 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 2020. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

Additional Data

Software ID:

Software Version:

EIN: 13-1739937

Name: THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

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

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019
Open to Public Inspection

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

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

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

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

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

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

Name of the organization THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL	Employer identification number 13-1739937
---	--

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ \$ _____

3 Volunteer hours for political campaign activities (see instructions)

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$ _____

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$ _____

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? Yes No

4a Was a correction made? Yes No

b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$ _____

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$ _____

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b..... ▶ \$ _____

4 Did the filing organization file **Form 1120-POL** for this year? Yes No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		19,178
j	Total. Add lines 1c through 1i			19,178
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
Schedule C, Part II-B, Line i	The other activities includes indirect lobbying cost paid as a percentage of membership dues to the Greater New York Hospital Association, The Health Care Association of New York State, and the American Medical Rehabilitation Provider Association that were used for lobbying efforts by these organizations during 2019.

SCHEDULE D (Form 990) Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

OMB No. 1545-0047 2019 Open to Public Inspection

Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. Attach to Form 990. Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL

Employer identification number 13-1739937

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows 1-4: Total number at end of year, Aggregate value of contributions to (during year), Aggregate value of grants from (during year), 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?
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?

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
Preservation of land for public use (e.g., recreation or education)
Protection of natural habitat
Preservation of open space
Preservation of an historically important land area
Preservation of a certified historic structure

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

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year
4 Number of states where property subject to conservation easement is located
5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?
6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year
7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year
8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?
9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.
b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:
(ii) Revenue included on Form 990, Part VIII, line 1
Assets included in Form 990, Part X
2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items:
a Revenue included on Form 990, Part VIII, line 1
b Assets included in Form 990, Part X

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

- c** Beginning balance
- d** Additions during the year
- e** Distributions during the year
- f** Ending balance

	Amount
1c	
1d	
1e	
1f	

- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . **Yes** **No**

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

Part V Endowment Funds.

Complete if the organization answered "Yes" 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	787,585	787,585	787,585	787,585	
b Contributions	125,000				
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	912,585	787,585	787,585	787,585	

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

- a** Board designated or quasi-endowment ▶
 - b** Permanent endowment ▶ 100.000 %
 - c** Temporarily restricted endowment ▶
- The percentages on lines 2a, 2b, and 2c should equal 100%.

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

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

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

- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?
- 4** Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		75,573,797	45,742,422	29,831,375
c Leasehold improvements				
d Equipment		41,473,510	36,958,874	4,514,636
e Other		33,438,798	25,338,198	8,100,600
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				42,446,611

Part VII Investments—Other Securities.

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

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A) COLLECTIVE TRUST FUNDS	19,873,000	F
(B) MANAGED CASH HELD FOR INVEST.	8,063,000	F
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)	27,936,000	

Part VIII Investments—Program Related.

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

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

Part IX Other Assets.

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

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

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.)	67,616,615

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.

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Additional Data

Software ID:

Software Version:

EIN: 13-1739937

Name: THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

Supplemental Information

Return Reference	Explanation
Schedule D, Part IV, Line 2b	The Winifred Masterson Burke Hospital holds security deposits from tenants in escrow pursuant to the individual lease agreements between the tenants and the organization. These deposits are returned to the tenants once they vacate their rental unit less any amount, if any, due from the tenants for damages or unpaid rent.

Supplemental Information

Return Reference	Explanation
Schedule D, Part V, Line 4	The organization's endowments were established pursuant to donor gifts. The earnings can provide support to the Winifred Masterson Burke Rehabilitation Hospital general activities, specifically treatment, hospitalization and care of needy patients as designated by individual donors.

Part II Fundraising Events. Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

Revenue		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events
		Award Gala (event type)	WC Races (event type)	1 (total number)	(add col. (a) through col. (c))
1	Gross receipts	512,877	26,221	13,183	552,281
2	Less: Contributions	457,052	23,150	150	480,352
3	Gross income (line 1 minus line 2)	55,825	3,071	13,033	71,929
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	48,733			48,733
	7 Food and beverages				
	8 Entertainment	300	2,150	400	2,850
	9 Other direct expenses	27,544	11,428	5,329	44,301
10	Direct expense summary. Add lines 4 through 9 in column (d) ▶				95,884
11	Net income summary. Subtract line 10 from line 3, column (d) ▶				-23,955

Part III Gaming. Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col.(a) through col.(c))
		1	Gross revenue		
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6	Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No
7	Direct expense summary. Add lines 2 through 5 in column (d) ▶				
8	Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				

9 Enter the state(s) in which the organization conducts gaming activities: _____

a Is the organization licensed to conduct gaming activities in each of these states? Yes No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? Yes No

b If "Yes," explain: _____

- 11** Does the organization conduct gaming activities with nonmembers? Yes No
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? Yes No
- 13** Indicate the percentage of gaming activity conducted in:
- | | | |
|--------------------------------------|------------|---|
| a The organization's facility | 13a | % |
| b An outside facility | 13b | % |

14 Enter the name and address of the person who prepares the organization's gaming/special events books and records:

Name ▶

Address ▶

15a Does the organization have a contract with a third party from whom the organization receives gaming revenue? Yes No

b If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ _____ and the amount of gaming revenue retained by the third party ▶ \$ _____.

c If "Yes," enter name and address of the third party:

Name ▶

Address ▶

16 Gaming manager information:

Name ▶

Gaming manager compensation ▶ \$

Description of services provided ▶

- Director/officer Employee Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? Yes No

b Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ _____

Part IV Supplemental Information. Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also provide any additional information. See instructions.

