

PUBLIC DISCLOSURE COPY

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

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

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

A For the 2021 calendar year, or tax year beginning 10/01/2021 **and ending** 09/30/2022

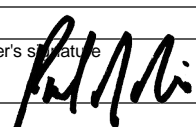
B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization CENTRAL VERMONT MEDICAL CENTER, INC.			D Employer identification number 22-2547186	
	Doing business as			E Telephone number (802) 371-4100	
	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		
	F Name and address of principal officer: MS. ANNA T. NOONAN 130 FISHER ROAD, BERLIN, VT 05602			G Gross receipts \$ 265,879,937. H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions	
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527					
J Website: WWW.CVMC.ORG					
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶					
L Year of formation: 1963				M State of legal domicile: VT	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: CVMC WORKS COLLABORATIVELY TO MEET THE NEEDS AND IMPROVE THE HEALTH OF THE RESIDENTS OF CENTRAL VERMONT.			
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.			
	3	Number of voting members of the governing body (Part VI, line 1a) 13		
	4	Number of independent voting members of the governing body (Part VI, line 1b) 9		
	5	Total number of individuals employed in calendar year 2021 (Part V, line 2a) 1,980		
	6	Total number of volunteers (estimate if necessary) 77		
	7a	Total unrelated business revenue from Part VIII, column (C), line 12 NONE		
7b	Net unrelated business taxable income from Form 990-T, Part I, line 11 NONE			
Revenue	8	Contributions and grants (Part VIII, line 1h) 2,456,635.	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g) 246,378,333.		6,297,264.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d) 3,261,175.		256,969,393.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 175,629.		2,304,410.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) 252,271,772.		235,551.
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3) 137,043.		183,698.
	14	Benefits paid to or for members (Part IX, column (A), line 4) NONE		NONE
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) 147,746,707.		152,188,161.
	16a	Professional fundraising fees (Part IX, column (A), line 11e) NONE		NONE
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 155,537.		
	17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 99,382,830.		124,870,185.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) 247,266,580.		277,242,044.	
19	Revenue less expenses. Subtract line 18 from line 12 5,005,192.		-11,435,426.	
Net Assets or Fund Balances	20	Total assets (Part X, line 16) 200,158,630.	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26) 79,226,379.		173,786,081.
	22	Net assets or fund balances. Subtract line 21 from line 20. 120,932,251.		82,407,234.

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 _____			
	KIMBERLY PATNAUDE CFO Type or print name and title			
Paid Preparer Use Only	Print/Type preparer's name PAUL TANIS	Preparer's signature 	Date 08/11/2023	Check <input type="checkbox"/> if self-employed PTIN P01441612
	Firm's name ▶ PWC TAX LLP		Firm's EIN ▶ 92-0460586	
	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** (2021)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

SEE SCHEDULE O

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No
If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses \$ 166,769,394. including grants of \$ 183,698.) (Revenue \$ 194,342,686.)

SEE SCHEDULE O

4b (Code:) (Expenses \$ 64,956,301. including grants of \$) (Revenue \$ 43,931,893.)

MEDICAL GROUP PRACTICES: AT THE END OF THE FISCAL YEAR WE HAD 28 PRIMARY CARE, INFIRMARY, AND SPECIALTY PRACTICES. THIS INCLUDED 10 PRIMARY AND FAMILY CARE CLINICS, 1 PEDIATRIC CLINIC, AS WELL AS SPECIALTY CLINICS FOR UROLOGY, CARDIOLOGY, PODIATRY, RHEUMATOLOGY, ENT, ENDOCRINOLOGY, ORTHOPAEDICS, PSYCHOLOGY, AND OBSTETRICS/GYNECOLOGY. THERE WERE A TOTAL OF 543,965 PRACTICE VISITS DURING FISCAL YEAR 2022.

4c (Code:) (Expenses \$ 22,602,415. including grants of \$) (Revenue \$ 18,694,814.)

SEE SCHEDULE O

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

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

4e Total program service expenses 254,328,110.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question, Yes, No. Rows 22-38 covering various organizational requirements and schedules.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

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 1,980		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note: If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. See instructions.	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		X
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation on Schedule O</i>		
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)?		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?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
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?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
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?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		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?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
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?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
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?		
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? 13a Note: See the instructions for additional information the organization must report on Schedule O.		
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?		X
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation on Schedule O</i>		
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? 15 If "Yes," see the instructions and file Form 4720, Schedule N.		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
17	Section 501(c)(21) organizations. Did the trust, any disqualified person, or mine operator engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953? 17 If "Yes," complete Form 6069.		

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (13), 1b (9), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

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

Table with 3 columns: Question, Yes, No. Rows include: 10a (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed -> 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.
19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records -> KIMBERLY PATNAUDE, CFO 130 FISHER RD BERLIN, VT 05602

