Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ **Do not enter Social Security numbers on this form as it may be made public.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2018 calendar year, or tax year beginning 10/01, **2018, and ending** 09/30, **20** 19

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Doing Business As

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
130 FISHER ROAD

City or town, state or province, country, and ZIP or foreign postal code
BERLIN, VT 05602

D Employer identification number
22-2547186

E Telephone number
(802) 371-4100

G Gross receipts $ 232,287,137.

F Name and address of principal officer: MS. ANNA T. NOONAN
130 FISHER ROAD, BERLIN, VT 05602

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.CVMC.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶ **L** Year of formation: 1963 **M** State of legal domicile: VT

Part I Summary

1 Briefly describe the organization's mission or most significant activities: WE WORK COLLABORATIVELY TO MEET THE NEEDS AND IMPROVE THE HEALTH OF THE RESIDENTS OF CENTRAL VERMONT.

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**	16.
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	11.
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	**5**	1,971.
6	Total number of volunteers (estimate if necessary)	**6**	150.
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0.
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	0.

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	648,136.	552,463.
9	Program service revenue (Part VIII, line 2g)	210,796,054.	228,844,006.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	11,617,315.	2,478,888.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	308,676.	330,998.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	223,370,181.	232,206,355.
13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	559,268.	134,444.
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)	138,210,840.	139,223,505.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 18,319.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	80,491,266.	94,883,749.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	219,261,374.	234,241,698.
19	Revenue less expenses. Subtract line 18 from line 12	4,108,807.	-2,035,343.

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		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	172,815,634.	163,844,396.
21	Total liabilities (Part X, line 26)	80,766,274.	81,845,107.
22	Net assets or fund balances. Subtract line 21 from line 20	92,049,360.	81,999,289.

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: 08/13/2020

▶ TODD KEATING — NETWORK 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
PAUL J TANIS		08/11/2020		P01441612

Firm's name ▶ PRICEWATERHOUSECOOPERS LLP — Firm's EIN ▶ 13-4008324

Firm's address ▶ 101 SEAPORT BLVD., SUITE 500 BOSTON, MA 02210 — Phone no. 617-530-5000

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

For Paperwork Reduction Act Notice, see the separate instructions. Form **990** (2018)

JSA
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Part III **Statement of Program Service Accomplishments**

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

1 Briefly describe the organization's mission:

SEE SCHEDULE O

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☒ 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 $ 157,459,849. including grants of $ 113,759.) (Revenue $ 166,668,447.)

ATTACHMENT 1

4b (Code:) (Expenses $ 49,562,057. including grants of $ 20,685.) (Revenue $ 44,647,054.)

MEDICAL GROUP PRACTICES: AT THE END OF THE FISCAL YEAR WE HAD 23 PRIMARY CARE, INFIRMARY, AND SPECIALTY PRACTICES. THIS INCLUDED 7 PRIMARY AND FAMILY CARE CLINICS, 1 PEDIATRIC CLINIC, AS WELL AS SPECIALTY CLINICS FOR UROLOGY, PODIATRY, RHEUMATOLOGY, DERMATOLOGY, ENDOCRINOLOGY, ORTHOPAEDICS, PSYCHOLOGY, AND OBSTETRICS/ GYNECOLOGY. THERE WERE A TOTAL OF 323,437 PRACTICE VISITS DURING FISCAL YEAR 2019.

4c (Code:) (Expenses $ 17,918,769. including grants of $ 0.) (Revenue $ 17,528,506.)

ATTACHMENT 2

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

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

4e Total program service expenses ▶ 224,940,675.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	X	
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b	X	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O.	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	78		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0.		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	

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

			Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. **2a** 1,971			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	**2b**	X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)			
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	**3a**		X
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O*	**3b**		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	**4a**		X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	**5a**		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	**5c**		
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	**6a**		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**		
7	**Organizations that may receive deductible contributions under section 170(c).**			
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	**7a**	X	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**	X	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**		X
d	If "Yes," indicate the number of Forms 8282 filed during the year **7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	**7e**		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	**7f**		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**		
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	**8**		
9	**Sponsoring organizations maintaining donor advised funds.**			
a	Did the sponsoring organization make any taxable distributions under section 4966?	**9a**		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	**9b**		
10	**Section 501(c)(7) organizations.** Enter:			
a	Initiation fees and capital contributions included on Part VIII, line 12 **10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities **10b**			
11	**Section 501(c)(12) organizations.** Enter:			
a	Gross income from members or shareholders **11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) **11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	**12a**		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year **12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**			
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O.	**13a**		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans **13b**			
c	Enter the amount of reserves on hand **13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	**14a**		X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	**14b**		
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.	**15**		X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	**16**		X

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

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

Section A. Governing Body and Management

			Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year . . . . . If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a 16		
b	Enter the number of voting members included in line 1a, above, who are independent	1b 11		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	X	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person? . .	3		X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		X
6	Did the organization have members or stockholders?	6	X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	X	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	X	
b	Each committee with authority to act on behalf of the governing body?	8b	X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9		X

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

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

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ▶ VT,

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ▶
TODD KEATING, CFO 130 FISHER RD BERLIN, VT 05602 802-847-9975

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) CAROL WELCH	1.00									
TRUSTEE, AS OF 01/2019	0.	X						0.	0.	0.
(2) JOHN BRUMSTED, MD	6.00									
TRUSTEE	44.00	X						0.	2,005,831.	214,241.
(3) JEREMIAH ECKHAUS, MD	50.00									
TRUSTEE, PRES-ELECT MED STAFF	0.	X						282,682.	0.	42,646.
(4) MICHAEL DELLIPRISCOLI	1.00									
TRUSTEE, IMMEDIATE PAST CHAIR	2.00	X						0.	0.	0.
(5) MARK DEPMAN, MD	44.00									
TRUSTEE, REGNAL PHYS LEADER	6.00	X						375,886.	0.	21,910.
(6) SARAH FIELD	1.00									
TRUSTEE, UNTIL 5/20/19	0.	X						0.	0.	0.
(7) THOMAS GOLONKA	1.00									
TRUSTEE, CHAIR-ELECT	2.00	X						0.	0.	0.
(8) JOYCE JUDY	1.00									
TRUSTEE	0.	X						0.	0.	0.
(9) MARY MOULTON	1.00									
TRUSTEE	0.	X						0.	0.	0.
(10) MARTA MURPHY (MARBLE)	1.00									
TRUSTEE, CHAIR	2.00	X						0.	0.	0.
(11) ANNA T. NOONAN	35.00									
TRUSTEE, PRESIDENT/COO	15.00	X		X				628,905.	0.	62,679.
(12) CATHY PALMER, MD	3.00									
TRUSTEE	42.00	X						30,150.	262,016.	47,844.
(13) TONI KAEDING	1.00									
TRUSTEE	0.	X						0.	0.	0.
(14) SANDY ROUSSE	1.00									
TRUSTEE	0.	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) CONNIE COLMAN	1.00									
TRUSTEE	0.	X						0.	0.	0.
(16) PAULETTE THABAULT	1.00									
TRUSTEE	0.	X						0.	0.	0.
(17) MARILYN WHITE	1.00									
TRUSTEE, UNTIL 01/2019	0.	X						0.	0.	0.
(18) CORY RICHARDSON	1.00									
TRUSTEE	0.	X						0.	0.	0.
(19) STEPHEN KENNEY	50.00									
TREASURER, CFO	0.			X				51,539.	0.	0.
(20) TODD KEATING	10.00									
INTRM TREAS/CFO UNTIL 7/2018	40.00			X				0.	865,295.	29,301.
(21) MATTHEW CHOATE	50.00									
VP OF PATIENT CARE SERVICES	0.				X			245,454.	0.	34,092.
(22) ROBERT PATTERSON	50.00									
VP OF HR & CLINICAL OPERATIONS	0.				X			276,077.	0.	41,614.
(23) DAVID TURNER	50.00									
VP PHYSICIAN SERVICES	0.				X			172,367.	0.	12,112.
(24) JAMES ALVAREZ	50.00									
VP SUPPORT SRVCS, AS OF 1/2018	0.				X			222,846.	0.	8,978.
(25) PATRICIA FISHER, MD	50.00									
CHIEF MEDICAL OFFICER, 3/2018	0.				X			274,231.	0.	33,762.
1b Sub-total ▶								1,317,623.	2,267,847.	389,320.
c Total from continuation sheets to Part VII, Section A ▶								4,445,984.	865,295.	441,440.
d Total (add lines 1b and 1c) ▶								5,763,607.	3,133,142.	830,760.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 195

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 3		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 26

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(26) RICHARD BURGOYNE	50.00									
MEDICAL DIRECTOR	0.					X		457,718.	0.	16,178.
(27) CHRISTIAN BEAN, MD	50.00									
PHYSICIAN	0.					X		660,789.	0.	64,168.
(28) JAVAD MASHKURI, MD	50.00									
PHYSICIAN/MEDICAL DIRECTOR	0.					X		410,282.	0.	50,961.
(29) CHRISTOPHER MERIAM, MD	50.00									
PHYSICIAN	0.					X		577,609.	0.	62,381.
(30) SARA GRAVES, MD	50.00									
PHYSICIAN	0.					X		541,500.	0.	47,558.
(31) CHEYENNE HOLLAND	0.									
TREASURER, CFO, UNTIL 07/2018	0.						X	339,488.	0.	40,335.
(32) JUDITH TARTAGLIA	0.									
TRUSTEE, PRES/CEO UNTIL 3/2017	0.						X	216,084.	0.	0.
1b Sub-total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶										

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 195

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

Section B. Independent Contractors

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

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

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

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c	17,090.			
	d	Related organizations	1d				
	e	Government grants (contributions)	1e	201,994.			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	333,379.			
	g	Noncash contributions included in lines 1a-1f: $					
	h	**Total.** Add lines 1a-1f ▶		552,463.			
Program Service Revenue			**Business Code**				
	2a	NET PATIENT SERVICE REVENUE	900099	172,364,431.	172,364,431.		
	b	REVENUE FROM MANAGED CARE AND PMPM	900099	41,249,882.	41,249,882.		
	c	340B CONTRACT PHARMACY REVENUE	900099	7,933,421.	7,933,421.		
	d	CONTRACT SERVICE REVENUE	900099	890,952.	890,952.		
	e	CAFETERIA REVENUE	900099	1,065,762.	1,065,762.		
	f	All other program service revenue		5,339,558.	5,339,558.		
	g	**Total.** Add lines 2a-2f ▶		228,844,006.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶		2,478,888.			2,478,888.
	4	Income from investment of tax-exempt bond proceeds ▶		0.			
	5	Royalties ▶		0.			
			(i) Real / (ii) Personal				
	6a	Gross rents	403,280.				
	b	Less: rental expenses	73,319.				
	c	Rental income or (loss)	329,961.				
	d	Net rental income or (loss) ▶		329,961.			329,961.
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory					
	b	Less: cost or other basis and sales expenses					
	c	Gain or (loss)					
	d	Net gain or (loss) ▶		0.			
	8a	Gross income from fundraising events (not including $ 17,090. of contributions reported on line 1c). See Part IV, line 18	a 8,500.				
	b	Less: direct expenses	b 7,463.				
	c	Net income or (loss) from fundraising events ▶		1,037.			1,037.
	9a	Gross income from gaming activities. See Part IV, line 19	a 0.				
	b	Less: direct expenses	b 0.				
	c	Net income or (loss) from gaming activities ▶		0.			
	10a	Gross sales of inventory, less returns and allowances	a 0.				
	b	Less: cost of goods sold	b 0.				
	c	Net income or (loss) from sales of inventory ▶		0.			
		Miscellaneous Revenue	**Business Code**				
	11a						
	b						
	c						
	d	All other revenue					
	e	**Total.** Add lines 11a-11d ▶		0.			
	12	**Total revenue.** See instructions. ▶		232,206,355.	228,844,006.		2,809,886.

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	134,444.	134,444.		
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	2,442,515.	278,034.	2,164,481.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	166,394.		166,394.	
7 Other salaries and wages	107,135,067.	104,432,629.	2,687,996.	14,442.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	5,632,091.	5,373,780.	257,570.	741.
9 Other employee benefits	16,420,366.	15,667,262.	750,945.	2,159.
10 Payroll taxes	7,427,072.	7,086,436.	339,659.	977.
11 Fees for services (non-employees):				
a Management	0.			
b Legal	138,440.		138,440.	
c Accounting	80,628.		80,628.	
d Lobbying	0.			
e Professional fundraising services. See Part IV, line 17	0.			
f Investment management fees	446,866.	207,778.	239,088.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	18,074,580.	17,072,101.	1,002,479.	
12 Advertising and promotion	1,140,494.	730,418.	410,076.	
13 Office expenses	2,005,107.	1,861,084.	144,023.	
14 Information technology	3,829,866.	3,714,054.	115,812.	
15 Royalties	0.			
16 Occupancy	5,398,430.	5,310,199.	88,231.	
17 Travel	181,249.	146,330.	34,919.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	823,939.	744,252.	79,687.	
20 Interest	459,183.	459,183.		
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	9,170,032.	9,170,032.		
23 Insurance	651,384.	651,384.		
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 BAD DEBT EXPENSE	5,607,318.	5,607,318.		
b STATE TAX ASSESMENT	11,393,875.	11,393,875.		
c MAINTENANCE & REPAIRS	2,301,763.	2,284,504.	17,259.	
d MEDICAL & SURGICAL SUPPLIES	29,260,151.	29,243,812.	16,339.	
e All other expenses	3,920,444.	3,371,766.	548,678.	
25 **Total functional expenses.** Add lines 1 through 24e	234,241,698.	224,940,675.	9,282,704.	18,319.
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 ▶ ☐ if following SOP 98-2 (ASC 958-720)	0.			

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing	0.	1	0.
	2	Savings and temporary cash investments	8,891,033.	2	6,088,055.
	3	Pledges and grants receivable, net	0.	3	0.
	4	Accounts receivable, net	20,572,298.	4	22,346,848.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0.	5	0.
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0.	6	0.
	7	Notes and loans receivable, net	3,376,944.	7	2,424,419.
	8	Inventories for sale or use	4,199,147.	8	4,481,927.
	9	Prepaid expenses and deferred charges	1,433,975.	9	1,449,525.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a: 179,289,287.			
	b	Less: accumulated depreciation — 10b: 111,918,597.	68,582,663.	10c	67,370,690.
	11	Investments - publicly traded securities	0.	11	0.
	12	Investments - other securities. See Part IV, line 11	62,488,384.	12	56,607,088.
	13	Investments - program-related. See Part IV, line 11	0.	13	0.
	14	Intangible assets	0.	14	0.
	15	Other assets. See Part IV, line 11	3,271,190.	15	3,075,844.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	172,815,634.	16	163,844,396.
Liabilities	17	Accounts payable and accrued expenses	42,049,256.	17	33,117,752.
	18	Grants payable	0.	18	0.
	19	Deferred revenue	0.	19	26,158.
	20	Tax-exempt bond liabilities	0.	20	0.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D	0.	21	0.
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0.	22	0.
	23	Secured mortgages and notes payable to unrelated third parties	16,308,604.	23	15,855,759.
	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	22,408,414.	25	32,845,438.
	26	**Total liabilities.** Add lines 17 through 25	80,766,274.	26	81,845,107.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	82,560,540.	27	73,718,001.
	28	Temporarily restricted net assets	6,215,144.	28	4,898,402.
	29	Permanently restricted net assets	3,273,676.	29	3,382,886.
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	92,049,360.	33	81,999,289.
	34	Total liabilities and net assets/fund balances	172,815,634.	34	163,844,396.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	232,206,355.
2	Total expenses (must equal Part IX, column (A), line 25)	2	234,241,698.
3	Revenue less expenses. Subtract line 2 from line 1	3	-2,035,343.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	92,049,360.
5	Net unrealized gains (losses) on investments	5	0.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-8,014,728.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	81,999,289.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**

2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)

3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)

9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____

10 ☐ An organization that normally receives: (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations . . . . . ☐

g Provide the following information about the supported organization(s).