Return Reference	Explanation
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SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service

Hospitals

OMB No. 1545-0047
2019
 Open to Public Inspection

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990EZ for instructions and the latest information.

Name of the organization
 THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL

Employer identification number
 13-1739937

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	
1b 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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		No
6a Did the organization prepare a community benefit report during the tax year?	Yes	
b If "Yes," did the organization make it available to the public?	Yes	

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1,388,401	101,366	1,287,035	1.330 %
b Medicaid (from Worksheet 3, column a)			8,230,896	8,753,681	0	0 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			9,619,297	8,855,047	1,287,035	1.330 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			1,537,038	0	1,537,038	1.590 %
f Health professions education (from Worksheet 5)			1,798,575	971,212	827,363	0.850 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			3,335,613	971,212	2,364,401	2.440 %
k Total. Add lines 7d and 7j			12,954,910	9,826,259	3,651,436	3.770 %

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?			No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2		
			183,605
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
			0
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5		45,337,896
6 Enter Medicare allowable costs of care relating to payments on line 5	6		35,231,645
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7		10,106,251
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other			

Section C. Collection Practices

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

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 %
1				
2				
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12				
13				

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

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

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

1

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

See Additional Data Table	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

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)
WINIFRED MAST BURKE REHAB HOSP

Name of hospital facility or letter of facility reporting group _____

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	Yes	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
6b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C.		No
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>See Part V - Section C</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>See Part V - Section C</u>	Yes	
10b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
12b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

WINIFRED MAST BURKE REHAB HOSP

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:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> .% and FPG family income limit for eligibility for discounted care of <u>300</u> .% b <input type="checkbox"/> Income level other than FPG (describe in Section C) c <input type="checkbox"/> Asset level d <input type="checkbox"/> Medical indigency e <input type="checkbox"/> Insurance status f <input type="checkbox"/> Underinsurance discount g <input type="checkbox"/> Residency h <input checked="" type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>See Part V - Section C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>See Part V - Section C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>See Part V - Section C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

WINIFRED MAST BURKE REHAB HOSP

Name of hospital facility or letter of facility reporting group _____

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

Policy Relating to Emergency Medical Care

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

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

WINIFRED MAST BURKE REHAB HOSP

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
23		No
24		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? 8

Name and address	Type of Facility (describe)
1 Armonk Outpatient Rehabilitation 99 Business Park Armonk, NY 10504	Outpatient Rehabilitation
2 Bronx Outpatient Rehabilitation 2826 Westchester Avenue Suite 201 Bronx, NY 10461	Outpatient Rehabilitation
3 Bronx-Hutch Metro OP Rehabilitation 1250 Waters Place Tower One 10th Bronx, NY 10461	Outpatient Rehabilitation
4 Mamaroneck Outpatient Rehabilitation 703 West Boston Post Road Mamaroneck, NY 10543	Outpatient Rehabilitation
5 Purchase Outpatient Rehabilitation 3020 Westchester Avenue Purchase, NY 10577	Outpatient Rehabilitation
6 Somers Outpatient Rehabilitation Somers Town Center 325 Route 100 Somers, NY 10589	Outpatient Rehabilitation
7 Yonkers-Ridge Hill OP Rehabilitation Ridge Hill 73 Market Street Suite Yonkers, NY 10710	Outpatient Rehabilitation
8 Yonkers-Exec Plaza OP Rehabilitation 6 Executive Plaza Suite 280 Yonkers, NY 10701	Outpatient Rehabilitation
9	
10	