802-371-4443

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) JOHN BRUMSTED, MD TRUSTEE	6.00 44.00	X						NONE	2,098,354.	66,714.
(2) CHRISTIAN BEAN, MD PHYSICIAN	50.00 NONE					X		NONE	595,994.	53,294.
(3) SARA GRAVES, MD PHYSICIAN	50.00 NONE					X		NONE	585,475.	50,351.
(4) CHRISTOPHER MERIAM, MD TRUSTEE, PRESIDENT MED STAFF	45.00 5.00	X						NONE	577,198.	55,491.
(5) JOHN BEGLY, MD PHYSICIAN	50.00 NONE					X		NONE	538,277.	56,280.
(6) ANNA T. NOONAN TRUSTEE, PRESIDENT/COO	35.00 15.00	X		X				475,876.	NONE	105,738.
(7) DAVID OSPINA, MD PHYSICIAN	50.00 NONE					X		NONE	400,181.	52,201.
(8) STEFAN LISCHKE, MD PHYSICIAN	50.00 NONE					X		NONE	396,026.	33,021.
(9) PATRICIA FISHER, MD FORMER CHIEF MED OFFICER	NONE NONE						X	305,772.	NONE	24,589.
(10) ROBERT PATTERSON VP OF HR & CLINICAL OPERATIONS	50.00 NONE					X		278,054.	NONE	49,895.
(11) JAMES ALVAREZ VP SUPPORT SERVICES	50.00 NONE					X		290,300.	NONE	35,544.
(12) JEREMIAH ECKHAUS, MD TRUSTEE, UNTIL 10/2021	50.00 NONE	X						NONE	271,349.	47,477.
(13) ANNA HANKINS, MD TRUSTEE, PRES-ELECT MED STAFF	45.00 5.00	X						NONE	256,608.	47,157.
(14) MATTHEW CHOATE VP PATIENT CARE SERVICES	50.00 NONE					X		261,579.	NONE	41,055.

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) KIMBERLY PATNAUDE TREASURER, CFO	50.00 NONE			X				257,242.	NONE	19,823.
(16) TODD KEATING FORMER INTERIM TREASURER	NONE NONE						X	NONE	196,134.	16,283.
(17) MICHAEL DELLIPRISCOLI TRUSTEE, UNTIL 12/2021	1.00 2.00	X						NONE	NONE	NONE
(18) LISA MULLER TRUSTEE, AS OF 12/2021	1.00 NONE	X						NONE	NONE	NONE
(19) THOMAS GOLONKA TRUSTEE, IMMEDIATE PAST CHAIR	1.00 2.00	X		X				NONE	NONE	NONE
(20) JOYCE JUDY TRUSTEE, CHAIR-ELECT	1.00 2.00	X		X				NONE	NONE	NONE
(21) MARY MOULTON TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(22) TONI KAEDING TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(23) SANDY ROUSSE TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(24) CONNIE COLMAN TRUSTEE, SECRETARY	1.00 NONE	X		X				NONE	NONE	NONE
(25) PAULETTE THABAULT TRUSTEE, CHAIR	1.00 2.00	X		X				NONE	NONE	NONE
1b Sub-total								1,868,823.	5,915,596.	754,913.
c Total from continuation sheets to Part VII, Section A								NONE	NONE	NONE
d Total (add lines 1b and 1c)								1,868,823.	5,915,596.	754,913.

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 ▶ 137

	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		
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		
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		

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								
	d	Related organizations	1d	153,275.							
	e	Government grants (contributions) . .	1e	5,914,343.							
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	229,646.							
	g	Noncash contributions included in lines 1a-1f	1g	\$							
	h	Total. Add lines 1a-1f			6,297,264.						
	Program Service Revenue	2a	NET PATIENT SERVICE REVENUE	Business Code	900099	185,790,735.	185,790,735.				
b		REV FROM MANAGED CARE AND CAPITATED	900099		54,595,886.	54,595,886.					
c		340B CONTRACT PHARMACY REVENUE	900099		8,904,183.	8,904,183.					
d		BLUEPRINT PMPM	900099		1,146,921.	1,146,921.					
e		OTHER CONTRACT/CLIENT REVENUE	900099		1,879,419.	1,879,419.					
f		All other program service revenue			4,652,249.	4,652,249.					
g		Total. Add lines 2a-2f			256,969,393.						
Other Revenue		3	Investment income (including dividends, interest, and other similar amounts)			2,304,410.		2,304,410.			
	4	Income from investment of tax-exempt bond proceeds .			NONE						
	5	Royalties			NONE						
	6a	Gross rents	6a	(i) Real							
				(ii) Personal							
					308,870.						
	b	Less: rental expenses	6b		73,319.						
	c	Rental income or (loss)	6c		235,551.	NONE					
	d	Net rental income or (loss)			235,551.		235,551.				
	7a	Gross amount from sales of assets other than inventory	7a	(i) Securities							
				(ii) Other							
	b	Less: cost or other basis and sales expenses . .	7b								
	c	Gain or (loss)	7c								
	d	Net gain or (loss)			NONE						
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a		NONE							
			b	Less: direct expenses	8b		NONE				
			c	Net income or (loss) from fundraising events			NONE				
			9a	Gross income from gaming activities. See Part IV, line 19	9a		NONE				
						b	Less: direct expenses	9b		NONE	
						c	Net income or (loss) from gaming activities			NONE	
			10a	Gross sales of inventory, less returns and allowances	10a		NONE				
						b	Less: cost of goods sold	10b		NONE	
						c	Net income or (loss) from sales of inventory			NONE	
Miscellaneous Revenue	11a	_____	Business Code								
	b	_____									
	c	_____									
	d	All other revenue									
	e	Total. Add lines 11a-11d			NONE						
12	Total revenue. See instructions			265,806,618.	256,969,393.	NONE	2,539,961.				

Part IX Statement of Functional Expenses

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

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

Table with 5 columns: (A) Total expenses, (B) Program service expenses, (C) Management and general expenses, (D) Fundraising expenses. Rows include categories like Grants, Compensation, Salaries, Pension, Payroll, Advertising, etc.

Part X Balance Sheet

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

Table with columns (A) Beginning of year, (B) End of year, and rows for Assets (1-16), Liabilities (17-26), and Net Assets or Fund Balances (27-33). Includes sub-rows 10a, 10b, 10c and checkboxes for FASB ASC 958 compliance.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	265,806,618.
2	Total expenses (must equal Part IX, column (A), line 25)	2	277,242,044.
3	Revenue less expenses. Subtract line 2 from line 1	3	-11,435,426.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	120,932,251.
5	Net unrealized gains (losses) on investments	5	-14,669,603.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	-3,448,375.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	91,378,847.