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) . . . . . 14 %

15 Public support percentage from 2017 Schedule A, Part II, line 14 . . . . . 15 %

16a **33 1/3 % support test - 2018.** 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 . . . . . ▶ ☐

b **33 1/3 % support test - 2017.** 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 . . . . . ▶ ☐

17a **10%-facts-and-circumstances test - 2018.** 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 . . . . . ▶ ☐

b **10%-facts-and-circumstances test - 2017.** 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 . . . . . ▶ ☐

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 . . . . . ▶ ☐

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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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 2018 (line 8, column (f), divided by line 13, column (f))	15	%
16	Public support percentage from 2017 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2018** (line 10c, column (f), divided by line 13, column (f))	17	%
18	Investment income percentage from **2017** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2018.** 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 - 2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3 %, and line 18 is not more than 33 1/3 %, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

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?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in* ***Part VI.***	11c		

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? *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.*	1		
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? *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.*	2		

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)? *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).*	1		

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?	1		
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? *If "No," explain in* ***Part VI*** *how the organization maintained a close and continuous working relationship with the supported organization(s).*	2		
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? *If "Yes," describe in* ***Part VI*** *the role the organization's supported organizations played in this regard.*	3		

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 ☐ The organization satisfied the Activities Test. *Complete* ***line 2*** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* ***line 3*** *below.*

c ☐ The organization supported a governmental entity. *Describe in* ***Part VI*** *how you supported a government entity (see instructions).*

			Yes	No
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? *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.*	2a		
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? *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.*	2b		
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? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI*** *the role played by the organization in this regard.*	3b		

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
a Average monthly value of securities	**1a**		
b Average monthly cash balances	**1b**		
c Fair market value of other non-exempt-use assets	**1c**		
d Total (add lines 1a, 1b, and 1c)	**1d**		
e Discount claimed for blockage or other factors (explain in detail in **Part VI**):			
2 Acquisition indebtedness applicable to non-exempt-use assets	**2**		
3 Subtract line 2 from line 1d.	**3**		
4 Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	**4**		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	**5**		
6 Multiply line 5 by .035.	**6**		
7 Recoveries of prior-year distributions	**7**		
8 Minimum Asset Amount (add line 7 to line 6)	**8**		

Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	**1**		
2 Enter 85% of line 1.	**2**		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	**3**		
4 Enter greater of line 2 or line 3.	**4**		
5 Income tax imposed in prior year	**5**		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	**6**		

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

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 2018 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-2018	(iii) Distributable Amount for 2018
1	Distributable amount for 2018 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2018 (reasonable cause required - explain in **Part VI**). See instructions.			
3	Excess distributions carryover, if any, to 2018			
a	From 2013			
b	From 2014			
c	From 2015			
d	From 2016			
e	From 2017			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2018 distributable amount			
i	Carryover from 2013 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2018 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2018 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2018, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in **Part VI**. See instructions.			
6	Remaining underdistributions for 2018. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in **Part VI.** See instructions.			
7	**Excess distributions carryover to 2019.** Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2014			
b	Excess from 2015			
c	Excess from 2016			
d	Excess from 2017			
e	Excess from 2018			

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

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2018

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[ ] For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** $5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.

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

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

Name of organization CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number 22-2547186

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 50,200.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 21,947.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3		$ 250,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization CENTRAL VERMONT MEDICAL CENTER, INC. | Employer identification number 22-2547186

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

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

Name of organization CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number 22-2547186

Part III ***Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** Complete columns **(a)** through **(e) and** the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once. See instructions.) ▶ $ ______________
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

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

2018

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 organization	Employer identification number
CENTRAL VERMONT MEDICAL CENTER, INC.	22-2547186

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

4-Year Averaging Period Under Section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		28,434.
j Total. Add lines 1c through 1i			28,434.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV **Supplemental Information**

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

SEE PAGE 4

Part IV **Supplemental Information** *(continued)*

LOBBYING ACTIVITY

SCHEDULE C, PART II-B, LINE 1I

CENTRAL VERMONT MEDICAL CENTER IS A MEMBER OF, AND PAYS DUES TO, THE VERMONT ASSOCIATION OF HOSPITALS AND HEALTH SERVICE PROVIDERS AS WELL AS THE AMERICAN HOSPITAL ASSOCIATION, AND THE VERMONT HEALTH CARE ASSOCIATION. A PORTION OF THE DUES IS USED FOR LOBBYING PURPOSES.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

		(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year		
2	Aggregate value of contributions to (during year)		
3	Aggregate value of grants from (during year)		
4	Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of a historically important land area
☐ Preservation of a certified historic structure

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

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

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

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

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ $ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

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

(i) Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

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

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

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	8,191,232.	7,997,540.	7,988,798.	7,726,226.	8,130,234.
b Contributions					
c Net investment earnings, gains, and losses	265,073.	193,692.	358,742.	306,265.	-366,990.
d Grants or scholarships					
e Other expenditures for facilities and programs			350,000.	43,693.	37,018.
f Administrative expenses					
g End of year balance	8,456,305.	8,191,232.	7,997,540.	7,988,798.	7,726,226.

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 ▶ 38.0000 %
- c Temporarily restricted endowment ▶ 62.0000 %

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:

		Yes	No
(i) unrelated organizations	3a(i)	X	
(ii) related organizations	3a(ii)	X	
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?	3b	X	

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		5,510,000.		5,510,000.
b Buildings		109,163,821.	66,248,170.	42,915,651.
c Leasehold improvements		5,555,077.	4,195,018.	1,360,059.
d Equipment		52,975,902.	41,475,409.	11,500,493.
e Other		6,084,487.		6,084,487.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				67,370,690.

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) BENEFICIAL INTEREST IN HEALTH		
(B) NETWORK INVESTMENT POOL	56,607,088.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 12.)* ▶	56,607,088.	

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

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

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

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ACCRUED PENSION LIABILITY	29,939,024.
(3) OTHER LIABILITIES	2,906,414.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	32,845,438.

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 [X]

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.

SEE PAGE 5

Part XIII Supplemental Information *(continued)*

ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

CVMC HAS ENDOWMENT INVESTMENTS AND SPENDING POLICIES THAT ATTEMPT TO PROVIDE A PREDICTABLE STREAM OF FUNDING FOR CAPITAL AND OPERATIONAL PROGRAMS PERTAINING TO THE DELIVERY OF HOSPITAL AND SKILLED NURSING CARE SERVICES AS WELL AS INTERNAL MEDICINE, FAMILY AND SPECIALTY PHYSICIAN SERVICES IN ORDER TO MEET THE HEALTH CARE NEEDS OF THE CENTRAL VERMONT COMMUNITY.

ASC 740 DISCLOSURE

SCHEDULE D, PART X, LINE 2, FIN 48 (ASC 740)

CENTRAL VERMONT MEDICAL CENTER, INC. IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK"). THE FOOTNOTE STATES: UVM HEALTH NETWORK ACCOUNTS FOR RECOGNITION AND MEASUREMENT OF UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH (ASC) 740 INCOME TAXES, WHICH ADDRESSES HOW TO ACCOUNT FOR AND REPORT THE EFFECTS OF TAXES BASED ON INCOME. NO PROVISION FOR UNCERTAIN TAX POSITIONS IS RECORDED IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS.

SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, line 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.

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

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

Part I **Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

- **a** ☐ Mail solicitations
- **b** ☐ Internet and email solicitations
- **c** ☐ Phone solicitations
- **d** ☐ In-person solicitations
- **e** ☐ Solicitation of non-government grants
- **f** ☐ Solicitation of government grants
- **g** ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees, or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

	(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions?		**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
			Yes	**No**			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total ▶							

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

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.

		(a) Event #1 GOLF TOURNAMENT (event type)	(b) Event #2 (event type)	(c) Other events (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	25,590.			25,590.
	2 Less: Contributions	17,090.			17,090.
	3 Gross income (line 1 minus line 2)	8,500.			8,500.
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	7,263.			7,263.
	7 Food and beverages				
	8 Entertainment	200.			200.
	9 Other direct expenses				
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				7,463.
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				1,037.

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.

		(a) Bingo	(b) Pull tabs/instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col. (a) through col. (c))
Revenue	1 Gross revenue				
Direct Expenses	2 Cash prizes				
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses				
	6 Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ 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 ▶ _____

15 a 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 to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $

Part IV **Supplemental Information.** Provide the explanation 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).

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			2,528,092.		2,528,092.	1.11
b Medicaid (from Worksheet 3, column a)			50,544,335.	25,845,008.	24,699,327.	10.80
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs			53,072,427.	25,845,008.	27,227,419.	11.91
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			97,818.		97,818.	.04
f Health professions education (from Worksheet 5)			408,498.		408,498.	.18
g Subsidized health services (from Worksheet 6)			51,074,955.	44,810,318.	6,264,637.	2.74
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			95,487.		95,487.	.04
j **Total.** Other Benefits			51,676,758.	44,810,318.	6,866,440.	3.00
k **Total.** Add lines 7d and 7j			104,749,185.	70,655,326.	34,093,859.	14.91

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?	1	X	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount 2 5,607,318.			
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 3 112,146.			
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	47,367,220.
6	Enter Medicare allowable costs of care relating to payments on line 5	6	106,916,384.
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-59,549,164.
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities

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

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

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

	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 CENTRAL VERMONT MEDICAL CENTER 130 FISHER ROAD BERLIN VT 05602 WWW.CVMC.ORG 470001	X	X					X			
2										
3										
4										
5										
6										
7										
8										
9										
10										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group CENTRAL VERMONT MEDICAL CENTER

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	[X] A definition of the community served by the hospital facility			
b	[X] Demographics of the community			
c	[X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	[X] How data was obtained			
e	[X] The significant health needs of the community			
f	[X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	[X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	[X] The process for consulting with persons representing the community's interests			
i	[X] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	[ ] Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
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	5	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	X	
7	Did the hospital facility make its CHNA report widely available to the public?	7	X	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	[X] Hospital facility's website (list url): SEE SECTION C			
b	[X] Other website (list url): HTTP://WWW.GMCBOARD.VERMONT.GOV			
c	[X] Made a paper copy available for public inspection without charge at the hospital facility			
d	[ ] 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	8	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 2015			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a	If "Yes," (list url): SEE SECTION C			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group CENTRAL VERMONT MEDICAL CENTER

			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	X	
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.0000 % and FPG family income limit for eligibility for discounted care of 400.0000 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[X] Asset level			
d	[X] Medical indigency			
e	[X] Insurance status			
f	[X] Underinsurance status			
g	[X] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[ ] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[ ] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE SECTION C			
b	[X] The FAP application form was widely available on a website (list url): SEE SECTION C			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE SECTION C			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] 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	[X] 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	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[X] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations			
j	[X] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group CENTRAL VERMONT MEDICAL CENTER

			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	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ 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	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			
f	☒ 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?	19		X
	If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ 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	☐ Actions that require a legal or judicial process			
e	☐ Other similar actions (describe in Section C)			

20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):

- **a** ☒ 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** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- **c** ☒ Processed incomplete and complete FAP applications (if not, describe in Section C)
- **d** ☒ Made presumptive eligibility determinations (if not, describe in Section C)
- **e** ☐ Other (describe in Section C)
- **f** ☐ 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?	21	X	
	If "No," indicate why:			
a	☐ The hospital facility did not provide care for any emergency medical conditions			
b	☐ The hospital facility's policy was not in writing			
c	☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group CENTRAL VERMONT MEDICAL CENTER

			Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a	☐ 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.	**23**		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	**24**		X

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

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

PART V, LINE 3E

REPRESENTATIVES FROM CVMC, THRIVE, AND CAN REVIEWED THE CHNA FINDINGS IN CONJUNCTION WITH THE VERMONT DEPARTMENT OF HEALTH 2019-23 STATE HEALTH IMPROVEMENT PLAN (SHIP) TO DETERMINE THE MOST PRESSING NEEDS IMPACTING RESIDENTS ACROSS WASHINGTON COUNTY AND THE CVMC SERVICE AREA. THE FOLLOWING CRITERIA WERE APPLIED TO DETERMINE PRIORITIES ON WHICH TO FOCUS COMMUNITY WIDE HEALTH IMPROVEMENT EFFORTS.

CHNA FINDINGS PRIORITIZATION CRITERIA:

- SCOPE: HOW MANY PEOPLE ARE AFFECTED?
- SEVERITY: HOW CRITICAL IS THE ISSUE?
- ABILITY TO IMPACT: CAN WE ACHIEVE THE DESIRED OUTCOME?
- COMMUNITY READINESS: IS THE COMMUNITY PREPARED TO TAKE ACTION?

APPLYING THESE CRITERIA TO THE LIST OF TOP HEALTH NEEDS IDENTIFIED BY THE CHNA RESEARCH, THRIVE AND CAN MEMBERS RANK ORDERED THE COMMUNITY'S HEALTH NEEDS IN THE FOLLOWING ORDER.

1. SUBSTANCE USE DISORDERS
2. MENTAL HEALTH
3. SOCIAL INFLUENCERS OF HEALTH (HOUSING, FOOD SECURITY, TRANSPORTATION, ECONOMIC STABILITY)
4. CHRONIC DISEASE PREVENTION
5. HEALTHY LIFESTYLES AND RISK BEHAVIORS

THE 2019 CHNA PRIORITIZED HEALTH NEEDS ALIGN WITH THE VT DOH SHIP PRIORITES, PROMOTING COLLABORATION BETWEEN PUBLIC HEALTH, HOSPITAL, AND COMMUNITY BASED ORGANIZATIONS.

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

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

PART V, LINE 5

THE 2019 CHNA WAS OVERSEEN BY REPRESENTATIVES FROM CVMC AND THE THRIVE ACCOUNTABLE HEALTH COMMUNITIES COMMITTEE. THE COMMUNITY ACTION NETWORK (CAN), A SUBCOMMITTEE OF THRIVE AND CVMC REPRESENTATIVES MET MONTHLY WITH OUR CONSULTANTS TO REVIEW AND GUIDE THE CHNA PROCESS. CONSULTANTS ASSISTED IN ALL PHASES OF THE CHNA INCLUDING PROJECT MANAGEMENT, QUANTITATIVE AND QUALITATIVE DATA COLLECTION, ANALYSIS, FACILITATION, AND REPORT WRITING. THE CVMC CHNA STEERING COMMITTEE AND THE CAN SUBCOMMITTEE MEMBERS ARE RESPRESENTATIVES FROM THE BELOW ORGANIZATIONS.