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
1. Part I, Line 7	THE COST-TO-CHARGE RATIO METHODOLOGY WAS UTILIZED TO CALCULATE THE AMOUNT INCLUDED IN THE TABLE. THE CALCULATION OF THE RATIO WAS DERIVED FROM RATIO OF PATIENT CARE COST-TO-CHARGES.
1. Part III, Section A, Line 2	The cost of bad debt expense is estimated based on the bad debt provision at charge, applied to the ratio of total patient care expenses to total charges for all services rendered. Any payments or discounts are excluded from bad debt expenses.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
1. Part III, Section A, Line 3	<p>The estimated amount of the organization's bad debt expense (at cost) attributed to patients under the organization's charity care policy was based on the results of predictive analysis. Bad debt should be included as a community benefit because the organization provides much needed health care service indiscriminately to the community-at-large without regard to whether or not the patient has insurance or if the bill will ever be paid. 1. Part III, Section A, Line 4 AS REPORTED IN MONTEFIORE HEALTH SYSTEM'S AUDITED CONSOLIDATED FINANCIAL STATEMENTS, BAD DEBT EXPENSE IS DESCRIBED AS FOLLOWS: "Subsequent changes to the estimate of the transaction price (determined on a portfolio basis when applicable) are generally recorded as adjustments to patient service revenue in the period of the change. For the years ended December 31, 2019 and 2018, changes in the Health Systems estimates of expected payments for performance obligations satisfied in prior years were not significant. Portfolio collection estimates are updated based on collection trends. Subsequent changes that are determined to be the result of an adverse change in the patients ability to pay (determined on a portfolio basis when applicable) are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2019 and 2018 was not significant"</p>
1. Part III, Section B, Line 8	<p>Medicare allowable costs reported on Part III, line 6, per Schedule H instructions, were derived using the Medicare cost report cost-finding methodology, which apportions routine costs to medicare using days and ancillary costs to medicare using departmental ratios of costs to charges (RCCS) and does not include the non-allowable Medicare costs.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
1. Part III, Section C, Line 9B	For patients who are known to qualify for financial assistance, all collection activity is halted and the patient is referred for financial aid. If an account is in collection and the patient requests financial aid or if the agency determines that the patient is eligible for financial assistance, the account is referred back to the hospital where the patient is provided assistance with completing an application for assistance.
2. Needs Assessment	The organization assesses community needs by: A) Community Advisory Boards - The Health System works extensively with representatives of the communities to identify health care needs and determine the appropriate configuration of services. B) Community Service Committee - Montefiore Health System, the parent company, has a board committee that is focused on community services. It is responsible for overseeing the Health System's community services and community benefit activities to ensure they are formulated to facilitate the fulfillment of the organization's mission and meet the needs of the community. C) Partnership and Collaborations - The health system participates in a variety of organized partnerships and collaboratives, working with other providers, the New York Department of Health and Mental Hygiene, community-based organizations and members of the community in planning and developing initiatives aimed at improving the health of the communities served.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
3. Patient Education of Eligibility for Assistance	All intake, registration and collection agency staff are trained on the Hospital's financial aid policy and how to provide patients with assistance. The organization has a policy that establishes guidelines for the billing office to follow when working with individuals who are having difficulty paying their medical bills. A referral is made to the financial aid office and a financial counselor will help the patient apply for free or low-cost insurance. If the financial counselor determines that the patient does not qualify for low-cost insurance, the counselor will help the patient apply for a financial aid discount based on income level. The organization makes its financial aid policy known to the public by providing written information including brochures at the admission area, information posted on the intranet and internet, and information sent out on patient's bills.
4. Community Information	Burke Rehabilitation Hospital has identified Westchester County as its primary service area. Westchester County is a large county located just north of New York City in the Hudson Valley. Westchester covers an area of 450 square miles and consists of 48 municipalities that includes urban, suburban and rural geographies. The estimated population of Westchester County is made up of more than 980,244 residents. The county seat of Westchester is the city of White Plains. Other major cities include Yonkers, New Rochelle and Mount Vernon. The median household income for Westchester was \$89,968, the fourth highest in New York State, after Nassau, Putnam and Suffolk Counties. Countywide 9.4% of the population lives in poverty including 11.7% of county children. Westchester is ethnically diverse. Its population is 55.9% non-hispanic white, 18.8% Hispanic, 14.4% non-hispanic black, 8.3% Asian/Pacific Islander and 2.3% non-hispanic other. A quarter of county residents were born outside the United States. Among the foreign-born population, more residents speak Spanish (59%) than English (13%) or another language (28%). Westchester County is the fifth healthiest county in New York State, according to the County Health Rankings, produced by the Robert Wood Foundation and the University of Wisconsin. Despite its overall high ranking, there is considerable room to both improve population health and reduce health disparities. Several of Westchester County individual municipalities continue to have significant health gaps. Portion of lower Westchester, specifically Mount Vernon, Yonkers, New Rochelle and White Plains are hot-spots for various health outcomes, such as asthma and preterm births in the county. Additionally, certain groups, such as some racial/ethnic minorities or those with less education, tend to experience poorer health outcomes.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
5. Promotion of Community Health	<p>Burke Rehabilitation has a longstanding commitment to the community and is at the forefront of rehabilitation medicine. Burke's continuum of care extends beyond its inpatient and outpatient programs and impacts people in the surrounding communities and throughout Westchester County. Burke facilitates over ten monthly support groups on its campus that are free of charge, including a spinal cord injury support group, stroke support group and amputee support group, often through partnerships with community organizations. Burke regularly holds community education programs and events for the community, with a focus both on the illnesses and injuries treated at Burke and the health and wellness of its community members. The Burke Fitness Center, which is open to the community and serves adults over age 40 and those with a qualifying disability, in a place where people from throughout the area can focus on their health is a setting in which they feel safe and comfortable. Burke's commitment to the community extends to our employees and the medical community as well. Continuing education events, lectures and conferences, many of which are free of charge, are regularly held on the Burke campus to promote research, innovative treatments and technology to ensure that Burke's physicians, nurses and therapists remain leaders in their field.</p>
6. Affiliated Health Care Systems	<p>Winifred Masterson Burke Rehabilitation Hospital is an affiliate of the Montefiore Health System. The Health System is a leader in community health and has a long history of developing innovative approaches to care and creating programs to best serve the changing needs of its community. These include, but are not limited to the following: community service plan, community service strategy, accountable care organizations, patient-centered medical home, disease management programs and community outreach. The integration of these innovative approaches support the Health System well in its provision of services to the community.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
7. State Filing of Community Benefit Report	Winifred Masterson Burke Rehabilitation Hospital files a community service plan with the state of New York.