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits

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

**SCHEDULE A
(Form 990)**

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization

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

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

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

Section A. Public Support

Table with 7 columns: (a) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f); 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 9 Net income from unrelated business activities, whether or not the business is regularly carried on; 10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.); 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Percentage, and a checkbox. Rows include: 14 Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f)); 15 Public support percentage from 2020 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2021. 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 - 2020. 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 - 2021. 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 - 2020. 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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

Section C. Computation of Public Support Percentage

15 Public support percentage for 2021 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2020 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2021. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

b 33 1/3% support tests - 2020. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

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

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	8
9	Distributable amount for 2021 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

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

**Schedule B
(Form 990)**

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2021

Name of the organization

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

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

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), 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), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990).

Name of organization <p style="text-align: center;">CENTRAL VERMONT MEDICAL CENTER, INC.</p>	Employer identification number <p style="text-align: center;">22-2547186</p>
---	---

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	N/A <hr/> <hr/> <hr/>	\$ 21,360.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	N/A <hr/> <hr/> <hr/>	\$ 153,275.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	N/A <hr/> <hr/> <hr/>	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	N/A <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	N/A <hr/> <hr/> <hr/>	\$ 69,140.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	N/A <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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
7	N/A 	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	N/A 	\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	N/A 	\$ 17,408.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	N/A 	\$ 8,136.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	N/A 	\$ 15,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	N/A 	\$ 7,736.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization <p style="text-align: center;">CENTRAL VERMONT MEDICAL CENTER, INC.</p>	Employer identification number <p style="text-align: center;">22-2547186</p>
---	---

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
13	N/A <hr/> <hr/> <hr/>	\$ 59,159.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	N/A <hr/> <hr/> <hr/>	\$ 47,083.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	N/A <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	N/A <hr/> <hr/> <hr/>	\$ 43,871.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/>	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<hr/>	<hr/> <hr/> <hr/>	\$	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

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
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

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)**

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2021

Open to Public Inspection

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**

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

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

Name of organization CENTRAL VERMONT MEDICAL CENTER, INC.	Employer identification number 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)				

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

Schedule C (Form 990) 2021

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grassroots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures															
e Total exempt purpose expenditures (add lines 1c and 1d)															
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.															
<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a. If zero or less, enter -0-															
i Subtract line 1f from line 1c. If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? <input type="checkbox"/> Yes <input type="checkbox"/> No															

4-Year Averaging Period Under Section 501(h)

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

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

Table with 3 main columns: (a) Yes/No, (b) Amount. Rows include: 1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation... a Volunteers? b Paid staff or management... c Media advertisements? d Mailings to members... e Publications... f Grants to other organizations... g Direct contact with legislators... h Rallies, demonstrations... i Other activities? j Total. Add lines 1c through 1i... 2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? 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).

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

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."

Table with 2 main columns: Question, Amount. Rows include: 1 Dues, assessments and similar amounts from members... 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... b Carryover from last year... c Total... 3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues... 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? 5 Taxable amount of lobbying and political expenditures. See instructions.

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

Blank lines for supplemental information.

Part IV Supplemental Information (continued)

LOBBYING ACTIVITY

SCHEDULE C, PART II-B, LINE 11

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)

Supplemental Financial Statements

OMB No. 1545-0047

2021

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

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.

Table with 3 columns: Line number, Description, (a) Donor advised funds, (b) Funds and other accounts. Includes rows for total number at end of year, aggregate value of contributions, grants, and end of year, and two Yes/No questions regarding donor advisement.

Part II Conservation Easements.

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

Table with 3 columns: Line number, Description, and Held at the End of the Tax Year. Includes questions about purpose of easements, total number, acreage, and monitoring expenses.

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.

Table with 3 columns: Line number, Description, and Amount. Includes questions about reporting art and historical treasures in financial statements.

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

Schedule D (Form 990) 2021

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

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

Part IV Escrow and Custodial Arrangements.

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

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

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	8,660,412.	7,967,045.	8,058,522.	9,330,090.	9,432,674.
b Contributions	NONE	NONE	NONE	274,389.	NONE
c Net investment earnings, gains, and losses	-1,640,633.	779,068.	380,580.	549,557.	580,255.
d Grants or scholarships	NONE	NONE	NONE	NONE	NONE
e Other expenditures for facilities and programs	NONE	40,000.	421,217.	2,050,133.	617,608.
f Administrative expenses	59,800.	45,701.	50,840.	45,381.	65,231.
g End of year balance	6,959,979.	8,660,412.	7,967,045.	8,058,522.	9,330,090.

- 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 47.4400 %
 - c Term endowment 52.5600 %
- 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 | X | |
| (ii) Related organizations | X | |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? | 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		117,990,573.	78,199,903.	39,790,670.
c Leasehold improvements		4,340,349.	3,978,036.	362,313.
d Equipment		48,638,955.	38,591,067.	10,047,888.
e Other		5,337,358.		5,337,358.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				61,048,229.

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	51,111,852.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) . ▶	51,111,852.	

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) OPR LEASE ROU ASSETS, NET	8,267,198.
(2) INVESTMENT 457 PLAN	2,993,241.
(3) PENSION ASSET	3,023,283.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	14,283,722.

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) OTHER LIABILITIES	6,859,571.
(3) LEASE LIABILITY - OPERATING	8,223,371.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	15,082,942.

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

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final column for totals. Rows include: 1 Total revenue, gains, and other support per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part VIII, line 12; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part VIII, line 12, but not on line 1; 5 Total revenue. Add lines 3 and 4c.