A. CAPSTONE COMMUNITY ACTION

B. CENTRAL VERMONT COUNCIL ON AGING

C. CENTRAL VERMONT HOME HEALTH & HOSPICE

D. CENTRAL VERMONT MEDICAL CENTER - LEADERSHIP, MEDICAL STAFF & COMMUNITY HEALTH TEAM

E. CENTRAL VERMONT REGIONAL PLANNING COMMISSION

F. FAMILY CENTER OF WASHINGTON COUNTY

G. GREEN MOUNTAIN UNITED WAY

H. PEOPLE'S HEALTH & WELLNESS CLINIC

I. VERMONT AGENCY OF HUMAN SERVICES

J. VERMONT DEPARTMENT OF HEALTH

K. WASHINGTON COUNTY MENTAL HEALTH SERVICES

PART V, LINE 6B

THE 2019 CHNA WAS CONDUCTED IN COLLABORATION WITH THRIVE, THE REGIONAL ACCOUNTABLE COMMUNITY FOR HEALTH MODEL. THIS MULTI-AGENCY COALITION,

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

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

MADE UP OF HEALTH PROVIDERS, SOCIAL SERVICE AGENCIES, GOVERNMENT, CIVIC, AND RELIGIOUS ENTITIES, AND NUMEROUS OTHER COMMUNITY PARTNERS, IS DEDICATED TO IMPROVING HEALTH FOR THE RESIDENTS OF WASHINGTON AND NORTHERN ORANGE COUNTIES. THRIVE MEMBERS PLAYED AN INTEGRAL ROLE IN OVERSEEING DATA COLLECTION AND REVIEWING FINDING TO DETERMINE COMMUNITY HEALTH PRIORITIES BASED ON CHNA STUDY.

PART V, LINE 7A

COMMUNITY HEALTH NEEDS ASSESSMENT

HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT-2019.PDF

PART V, LINE 10A

COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY

HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/COMMUNITY-NEEDS-ASSESSMENT-2016.PDF

PART V, LINE 11

AT CENTRAL VERMONT MEDICAL CENTER (CVMC), WE COLLABORATE WITH OTHER NON-PROFITS, BUSINESSES, COMMUNITY LEADERS, AND GOVERNMENTAL AGENCIES TO PROVIDE A VARIETY OF PROGRAMS AND EDUCATIONAL OFFERINGS INTENDED TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE. BELOW IS THE ANNUAL PROGRESS REPORT FOR THE 2016 IMPLEMENTATION STRATEGY, WHICH WAS EFFECTIVE DURING FY19.

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

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

DRUG ABUSE

CVMC CONTINUES TO WORK WITH COMMUNITY PARTNERS INCLUDING THE VERMONT DEPARTMENT OF HEALTH ALCOHOL AND DRUG ABUSE PROGRAM, WASHINGTON COUNTY MENTAL HEALTH SERVICES, CENTRAL VERMONT SUBSTANCE ABUSE SERVICES, TREATMENT ASSOCIATES AND CENTRAL VERMONT ADDICTION MEDICINE, TO INCREASE ACCESS TO CARE AND SUPPORT TRANSITIONS OF CARE AS INDIVIDUALS MOVE THROUGH THE TREATMENT CYCLE. IT IS IMPORTANT THAT COMMUNITY MEMBERS HAVE KNOWLEDGE OF THE RESOURCES THAT ARE CURRENTLY AVAILABLE TO THEM.

CVMC SPONSORS THE WASHINGTON COUNTY SUBSTANCE ABUSE REGIONAL PARTNERSHIP (WCSARP), WHICH MEETS MONTHLY TO COORDINATE SERVICES, SOLVE ACCESS AND CARE MANAGEMENT PROBLEMS, AND ERASE BOUNDARIES OF CARE. THE GROUP INCLUDES, AMONG OTHERS, THE AGENCY FOR HUMAN SERVICES BARRE HSA, VERMONT DEPARTMENT OF HEALTH, LOCAL HUB-AND-SPOKE PARTNERS, THE DESIGNATED AGENCIES FOR MENTAL HEALTH AND SUBSTANCE ABUSE (WASHINGTON COUNTY MENTAL HEALTH SERVICES, CENTRAL VERMONT SUBSTANCE ABUSE SERVICES, CENTRAL VERMONT ADDICTION MEDICINE), PREVENTION PARTNERS, THE TURNING POINT RECOVERY CENTER, THE YOUTH SERVICES BUREAU, RESIDENTIAL CARE PROVIDERS, LOCAL CRIMINAL JUSTICE, AND NUMEROUS OTHER ORGANIZATIONS AND INDIVIDUALS WHO ARE INVESTED IN IMPROVING ACCESS TO, AND QUALITY OF SUBSTANCE USE TREATMENT, RECOVERY, AND PREVENTION.

IN COLLABORATION WITH WCSARP, CVMC WAS THE RECIPIENT OF FEDERAL FUNDS FROM THE RURAL COMMUNITIES OPIOID RESPONSE PROGRAM (RCORP) BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA). RCORP'S AIM IS TO REDUCE THE MORBIDITY AND MORTALITY OF SUBSTANCE USE DISORDER (SUD), INCLUDING OPIOID USE DISORDER (OUD), IN HIGH RISK RURAL COMMUNITIES. THIS FUNDING

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

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

WAS USED TO COMPLETE A NEEDS ASSESSMENT EVALUATION AND DEVELOP A STRATEGIC PLAN TO STRENGTHEN AND EXPAND SUD/OUD PREVENTION, TREATMENT, AND RECOVERY SERVICES IN OUR HSA.

THREE IMPORTANT PROGRAMS EMERGED OUT OF GAPS IDENTIFIED BY WCSARP:

-CVMC'S EMERGENCY DEPARTMENT INITIATED AN ALCOHOL WITHDRAWAL PROTOCOL IN COLLABORATION WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES AND THE TURNING POINT RECOVERY CENTER TO PROVIDE ACCESS TO COMMUNITY-LOCATED SUPERVISED MEDICALLY ASSISTED WITHDRAWAL (MAW);

-THE EMERGENCY DEPARTMENT HAS INITIATED THE STATE'S FIRST RAPID ACCESS TO MEDICATION ASSISTED TREATMENT (RAM) TO PROVIDE IMMEDIATE 24/7 INDUCTION WITH BUPRENORPHINE LINKED TO RAPID HUB-AND-SPOKE ACCESS;

-THE TURNING POINT CENTER IS CURRENTLY A RECIPIENT OF VERMONT DEPARTMENT OF HEALTH FUNDING TO MAINTAIN PEER RECOVERY SUPPORTS INTO THE EMERGENCY DEPARTMENT AND HOSPITAL INPATIENT UNITS TO ASSURE ONGOING RECOVERY SUPPORT AND IMPROVE TRANSITIONS TO THE COMMUNITY.

MENTAL HEALTH

CVMC, IN PARTNERSHIP WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES, HAS CREATED A MODEL OF EMBEDDING BEHAVIORAL HEALTH PRACTITIONERS WITHIN CVMC PRIMARY CARE PRACTICES.

CVMC IN COLLABORATION WITH THE FAMILY CENTER OF WASHINGTON COUNTY AND WASHINGTON COUNTY MENTAL HEALTH SERVICES INITIATED THE ADVERSE CHILDHOOD EXPERIENCES (ACES) PROJECT. THE GOAL USE OF FAMILY SUPPORT SPECIALISTS EMBEDDED IN CVMC'S PEDIATRIC PRACTICE, TARGETING AGE GROUPS 0-36 MONTHS TO PROMOTE CHILD AND FAMILY PROTECTIVE FACTORS, PREVENT AND MITIGATE

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

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

TOXIC STRESS, AND PROMOTE HEALTHY CHILD DEVELOPMENT FOR A PERIOD OF ONE YEAR.

TOBACCO USE

CVMC OFFERS A TOBACCO CESSATION PROGRAM ON AND OFF SITE THROUGHOUT THE YEAR. CURRENTLY, WE ARE ABLE TO ASSIST PARTICIPANTS WITH SUPPORT AND FREE NICOTINE REPLACEMENT THERAPY SUCH AS GUM, PATCHES AND LOZENGES. IN ADDITION, SBIRT CLINICIANS, ALSO TRAINED AS TOBACCO TREATMENT SPECIALISTS, PROVIDE INDIVIDUAL TOBACCO CESSATION COUNSELING TO PROMOTE SUCCESSFUL QUITTING. CVMC HAS TRAINED THREE (3) ADDITIONAL TOBACCO TREATMENT SPECIALISTS FOR THE HSA IN 2019. CVMC PROVIDED SUCCESSFUL ON-SITE WORKSHOPS FOR A LOCAL MANUFACTURER COVERING ALL SHIFTS THAT WERE BOTH WELL ATTENDED AND WELL RECEIVED. CVMC CONTINUES TO STRENGTHEN CONNECTIONS WITH LOCAL BUSINESSES TO PROMOTE TOBACCO CESSATION EFFORTS. THROUGH THE CVMC SELF-MANAGEMENT PROGRAM, WE CONTINUE TO ATTEND LOCAL EMPLOYERS' WELLNESS FAIRS, INCLUDING: STATE EMPLOYEE WELLNESS, WASHINGTON COUNTY MENTAL HEALTH SERVICES, NORWICH UNIVERSITY AND COMMUNITY BASED OUTREACH (BARRE HERITAGE FESTIVAL, MONTPELIER ALIVE) AND EXPANDED OUTREACH BY PARTICIPATING IN NATIONAL PROMOTIONS SUCH AS THE GREAT AMERICAN SMOKE-OUT. OUR OUTREACH WORK SERVES AS A TOOL FOR EDUCATING AND NETWORKING WITH COMMUNITY MEMBERS, WE CONTINUE TO WORK WITH OUR LOCAL PARTNERS, CONNECT WITH LOCAL COLLABORATIVES AND WORKGROUPS TO EXPAND OUR REACH AND SERVICE TO DIFFERENT POPULATIONS.

HEALTHY DIETS

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

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

CVMC RECOGNIZES THE IMPORTANCE OF INSPIRING HEALTHY LIFESTYLE CHANGES AND PROVIDING RESOURCES TO THE COMMUNITY TO ASSIST PEOPLE TRYING TO STAY HEALTHY THROUGH COMMUNITY HEALTH FAIRS. HEALTH FAIRS ARE A WAY TO MAKE IMPORTANT SCREENINGS (BLOOD PRESSURE CHECKS, BODY COMPOSITION) ASSESSABLE TO THE GENERAL POPULATION FOR LITTLE OR NO COST. CVMC CHOSE THREE UNIQUE POPULATIONS TO PROMOTE HEALTH (MONTPELIER, NORTHFIELD, AND BARRE) AND BY TAILORING CONTENT FOR EACH ONE LED TO HIGH VOLUME COMMUNITY PARTICIPATION RATES STAFFED BY REGISTERED DIETITIANS, NURSES, AND CERTIFIED HEALTH WELLNESS COACHES. CONSISTENTLY PROVIDED WAS PROACTIVE INFORMATION AND FUN, INTERACTIVE ACTIVITIES SUCH AS NUTRITIONAL DISPLAYS, RECIPES, SMOOTHIE BIKE, HEALTHY LIVING WORKSHOPS, WORKSITE WELLNESS IDEAS, AND WALKING EXERCISE PROGRAMS. BEING PRESENT AND OFFERING ENGAGING ACTIVITIES PROVIDED THE COMMUNITY THE VENUE TO ASK HEALTH-RELATED QUESTIONS, IDEAS FOR NEEDED RESOURCES, AND MAKE CONNECTIONS FOR MEMBERS THAT MAY NOT ASK OTHERWISE. LEADING BY EXAMPLE, CVMC PARTICIPATED IN NATIONAL WALK AT LUNCH DAY AND THE CONNECTING HOPE ANNUAL EVENT-WINTER WARM UP AND PROMOTED WELLNESS AT SPORTING EVENTS SUCH AS THE MUDDY ONION BIKE RACE.

YOUTH PARTICIPATION IN PHYSICAL ACTIVITIES

CVMC'S POPULATION HEALTH MANAGEMENT GOALS REVOLVE AROUND THE IDENTIFICATION OF RISK FACTORS THAT, IF ADDRESSED EARLY, CAN REDUCE THE PREVALENCE OF CHRONIC MEDICAL CONDITIONS LATER IN LIFE.

PANEL MANAGEMENT EFFORTS CONTINUE WITHIN OUR CVMC PEDIATRIC PRIMARY CARE PRACTICE TO IDENTIFY CHILDREN THAT ARE OVERDUE FOR WELL-CHILD VISITS AND

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

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

PROVIDE OUTREACH TO ENCOURAGE THEM TO ATTEND. BODY MASS INDEX IS CALCULATED AT EACH WELL-CHILD VISIT AND EDUCATION IS PROVIDED AROUND THE IMPORTANCE OF PHYSICAL ACTIVITY FOR OUR PEDIATRIC PATIENTS. IN ADDITION, THE CVMC SCHOOL-BASED HEALTH PROGRAM, AN EXTENSION OF OUR PEDIATRIC PRIMARY CARE PRACTICE AND OPERATES TWO DAYS EACH WEEK AT THE BARRE CITY ELEMENTARY AND MIDDLE SCHOOL, OFFERS THE BENEFIT OF BEING EMBEDDED IN THE SCHOOL SETTING. THIS PROVIDES GREATER OPPORTUNITIES FOR OUR PEDIATRIC CLINICIANS TO DISCUSS AND PROMOTE THE IMPORTANCE OF PHYSICAL ACTIVITY AND HOW IT IMPACTS OVERALL HEALTH AND WELL-BEING WITH OUR PEDIATRIC PATIENTS.

CVMC HAS UPDATED ITS HEALTHY LIVING FOR KIDS WORKSHOP TO FOCUS ON HEALTHY HABITS FOR A HEALTHY LIFESTYLE WHILE STAYING WEIGHT NEUTRAL IN ITS MESSAGE. BY OPENING UP THE CLASS EXPERIENCE TO THE FAMILY AS A WHOLE, CVMC IS STRIVING TO REACH A BROADER AUDIENCE, AND PROMOTE ACTIVE PARTICIPATION OF YOUTH IN PREPARATION OF HEALTHY FOODS AND PAIRING FOOD WITH PHYSICAL ACTIVITY TO FOSTER POSITIVE SELF-IMAGE AND LIFELONG HEALTHY HABITS.