Additional Data**Software ID:****Software Version:****EIN:** 13-1739937**Name:** THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		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	WINIFRED MAST BURKE REHAB HOSPITAL 785 MAMARONECK AVENUE WHITE PLAINS, NY 10605 WWW.BURKE.ORG 5902002H	X			X						

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
Schedule H, Part V, Section B, Line 5	<p>The process for preparing the 2019-2022 Community Health Needs Assessment was an inter-organization and community collaborative process, initiated with the goal of developing an assessment that was reflective of the needs of the community including the clinical and social determinants of health. The process to identify the needs of the community involved the collection of both primary and secondary data. Multiple conversations and meetings were convened internally and with external partners and a thorough review of the data was conducted to develop the implementation strategies. The collection of data from a sample of the Westchester County residents was an important element of the development of the community health needs assessment. Burke Rehabilitation Hospital collaborated with the Westchester County Department of Health and other Westchester Hospitals in conducting a survey of county residents to determine their individual and community health priority issues and needs. This survey was distributed to residents of Westchester County between January and April 2019 through a grassroots effort in paper and digital format. The survey was available in English and Spanish, and made available in other languages upon request. For this CHNA cycle, there was more emphasis on collecting surveys from a true cross section of the county. To this end, the Department of Health deployed volunteers to specific zip codes that were under-represented in the 2016-2018 CHNA due to low survey response rate. Primary data was also collected from Westchester community-based organizations through the in-person focus group summit. The summit was comprised of over 70 representatives from community-based organizations attending breakout sessions focused on the prevention agenda priorities areas. From the summit, it was noted that there were already resources available for many of the health issues addressed that the community needed to be made better informed about along with improved transition and coordination across the continuum of providers. Secondary data was compiled to further supplement the data collected and show health indicators for the Region. The socio-demographically similar counties, and sub county differences, when available, for more than twenty measures was evaluated. The priority areas were then selected and each of the planned intervention focused on specific priority population to address the ethnic and culture disparity defined in the indicators for the population served by Burke. Burke Rehabilitation Hospital did not receive any written feedback on the Community Health Needs Assessment for 2016-2018. Community members who wish to provide written feedback on the 2019-2021 CHNA were requested to send their comments to the Community Relations Manager at the Hospital.</p>

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
Schedule H, Part V, Section B, Line 7a	The direct website where the hospital facility's CHNA report is available is: https://www.burke.org/docs/2019_BurkeRehabilitationHospitalCHNA_FINAL_12_24_19.pdf

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
Schedule H, Part V, Section B, Line 10a	The hospital facility's most recently adopted implementation strategy is posted on the website: https://www.burke.org/docs/2019_BurkeRehabilitationHospitalCHNA_FINAL_12_24_19.pdf

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
Schedule H, Part V, Section B, Line 11	<p>Burke Rehabilitation Hospitals specialty rehabilitation programs and services differ from that provided at the other Westchester hospitals contributing to which priority areas Burke has selected in its implementation strategy. The results of the Westchester survey align with Burkes selection of prevent chronic disease as one of its priority areas. The second priority area selected was based on the population that Burke serves that is drastically different than the age demographics of the county and is where the hospital has the capacity to have a large impact. Based on this, Burke chose the second priority area to align with the skew of vulnerable elderly populations that it serves and selected to promote a healthy and safe environment. To prevent chronic disease, Burke had chosen to focus on physical activity with the goal to increase access for people of all ages and abilities to indoor and/or outdoor places for physical activity. Burke is addressing this need through the Burke adult fitness center that operates on Burkes main campus. The center is open to adults 40 and older, or those younger with a qualifying disability, to participate in individualized exercise plans designed by certified trainers and exercise physiologists as well as group classes. As of October of 2019, the average age of a fitness center member was 78 years old. Classes are offered for specialty populations, such as the Fit for life classes available to individuals with Parkinsons disease, pulmonary conditions or post-stroke. Other classes offer include yoga, tai chi, strengthening, stretching, mobility, conditioning, cardiovascular and muscular endurance, balance and meditation. Many of these classes, such as yoga, are offered in adaptive forms, such as seated, to include individuals of any ability level. Since Burke is a rehabilitation hospital serving a population of generally older patients, the second priority area selected was to Promote a healthy and safe environment by focusing on injuries and occupational health with the goal of reducing falls among its vulnerable populations. Burke will employ a number of different strategies to achieve the goal of reducing fall risk and in turn hospitalizations due to falls. Burkes interventions will include promoting health care provider screening for fall risk among older adults and people with disabilities and engage health care providers in identifying modifiable risk factors and developing a fall prevention plan of care and integrate exercise and fall prevention activities into physical or occupational therapy. Though Burke has specifically selected to allocate resources for its Community Service plan to the two areas described above, the hospital, and the Montefiore Health System, which Burke is a member of, offer many resources that address most of the significant health needs identified. Being a member of a larger health system allows Burke to provide referrals to many more community resources than it would be able to</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
Schedule H, Part V, Section B, Line 11	<p>do alone. Burke Hospital is not specifically addressing three of the significant needs identified as affordable housing, employment opportunities and drug and alcohol treatment services due to a lack of appropriate resources and/or expertise to do so. Burkes collaboration with the Westchester County Department of Health and its attendance at county-wide events and networking opportunities through organizations such as the Business Council Of Westchester and the Westchester County Association allow Burke to learn about what resources are available in the county and provide referrals when needed. In addition to the multiple resources that have been developed at Burke and Montefiore independently and through partnership with other organizations, there is an extensive need for community-based programs and resources that can augment these programs and services. Knowing how to access these resources is a particular challenge for the healthcare sector. Multiple free and low cost online tools have been developed recently that are now available to community members as well as the Westchester government website that provides a variety of lists and links to resources. In order to have the largest impact on the health of the population of Westchester County and the population that Burke has the most access to, the hospital chose to focus on a priority area identified highly on the community survey and a second priority area that is extremely important to the population Burke has expertise and access to. The hospital will continue with the work that it does to address some of the other significant health needs that were identified, though they are not the selected areas for our Community service report.</p>