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

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

Table with 5 main rows and sub-rows (a-e) for adjustments. Columns include line numbers and a final column for totals. Rows include: 1 Total expenses and losses per audited financial statements; 2 Amounts included on line 1 but not on Form 990, Part IX, line 25; 3 Subtract line 2e from line 1; 4 Amounts included on Form 990, Part IX, line 25, but not on line 1; 5 Total expenses. Add lines 3 and 4c.

Part XIII Supplemental Information.

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

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information (continued)

ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

CVMC HAS ENDOWMENT INVESTMENTS AND AN INVESTMENT SPENDING POLICY THAT GUIDES THE DISTRIBUTION OF THE FUNDS TO SUPPORT THE MISSION OF CENTRAL VERMONT MEDICAL CENTER.

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 H
(Form 990)**

Hospitals

OMB No. 1545-0047

2021

Open to Public Inspection

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

▶ Attach to Form 990.

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

Department of the Treasury
Internal Revenue Service

Name of the organization

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1,136,759.		1,136,759.	0.41
b Medicaid (from Worksheet 3, column a)			59,589,649.	28,936,924.	30,652,725.	11.06
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			60,726,408.	28,936,924.	31,789,484.	11.47
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			183,698.		183,698.	0.07
f Health professions education (from Worksheet 5)			386,461.		386,461.	0.14
g Subsidized health services (from Worksheet 6)			66,815,792.	45,606,481.	21,209,311.	7.65
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			183,698.	37,500.	146,198.	0.05
j Total. Other Benefits			67,569,649.	45,643,981.	21,925,668.	7.91
k Total. Add lines 7d and 7j			128,296,057.	74,580,905.	53,715,152.	19.38

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?	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	52,066,093.
6 Enter Medicare allowable costs of care relating to payments on line 5	136,661,016.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	-84,594,923.
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	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	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	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?		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: <u>2021</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SECTION C</u>		
b	<input checked="" type="checkbox"/> Other website (list url): <u>SEE SECTION C</u>		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 21</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a	If "Yes," (list url): <u>SEE SECTION C</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group 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:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? 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):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input checked="" type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE SECTION C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group 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?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

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	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		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.		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, SECTION B, LINE 3E

IN ACCORDANCE WITH REQUIREMENTS SET FORTH IN THE AFFORDABLE CARE ACT AND IN SUPPORT OF ITS COMMUNITY MISSION, CENTRAL VERMONT MEDICAL CENTER (CVMC) IS UNDERTAKING A FY2022/TAX YEAR 2021 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND SUPPORTING A THREE-YEAR IMPLEMENTATION PLAN. THE FY2022 CHNA IS A CONTINUATION OF PAST ASSESSMENTS CONDUCTED SINCE ITS INCEPTION IN 2013. THE FY2022 CHNA SEEKS TO EXPAND UPON PAST ASSESSMENTS TO STRENGTHEN COMMUNITY AND POPULATION HEALTH MANAGEMENT STRATEGIES, WITH A FOCUS ON SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY, WHICH IS CONSISTENT WITH PRIOR ASSESSMENTS. THE FY2022 CHNA FOCUSES ON CVMC'S PRIMARY SERVICE AREA IN WASHINGTON COUNTY. THE FY2022 CHNA IS BEING CONDUCTED IN COLLABORATION WITH THRIVE, CENTRAL VERMONT'S ACCOUNTABLE COMMUNITY FOR HEALTH. CVMC HAS ALSO CONTRACTED WITH COMMUNITY RESEARCH CONSULTING (CRC) WHO ASSISTED IN CONDUCTING THE FY2022 CHNA AND OVERSEES THE FY2022 CHNA RESEARCH AND REPORTING.

REPRESENTATIVES FROM CVMC, THRIVE, AND COMMUNITY ACTION NETWORK (CAN) REVIEWED THE COMMUNITY HEALTH NEEDS ASSESSMENT (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 RANKED AND ORDERED THE COMMUNITY'S HEALTH NEEDS IN THE FOLLOWING ORDER.

1. CHRONIC DISEASE PREVENTION
2. MENTAL HEALTH
3. SUBSTANCE USE DISORDERS
4. SOCIAL DRIVERS OF HEALTH

FY2022 CHNA PRELIMINARY FINDINGS:

OVERALL, WASHINGTON COUNTY CONTINUES TO BE A HEALTHIER COMMUNITY, SUPPORTED BY NATURAL RESOURCES, BETTER ACCESS TO HEALTHCARE, AND A COLLABORATIVE NETWORK OF HEALTH AND SOCIAL SERVICE PROVIDERS. THE TOP AREAS OF HEALTH NEED ARE CONSISTENT WITH FY2022 CHNA PRIORITY AREAS AND HAVE BEEN GREATLY IMPACTED BY THE COVID-19 PANDEMIC.

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.

THE FY2022 CHNA PRIORITIZED THE HEALTH NEEDS AND ALIGNED WITH THE VERMONT DEPARTMENT OF HEALTHSHIP PRIORITIES, PROMOTING COLLABORATION BETWEEN PUBLIC HEALTH, HOSPITAL, AND COMMUNITY BASED ORGANIZATIONS. AS A RESULT OF THE CHNA PROCESS, SIGNIFICANT INVESTMENT HAS OCCURRED WITHIN THE COMMUNITY. ALTHOUGH IT TAKES TIME TO EVALUATE WHETHER OR NOT SPECIFIC ACTIONS ARE MOVING THE NEEDLE ON ISSUES, THE ORGANIZATION FIRMLY BELIEVES THAT THE ACTIONS TAKEN AND FUNDING PROVIDED HAVE HAD A POSITIVE IMPACT ON THE COMMUNITY.