NEEDS NOT BEING ADDRESSED

THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY IDENTIFIED ADDITIONAL DETERMINANTS OF HEALTH THAT FALL OUTSIDE THE REALM OF OUR CAPABILITIES AT CVMC. A PROMINENT NEED THAT WE ARE NOT DIRECTLY ADDRESSING IS ORAL HEALTH. SEVERAL OF OUR PHYSICIANS HAVE UNDERGONE FLUORIDE TREATMENT TRAINING, AND ARE ABLE TO PROVIDE THIS SERVICE FOR CHILDREN UP TO FOUR YEARS OF AGE WHO DO NOT HAVE ACCESS TO DENTAL CARE. HOWEVER, ONE OUT OF FOUR ADULTS IN WASHINGTON COUNTY HAS NOT VISITED A

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

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

DENTIST IN THE LAST YEAR. AS A MEDICAL HOSPITAL, WE DO NOT HAVE THE FACILITIES OR EXPERTISE TO ADDRESS THIS NEED DIRECTLY. WITH THIS SAID, IT IS IMPORTANT THAT WE RECOGNIZE ALL FACTORS THAT MAY BE AFFECTING THE OVERALL HEALTH OF PATIENTS WALKING THROUGH OUR DOORS AT CVMC. WE INTEND TO CONTINUE COLLABORATION WITH COMMUNITY FACILITIES SUCH AS THE HEALTH CENTER IN PLAINFIELD AND THE PEOPLE'S HEALTH AND WELLNESS CENTER IN BARRE THAT OFFER DENTAL CARE. OTHER AREAS WERE IDENTIFIED WHICH WE HAVE CHOSEN TO ACKNOWLEDGE, BUT NOT ADDRESS DIRECTLY AS PART OF OUR STRATEGIC PLAN. SOME OF THOSE NEEDS WERE:

- INCREASE AVAILABLE HOUSING FOR THOSE IN NEED
- DECREASE TEENAGE PREGNANCIES
- DECREASE UNPLANNED PREGNANCIES
- EXPAND SERVICES TARGETING THE ELDERLY IN OUR COMMUNITY
- INCREASE THE NUMBER OF WALKING PATHS AND/OR BIKE LANES IN OUR COMMUNITY
- INCREASE AVAILABILITY TO MENTAL HEALTH SERVICES MENTAL HEALTH HAS BEEN IDENTIFIED AS THE COSTLIEST MEDICAL CONDITION IN THE COUNTRY AND AN AREA THAT SUFFERS FROM INADEQUATE CAPACITY.
- CVMC IS WORKING ALONGSIDE WASHINGTON COUNTY MEDICAL HEALTH SERVICES TO INTEGRATE MENTAL HEALTH PRACTITIONERS INTO EVERY PRIMARY CARE PRACTICE
- FAMILY PSYCHIATRY ADOPTED A FORMAL STANDARDIZED DEPRESSION SCREENING FOR PATIENTS AGED 12 AND OLDER
- CVMC, IN COLLABORATION WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES, IS OFFERING ADDITIONAL PRE-NATAL AND POSTPARTUM SUPPORT FOR WOMEN WITH A HISTORY OF, OR AT RISK FOR DEPRESSION.

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

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

PART V, LINES 16A, 16B & 16C

HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/CVMC-FINANCIAL-ASSISTAN

CE-POLICY-2020.PDF

HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/CVMC-FINANCIAL-ASSISTAN

CE-APPLICATION-2020.PDF

HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/CVMC-FINANCIAL-ASSISTAN

CE-POLICY-SUMMARY-2020.PDF

PART V, LINE 16J

IN ADDITION TO HAVING THE APPLICATION FOR FINANCIAL ASSISTANCE AND THE SLIDING SCALE GRID OF HOW FINANCIAL ASSISTANCE IS AWARDED. CVMC HAS COMPREHENSIVE INFORMATION ON THE WEBSITE ABOUT THE POLICY, MATERIALS REQUIRED TO APPLY AND CONTACT INFORMATION FOR THE FINANCIAL COUNSELORS, SO INTERESTED INDIVIDUALS CAN APPLY. ADDITIONALLY, THERE IS REFERENCE MADE TO THE POLICY ON PATIENT'S BILLS AS WELL AS APPLICATIONS AND INFORMATION AVAILABLE IN REGISTRATION AREAS IN THE HOSPITAL AND CLINIC LOCATIONS. CVMC ALSO EMPLOYS A TEAM OF FINANCIAL COUNSELORS WHO WORK WITH PATIENTS THROUGHOUT THEIR VISIT TO ENSURE THAT WE COMMUNICATE WITH AS MANY ELIGIBLE INDIVIDUALS AS POSSIBLE. THESE FINANCIAL COUNSELORS ALSO WORK WITH PATIENTS TO EXPLORE THE OTHER OPPORTUNITIES AVAILABLE TO INDIVIDUALS IN NEED THROUGHOUT THE STATE OF VERMONT.

PART V, LINE 18F

CVMC DID NOT INITIATE ANY OF THE ACTIONS DESCRIBED IN SCHEDULE H, PART V, SECTION B, LINE 18. HOWEVER, IF THE HOSPITAL HAD UNDERTAKEN ANY OF THE

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

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

LISTED ACTIONS, IT WOULD HAVE FIRST NOTIFIED PATIENTS OF ITS FINANCIAL ASSISTANCE POLICY ON ADMISSION, PRIOR TO DISCHARGE, AND IN COMMUNICATIONS WITH THE PATIENTS REGARDING THEIR BILLS. ADDITIONALLY, CVMC WOULD HAVE DOCUMENTED ITS DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY.

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? 1

Name and address	Type of Facility (describe)
1 CVMC - WOODRIDGE NURSING HOME 142 WOODRIDGE DRIVE BERLIN VT 05602	SKILLED NURSING FACILITY
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

SCHEDULE H, PART VI, LINE 1

THE ORGANIZATION'S REQUIRED SCHEDULE H SPECIFIC LINE ITEM DESCRIPTIONS

ARE AS FOLLOWS:

PART I, LINES 3A-C:

PATIENT ELIGIBILITY:

ELIGIBILITY FOR FINANCIAL ASSISTANCE WILL BE CONSIDERED FOR THOSE

INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR ANY

GOVERNMENT HEALTH CARE BENEFIT PROGRAM, AND WHO ARE UNABLE TO PAY FOR

THEIR CARE, BASED UPON A DETERMINATION OF FINANCIAL NEED IN ACCORDANCE

WITH THIS POLICY. THE GRANTING OF CHARITY SHALL BE BASED ON AN

INDIVIDUALIZED DETERMINATION OF FINANCIAL NEED, AND SHALL NOT TAKE INTO

ACCOUNT AGE, GENDER, RACE, SOCIAL OR IMMIGRANT STATUS, SEXUAL

ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR RELIGIOUS AFFILIATION.

ELIGIBILITY FOR FINANCIAL ASSISTANCE IS BASED ON BOTH AN INCOME AND ASSET

TEST.

A. INCOME TEST: THIS PROGRAM IS LIMITED TO PATIENTS WITH DEMONSTRATED

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

FINANCIAL NEED EITHER DUE TO LIMITED INCOME OR IF THEIR MEDICAL BILLS ARE AN EXCESSIVE PORTION OF THEIR INCOME. THE MOST RECENTLY PUBLISHED FEDERAL PROVIDER GUIDELINES WILL BE USED AS THE PRIMARY DETERMINANT. A PATIENT WHOSE HOUSEHOLD INCOME IS AT OR BELOW 400% OF THE FEDERAL POVERTY LEVEL GUIDELINES (FPLG), AS ADJUSTED FOR HOUSEHOLD SIZE, MAY PASS THE INCOME TEST AND ARE CONSIDERED FOR CHARITY CARE ASSISTANCE IF THEY ALSO PASS THE ASSET TEST.

-NON-CUSTODIAL PARENTS MAY HAVE THEIR INCOME ADJUSTED FOR CHILD SUPPORT WHEN SUPPORTING DOCUMENTATION OF PAYMENT IS PROVIDED.

-PATIENTS MAY HAVE THEIR INCOME ADJUSTED FOR ALIMONY WHEN SUPPORTING DOCUMENTATION OF PAYMENT IS PROVIDED.

-DEPENDENTS MAY BE INCLUDED WITHIN THE HOUSEHOLD WHEN MORE THAN 50% OF THE SUPPORT IS PROVIDED BY THE GUARANTOR. TO QUALIFY FOR THIS HOUSEHOLD EXTENSION, THE DEPENDENT MUST BE LISTED AS A DEPENDENT ON THE FEDERAL INCOME TAX RETURN.

B. ASSET TEST: EACH INDIVIDUAL/HOUSEHOLD RESIDING IN VERMONT OR APPLICABLE COUNTIES IN NEW YORK AND NEW HAMPSHIRE ARE ALLOWED LIQUID ASSETS TO EQUAL $50,000. IF ASSETS ARE BELOW THIS GUIDELINE, THE PATIENT

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

PASSES THE ASSETS TEST.

-INCLUDED IN THE ASSET TEST:

-CASH, SAVINGS ACCOUNT BALANCES, CHECKING ACCOUNT BALANCES, MONEY MARKETS, CD'S, TERM CERTIFICATES, ANNUITIES, STOCKS, BONDS, MUTUAL FUNDS AND OTHER "LIQUID" ASSETS.

-HOMES (EXCLUDING THE PRIMARY RESIDENCE), RENTAL PROPERTIES, AND FAIR MARKET VALUE FOR RECREATIONAL VEHICLES. DEPENDING UPON THE VALUE, RENTAL PROPERTIES MAY BE EXCLUDED FROM THE CALCULATION PROVIDED RENTAL INCOME IS INCLUDED IN THE MONTHLY HOUSEHOLD CALCULATION.

EXCLUSIONS:

-PRIMARY RESIDENCE, ASSETS HELD IN A TAX DEFERRED COMPARABLE RETIREMENT SAVINGS ACCOUNT AND COLLEGE SAVINGS ACCOUNTS HELD BY THE PATIENT FOR THE PATIENT ARE EXCLUDED FROM THE ASSETS REVIEW.

-ACCOUNTS ALREADY REFERRED TO A COLLECTION AGENCY GREATER THAN 120 DAYS FROM PLACEMENT TO AGENCY, UNLESS REFERRED IN ERROR;

-SERVICES REIMBURSED DIRECTLY TO THE PATIENT(S) BY AN INSURANCE CARRIER OR ALREADY COVERED BY ANOTHER THIRD PARTY.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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

-TUITION STIPENDS AND/OR GRANTS FOR EDUCATION ARE NOT CONSIDERED A LIQUID

ASSET AND SHALL NOT BE FACTORED INTO THE ASSETS TEST.

PUBLIC HEALTH CARE PROGRAM/HEALTHCARE EXCHANGE CRITERION:

PATIENTS APPLYING FOR CVMC FINANCIAL ASSISTANCE ARE REVIEWED FOR THEIR

POTENTIAL ELIGIBILITY FOR STATE OR FEDERAL HEALTHCARE PROGRAM BENEFITS

AND/OR BENEFITS OFFERED THROUGH THE VERMONT OR NY HEALTHCARE EXCHANGE

PROGRAMS. ANY PATIENT IDENTIFIED WITH POTENTIAL TO BE GRANTED SUCH

ASSISTANCE WILL BE INSTRUCTED TO APPLY. FOR THOSE PATIENTS IDENTIFIED AS

CANDIDATES FOR ELIGIBILITY FOR EITHER THE NY OR VT OR NH HEALTHCARE

EXCHANGE PROGRAM; APPLICATION FOR AND COMPLIANCE WITH THOSE PROGRAM

GUIDELINES IS A PRE-REQUISITE FOR CVMC PATIENT FINANCIAL ASSISTANCE.

EXCLUSIONS: A PATIENT WHOSE RELIGIOUS OR CULTURAL BELIEF SYSTEM PROHIBITS

SEEKING OR RECEIVING FINANCIAL ASSISTANCE FROM A GOVERNMENT ENTITY MAY BE

EXCLUDED FROM THE PUBLIC HEALTH CARE PROGRAM CRITERION. THE PATIENT WILL,

HOWEVER, BE REQUIRED TO ASSUME A PORTION OF FINANCIAL RESPONSIBILITY TO

BE ASSESSED BY THE PATIENT ASSISTANCE PROGRAM APPEALS COMMITTEE.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

DETERMINATION OF FINANCIAL NEED:

FINANCIAL NEED WILL BE DETERMINED IN ACCORDANCE WITH PROCEDURES THAT

INVOLVE AN INDIVIDUAL ASSESSMENT OF FINANCIAL NEED WHICH WILL INCLUDE THE

FOLLOWING: NOTE, IN THE CASE OF PRESUMPTIVE CHARITY, THE APPLICATION

PROCESS MAY BE EXCLUDED.

-INCLUDE AN APPLICATION PROCESS, IN WHICH THE PATIENT OR THE PATIENT'S

GUARANTOR ARE REQUIRED TO COOPERATE AND SUPPLY PERSONAL, FINANCIAL AND

OTHER INFORMATION AND DOCUMENTATION RELEVANT TO MAKING A DETERMINATION OF

FINANCIAL NEED;

-INCLUDE REASONABLE EFFORTS BY CVMC TO EXPLORE APPROPRIATE ALTERNATIVE

SOURCES OF PAYMENT AND COVERAGE FROM PUBLIC AND PRIVATE PAYMENT PROGRAMS,

AND TO ASSIST PATIENTS TO APPLY FOR SUCH PROGRAMS;

-TAKE INTO ACCOUNT THE PATIENT'S AVAILABLE ASSETS, AND ALL OTHER

FINANCIAL RESOURCES AVAILABLE TO THE PATIENT;

IT IS PREFERRED BUT NOT REQUIRED THAT A REQUEST FOR FINANCIAL ASSISTANCE

AND A DETERMINATION OF FINANCIAL NEED OCCUR PRIOR TO RENDERING OF

SERVICES. A PATIENT MUST HAVE A CURRENT PATIENT BALANCE THAT IS DUE TO

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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

CVMC, AN EXPECTATION THAT AN ACCOUNT CURRENTLY PENDING INSURANCE WILL LEAVE A BALANCE THAT IS DUE TO CVMC, OR A FUTURE SCHEDULED/REFERRED SERVICE AT CVMC THAT IS EXPECTED TO LEAVE A PATIENT BALANCE. HOWEVER, THE DETERMINATION MAY BE DONE AT ANY POINT IN THE BILLING CYCLE. CENTRAL VERMONT MEDICAL CENTER'S VALUES OF HUMAN DIGNITY AND STEWARDSHIP SHALL BE REFLECTED IN THE APPLICATION PROCESS, FINANCIAL NEED DETERMINATION AND GRANTING OF FINANCIAL ASSISTANCE. REQUESTS FOR CHARITY SHALL BE PROCESSED PROMPTLY AND CVMC SHALL NOTIFY THE PATIENT/APPLICANT OF DECISION IN WRITING WITHIN 30 DAYS OF RECEIPT OF A COMPLETED APPLICATION.

FINANCIAL ASSISTANCE ELIGIBILITY PERIOD:

THE NEED FOR CHARITY ASSISTANCE SHALL BE RE-EVALUATED AT EACH SUBSEQUENT TIME OF SERVICE IF THE LAST FINANCIAL EVALUATION WAS COMPLETED MORE THAN SIX MONTHS PRIOR, OR AT ANY TIME ADDITIONAL INFORMATION RELEVANT TO THE ELIGIBILITY OF THE PATIENT FOR CHARITY BECOMES KNOWN. RE-EVALUATION OF PATIENTS WHOSE AGE EXCEEDS 65 AND WHOSE INCOME IS FIXED BELOW 400% FPLG SHALL OCCUR ANNUALLY. NOTE: IT IS PERMISSIBLE FOR PATIENTS TO SUBMIT NEW SUPPORTING FINANCIAL DOCUMENTATION PROVIDED THE APPLICATION ON FILE IS

Part VI Supplemental Information

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5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

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LESS THAN ONE YEAR OLD. SUPPORTING FINANCIAL DOCUMENTATION PROVIDED THE

APPLICATION ON FILE IS LESS THAN ONE YEAR OLD. CENTRAL VERMONT MEDICAL

CENTER'S VALUE OF HUMAN DIGNITY AND STEWARDSHIP SHALL BE REFLECTED IN THE

APPLICATION PROCESS, FINANCIAL NEED DETERMINATION AND GRANTING OF

FINANCIAL ASSISTANCE. REQUESTS FOR CHARITY SHALL BE PROCESSED PROMPTLY

AND CVMC SHALL NOTIFY THE PATIENT/APPLICANT OF DECISION IN WRITING WITHIN

30 DAYS OF RECEIPT OF A COMPLETED APPLICATION.

PART I, LINE 7:

CVMC FOLLOWS THE IRS GUIDELINE FOR THE COMPLETION OF SCHEDULE H, PART I,

LINES 7A-K, COLUMNS A-F. CVMC'S COST-TO-CHARGE RATIO IS USED FOR EACH OF

THESE CALCULATIONS.