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
Schedule H, Part V, Section B, Line 13h	Family size is factored into the eligibility criteria for financial assistance.

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
Schedule H, Part V, Section B, Lines 16a, 16b & 16c	The hospital's Financial assistance policy, summary and application for assistance are posted on the website: https://www.burke.org/community/resources/charitablecare

Schedule J
(Form 990)

Compensation Information

OMB No. 1545-0047

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
 ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
 ▶ Attach to Form 990.
 ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

Employer identification number
13-1739937

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.		
<input type="checkbox"/>	First-class or charter travel	<input type="checkbox"/>	Housing allowance or residence for personal use
<input type="checkbox"/>	Travel for companions	<input type="checkbox"/>	Payments for business use of personal residence
<input type="checkbox"/>	Tax idemnification and gross-up payments	<input type="checkbox"/>	Health or social club dues or initiation fees
<input type="checkbox"/>	Discretionary spending account	<input type="checkbox"/>	Personal services (e.g., maid, chauffeur, chef)
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	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.		
<input type="checkbox"/>	Compensation committee	<input type="checkbox"/>	Written employment contract
<input type="checkbox"/>	Independent compensation consultant	<input type="checkbox"/>	Compensation survey or study
<input type="checkbox"/>	Form 990 of other organizations	<input type="checkbox"/>	Approval by the board or compensation committee
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:		
a	Receive a severance payment or change-of-control payment?	4a	No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b	Yes
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c	No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.		
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:		
a	The organization?	5a	No
b	Any related organization?	5b	No
	If "Yes," on line 5a or 5b, describe in Part III.		
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:		
a	The organization?	6a	No
b	Any related organization?	6b	No
	If "Yes," on line 6a or 6b, describe in Part III.		
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7	Yes
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	

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
Schedule J, Part I, Line 3	The organization's current CEO compensation is paid and determined by Montefiore Health System, the sole member of the Winifred Masterson Burke's Rehabilitation Hospital. The Compensation Committee of the Montefiore Health System's Board of Trustees reviews and approves ALL FORMS OF COMPENSATION AND BENEFITS provided TO the CEO of Burke WITH THE ASSISTANCE OF A NATIONAL Independent COMPENSATION CONSULTING FIRM. THE CONSULTING FIRM ASSISTS THE COMPENSATION COMMITTEE WITH ITS DECISION-MAKING PROCESS TO ENSURE EXECUTIVE compensation LEVELS ARE REASONABLE AND APPROPRIATE RELATIVE TO THOSE OF other SIMILAR ORGANIZATIONS. BASE SALARIES ARE DETERMINED BASED ON competitive MARKET PRACTICES FOR COMPARABLE POSITIONS WITH SIMILAR size organizations AND SCOPE OF RESPONSIBILITIES. BONUS AND INCENTIVE compensation is BASED ON THE ACHIEVEMENT OF PERFORMANCE GOALS. THE executives' COMPENSATION PROGRAM HAS A SIGNIFICANT PAY-AT-RISK COMPONENT to ENSURE THE ALIGNMENT OF PAY AND ORGANIZATIONAL PERFORMANCE. GOALS ARE set IN ADVANCE IN AREAS SUCH AS QUALITY OF CARE, PATIENT SATISFACTION, community SERVICES AND FINANCIAL PERFORMANCE. COMPENSATION IS AT RISK IF the GOALS ESTABLISHED BY THE COMPENSATION COMMITTEE ARE NOT MET.
Schedule J, Part I, Line 4b	During the year, various individuals reported in Form 990, Part VII, Section A, participated in supplemental nonqualified retirement plans paid by related organizations of the Montefiore Health System. IN A MANNER DESIGNED TO QUALIFY FOR THE "REBUTTABLE PRESUMPTION OF reasonableness" THE COMPENSATION COMMITTEE OF either Montefiore Health System's BOARD OF TRUSTEES or White Plains Hospital Medical Center EXPRESSLY REVIEWED AND APPROVED THESE retirement BENEFIT ARRANGEMENTS IN A MANNER THAT QUALIFIED UNDER THE intermediate SANCTIONS RULES OF THE FEDERAL TAX LAW, AND IN RECOGNITION of (A) THE EXECUTIVES' YEARS OF SERVICE TO THE Health System AND (B) THE significant CONTRIBUTIONS TO ENHANCING THE ABILITY OF THE Health System to achieve ITS CHARITABLE MISSION IN A MANNER CONSISTENT WITH FINANCIAL solvency. ACCORDINGLY, THIS BENEFIT SHOULD BE VIEWED AS APPLYING TO YEARS of SERVICE FOR THE Health System. Pooled supplemental executive retirement plan distribution based on multiple years of service: Andrew D. Racine, M.D.,PH.D - \$642,732. Michael J. Palumbo, M.D. - \$78,011 Deferred compensation supplemental executive retirement plan contributions by a related organization: Michael J. Palumbo, M.D. - \$123,750.
Schedule J, Part I, Line 7	Part of the annual incentive awards paid by the organization to an officer, a key employee and four of the five highest compensated were based on the compensation Board or management discretion.