PART V, SECTION B, LINE 5

THE CHNA INCLUDED AN IN-DEPTH REVIEW OF PRIMARY AND SECONDARY DATA TO COLLECT AND ANALYZE HEALTH TRENDS, SOCIO-ECONOMIC DATA, AND STAKEHOLDER PERSPECTIVES, TO INFORM COMMUNITY HEALTH PLANNING. PRIMARY STUDY METHODS WERE USED TO SOLICIT INPUT FROM HEALTH CARE CONSUMERS AND KEY 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 CHNA WITH WIDE PARTICIPATION BY MORE THAN 1,500 COMMUNITY STAKEHOLDERS WHO PARTICIPATED IN SURVEYS, FOCUS GROUPS, PLANNING MEETINGS, AND OTHER DIALOGUE.

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
- AN ELECTRONIC KEY STAKEHOLDER SURVEY WITH 171 COMMUNITY REPRESENTATIVES TO SOLICIT INFORMATION ABOUT PERCEIVED HEALTH PRIORITIES, PERSPECTIVES ON EMERGING HEALTH TRENDS, AND RECOMMENDATIONS TO ADVANCE COMMUNITY HEALTH AND WELL-BEING STRATEGIES
- A COMMUNITY MEMBER SURVEY COMPLETED BY 1,344 RESIDENTS TO COLLECT COMMUNITY PERSPECTIVES ON HEALTH CONCERNS, BARRIERS TO CARE, AND RECOMMENDATIONS, AND RELATED INSIGHTS
- VIRTUAL FOCUS GROUPS WITH INDIVIDUALS REPRESENTING BLACK, INDIGENOUS, AND PEOPLE OF COLOR (BIPOC) AND LGBTQ+ COMMUNITIES
- INDIVIDUAL AND SMALL GROUP INTERVIEWS WITH HEALTH AND SOCIAL SERVICE AGENCY REPRESENTATIVES, INCLUDING CVMC, CENTRAL VERMONT HOME HEALTH AND HOSPICE, GREEN MOUNTAIN UNITED WAY, PEOPLE'S HEALTH AND WELLNESS CLINIC, TURNING POINT OF CENTRAL VERMONT, AND WASHINGTON COUNTY SUBSTANCE ABUSE REGIONAL PARTNERSHIP

INPUT WAS RECEIVED FROM PERSONS REPRESENTING BROAD INTERESTS OF THE COMMUNITY, INCLUDING LEADERS WITH SPECIAL KNOWLEDGE AND OR EXPERTISE AS WELL AS COMMUNITY RESIDENTS. THE CHNA COMMUNITY STEERING GROUP DISTRIBUTED A COMMUNITY SURVEY THAT WAS COMPLETED BY MORE THAN 1,500

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.

RESIDENTS. IN ADDITION, THE GROUP CIRCULATED A KEY INFORMANT SURVEY THROUGH THRIVE TO COMMUNITY MEMBERS WITH SPECIAL KNOWLEDGE OF COMMUNITY HEALTH STATUS, AND CONDUCTED ADDITIONAL INTERVIEWS WITH 33 KEY INFORMANT STAKEHOLDERS TO OBTAIN A BETTER UNDERSTANDING OF NEEDS AMONG UNDERSERVED POPULATIONS. INPUT WAS COLLECTED, STARTING IN THE BEGINNING OF FALL 2021 AND CONCLUDING DURING THE SUMMER OF 2022.

PART V, SECTION B, LINE 6B

THE FY2022 CHNA WAS CONDUCTED IN COLLABORATION WITH THRIVE, THE REGIONAL ACCOUNTABLE COMMUNITY FOR HEALTH. THIS MULTI-AGENCY COALITION, 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 FINDINGS TO DETERMINE COMMUNITY HEALTH PRIORITIES BASED ON THE CHNA STUDY.

IN ADDITION TO THRIVE MEMBERS, MORE THAN 1,500 COMMUNITY RESIDENTS SHARED THEIR PERSPECTIVES ON COMMUNITY NEEDS THROUGH SURVEYS AND OPEN DIALOGUE. WE VALUE THIS FEEDBACK AND RECOGNIZE THAT ALL COMMUNITY STAKEHOLDERS PLAY AN INTEGRAL PART IN ADVANCING THE HEALTH OF CENTRAL VERMONT.

THE CHNA REPORT PROVIDES AN IN-DEPTH VIEW OF THE MANY FACTORS THAT INFLUENCE HEALTH IN OUR COMMUNITY. KNOWING THAT SOCIAL AND ECONOMIC MEASURES OFTEN IMPACT HEALTH MORE THAN HEALTH CARE DELIVERY ALONE, WE SOUGHT TO DEMONSTRATE THE CORRELATION BETWEEN HEALTH DISPARITIES AND SOCIAL DRIVERS OF THE HEALTH ENVIRONMENTAL FACTORS THAT IMPACT OUR HEALTH.

IN RESPONSE TO THE FINDINGS FROM THE CHNA REPORT, CENTRAL VERMONT MEDICAL CENTER (CVMC) WORKED WITH OUR COMMUNITY PARTNERS TO OUTLINE A PLAN TO GUIDE OUR COMMUNITY HEALTH AND BENEFIT ACTIVITIES FOR THE 2022-25 PLANNING CYCLE. THROUGHOUT THIS PLANNING CYCLE, CVMC WILL CONTINUE TO EVALUATE OUR ACTIVITIES AND TRACK OUR PROGRESS TOWARD IMPROVING THE ISSUES THAT MOST IMPACT THE HEALTH OF OUR COMMUNITY. IN DOING SO, CVMC WILL CONTINUE TO COLLABORATE WITH OUR PARTNERS, EDUCATE OUR POLICY MAKERS, AND ENGAGE COMMUNITY RESIDENTS TO PROMOTE HEALTH FOR ALL RESIDENTS OF CENTRAL VERMONT.