PART I, LINE 7, COLUMN 7:

THE PROVISION FOR BAD DEBT INCLUDED ON FORM 990, PART IX, LINE 25 BUT

SUBTRACTED FOR PURPOSE OF CALCULATING THE AMOUNT REPORTED ON LINE 7(F) IS

$5,607,318.

Part VI Supplemental Information

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PART III, LINE 2:

BAD DEBT EXPENSE WAS CALCULATED BY TAKING THE CHARGES THAT WERE WRITTEN OFF TO ALLOWANCE TO BAD DEBT RESERVE AND REDUCING BY ANY RECOVERIES. THE BAD DEBT RESERVE IS BASED ON AN EVALUATION OF THE COLLECTABILITY OF ACCOUNTS RECEIVABLE. CVMC ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR CATEGORIES OF REVENUE TO ESTIMATE THE APPROPRIATE BAD DEBT RESERVE. MANAGEMENT REGULARLY REVIEWS ACCOUNTS RECEIVABLE DATA AND THE BAD DEBT RESERVE FOR REASONABLENESS.

PART III, LINE 3:

THE AMOUNT ATTRIBUTABLE TO PATIENTS ELIGIBLE FOR CHARITY CARE WAS CALCULATED USING A PERCENTAGE OF COLLECTION CASES WHEREBY THE COLLECTION AGENCY HAS, UPON FURTHER COLLECTION ACTIVITY BEEN INFORMED THAT THE PATIENT REQUESTED FINANCIAL ASSISTANCE WITH HIS/HER BILL. THIS PERCENTAGE IS APPROXIMATELY 2% OF ALL COLLECTION CALL ACTIVITY. THIS PERCENTAGE WAS CALCULATED FROM THE NUMBER OF CALLS WITH A REQUEST FOR FINANCIAL ASSISTANCE LISTED ON THE COLLECTION AGENCY'S LOG AS A PERCENTAGE OF THE TOTAL NUMBER OF CALLS THE COLLECTION AGENCY MADE.

Part VI Supplemental Information

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

PART III, LINE 4:

PLEASE REFERENCE FOOTNOTE NUMBER 3 ON PAGE 16-17 IN THE FISCAL YEAR 2019

AUDITED CONSOLIDATED FINANCIAL STATEMENTS.

PART III, LINE 8:

SERVING PATIENTS WITH GOVERNMENT HEALTH BENEFITS SUCH AS MEDICARE IS A

COMPONENT OF THE COMMUNITY BENEFIT STANDARD TO WHICH TAX-EXEMPT HOSPITALS

ARE HELD. THIS IMPLIES THAT SERVING MEDICARE PATIENTS IS A COMMUNITY

BENEFIT AND THAT THE HOSPITAL OPERATES TO PROMOTE THE HEALTH OF THE

COMMUNITY. CVMC DETERMINES THE ALLOWABLE MEDICARE COSTS BY USING A COST

TO CHARGE RATIO CALCULATION.

PART III, LINE 9B:

INDIVIDUALS WHO RECEIVE SERVICES ARE EXPECTED TO PAY FOR THESE SERVICES

AND/OR FIND OTHER MEANS OF RESOLUTION WHICH MAY INCLUDE HEALTH INSURANCE

COVERAGE, AN APPROVED PAYMENT PLAN AND/OR IF ELIGIBLE THE PATIENT

FINANCIAL ASSISTANCE PROGRAM. WHEN ALL EFFORTS TO OBTAIN PAYMENT FROM THE

PATIENT OR SPONSORSHIP FROM THE FINANCIAL ASSISTANCE PROGRAM HAVE BEEN

Part VI Supplemental Information

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EXHAUSTED, ACCOUNTS WILL BE REFERRED TO A THIRD-PARTY COLLECTION AGENCY

AT THE END OF THE BILLING CYCLE. CENTRAL VERMONT MEDICAL CENTER DOES NOT

ENGAGE IN EXTRAORDINARY COLLECTION ACTIONS AND MAKES REASONABLE ATTEMPTS

TO INFORM, EDUCATE, AND ENCOURAGE PATIENTS TO APPLY FOR FINANCIAL

ASSISTANCE WHERE HARDSHIP EXISTS. CENTRAL VERMONT MEDICAL CENTER DOES NOT

DISCRIMINATE ON THE BASIS OF RACE, COLOR, SEX, SEXUAL ORIENTATION, GENDER

IDENTITY OR EXPRESSION, AGE, LANGUAGE, OR PHYSICAL OR MENTAL DISABILITY.

PROCEDURE:

1. CENTRAL VERMONT MEDICAL CENTER WILL SUBMIT CLAIMS TO INSURERS AND WILL

WORK WITH THEM TO FACILITATE TIMELY PROCESSING. THE PATIENT IS

RESPONSIBLE FOR COMPLYING WITH ALL PRE-AUTHORIZATION, PRE-CERTIFICATION,

REFERRAL AND OTHER POLICY REQUIREMENTS. THE PATIENT'S INSURANCE POLICY IS

AN AGREEMENT BETWEEN THE PATIENT AND THE INSURANCE CARRIER; IT IS NOT AN

AGREEMENT BETWEEN THE ORGANIZATION AND THE INSURANCE CARRIER.

2. A GUARANTOR SYSTEM DETERMINES WHO IS FINANCIALLY RESPONSIBLE FOR

SELF-PAY BALANCES. ADULTS ARE RESPONSIBLE FOR THEMSELVES AS WELL AS THEIR

MINOR CHILDREN. IN THE CASE OF MARRIED INDIVIDUALS, THE PATIENT SHALL

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

MAINTAIN FINANCIAL RESPONSIBILITY REGARDLESS OF WHO IS THE INSURANCE

POLICYHOLDER.

3.THE GUARANTOR WILL BE BILLED ON A MONTHLY (28-DAY MONTH) CYCLE FOR ALL

SELF-PAY BALANCES DETERMINED TO BE THEIR RESPONSIBILITY. STATEMENTS WILL

BE SENT AFTER INSURANCES HAVE ACTED ON THE CLAIMS AND/OR NO RESPONSE HAS

BEEN RECEIVED FROM THE INSURER. IN THE CASE OF AN UNINSURED PATIENT, A

STATEMENT WILL BE GENERATED BASED UPON AN ALPHA CYCLE DURING THE MONTH

AFTER SERVICES HAVE BEEN RENDERED. PAYMENT IN FULL IS DUE AT TIME OF

SERVICE AND/OR NO LATER THAN THE DUE DATE ON THE INITIAL BILLING

STATEMENT.

4. THE GUARANTOR WILL RECEIVE A TOTAL OF THREE STATEMENTS FOLLOWED BY A

PRE-COLLECTION LETTER (FINAL NOTICE) OVER THE COURSE OF 120 DAYS.

SEPARATE STATEMENTS WILL BE GENERATED FOR HOSPITAL, PHYSICIAN AND

ANESTHESIA SERVICES. THE SAME 120-DAY COURSE OF BILLING WILL OCCUR ACROSS

EACH LINE OF BUSINESS WITH THE EXCEPTION SITED IN #8. SHOULD STATEMENTS

BE RETURNED AS UNDELIVERABLE, CUSTOMER SERVICE WILL CONTACT THE PATIENT

VIA PHONE TO OBTAIN AN ACCURATE BILLING ADDRESS. IN THIS CASE, THE NEW

MAILING DATE WILL BEGIN THE 120-DAY COURSE OF BILLING. IF NO CONTACT CAN

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BE MADE WITH THE PATIENT AND PAYMENT IS NOT RECEIVED WITHIN 120 DAYS, THE

ACCOUNT WILL BE REFERRED TO A COLLECTION AGENCY FOR FOLLOW-UP. ALL

STATEMENTS INDICATE THAT FINANCIAL ASSISTANCE IS AVAILABLE; THE PHONE

NUMBER TO CONTACT A CUSTOMER SERVICE REPRESENTATIVE IS ALSO INCLUDED.

5. WHEN PAYMENT IS NOT RECEIVED, CUSTOMER SERVICE REPRESENTATIVES WILL

ATTEMPT TO CONTACT THE PATIENT WITHIN 30 DAYS OF STATEMENT MAILING TO

OBTAIN PAYMENT AND/OR ESTABLISH A PAYMENT PLAN. IF WE ARE UNABLE TO

CONNECT WITH THE PATIENT, FOLLOW-UP CALLS VIA AUTOMATED MESSAGING WILL

OCCUR OVER THE COURSE OF THE 120-DAY BILLING CYCLE. ADDITIONAL MESSAGING

OF INCREASE URGENCY WILL BE REFLECTED ON SECOND AND THIRD STATEMENTS WITH

THE MAILING OF A PRE-COLLECTION (FINAL NOTICE) LETTER URGING THE PATIENT

CONTACT THE CUSTOMER SERVICE DEPARTMENT.

6. PATIENTS WHO ARE UNABLE TO MAKE PAYMENT IN FULL MAY BE OFFERED A

BUDGET PLAN. BUDGET PLANS ARE A COURTESY AND WHEN A PATIENT ENTERS INTO

THE AGREEMENT AN EXPECTATION FOR TIMELY AND CONSISTENT PAYMENT IS

EXPECTED. BUDGET PLANS MAY BE OFFERED UP TO A MAXIMUM OF 36 MONTHS

DEPENDING UPON THE TOTAL ACCOUNT BALANCE. SHOULD A PATIENT REQUEST AN

EXTENDED TIMEFRAME, MANAGEMENT RESERVES THE RIGHT TO EXTEND BEYOND 36

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MONTHS.

7. GUARANTORS/PATIENTS WHO ARE UNABLE TO MAKE PAYMENT IN FULL OR THROUGH

A BUDGET PLAN SHALL BE INFORMED OF AND COUNSELED ON THE PATIENT FINANCIAL

ASSISTANCE PROGRAM. CUSTOMER SERVICE REPRESENTATIVES WILL EDUCATE AND

ENCOURAGE PATIENTS TO APPLY FOR ASSISTANCE AND WILL DIRECT PATIENTS TO

OUR WEBSITE FOR APPLICATIONS TO MAIL AN APPLICATION DIRECTLY TO THE

PATIENT. AT THE TIME AN APPLICATION IS SENT TO THE PATIENT, ACCOUNTS IN

ARREARS WILL HAVE ONE MONTH OF AGING REDUCED TO ALLOW TIME FOR THE

PATIENT TO COMPLETE AND RETURN THE APPLICATION.

8. STATEMENTS INCLUDE ALL SERVICES PROVIDED TO THE PATIENT WHERE A

PATIENT RESPONSIBILITY REMAINS. ALTHOUGH BILLED IN AGGREGATE ON A MONTHLY

BASIS, AGING OF INDIVIDUAL ENCOUNTERS OCCURS INDEPENDENTLY OF OTHER

SERVICES. EACH ENCOUNTER SHALL RECEIVE A MINIMUM OF 120 DAYS OF BILLING

FROM THE DATE OF INITIAL SELF-PAY BALANCE PRIOR TO A COLLECTION AGENCY

REFERRAL. THERE IS ONE EXCEPTION TO THIS RULE; PHYSICIAN SERVICES WHERE

NO PAYMENT HAS BEEN RECEIVED OVER 120DAYS SHALL HAVE ALL SELF-PAY

BALANCES SENT TO COLLECTIONS AS A ONE-TIME TRANSACTION. SUBSEQUENT

SERVICES WILL RE-START THE 120-DAY AGING PROCESS.

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

9. IT IS THE PATIENT'S/GUARANTOR'S RESPONSIBILITY TO UPDATE THE ORGANIZATION WITH ANY CHANGES IN THEIR BILLING ADDRESS AND THEIR TELEPHONE NUMBER. STATEMENTS RETURNED FOR A BAD ADDRESS AND WHERE A VIABLE ADDRESS CANNOT BE OBTAINED VIA PHONE SHALL REMAIN IN-HOUSE FOR THE FULL 120 DAYS. AN EXCEPTION TO THIS PROCESS MAY OCCUR FOR INTERNATIONAL PATIENTS WHICH MAY HAVE AN EXPEDITED TRANSFER TO A THIRD-PARTY FOLLOW-UP AGENCY. IN CASES WHERE THERE IS NO WAY TO CONTACT A GUARANTOR, THE ACCOUNT MAY BE SENT TO AN OUTSIDE COLLECTION AGENCY PRIOR TO THE 120-DAY WINDOW FOR SKIP TRACKING FOLLOW-UP.

10. WHEN BILLING STATEMENTS, PRE-COLLECTION LETTERS (FINAL NOTICE), FOLLOW-UP PHONE CALLS AND MAILED FINANCIAL ASSISTANCE APPLICATIONS FAIL TO RESULT IN PAYMENT; AND A MINIMUM OF 120 DAYS HAVE BEEN EXHAUSTED, THE AGED ACCOUNT SHALL BE SENT TO A THIRD-PARTY COLLECTION AGENCY FOR FOLLOW-UP.

11. ACCOUNTS REFERRED TO A COLLECTION AGENCY WITHIN SEVEN DAYS OF PLACEMENT, SHALL BE RECALLED IF PAYMENT IS MADE, BUDGET ARRANGEMENTS ARE ESTABLISHED OR IF THE PATIENT HAS REQUESTED FINANCIAL ASSISTANCE. NOTE: APPROVED FINANCIAL ASSISTANCE APPLICATIONS MAY HAVE ACCOUNTS RECALLED

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FROM THE THIRD-PARTY AGENCY IF THEY FALL WITHIN THE APPLICATION WINDOW.

12. CENTRAL VERMONT MEDICAL CENTER DOES NOT ENGAGE IN EXTRAORDINARY COLLECTION ACTIONS, THIS INCLUDES: THE SELLING OF AN INDIVIDUAL'S DEBT TO A THIRD PARTY, REPORTING ADVERSE INFORMATION TO CONSUMER CREDIT REPORTING AGENCIES OR CREDIT BUREAUS, DEFERRING OR DENYING OR REQUIRING A PAYMENT BEFORE PROVIDING MEDICALLY NECESSARY CARE BECAUSE OF AN INDIVIDUAL'S NONPAYMENT OF ONE OR MORE BILLS FOR PREVIOUSLY PROVIDED CARE COVERED UNDER THE FINANCIAL ASSISTANCE PROGRAM, AND ACTIONS THAT REQUIRE A LEGAL OR JUDICIAL PROCESS. CVMC MAY FILE A LIEN ON THE PROCEEDS OF A JUDGMENT OR SETTLEMENT TO AN INDIVIDUAL AS A RESULT OF PERSONAL INJURIES FOR WHICH CVMC PROVIDED CARE, E.G., AUTO ACCIDENT.

13. CENTRAL VERMONT MEDICAL CENTER STAFF WILL ADHERE TO ALL LOCAL, STATE AND FEDERAL COLLECTION LAWS AND REGULATIONS REGARDING CREDIT AND COLLECTIONS. THE FAIR DEBT COLLECTION PRACTICES ACT IS THE CURRENT STANDARD.