SCHEDULE O
(Form 990 or 990-EZ)**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 for the latest information.

OMB No. 1545-0047

2019**Open to Public Inspection**

Department of the Treasury

Name of the organization

THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

Employer identification number

13-1739937

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6:	MONTEFIORE HEALTH SYSTEM, INC. IS THE SOLE MEMBER OF THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A:	THE BOARD OF TRUSTEES OF MONTEFIORE HEALTH SYSTEM, INC., THE SOLE MEMBER OF THE WINIFRED M ASTERSON BURKE REHABILITATION HOSPITAL, HAS THE AUTHORITY TO appoint and remove members of the Board of Trustees of the Corporation.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B:	THE BOARD OF TRUSTEES OF MONTEFIORE HEALTH SYSTEM, INC., THE SOLE MEMBER OF THE WINIFRED M ASTERSON BURKE REHABILITATION HOSPITAL, HAS THE AUTHORITY TO APPROVE CERTAIN DECISIONS OF THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL BOARD OF DIRECTORS. Such decisions include amendments to the Certificate of Incorporation and Bylaws, approval of the operating and capital budgets and any strategic plans of the corporation, managed care contracting, expansion/subtraction of the Medical Center's operations, and certain administrative procedures, among others.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B:	THE FORM 990 WAS PREPARED BY THE Montefiore's Tax Department working closely with the Burke's Finance team and assisted by various departments throughout the HEALTH SYSTEM. THE FORM 990 WAS REVIEWED AND APPROVED BY THE VICE PRESIDENT-FINANCE AND THE Burke's Hospital senior leadership including the Chief Financial Officer. IN ADDITION, AN INDEPENDENT ACCOUNTING FIRM WAS ENGAGED TO REVIEW THE FORM 990. UPON COMPLETION OF THE VARIOUS REVIEWS, THE FORM 990 WAS PRESENTED TO THE BOARD OF TRUSTEES FOR REVIEW AND APPROVAL.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C:	THE ORGANIZATION REGULARLY AND CONSISTENTLY MONITORS AND ENFORCES Compliance WITH THE CONFLICTS OF INTEREST POLICY BY MEANS OF AN ANNUAL conflict OF INTEREST QUESTIONNAIRE THAT ALL OFFICERS, TRUSTEES AND KEY employees OF THE WINIFRED MASTERSON BURKE REHABILITATION HOSPITAL ARE required TO COMPLETE. COMPLETED QUESTIONNAIRES ARE REVIEWED BY THE Chairman OF THE EXECUTIVE COMMITTEE AND ANY CONCERNS PRESENTED BY THE responses ARE DISCLOSED TO THE FULL COMMITTEE WITH THE INTERESTED PARTY recused FROM DISCUSSION OF THE MATTER.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15A & 15B:	<p>The compensation of the organization's CEO is paid by Montefiore Health System, Inc., the sole member of the Winifred Masterson Burke Rehabilitation Hospital. The compensation of other select senior management of the organization is determined by the Compensation Committee of the Burke's Board of Trustees. The Winifred Masterson Burke Rehabilitation Hospital is committed to ensuring that its executive compensation program adheres to the highest standards of regulatory compliance and best corporate governance. The Board of Trustees has charged the Compensation Committee of the Board (which is comprised of independent Board members with no conflicts of interest in regards to executive compensation) with reviewing and recommending for approval by the member, all decisions related to compensation for selected senior management of the Corporation. All decisions made by the Compensation Committee are appropriately and timely documented in meeting minutes. The compensation committee's review process follows the Intermediate Sanctions guidelines for qualifying for the rebuttable presumption of reasonableness. Compensation levels are established considering data for comparable organizations, an assessment of management performance (including the services provided to the community), and other business judgement factors, consistent with Burke's executive compensation philosophy. The Committee's decisions are made in the best interest of Burke, and are intended to ensure the recruitment and retention of key executive talent, consistent with the market practices of other not-for-profit healthcare organizations of comparable scope, mission and complexity.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19:	The conflict of interest policy and governing documents are made available upon request.

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part XI, Line 9:	The other decrease in net assets of \$7,970,178 was due to the increase in the defined pension and other postretirement plan liabilities to be recognized in future periods.

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2019

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization
THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

Employer identification number

13-1739937

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.

See Additional Data Table

(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.