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, SECTION B, LINES 7A, 7B AND 10A

COMMUNITY HEALTH NEEDS ASSESSMENT

[HTTPS://WWW.CVMC.ORG/ABOUT-CVMC/COMMUNITY/COMMUNITY-HEALTH-NEEDS-ASSESSMENT](https://www.cvmc.org/about-cvmc/community/community-health-needs-assessment)

[HTTPS://GMCBOARD.VERMONT.GOV/SITES/GMCB/FILES/DOCUMENTS/CVMC_2022_CHNA_FINAL_REPORT_-_2022-06-16.PDF](https://gmcboard.vermont.gov/sites/gmcb/files/documents/cvmc_2022_chna_final_report_-_2022-06-16.pdf)

IMPLEMENTATION STRATEGY

[HTTPS://WWW.CVMC.ORG/ABOUT-CVMC/COMMUNITY/COMMUNITY-HEALTH-NEEDS-ASSESSMENT](https://www.cvmc.org/about-cvmc/community/community-health-needs-assessment)

HOSPITAL FACILITY WEBSITE:

[HTTPS://WWW.CVMC.ORG/SITES/DEFAULT/FILES/DOCUMENTS/CVMC-FINANCIAL-ASSISTANCE-POLICY.PDF](https://www.cvmc.org/sites/default/files/documents/cvmc-financial-assistance-policy.pdf)

PART V, SECTION B, LINE 11

CENTRAL VERMONT MEDICAL CENTER'S 2022 CHNA IMPLEMENTATION STRATEGY WAS APPROVED BY THE BOARD OF DIRECTORS FEBRUARY 2022. THIS SPECIFIC IMPLEMENTATION STRATEGY SET OUT THE FOLLOWING OBJECTIVES TO EXPAND ACCESS TO HIGH-QUALITY, COMPREHENSIVE MENTAL HEALTH RESOURCES TO IMPROVE THE HEALTH AND WELL-BEING OF PATIENTS, THEIR FAMILIES, AND COMMUNITY MEMBERS IN WASHINGTON COUNTY:

1. CHRONIC DISEASE PREVENTION:

WASHINGTON COUNTY AND VERMONT RESIDENTS ARE GENERALLY HEALTHIER THAN THEIR PEERS NATIONALLY, WITH FEWER HEALTH RISK FACTORS AND LOWER PREVALENCE AND MORTALITY DUE TO CHRONIC DISEASE. HOWEVER, WITH THE COMBINATION OF THE AGING POPULATION OF WASHINGTON COUNTY RESIDENTS, A SLIGHTLY LOWER PERCENTAGE OF ADULTS ACCESSING ROUTINE CARE (72%-72.5%) COMPARED TO THE NATION (75%), AND ADDITIONAL BARRIERS TO ACCESSING CARE, RESIDENTS AREN'T ALWAYS ABLE TO RECEIVE THE PREVENTION CARE THEY NEED.

A. PROMOTE UVM HEALTH NETWORK POPULATION HEALTH MANAGEMENT STRATEGY THROUGH IMPROVED CLINICAL COMMUNICATION AND COORDINATION OF CARE.

-CONTINUE THE DEVELOPMENT AND IMPLEMENTATION OF OUR PRIMARY CARE DELIVERY MODEL AND THE UVM HEALTH NETWORK POPULATION HEALTH SERVICES ORGANIZATION (PHSO). THE INTENT IS TO CREATE AN EXTENDED CARE TEAM OF RESOURCES INCLUDING CARE COORDINATION, SOCIAL SERVICES, HEALTH COACHING, AND MENTAL HEALTH AND RESOURCE COORDINATION TO POSITIVELY IMPACT CLINICAL HEALTH OUTCOMES FOR OUR PATIENTS, WOODRIDGE RESIDENTS AND OUR COMMUNITY, WHILE MAXIMIZING THE VALUE OF THE SERVICES WE PROVIDE.

B. REDUCE DISPARITIES IN CHRONIC DISEASE PREVALENCE AND DEATH RATES.

-CVMC PRIMARY CARE AND COMMUNITY PARTNERS WILL IDENTIFY COLLABORATIVE OPPORTUNITIES TO IMPROVE CARE AND SERVICE.

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.

C. ADOPT ORGANIZATIONAL AND INSTITUTIONAL PRACTICES THAT ADVANCE EQUITY.
 -PARTNER WITH CVMC DEI (DIVERSITY, EQUITY, AND INCLUSION) COMMITTEE AND THE PRIDE CENTER OF VERMONT TO IMPROVE CULTURAL COMPETENCE OF PROVIDERS AND ADOPT INCLUSIVE HEALTH CARE ENVIRONMENTS. ASSESS EXISTING PATIENT AND EDUCATION MATERIAL FOR LITERACY LEVELS AND LANGUAGE AVAILABILITY.
 -ACUTE STROKE READY HOSPITAL (ASRH) CERTIFICATION PROVIDED THROUGH A PARTNERSHIP BETWEEN THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION AND THE JOINT COMMISSION RECOGNIZES HOSPITALS THAT MEET STANDARDS TO SUPPORT BETTER OUTCOMES FOR STROKE CARE AS PART OF A STROKE SYSTEM OF CARE.
 -THROUGH COLLABORATION WITH UVM HEALTH NETWORK AND WITH THE SUPPORT OF TELEMEDICINE SERVICES, CVMC IS PURSUING A CERTIFICATION AS AN ACUTE STROKE READY HOSPITAL FOR FY2024. THIS WILL HELP CVMC STANDARDIZE THE CARE OF PATIENTS WHO ARE SEEN AT THE EMERGENCY DEPARTMENT WITH SIGNS/SYMPTOMS OF A STROKE. THIS WOULD ALSO ASSIST WITH EXPEDITING THEIR TRANSFER, IF NEEDED, TO A HIGHER LEVEL OF CARE.