14. ACCOUNTS WILL BE PLACED WITH AN OUTSIDE COLLECTION AGENCY ONCE MATURED OVER 120-DAYS, RECEIVED THREE STATEMENTS, A PRE-COLLECTION LETTER (FINAL NOTICE), AND ALL EFFORTS TO SECURE PAYMENT HAVE BEEN EXHAUSTED.

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ACCOUNTS PLACED IN COLLECTIONS WILL REMAIN WITH THE COLLECTION AGENCY FOR A PERIOD OF 2.5 YEARS. HOWEVER, IF AN ACCOUNT HAS NOT RECEIVED PAYMENT WITHIN 12 MONTHS, IT WILL BE RETURNED TO CVMC AS UNCOLLECTABLE FOR ALL LINES OF BUSINESS. ALL MEDICARE ACCOUNTS RETURNED WILL BE REPORTED ON A SEPARATE SPREADSHEET FOR REVIEW.

NEEDS ASSESSMENT

PART VI, LINE 2

THE COMPREHENSIVE 2019 CHNA INCLUDED AN IN-DEPTH REVIEW OF PRIMARY AND SECONDARY DATA. HEALTH TRENDS, SOCI-ECONOMIC STATISTICS, AND STAKEHOLDER PERCEPTIONS, AMONG OTHER INFORMATION WE ANALYZED TO INFORM COMMUNITY HEALTH PLANNING. PRIMARY STUDY METHODS WERE USED TO SOLICIT INPUT FROM HEALTH CARE CONSUMERS AND KEY COMMUNITY STAKEHOLDERS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY. SECONDARY STUDY METHODS WERE USED TO IDENTIFY AND ANALYZE STATISTICAL DEMOGRAPHIC AND HEALTH TRENDS. COMMUNITY ENGAGEMENT WAS AN INTEGRAL PART OF THE 2019 CHNA WITH WIDE PARTICIPATION FROM NEARLY 1,500 COMMUNITY STAKEHOLDERS WHO PARTICIPATED IN SURVEYS, FOCUS GROUPS, PLANNING MEETINGS, AND OTHER DIALOGUE.

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SPECIFIC CHNA STUDY METHODS INCLUDED:

-AN ANALYSIS OF SECONDARY DATA SOURCES, INCLUDING NATIONAL AND STATE HEALTH STATISTICS, DEMOGRAPHIC AND SOCIAL MEASURES, AND HEALTH CARE UTILIZATION DATA.

-A COMMUNITY MEMBER SURVEY COMPLETED BY 1,429 RESIDENTS COLLECTED COMMUNITY PERSPECTIVES ON HEALTH CONCERNS, BARRIERS TO CARE, RECOMMENDATIONS AND RELATED INSIGHTS.

-FOCUS GROUPS WITH 33 HEALTH CARE CONSUMERS INFORMED ACTION PLANNING AND STRATEGIES TO ADDRESS COMMUNITY HEALTH PRIORITIES.

-PRIORITIZATION OF HEALTH NEEDS IN COLLABORATION WITH THRIVE COMMUNITY ACTION NETWORK (CAN) MEMBERS AND CVMC CLINICAL AND ADMINISTRATIVE LEADERSHIP MEMBERS (CALM) LEADERS.

THE COMMUNITY HEALTH NEEDS ASSESSMENT IS AVAILABLE AT THE FOLLOWING WEB ADDRESS:

HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/COMMUNITY-HEALTH-NEEDS-ASSESSMENT-2019.PDF

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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.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

CVMC PROVIDES THE BELOW INFORMATION AND EDUCATION TO PATIENTS REGARDING

ELIGIBILITY OF FINANCIAL ASSISTANCE:

CVMC'S FINANCIAL ASSISTANCE SUMMARIES ARE INCLUDED IN ALL PATIENT

ADMISSION PACKETS IN ADDITION OF BEING POSTED ON THE CVMC WEBSITE.

THROUGHOUT THE CVMC CAMPUS AND OFFSITE PRACTICES CONSPICUOUS DISPLAYS

REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE ARE DISPLAYED.

INCLUDED ON ALL PATIENT INVOICES IS THE CONTACT INFORMATION FOR CVMC

PATIENT FINANCIAL SERVICES FOR PATIENTS WITH QUESTIONS OR CONCERNS

REGARDING PAYING THEIR BILL.

PATIENT FINANCIAL SERVICES HAS APPLICATIONS FOR ALL STATE FINANCIAL AID

PROGRAMS ON FILE. CVMC EMPLOYS A FINANCIAL COUNSELING TEAM WHO WILL MEET

WITH PATIENTS TO ASSIST IN DETERMINING WHICH PROGRAMS THE PATIENT MAY

QUALIFY FOR. THEY WILL ALSO PROVIDE ASSISTANCE IN FILLING OUT ANY

REQUIRED PAPERWORK.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

CVMC PATIENT FINANCIAL SERVICES PROACTIVELY SCREENS PATIENT BILLING INFORMATION TO IDENTIFY INDIVIDUALS WHO MAY BE ELIGIBLE FOR STATE OR CVMC ASSISTANCE, AND WILL EITHER VISIT THE PATIENT IN THE HOSPITAL, CALL THEM AT HOME, OR MAIL THEM THE INFORMATION.

COMMUNITY INFORMATION

PART VI, LINE 4

THE 2018 POPULATION OF WASHINGTON COUNTY IS 60,317. THE POPULATION INCREASED 1.3% FROM THE 2010 CENSUS, AND IS PROJECTED TO INCREASE BY 0.9% BY 2023. THE PROJECTED POPULATION GROWTH IS CONSISTENT WITH VERMONT OVERALL, AND LOWER THAN THE NATIONAL PROJECTION OF 4%.

THE POPULATION OF WASHINGTON COUNTY IS LESS RACIALLY DIVERSE THAN THE STATE AND THE NATION, WITH 95.3% OF RESIDENTS IDENTIFYING AS WHITE. WASHINGTON COUNTY IS ALSO OLDER THAN THE STATE AND THE NATION, WITH A MEDIAN AGE (44.5) THAT IS SIX YEARS OLDER THAN THE NATIONAL MEDIAN (38.3).

Part VI Supplemental Information

Provide the following information.

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2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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

THE MEDIAN INCOME IN WASHINGTON COUNTY ($58,611) IS SIMILAR TO THE NATIONAL MEDIAN ($58,100), BUT THE RATE OF POVERTY (11.8%) IS LOWER (14.6%). HOWEVER, FOR BLACKS/AFRICAN AMERICAN RESIDENTS LIVING IN WASHINGTON COUNTY, THE RATE OF POVERTY (19.0%) IS HIGHER THAN FOR WHITE RESIDENTS LIVING IN THE COUNTY (11.5%) AND HIGHER THAN FOR BLACKS/AFRICAN AMERICANS NATIONALLY (11.9%). UNEMPLOYMENT IN WASHINGTON COUNTY (2.8%) IS LOWER THAN THE NATIONAL RATE (4.8%), EXCEPT AMONG HISPANIC/LATINOS (15.2%). THESE RACIAL DISPARITIES IN ECONOMIC INDICATORS DECREASE THE QUALITY OF LIFE FOR ALL PEOPLE IN WASHINGTON COUNTY.

WASHINGTON COUNTY RESIDENTS ARE GENERALLY WELL EDUCATED. PEOPLE OF ALL RACES AND ETHNICITIES IN THE COUNTY ARE MORE LIKELY TO HAVE COMPLETED A BACHELOR'S DEGREE THAN OTHER PEOPLE FROM VERMONT OR ACROSS THE NATION. WHILE THIS FINDING IS A STRENGTH FOR THE COMMUNITY, IT IS WORTH NOTING THAT DESPITE HIGHER EDUCATION, NON-WHITE POPULATIONS CONTINUE TO EXPERIENCE GREATER ECONOMIC BARRIERS.

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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VERMONT HAS PROPORTIONATELY MORE LGBTQ PEOPLE THAN THE US IN GENERAL. THE STATE LGBTQ POPULATION TENDS TO BE YOUNGER AND MORE LIKELY TO BE FEMALE, HAS LOWER INCOMES, AND LESS SOCIAL SUPPORT THAN OTHER RESIDENTS. LGBTQ PEOPLE ARE ALSO MORE LIKELY TO EXPERIENCE HEALTH CHALLENGES, INCLUDING MORE POOR MENTAL HEALTH DAYS AND SUBSTANCE USE DISORDER CONDITIONS.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

AS A PARTNER IN THE UNIVERSITY OF VERMONT HEALTH NETWORK, CENTRAL VERMONT MEDICAL CENTER IS PART OF A REGION-WIDE EFFORT TO TRANSFORM HEALTH CARE THAT IS TRANSLATING TO BETTER CARE HERE IN OUR LOCAL CENTRAL VERMONT COMMUNITIES. IN ADDITION TO OUR NETWORK PARTNERSHIP, WE BELIEVE THAT MAINTAINING THE HIGHEST QUALITY CARE FOR OUR PATIENTS ALSO DEPENDS ON OUR SUPPORT AND COLLABORATION WITH THE MANY LOCAL ORGANIZATIONS THROUGHOUT CENTRAL VERMONT THAT ARE ALSO PROVIDING VITAL SERVICES TO OUR COMMUNITY.

SOME OF OUR COMMUNITY PARTNERS INCLUDE:

A. CENTRAL VERMONT HOME HEALTH AND HOSPICE

B. GREEN MOUNTAIN TRANSIT AUTHORITY (GMTA)

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

C. GREEN MOUNTAIN UNITY WAY

D. PEOPLE'S HEALTH AND WELLNESS CLINIC (PHWC)

E. PHARMACIES

F. VERMONT STATE DEPARTMENT OF HEALTH

G. WASHINGTON COUNTY MENTAL HEALTH

THE MAJORITY OF CVMC'S GOVERNING BODY (BOARD OF TRUSTEES) IS COMPRISED OF INDIVIDUALS WHO RESIDE IN CVMC'S PRIMARY SERVICE AREA WHO ARE NEITHER EMPLOYEES, FAMILY MEMBERS, NOR CONTRACTORS OF THE ORGANIZATION. CVMC EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITY.

CENTRAL VERMONT MEDICAL CENTER (CVMC) IS ALSO THE ADMINISTRATIVE ENTITY FOR THE VERMONT BLUEPRINT FOR HEALTH, PATIENT CENTERED MEDICAL HOMES FOR THE BARRE HEALTH SERVICE AREA (HSA). THE GOAL OF THE VERMONT BLUEPRINT FOR HEALTH, PASSED BY THE VERMONT LEGISLATURE IN 2010, IS TO SUPPORT VERMONT'S EFFORTS TO DEVELOP A COMPREHENSIVE, PROACTIVE SYSTEM OF CARE THAT IMPROVES THE QUALITY OF LIFE FOR PEOPLE WITH, OR AT RISK FOR CHRONIC CONDITIONS. AT THE END OF 2019, OVER 50 PRIMARY CARE PROVIDERS WERE ALL PART OF A RECOGNIZED NATIONAL COMMITTEE FOR QUALITY ASSURANCE, PATIENT

Part VI Supplemental Information

Provide the following information.

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6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

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

CENTERED MEDICAL HOME IN THE BARRE HSA CARING FOR OVER 30,000 PATIENTS.

THE CVMC COMMUNITY HEALTH TEAM (CHT) IS A PATIENT-CENTERED

MULTIDISCIPLINARY TEAM THAT STRIVES TO IMPROVE THE PRIMARY HEALTH AND

WELLNESS FOR ALL PATIENTS IN CENTRAL VERMONT. CHT IS COMMITTED TO

REMOVING HEALTH BARRIERS BY OFFERING SERVICE FREE OF CHARGE, WHICH

CONSISTS OF A NURSE, OR DIETITIAN, OR WELLNESS COACH, OR CLINICAL SOCIAL

WORKERS IN THE COMFORT OF YOUR PRIMARY CARE OFFICE. CHT SERVICES CAN HELP

YOU OR THOSE YOU LOVE IMPROVE THEIR CHANCES FOR REACHING GOALS WHILE

PROVIDING ONE-ON-ONE SUPPORT. THE CHT TEAM WORKS WITHIN THE CVMC PRIMARY

CARE PRACTICES AROUND CENTRAL VERMONT, AS WELL AS WOMEN'S HEALTH.

CVMC APPLIES SURPLUS FUNDS TO REVITALIZE FACILITIES, PURCHASE EQUIPMENT,

STAFF EDUCATION AND TO ENHANCE PROGRAMS TO PROVIDE BETTER PATIENT AND

FAMILY CENTERED CARE (PFCC).

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AS OF OCTOBER 1, 2011, CENTRAL VERMONT MEDICAL CENTER, INC. (CVMC) AND

THE UNIVERSITY OF VERMONT MEDICAL CENTER (UVMMC) BECAME MEMBERS OF THE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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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.

UNIVERSITY OF VERMONT HEALTH NETWORK (UVMHN), AN INTEGRATED SYSTEM OF CARE SERVING THE COMMUNITIES OF VERMONT AND NORTHERN NEW YORK. THE UNIVERSITY OF VERMONT HEALTH NETWORK IS CARRYING OUT CENTRALIZED ACTIVITIES FOR THE BENEFIT OF PATIENTS OF PARTNER ORGANIZATIONS, INCLUDING IMPROVING ACCESS TO LOCAL CARE, COST SAVINGS THROUGH GREATER JOINT PURCHASING POWER, ENHANCING INFORMATION TECHNOLOGY, INCREASING ACADEMIC OPPORTUNITIES FOR PHYSICIANS, ENGAGING IN REGIONAL STRATEGIC PLANNING, AND PARTICIPATING IN JOINT QUALITY AND CLINICAL INITIATIVES. SINCE THE HEALTH NETWORK'S INCEPTION, CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER, ELIZABETH COMMUNITY HOSPITAL, ALICE HYDE MEDICAL CENTER, PORTER MEDICAL CENTER, AND UVM HEALTH NETWORK HOME HEALTH & HOSPICE HAVE ALSO JOINED.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

VT

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments, and Individuals in the United States

Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . [X] **Yes** [ ] **No**

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) PEOPLES HEALTH AND WELLNESS CENTER 553 NORTH MAIN ST, SUITE 5 BARRE, VT 05641	03-0343290	501(C)(3)	36,000.				HEALTH CARE FOR THE SVCS TO UNINSURED
(2) AREA HLTH EDU CNTRS PRM UNIV VT COL OF MED UHC CMP ARNLD 5,1 S.PRPCT BRLNGTN, VT 05401	03-0179440	501(C)(3)	27,580.				EDU LOAN RPMT TO HLT HLTHCR PRFSNLS
(3) CAPSTONE COMMUNITY ACTION 20 GABLE PLACE BARRE, VT 05641	03-0216254	501(C)(3)	15,000.				SUPPORT EMERGENCY FO OD AND HEATING
(4) VERMONT YOUTH CONSERVATION CORPS 1949 EAST MAIN ST RICHMOND, VT 05477	03-0328834	501(C)(3)	17,277.				SUPPORT FOOD INSECUR
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 4.

3 Enter total number of other organizations listed in the line 1 table . . . . . ▶

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

	(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1						
2						
3						
4						
5						
6						
7						

Part IV **Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b); and any other additional information.