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

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

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: 13-1739937

Name: THE WINIFRED MASTERSON BURKE
REHABILITATION HOSPITAL

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
111 EAST 210TH STREET BRONX, NY 10467 13-1740114	ACD MED CTR	NY	501(C)(3)	3	MHS	Yes	
111 EAST 210TH STREET BRONX, NY 10467 13-3430322	REAL ESTATE	NY	501(C)(3)	12A TYPE I	MMC	Yes	
3411 WAYNE AVENUE BRONX, NY 10467 91-1943271	STAFF HOUSING	NY	501(C)(2)		MMC	Yes	
3450 WAYNE AVENUE BRONX, NY 10467 23-7160641	STAFF HOUSING	NY	501(C)(2)		MMC	Yes	
3400 RESEVOIR OVAL EAST BRONX, NY 10467 13-3109387	COMMUNITY SER	NY	501(C)(3)	12A TYPE I	MMC	Yes	
200 EAST GUN HILL ROAD BRONX, NY 10467 13-3734486	DIAG SERVICES	NY	501(C)(3)	12A TYPE I	MMC	Yes	
16 GUION PLACE NEW ROCHELLE, NY 10801 46-2931956	HOSPITAL	NY	501(C)(3)	3	MHS	Yes	
12 NORTH SEVENTH AVENUE MOUNT VERNON, NY 10550 46-2916938	HOSPITAL	NY	501(C)(3)	3	MHS	Yes	
16 GUION PLACE NEW ROCHELLE, NY 10801 46-2929888	NURSING HOME	NY	501(C)(3)	3	MHS	Yes	
111 EAST 210TH STREET BRONX, NY 10467 47-1600439	INACTIVE	NY	501(C)(3)	7	MMAHS	Yes	
1300 MORRIS PARK AVENUE BRONX, NY 10461 47-2209056	MED COLLEGE	NY	501(C)(3)	2	MMAHS	Yes	
555 SOUTH BROADWAY BLDG A FL 1 TARRYTOWN, NY 10591 47-1582973	SYSTEM PARENT	NY	501(C)(3)	12B TYPE II	NA	Yes	
160 NORTH MIDLAND AVENUE NYACK, NY 10960 13-1740119	HOSPITAL	NY	501(C)(3)	3	MHS	Yes	
41 EAST POST ROAD WHITE PLAINS, NY 10601 13-1740130	HOSPITAL	NY	501(C)(3)	3	MHS	Yes	
1300 MORRIS PARK AVENUE BRONX, NY 10461 23-7075620	STUDENT HOUS	NY	501(C)(2)		AECOM	Yes	
111 EAST 210TH STREET BRONX, NY 10467 47-4853506	REHAB CENTER	NY	501(c)(3)	3	MMC	Yes	
41 EAST POST ROAD DAVIS AVE WHITE PLAINS, NY 10601 13-3281507	FUNDRAISING	NY	501(C)(3)	12A TYPE I	WPHMC	Yes	
160 NORTH MIDLAND AVENUE NYACK, NY 10960 13-3245804	FUNDRAISING	NY	501(C)(3)	7	NYACK HOSP	Yes	
555 SOUTH BROADWAY BLDG A FL 1 TARRYTOWN, NY 10591 20-1615393	PARENT	NY	501(C)(3)	12B TYPE II	MMAHS	Yes	
70 DUBOIS STREET NEWBURGH, NY 12550 14-1340054	HOSPITAL	NY	501(C)(3)	3	MHS	Yes	