2. MENTAL HEALTH CARE:

ACCESS TO MENTAL HEALTH SERVICES AND TREATMENT WAS IDENTIFIED AS THE #2 HEALTH CHALLENGE IN CHNA SURVEY. IN WASHINGTON COUNTY 21% OF ADULTS ARE DIAGNOSED WITH DEPRESSION AND AN INCREASE OF TEENAGERS WHO REPORTED FEELING CONSISTENTLY SAD OR HOPELESS INCREASED FROM 23.2% TO 30.9% FROM 2013 TO 2019.

A. AS PART OF AN INTEGRATED SYSTEM OF CARE IN VERMONT, CVMC WILL ADVANCE BEHAVIORAL HEALTH INTEGRATION WITHIN OUR PRIMARY CARE PRACTICES AND LEVERAGE THE PHSO (POPULATION HEALTH SERVICES ORGANIZATION) MENTAL HEALTH RESOURCE MODEL TO EXTEND RESOURCES IN OUR PRIMARY CARE PRACTICES.

B. 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 OR THE OTHER REMAINING SIGNIFICANT NEEDS IDENTIFIED IN THE CHNA (SUBSTANCE USE DISORDER, AFFORDABLE HOUSING, CHILDHOOD AND FAMILY HEALTH, DISEASE PREVENTION, AND CANCER) HAVE BEEN PRIORITY AREAS IN PREVIOUS CHNA.

C. CVMC WILL WORK WITH COMMUNITY PARTNERS TO SUPPORT COMMUNITY MENTAL HEALTH EDUCATION AND MENTAL WELLNESS PROGRAMS (E.G. PHYSICAL ACTIVITY, YOGA, AND MEDITATION).

3. SUBSTANCE USE DISORDERS:

WASHINGTON COUNTY RESIDENTS NAMED SUBSTANCE ABUSE INCLUDING ALCOHOL, OPIOID, PRESCRIPTION MEDICATIONS AND MARIJUANA AS THE TOP COMMUNITY HEALTH ISSUE IN THIS SURVEY. WASHINGTON COUNTY ADULTS AND TEENS HAVE HIGH RATES OF BINGE DRINKING AND MARIJUANA USE, AND DEATHS FROM OPIOIDS CONTINUE TO CLIMB.

A. IMPROVE ACCESS TO SUBSTANCE USE DISORDER SERVICES AND SUPPORTS ALONG A FULL CONTINUUM OF CARE:

-CVMC PROVIDERS, LEADERS AND COMMUNITY PARTNERS WILL COLLABORATE AND SUPPORT STRONGER INTEGRATION OF SUBSTANCE USE INTERVENTIONS:

-PEER RECOVERY/SUPPORT SERVICES IN BOTH COMMUNITY AND EMERGENCY DEPARTMENT SETTINGS;

-ACCESS TO MEDICATION-ASSISTED TREATMENT (MAT) IN THE EMERGENCY

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.

DEPARTMENT AND COORDINATION OF FOLLOW-UP TREATMENT;
-EDUCATION AND TRAINING RELATED TO DISTRIBUTION AND USE OF OPIOID OVERDOSE REVERSAL MEDICATIONS;
-EDUCATION AND TRAINING RELATED TO OPIOID PRESCRIBING, CHRONIC PAIN MANAGEMENT, AND MAT PROTOCOLS FOR PRESCRIBING PRACTITIONERS.
B. PROMOTE A "COMMUNITY-WIDE SYSTEMS" FRAMEWORK FOR PREVENTION AND TREATMENT OF SUBSTANCE USE DISORDERS:
-CVMC SERVICES AS THE CONVENER FOR THE CENTRAL VERMONT PREVENTION COALITION (CVPC):
-SUPPORT CVPC IN BUILDING SAFE HARBOR INITIATIVES TO PREVENT SUBSTANCE USE;
-ANALYZE AND UNDERSTAND THE IMPACT OF COVID-19;
-SUPPORT ELIMINATION OF STIGMA AND MISUNDERSTANDING OF SUBSTANCE USE;
-ADDRESS EQUITABLE AND AFFORDABLE ACCESS TO SERVICES.
C. IMPROVE ACCESS TO TREATMENT AND SERVICES FOR ALCOHOL USE DISORDERS:
-CVMC IN PARTNERSHIP WITH COMMUNITY AGENCIES AND PEER RECOVER SERVICES, SUPPORT THE REFOCUS ON ALCOHOL DEPENDENCE (ROAD) PROGRAM, AN INNOVATIVE HUB/SPOKE APPROACH TO OUTPATIENT DETOX SERVICES.
4. SOCIAL DETERMINANTS OF HEALTH:
ACCESS TO HEALTHY FOODS, HOUSING, TRANSPORTATION AND ECONOMIC STABILITY IMPACT A PERSON'S HEALTH. RESIDENTS OF WASHINGTON COUNTY HAVE LOW RATES OF CONSUMING HEALTHY FOODS, HIGH RATES OF CHRONIC DISEASE BURDEN, DIFFICULTY ACCESSING TRANSPORTATION SERVICES, AND A HIGH HOUSING COST BURDEN, WHICH RESULTS IN HOMELESSNESS OR MARGINAL HOUSING FOR MANY INDIVIDUALS. OTHER AREAS WERE IDENTIFIED WHICH CVMC HAS CHOSEN TO ACKNOWLEDGE, BUT NOT ADDRESS DIRECTLY AS PART OF THE STRATEGIC PLAN BUT CONTINUE TO PARTNER WITH COMMUNITY GROUPS TO ADDRESS:
A. COMMUNITY COLLABORATION-CVMC SERVES AS THE CONVENER ORGANIZATION FOR THRIVE, THE WASHINGTON COUNTY ACCOUNTABLE COMMUNITY FOR HEALTH, IN SUPPORTING NEEDS IDENTIFIED IN THIS CHNA.
B. FOOD SECURITY-CVMC PARTNERS WITH VERMONT YOUTH CONSERVATION CORPS TO PROVIDE FREE, FRESH PRODUCE AND OTHER STAPLES TO COMMUNITY MEMBERS EVERY MONTH. THROUGH THIS PROGRAM THE HOSPITAL ALSO PROVIDES A SOCIAL GATHERING SPACE TO SUPPORT EDUCATION AND CONVERSATION AROUND HEALTHY FOOD.
C. HOMELESSNESS AND AFFORDABLE HOUSING-CVMC PARTICIPATES IN AND SUPPORTS FINDING SOLUTIONS TO END HOMELESSNESS IN CENTRAL VERMONT AND SURROUNDING AREAS AS PART OF THE THRIVE ACCOUNTABLE COMMUNITY FOR HEALTH.
D. TRANSPORTATION-CVMC PARTICIPATES IN AND SUPPORTS FINDING SOLUTIONS FOR BARRIERS TO TRANSPORTATION FOR RESIDENTS OF CENTRAL VERMONT AND THE SURROUNDING AREA AS PART OF THE THRIVE ACCOUNTABLE COMMUNITY FOR HEALTH.
E. ADOPT ORGANIZATIONAL AND INSTITUTIONAL PRACTICES THAT ADVANCE EQUITY BY PARTNERING CVMC DEI COMMITTEE AND THE PRIDE CENTER OF VERMONT TO IMPROVE CULTURAL COMPETENCE OF PROVIDERS AND ADOPT INCLUSIVE HEALTH CARE ENVIRONMENT. IN ADDITION, CVMC IS ASSESSING EXISTING PATIENT EDUCATION MATERIALS FOR LITERACY LEVELS AND LANGUAGE AVAILABILITY.