DESCRIPTION OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS

SCHEDULE I, PART I, LINE 2

CENTRAL VERMONT MEDICAL CENTER OCCASIONALLY GRANTS FUNDS TO ORGANIZATIONS THAT SUPPORT CVMC'S EXEMPT PURPOSE OF SERVING THE HEALTHCARE NEEDS OF CENTRAL VERMONT RESIDENTS. GRANT FUNDS ARE APPROVED AND OVERSEEN BY THE BOARD.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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.**

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

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.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (such as maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**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.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ 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**	X	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	X	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	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**		X
b	Any related organization?	**6b**		X
	If "Yes" on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**		X
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**		X
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 II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	JOHN BRUMSTED, MD TRUSTEE	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	1,012,428.	428,283.	565,120.	187,243.	26,998.	2,220,072.	287,334.
2	JEREMIAH ECKHAUS, MD TRUSTEE, PRES-ELECT MED STAFF	(i)	216,690.	10,932.	55,060.	16,297.	26,349.	325,328.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
3	MARK DEPMAN, MD TRUSTEE, REGNAL PHYS LEADER	(i)	307,293.	10,195.	58,398.	0.	21,910.	397,796.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
4	ANNA T. NOONAN TRUSTEE, PRESIDENT/COO	(i)	325,995.	274,143.	28,767.	29,742.	32,937.	691,584.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
5	CATHY PALMER, MD TRUSTEE	(i)	30,150.	0.	0.	0.	0.	30,150.	0.
		(ii)	241,488.	0.	20,528.	18,425.	29,419.	309,860.	0.
6	RICHARD BURGOYNE MEDICAL DIRECTOR	(i)	311,938.	0.	145,780.	0.	16,178.	473,896.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
7	CHEYENNE HOLLAND TREASURER, CFO, UNTIL 07/2018	(i)	138,352.	42,650.	158,486.	10,274.	30,061.	379,823.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
8	MATTHEW CHOATE VP OF PATIENT CARE SERVICES	(i)	203,014.	41,348.	1,092.	13,642.	20,450.	279,546.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
9	CHRISTIAN BEAN, MD PHYSICIAN	(i)	441,421.	2,850.	216,518.	36,572.	27,596.	724,957.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
10	JAVAD MASHKURI, MD PHYSICIAN/MEDICAL DIRECTOR	(i)	340,056.	34,440.	35,786.	23,343.	27,618.	461,243.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
11	CHRISTOPHER MERIAM, MD PHYSICIAN	(i)	434,136.	2,200.	141,273.	33,841.	28,540.	639,990.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
12	SARA GRAVES, MD PHYSICIAN	(i)	372,301.	2,200.	166,999.	20,001.	27,557.	589,058.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
13	ROBERT PATTERSON VP OF HR & CLINICAL OPERATIONS	(i)	202,801.	45,367.	27,909.	15,154.	26,460.	317,691.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
14	DAVID TURNER VP PHYSICIAN SERVICES	(i)	171,547.	0.	820.	10,295.	1,817.	184,479.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
15	JAMES ALVAREZ VP SUPPORT SRVCS, AS OF 1/2018	(i)	193,917.	28,922.	7.	0.	8,978.	231,824.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
16	PATRICIA FISHER, MD CHIEF MEDICAL OFFICER, 3/2018	(i)	236,422.	33,184.	4,625.	10,462.	23,300.	307,993.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

	(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
			(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1	TODD KEATING INTRM TREAS/CFO UNTIL 7/2018	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	583,615.	193,123.	88,557.	24,750.	4,551.	894,596.	0.
2	JUDITH TARTAGLIA TRUSTEE, PRES/CEO UNTIL 3/2017	(i)	216,084.	0.	0.	0.	0.	216,084.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
3		(i)							
		(ii)							
4		(i)							
		(ii)							
5		(i)							
		(ii)							
6		(i)							
		(ii)							
7		(i)							
		(ii)							
8		(i)							
		(ii)							
9		(i)							
		(ii)							
10		(i)							
		(ii)							
11		(i)							
		(ii)							
12		(i)							
		(ii)							
13		(i)							
		(ii)							
14		(i)							
		(ii)							
15		(i)							
		(ii)							
16		(i)							
		(ii)							

Part III Supplemental Information

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

SCHEDULE J, PART I, LINE 3

IN ADDITION TO THE TOOLS AND PROCESSES IDENTIFIED IN PART I, CVMC RECEIVES GUIDANCE REGARDING ITS PRESIDENT'S COMPENSATION FROM THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES OF THE UNIVERSITY OF VERMONT HEALTH NETWORK, WHICH IS THE SOLE MEMBER OF THE HOSPITAL. THAT NETWORK COMPENSATION COMMITTEE UTILIZES THE FOLLOWING METHODS TO ESTABLISH THE GUIDANCE:

- COMPENSATION COMMITTEE
- INDEPENDENT COMPENSATION CONSULTANT
- COMPENSATION SURVEY OR STUDY
- APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

SCHEDULE J, PART I, LINE 4A

DURING CALENDAR YEAR 2018, CHEYENNE HOLLAND RECEIVED $113,432 IN SEVERANCE PAYMENTS AFTER HER DEPARTURE IN JULY 2018.

EXECUTIVE BENEFITS

SCHEDULE J, PART I, LINE 4B

CERTAIN LISTED INDIVIDUALS PARTICIPATED IN THE UVM MEDICAL CENTER

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.

EXECUTIVE BENEFIT PLAN UNDER WHICH PARTICIPANTS ARE CREDITED A BENEFIT ALLOWANCE EQUAL TO A SPECIFIED PERCENTAGE OF BASE PAY. UNDER THE PLAN, PARTICIPANTS MAY ELECT TO HAVE THE AMOUNT OF THE BENEFIT ALLOWANCE DEFERRED TO A CAPITAL ACCUMULATION ACCOUNT SUBJECT TO SECTION 457(F). NO AMOUNTS WERE DEFERRED TO OR PAID FROM A CAPITAL ACCUMULATION ACCOUNT IN CALENDAR 2018.

DURING CALENDAR YEAR 2015, THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. ENTERED INTO A SUPPLEMENTAL RETIREMENT BENEFIT PLAN (SRP) WITH CHIEF EXECUTIVE OFFICER BRUMSTED. UNDER THE TERMS OF THE SRP, UVM MEDICAL CENTER MAKES ANNUAL CREDITS EQUAL TO 15% OF THE PRESIDENT'S BASE SALARY FOR EACH YEAR THROUGH THE PLAN YEAR ENDING SEPTEMBER 30, 2019. THE AMOUNT DEFERRED FOR CALENDAR YEAR 2018 IS REPORTED ON SCHEDULE J, PART II, COLUMN C. A DISTRIBUTION OF $371,381 IN CALENDAR 2018 IS REPORTED IN COLUMN B(III). AMOUNTS DEFERRED REMAIN SUBJECT TO FORFEITURE IF CERTAIN CONDITIONS ARE NOT MET.

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

DESCRIPTION OF THE ORGANIZATION'S MISSION

FORM 990, PART III, LINE 1

CENTRAL VERMONT MEDICAL CENTER TRUSTEES AND ITS STAFF ARE COMMITTED TO PROVIDING EXCELLENT CARE TO CENTRAL VERMONTERS. TO STAY ABREAST OF BEST PRACTICES, CVMC COLLABORATES WITH MANY HEALTHCARE ENTITIES TO ENSURE THIS COMMITMENT. PARTICIPATING IN THE JOINT COMMISSION ACCREDITATIONS PROCESS IS ONE MEASURE OF HOW CVMC CONTINUOUSLY STRIVES TO IMPROVE THE SAFETY AND QUALITY OF CARE PROVIDED TO ITS PATIENTS. THE HOSPITAL AND THE PHYSICIAN PRACTICE GROUPS (CVMGP, CENTRAL VERMONT MEDICAL GROUP PRACTICES) WERE ACCREDITED IN JANUARY 2016 FOR A THREE-YEAR PERIOD. JOINT COMMISSION ACCREDITATION IS THE EQUIVALENT OF THE GOOD HOUSEKEEPING "SEAL OF APPROVAL" FOR MEDICAL CENTERS. THE JOINT COMMISSION EVALUATES THE QUALITY AND SAFETY OF CARE PROVIDED BY HEALTH CARE ORGANIZATIONS. TO EARN AND MAINTAIN ACCREDITATION, ORGANIZATIONS MUST HAVE AN EXTENSIVE ON-SITE REVIEW BY A TEAM OF JOINT COMMISSION HEALTH CARE PROFESSIONALS AT LEAST ONCE EVERY THREE YEARS. THE PURPOSE OF THE REVIEW IS TO EVALUATE THE ORGANIZATION'S PERFORMANCE IN AREAS THAT AFFECT PATIENT CARE. ACCREDITATION IS AWARDED BASED ON HOW WELL THE ORGANIZATION MEETS THE JOINT COMMISSION STANDARDS. CVMC PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. ALL OF CVMC'S SERVICES, INCLUDING EMERGENCY CARE, ARE PROVIDED TO ALL PERSONS REGARDLESS OF ABILITY TO PAY.

Name of the organization	Employer identification number
CENTRAL VERMONT MEDICAL CENTER, INC.	22-2547186

FORM 990, PART VI, LINE 2

THERE IS A BUSINESS RELATIONSHIP BETWEEN DR. JOHN BRUMSTED AN OFFICER OF THE UNIVERSTIY OF VERMONT MEDICAL CENTER (UVMMC), DR. CATHY PALMER AN EMPLOYEE OF UVMMC AND TODD KEATING, INTERIM TREASURER, CFO OF CENTRAL VERMONT MEDICAL CENTER INC. (CVMC).

DESCRIPTION OF CLASSES OF MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, LINE 6

THE UNIVERSITY OF VERMONT HEALTH NETWORK IS THE SOLE MEMBER AND PARENT CORPORATION OF CENTRAL VERMONT MEDICAL CENTER, INC. (CVMC). THE UNIVERSITY OF VERMONT HEALTH NETWORK IS A VERMONT NON-PROFIT CORPORATION WHICH HAS BEEN RECOGNIZED BY THE IRS AS A 501(C)(3) ORGANIZATION THAT IS NOT A PRIVATE FOUNDATION.

ELECTION OF GOVERNING BODY & GOVERNANCE DECISIONS

FORM 990, PART VI, LINE 7A & 7B

THE UNIVERSITY OF VERMONT HEALTH NETWORK HOLDS THE POWER TO ELECT CVMC'S BOARD OF TRUSTEES AND TO APPROVE SIGNIFICANT CORPORATE ACTIONS, INCLUDING ANNUAL OPERATING AND CAPITAL BUDGETS, STRATEGIC PLANS, THE APPOINTMENT OF THE PRESIDENT/COO, THE INCURRENCE OF LONG-TERM INDEBTEDNESS, AND AMENDMENTS TO CVMC'S BYLAWS AND ARTICLES OF ORGANIZATION.

DESCRIPTION OF PROCESS USED BY MGMNT &/OR GOVERNING BODY TO REVIEW 990

FORM 990, PART VI, LINE 11B

THE FORM 990 IS PREPARED BY THE ACCOUNTING MANAGER AND REVIEWED IN DETAIL

Name of the organization	Employer identification number
CENTRAL VERMONT MEDICAL CENTER, INC.	22-2547186

BY CVMC'S OUTSIDE TAX ADVISORS BEFORE BEING REVIEWED BY THE OFFICERS OF THE CORPORATION AND BY THE OTHER MEMBERS OF THE SENIOR MANAGEMENT TEAM. THE ACCOUNTING MANAGER PROVIDES REGULATORY UPDATES REGARDING THE FORM 990 TO THE OPERATIONAL RISK COMMITTEE AND MAKES AVAILABLE TO THE OPERATIONAL RISK COMMITTEE THE FORM 990 ALONG WITH HIGHLIGHTS OF ALL SIGNIFICANT PARTS OF THE FORM 990. THE BOARD OF TRUSTEES IS ALSO PROVIDED VIA EMAIL A COPY OF THE "AS FILED" FORM 990 BEFORE IT IS FILED WITH THE IRS, WITH A STATEMENT NOTATING THAT SCHEDULE B IS NOT FOR PUBLIC VIEWING. THE FORM 990 IS ALSO AVAILABLE IN HARD COPY FOR THOSE THAT DO NOT HAVE ACCESS TO EMAIL.

DESCRIPTION OF PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST
FORM 990, PART VI, LINE 12C

THE COMPLIANCE OFFICER FOR CVMC MAINTAINS THE CONFLICT OF INTEREST STATEMENTS AND REGULARLY MONITORS THEM AS WELL AS ANY OTHER ACTIVITIES THAT MAY CONSTITUTE A CONFLICT OF INTEREST. THE ORGANIZATION'S PRACTICE IS TO SEND OUT ANNUAL DISCLOSURE QUESTIONNAIRES TO BOARD OF TRUSTEE MEMBERS, SENIOR OFFICERS, AND DIRECTORS OF THE ORGANIZATION OR OTHER INDIVIDUALS IN A POSITION TO EXERCISE SUBSTANTIAL INFLUENCE OVER THE AFFAIRS OF THE ORGANIZATION WHO HAVE A DIRECT OR INDIRECT FINANCIAL INTEREST, AS DEFINED BELOW, AS AN "INTERESTED PERSON." THIS DEFINITION SHALL ALSO INCLUDE MEMBERS OF THE ORGANIZATION'S LEADERSHIP GROUP, MEDICAL DIRECTORS AND ANY EMPLOYEES INVOLVED WITH RECOMMENDING OR PURCHASING PRODUCTS/SERVICES.

THE RESPONSES ARE TAKEN TO THE GOVERNANCE AND HUMAN RESOURCES COMMITTEE

Name of the organization	Employer identification number
CENTRAL VERMONT MEDICAL CENTER, INC.	22-2547186

OF THE BOARD OF TRUSTEES TO DETERMINE IF A CONFLICT OF INTEREST EXISTS. THE GOVERNANCE AND HUMAN RESOURCES COMMITTEE SHALL MAINTAIN A LIST OF INDIVIDUALS WHO MAY BE CONSIDERED DISQUALIFIED PERSONS UNDER IRS REGULATIONS. THE GOVERNANCE AND HUMAN RESOURCES COMMITTEE SHALL REPORT THE RESULTS OF ITS REVIEW ANNUALLY TO THE BOARD OF TRUSTEES. IF THERE IS ANY POSSIBILITY OF FINANCIAL GAIN BY A TRUSTEE AND OR EMPLOYEE FROM ANY DECISION THAT IS TO BE DELIBERATED ON, THEN THAT TRUSTEE/EMPLOYEE MAY MAKE A PRESENTATION, BUT IS THEN REMOVED FROM THOSE DISCUSSIONS TO ENSURE THAT THE TRUSTEE/EMPLOYEE WILL NOT TAKE PART IN ANY DELIBERATIONS THAT HE OR SHE MIGHT PERSONALLY GAIN FROM. THE TRUSTEE/EMPLOYEE OPERATING UNDER A CONFLICT IS PROHIBITED FROM VOTING ON ANY MATTER TO WHICH THE CONFLICT RELATES.

WHISTLEBLOWER & DOCUMENT RETENTION - DESTRUCTION POLICIES
FORM 990, PART VI, LINES 13 & 14

CVMC HAS BOTH A WHISTLEBLOWER AND A DOCUMENT RETENTION - DESTRUCTION POLICY. THESE POLICIES ARE EFFECTIVE WITHOUT FORMAL BOARD APPROVAL.