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
70 DUBOIS STREET NEWBURGH, NY 12550 45-2526738	HEALTHCARE	NY	501(C)(3)	12A Type I	SLCH	Yes	
70 DUBOIS STREET NEWBURGH, NY 12550 27-2020746	HEALTHCARE	NY	501(C)(3)	12A Type I	SLCH	Yes	
70 DUBOIS STREET NEWBURGH, NY 12550 22-3026261	HOLDING COMP	NY	501(C)(3)	12A Type I	MHS	Yes	
70 DUBOIS STREET NEWBURGH, NY 12550 22-3026263	FUNDRAISING	NY	501(C)(3)	7	SLCHS	Yes	
70 DUBOIS STREET NEWBURGH, NY 12550 14-1365995	ASST LIVING	NY	501(C)(3)	PF	SLCHS	Yes	
785 Mamaroneck Avenue White Plains, NY 10605 13-3434924	Research	NY	501(C)(3)	4	Burke Hosp	Yes	
555 South Broadway Tarrytown, NY 10591 82-4019223	Ins Trust	NY	501(c)(3)	12A TYPE I	MMAHS	Yes	
1300 Morris Park Avenue Bronx, NY 10461 83-0621846	Med College	NY	501(c)(3)	2	MMAHS	Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(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
UNIVERSITY BEHAVIORAL ASSOCIATES INC 111 EAST 210TH STREET BRONX, NY 10467 13-3877781	MGMT SERVICES	NY	NA	C CORP				Yes	
THE MONTEFIORE IPA INC 111 EAST 210TH STREET BRONX, NY 10467 13-4114915	INTEG PROVR ASSOC	NY	NA	C CORP				Yes	
MMC GI HOLDING EAST INC 111 EAST 210TH STREET BRONX, NY 10467 72-1610013	HOLDING COMPANY	NY	NA	C CORP				Yes	
MMC GI HOLDING WEST INC 111 EAST 210TH STREET BRONX, NY 10467 72-1610015	HOLDING COMPANY	NY	NA	C CORP				Yes	
MONTEFIORE BEHAVIORAL CARE IPA NO 1 INC 111 EAST 210TH STREET BRONX, NY 10467 13-3952750	INTEG PROVR ASSOC	NY	NA	C CORP				Yes	
BRONX ACCOUNTABLE CARE NETWORK IPA INC 111 EAST 210TH STREET BRONX, NY 10467 30-0689571	INTEG PROVR ASSOC	NY	NA	C CORP				Yes	
MONTEFIORE CONSOLIDATED VENTURES INC 111 EAST 210TH STREET BRONX, NY 10467 61-1728539	HOLDING COMPANY	NY	NA	C CORP				Yes	
MONTEFIORE INSURANCE COMPANY INC 111 EAST 210TH STREET BRONX, NY 10467 32-0436594	INACTIVE	NY	NA	C CORP				Yes	
HUDSON VALLEY IPA INC 111 EAST 210TH STREET BRONX, NY 10467 38-3978087	Integ Provr Assoc	NY	NA	C CORP				Yes	
MONTEFIORE INNOVATIONS INC 111 EAST 210TH STREET BRONX, NY 10467 47-5106910	Holding Company	NY	NA	C CORP				Yes	
HIGHLAND MEDICAL PC 160 NORTH MIDLAND AVENUE NYACK, NY 10960 13-4034481	HEALTHCARE SERV	NY	NA	C CORP				Yes	
8 LONGVIEW DEVELOPMENT CORP DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 26-3321278	HOUSING	NY	NA	C CORP				Yes	
WHITE PLAINS MEDICAL DIAGNOSTIC SVCS PC 41 EAST POST ROAD WHITE PLAINS, NY 10601 45-3164626	HEALTHCARE SERV	NY	NA	C CORP				Yes	
CANCER AND BLOOD MEDICAL SERVS OF NY PC 41 EAST POST ROAD WHITE PLAINS, NY 10601 46-2021804	HEALTHCARE SERV	NY	NA	C CORP				Yes	
DAVIS AVENUE CORP DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 13-3331643	Property holding	NY	NA	C CORP				Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust									
(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
WHITE PLAINS MANAGEMENT CO INC 41 EAST POST ROAD WHITE PLAINS, NY 10601 13-3331641	Property holding	NY	NA	C CORP				Yes	
WPHC BUILDING CORP 41 EAST POST ROAD WHITE PLAINS, NY 10601 13-3676932	Property holding	NY	NA	C CORP				Yes	
WHITE PLAINS MEDICAL SERVICES PC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 81-5369152	HEALTHCARE SERV	NY	NA	C CORP				Yes	
WHITE PLAINS PHYSICIAN SERVICES PC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 81-5309615	HEALTHCARE SERV	NY	NA	C CORP				Yes	
CHARITABLE REMAINDER TRUST (4)	CHARIT REMR TRUST	NY	NA	TRUST				Yes	
CRHT ACQUISITION INC 555 SOUTH BROADWAY BLDG A FL 1 TARRYTOWN, NY 10591 81-5220651	HOLDING COMPANY	NY	NA	C CORP				Yes	
QUANTUM BIOTHERAPEUTICS LLC 111 EAST 210TH STREET BRONX, NY 10467 61-1793667	INACTIVE	NY	NA	C CORP				Yes	
WHITE PLAINS PHYSICIAN MEDICAL SERV PC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 83-0519787	INACTIVE	NY	NA	C CORP				Yes	
EAST POST ROAD MEDICAL SERVICES PC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 83-0535258	HEALTHCARE SERV	NY	NA	C CORP				Yes	
EAST POST ROAD PHYSICIAN SERVICES PC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 83-0563325	INACTIVE	NY	NA	C CORP				Yes	
DAVIS AVENUE MEDICAL SERVICES PC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 83-0579310	INACTIVE	NY	NA	C CORP				Yes	
WPH HOLDINGS INC DAVIS AVENUE AT EAST POST ROAD WHITE PLAINS, NY 10601 83-3893119	HOLDING COMPANY	NY	NA	C CORP				Yes	
INNOVATOR ACQUISITION CORP 111 EAST 210TH STREET BRONX, NY 104672401 83-3394059	HOLDING COMPANY	NY	NA	C CORP				Yes	

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
THE MONTEFIORE IPA INC	L	3,310,834	COST
WHITE PLAINS HOSPITAL MEDICAL CENTER	M	1,142,575	COST
Monterfiore Health System Inc	M	1,346,599	Cost
ST LUKE'S CORNWALL HOSPITAL	L	235,706	Cost
WHITE PLAINS HOSPITAL MEDICAL CENTER	L	191,730	Cost
MONTEFIORE NEW ROCHELLE HOSPITAL	L	233,601	Cost
MONTEFIORE MOUNT VERNON HOSPITAL	L	100,115	COST
SCHAFFER EXTENDED CARE CENTER	L	150,571	COST
MONTEFIORE MEDICAL CENTER	L	735,078	COST
MONTEFIORE MEDICAL CENTER	K	159,116	COST
Winifred Masterson Burke Med Research	L	1,030,066	cost
MONTEFIORE MEDICAL CENTER	M	1,479,776	COST