OFFICES & POSITIONS FOR WHICH PROCESS WAS USED, & YEAR PROCESS WAS BEGUN
FORM 990, PART VI, LINES 15A & 15B

THE PROCESS FOR DETERMINING COMPENSATION FOR THE ORGANIZATION'S PRESIDENT/COO AND CFO INCLUDES A REVIEW AND APPROVAL BY THE BOARD OF TRUSTEES. AN INDEPENDENT COMPENSATION STUDY IS ALSO PERIODICALLY PERFORMED. THE MOST RECENT STUDY WAS PERFORMED IN 2019. THIS STUDY INCLUDED COMPENSATION DATA FOR CHIEF EXECUTIVE OFFICERS AND VICE PRESIDENTS. INDEPENDENT RESEARCH IS COMPLEMENTED BY A MARKET STUDY

Name of the organization: CENTRAL VERMONT MEDICAL CENTER, INC.
Employer identification number: 22-2547186

ANALYSIS PERFORMED BY THE HUMAN RESOURCES DEPARTMENT AND REVIEWED BY THE BOARD OF TRUSTEES. MARKET STUDY DATA COMES FROM, BUT IS NOT LIMITED TO, HFMA, VAHHS, NEAH, AHA, INDUSTRY SPECIFIC COMPENSATION SURVEYS AND OTHER HEALTHCARE SOURCES.

THE COMPENSATION OF OTHER KEY EMPLOYEES OF THE ORGANIZATION IS DETERMINED THROUGH MARKET STUDY ANALYSIS PERFORMED BY THE HUMAN RESOURCES DEPARTMENT AND REVIEWED BY THE BOARD OF TRUSTEES IF NECESSARY.

IN ADDITION TO THE TOOLS AND PROCESSES IDENTIFIED IN SCHEDULE J, PART I, CVMC RECEIVES GUIDANCE REGARDING ITS PRESIDENT'S COMPENSATION FROM THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES OF THE UNIVERSITY OF VERMONT HEALTH NETWORK, WHICH IS THE SOLE MEMBER OF THE HOSPITAL. THAT NETWORK COMPENSATION COMMITTEE UTILIZES THE FOLLOWING METHODS TO ESTABLISH THE GUIDANCE:

- COMPENSATION COMMITTEE
- INDEPENDENT COMPENSATION CONSULTANT
- COMPENSATION SURVEY OR STUDY
- APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

AVAIL OF GOV DOCS, CONFLICT OF INTEREST POLICY, & FIN STMTS TO GEN PUBLIC
FORM 990, PART VI, LINE 19

THE ORGANIZATION MAKES AVAILABLE GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICIES AND FINANCIAL STATEMENTS TO THE GENERAL PUBLIC UPON REQUEST. THE FINANCIAL STATEMENTS OF THE ORGANIZATION FOR FY2019 CAN ALSO BE FOUND ON THE WEBSITE, WWW.CVMC.ORG.

Name of the organization	Employer identification number
CENTRAL VERMONT MEDICAL CENTER, INC.	22-2547186

FORM 990, PART VII

THREE PHYSICIANS SERVING AS BOARD MEMBERS, DR. PALMER, DR. DEPMAN AND DR. ECKHAUS, RECEIVE COMPENSATION FROM THE ORGANIZATION FOR THEIR SERVICES AS PHYSICIANS. THIS COMPENSATION IS NOT RELATED TO THEIR PARTICIPATION AS MEMBERS OF THE BOARD OF TRUSTEES.

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES:

CHANGE IN MINIMUM PENSION LIABILITY	($14,438,385)
TRANSFER OF NET ASSETS	7,631,189
OTHER CHANGES TO TEMP RESTRICTED ASSETS	(1,316,742)
CHANGE IN PERPETUAL TRUST	109,210

TOTAL: ($8,014,728)

CIRCULAR A-133 AUDIT

FORM 990, PART XII, LINE 3B:

DURING FY19, CVMC DID NOT REACH THE LEVEL REQUIRED TO WARRANT AN AUDIT UNDER OMB CIRCULAR A-133. HOWEVER, BECAUSE OF CVMC'S AFFILIATION WITH THE UNIVERSITY OF VERMONT HEALTH NETWORK, CVMC WAS INCLUDED IN THE A-133 THAT WAS PERFORMED FOR THE UNIVERSITY OF VERMONT MEDICAL CENTER.

Name of the organization
CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number
22-2547186

ATTACHMENT 1

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

HOSPITAL SERVICES: INPATIENT, OUTPATIENT, AND 24/7 EMERGENCY DEPARTMENT SERVICES: CVMC HAS 122 LICENSED BEDS TO PROVIDE FOR A FULL SPECTRUM OF INPATIENT, OUTPATIENT, AND EMERGENCY CARE SERVICES. 19,947 INPATIENT DAYS, MORE THAN 245,000 OUTPATIENT PROCEDURES, AND 25,822 EMERGENCY ROOM VISITS WERE RECORDED DURING FISCAL YEAR 2019. OUTPATIENT ANCILLARY SERVICE UNITS MAKE UP THE MAJORITY OF SERVICE VOLUME, INCLUDING 38,480 RADIOLOGY PROCEDURES, 478,604 LAB TESTS, 16,799 CARDIOLOGY TESTS, AND 151,173 UNITS OF PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY. EMERGENCY DEPARTMENT: THE ER IS OPEN 24 HOURS A DAY 365 DAYS A YEAR. THE NUMBER OF PATIENTS SEEN IN THE ER IN FISCAL YEAR 19 WAS 25,822. THE CANCER TREATMENT CENTER PROVIDED 4,794 ONCOLOGY AND RADIATION TREATMENTS. THE HOSPITAL ALSO HAS BEEN ACTIVE IN ITS OUTREACH TO CENTRAL VERMONT'S UNINSURED AND UNDER INSURED RESIDENTS.

ATTACHMENT 2

FORM 990, PART III - PROGRAM SERVICE, LINE 4C

WOODRIDGE REHAB & NURSING IS A MEDICARE-CERTIFIED 153-BED SKILLED NURSING FACILITY LOCATED ON THE CAMPUS OF CENTRAL VERMONT MEDICAL CENTER. APPROXIMATELY TWO-THIRDS OF THE FACILITIES BEDS ARE DEDICATED TO LONG TERM CARE, INCLUDING PALLIATIVE CARE/END OF LIFE CARE AND THE OTHER ONE-THIRD PROVIDE SHORT TERM REHABILITATION THERAPY AND POST-ACUTE CARE FOR A GREAT VARIETY OF MEDICAL CARE CATEGORIES, INCLUDING PAIN MANAGEMENT AND WOUND CARE. THE FACILITY

Name of the organization: CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number: 22-2547186

ATTACHMENT 2 (CONT'D)

PROVIDES "PERSON-CENTERED", ROUND THE CLOCK NURSING CARE AND SOCIAL SERVICES SUPPORT COMPLEMENTING DAILY, ROBUST ACTIVITIES PROGRAMS, FINE DINING AND HAS A FULL COMPLIMENT OF SUPPORT SERVICES INCLUDING HOUSEKEEPING/LAUNDRY, MAINTENANCE AND TRANSPORTATION. MANY OTHER AMENITIES ARE AVAILABLE TO FACILITY RESIDENTS.

ATTACHMENT 3

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
E F WALL & ASSOCIATES, INC. 131 SOUTH MAIN ST, PO BOX 259 BARRE, VT 05641	CONSTRUCTION CNTRCTR	1,493,851.
MARCAM ASSOCIATES, LLC PO BOX 60 ROCHESTER, NH 03866	AR BILLING/COLLECT	721,168.
PC CONSTRUCTION COMPANY 193 TILLEY DRIVE SOUTH BURLINGTON, VT 05403	CONSTRUCTION CNTRCTR	902,127.
WEATHERBY LOCUMS, INC. PO BOX 972633 DALLAS, TX 75397-2633	PHYSICIAN STAFFING	576,008.
MAZARS USA LLP 135 WEST 50TH ST NEW YORK, NY 10020	REVEN CYCLE CONSLTNT	751,705.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) UNIVERSITY OF VERMONT MEDICAL CENTER,INC 03-0219309 111 COLCHESTER AVE BURLINGTON, VT 05401	HOSPITAL	VT	501(C)(3)	3	UVMHN	X	
(2) UNIV OF VERMONT HEALTH NETWORK, INC. 45-2880726 111 COLCHESTER AVE BURLINGTON, VT 05401	HOLDING CO	VT	501(C)(3)	12A-I	N/A		X
(3) UNIV OF VERMONT MEDICAL GROUP - NEW YORK 20-3905216 183 PARK STREET MALONE, NY 12953	PHYS SVCS	NY	501(C)(3)	3	UVMMG	X	
(4) UNIVERSITY OF VERMONT MEDICAL GROUP 03-0225105 111 COLCHESTER AVE BURLINGTON, VT 05401	PHYS SVCS	VT	501(C)(3)	12A-I	UVMHN	X	
(5) UNIV OF VERMONT MEDICAL CTR. FDN, INC. 26-3159849 111 COLCHESTER AVE BURLINGTON, VT 05401	FUNDRAISING	VT	501(C)(3)	12A-I	UVMMC	X	
(6) CENTRAL VERMONT HOSPITAL AUXILIARY 03-0264240 130 FISHER RD BERLIN, VT 05602	SERVICE	VT	501(C)(3)	12D-III-O	N/A		X
(7) COMMUNITY PROVIDERS, INC. 22-2544844 75 BEEKMAN ST. PLATTSBURGH, NY 12901	HLTH SVC COOR	NY	501(C)(3)	12A-I	UVMHN	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) CHAMPLAIN VALLEY PHYSICIANS HOSPITAL 14-1338471 75 BEEKMAN STREET PLATTSBURGH, NY 12901	HOSPITAL	NY	501(C)(3)	3	CPI	X	
(2) ELIZABETHTOWN COMMUNITY HOSPITAL 14-1364513 75 PARK STREET ELIZABETHTOWN, NY 12932	HOSPITAL	NY	501(C)(3)	3	CPI	X	
(3) EMERGENCY MEDICAL TRANSPORT OF CVPH, INC 06-1718419 75 BEEKMAN ST PLATTSBURGH, NY 12901	AMBULANCE SVC	NY	501(C)(3)	12B-II	CPI	X	
(4) CVPH MEDICAL CENTER FOUNDATION 14-1727048 75 BEEKMAN ST PLATTSBURGH, NY 12901	HLTH SVC SUPP	NY	501(C)(3)	12B-II	CVPH	X	
(5) UNIVERSITY MEDICAL EDUCATION ASSOCIATES 23-7107832 89 BEAUMONT AVE BURLINGTON, VT 05405	EDUCATIONAL	VT	501(C)(3)	11	UVMMG	X	
(6) UNIVERSITY HEALTH CENTER 03-0229931 111 COOLCHESTER AVE BURLINGTON, VT 05401	HOSPITAL	VT	501(C)(3)	12C-III-FI	UVMMG	X	
(7) ALICE HYDE MEDICAL CENTER 15-0346515 133 PARK STREET MALONE, NY 12953	HOSPITAL	NY	501(C)(3)	3	CPI	X	

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2018

Open to Public Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1) PORTER MEDICAL CENTER INC 03-0310862 115 PORTER DRIVE MIDDLEBURY, VT 05753	SUPPTG ORG	VT	501(C)(3)	12-BII	UVMHN	X	
(2) HELEN PORTER NURSING HOME 03-0306549 37 PORTER DRIVE MIDDLEBURY, VT 05753	NURSING HOME	VT	501(C)(3)	3	PMC	X	
(3) AUXILIARY OF PORTER MEDICAL CENTER 23-7363227 37 PORTER DRIVE MIDDLEBURY, VT 05753	SUPPORTG ORG	VT	501(C)(3)	12-B,II	PMC	X	
(4) PORTER HOSPITAL INC 03-0181058 37 PORTER DRIVE MIDDLEBURY, VT 05753	HOSPITAL	VT	501(C)(3)	3	PMC	X	
(5)							
(6)							
(7)							

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) ONECARE VERMONT ACCOUNTABLE CA 111 COLCHESTER AVENUE BURLINGT	ACCOUNTABLE C	VT	N/A									
(2) ADIRONDACKS ACO, LLC 46-284092 75 BEEKMAN STREET PLATTSBURGH,	ACCOUNTABLE C	NY	N/A									
(3) OBNET SERVICES, LLC 04-3746287 ONE MEDICAL CENTER DR LEBANON,	HEALTH RESEAR	NH	N/A									
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) CHARITABLE IRREVOCABLE TRUST (7)	SUPPORT	VT	UVMMC/CVMC	TRUST					
(2) UNIV OF VT MED CTR HEALTH VENT INC 04-3380045 111 COLCHESTER AVE BURLINGTON, VT 05401	HOLDING COMPA	VT	UVMMC	C CORP					
(3) VMC INDEMNITY COMPANY, LTD 99-9999999 PO BOX HM 3103, 25 CHURCH ST., HM F HAMILTON, BD HM FX F	CAPTIVE INSUR	BD	UVMMC	C CORP					
(4) VERMONT MANAGED CARE 03-0333056 111 COLCHESTER AVE BURLINGTON, VT 05401	ADMIN SERVICE	VT	UVMMCHV	C CORP					
(5) CHARITABLE REMAINDER TRUST (5)	SUPPORT	VT	UVMMC/CVMC	TRUST					
(6) PERPETUAL TRUST (4)	SUPPORT	VT	UVMMC	TRUST					
(7) CHAMPLAIN VALLEY HEALTH NETWORK 16-1586102 75 BEEKMAN STREET PLATTSBURGH, NY 12901	ADMIN SERVICE	NY	N/A	C CORP					

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? Yes	(h) No	(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1) MEDQUEST INC 14-1663061 PO BOX 1656 PLATTSBURGH, NY 12901	MED OFFICE LE	NY	N/A	C CORP					
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	UNIVERSITY OF VERMONT MEDICAL CENTER	J	866,761.	FMV
(2)	PERPETUAL TRUSTS	S	129,176.	FMV
(3)	UNIVERSITY OF VERMONT MEDICAL CENTER	O	18,418,847.	FMV
(4)	UNIVERSITY OF VERMONT MEDICAL CENTER	P	18,469,913.	FMV
(5)	UNIVERSITY OF VERMONT MEDICAL CENTER	Q	2,400,000.	FMV
(6)	UNIVERSITY OF VERMONT MEDICAL CENTER	R	452,887.	FMV

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

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

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

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)	UNIVERSITY OF VERMONT MEDICAL CENTER	S	3,903,292.	FMV
(2)				
(3)				
(4)				
(5)				
(6)				

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

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

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

Part VII **Supplemental Information**

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

SCHEDULE R, PART IV, LINE 1

UNIVERSITY OF VERMONT MEDICAL CENTER, INC. (UVM MEDICAL CENTER) HAS A BENEFICIAL INTEREST IN FOUR OF THESE TRUSTS. CVMC HAS A BENEFICIAL INTEREST IN THREE OF THESE TRUSTS.

SCHEDULE R, PART V, TRANSACTION K

UVM MEDICAL CENTER LEASES AND SHARES FACILITIES, EQUIPMENT, AND OTHER ASSETS WITH CVMC. THE VALUE OF THESE TRANSACTIONS IS INDETERMINABLE.