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, SECTION B, LINE 15E

FROM REGISTRATION, PATIENTS ARE ROUTINELY REFERRED TO THE CVMC FINANCIAL ADVOCACY DEPARTMENT OR COMMUNITY HEALTH IMPROVEMENT DEPARTMENT. BOTH AREAS PROVIDE KNOWLEDGE AND ASSISTANCE IN THE APPLICATION PROCESS FOR CHARITY AND OTHER APPLICABLE FUNDING SOURCES. ADVOCATES ACTIVELY EDUCATE ALL INPATIENT, OBSERVATION AND OUTPATIENT INVASIVE SERVICE PATIENTS OF OUR PROGRAM, PRIOR TO OR CONCURRENT WITH THE PATIENTS' STAY, SUBSEQUENTLY AIDING IN THE APPLICATION PROCESS FOR STATE AID AND CENTRAL VERMONT MEDICAL CENTER'S FINANCIAL PROGRAM.

WHILE THE FINANCIAL ASSISTANCE POLICY DOES NOT PROVIDE A LIST OF "EXTERNAL" CONTACT INFORMATION FOR NON-CENTRAL VERMONT MEDICAL CENTER PARTIES OR AGENCIES WHO MAY ASSIST PATIENTS IN THE APPLICATION PROCESS, APPLICATION COMPLETION AID IS WELL PUBLISHED WITH MULTIPLE INTERNAL, ORGANIZATIONAL AND CENTRAL VERMONT MEDICAL CENTER COMMUNITY HEALTH ASSISTANCE TEAM MEMBERS AVAILABLE TO ASSIST OUR PATIENTS. IT IS ALSO IMPORTANT TO NOTE, PATIENTS ARE REVIEWED IN ADVANCE OF SERVICE FOR POTENTIAL HARDSHIP; THE UNINSURED AND UNDERINSURED PATIENTS WHO ARE IDENTIFIED ARE ACTIVELY COUNSELED WITH HELP FOR GOVERNMENT AND EXCHANGE PROGRAMS AS WELL AS ASSISTANCE IN THE CENTRAL VERMONT MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM.

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

FINANCIAL ASSISTANCE POLICY (FAP) RESOURCES
THE FAP, THE FAP APPLICATION FORM, AND A PLAIN LANGUAGE SUMMARY (FINANCIAL ASSISTANCE POLICY - SUMMARY) OF THE FAP WAS WIDELY AVAILABLE AT THE CENTRAL VERMONT MEDICAL CENTER FINANCIAL ASSISTANCE WEBPAGE LOCATED AT:
[HTTPS://WWW.CVMC.ORG/PATIENTS-VISITORS/PATIENT-FINANCIAL-SERVICES/PATIENT-FINANCIAL-SERVICE-DOCUMENTS](https://www.cvmc.org/patients-visitors/patient-financial-services/patient-financial-service-documents)

PART V, SECTION B, LINE 16J

WHILE THE FINANCIAL ASSISTANCE POLICY DOES NOT PROVIDE A LIST OF "EXTERNAL" CONTACT INFORMATION FOR NON-CENTRAL VERMONT MEDICAL CENTER PARTIES OR AGENCIES WHO MAY ASSIST PATIENTS IN THE APPLICATION PROCESS, APPLICATION COMPLETION AID IS WELL PUBLISHED WITH MULTIPLE INTERNAL, ORGANIZATIONAL AND CENTRAL VERMONT MEDICAL CENTER COMMUNITY HEALTH ASSISTANCE TEAM MEMBERS AVAILABLE TO ASSIST OUR PATIENTS. IT IS ALSO IMPORTANT TO NOTE, PATIENTS ARE REVIEWED IN ADVANCE OF SERVICE FOR POTENTIAL HARDSHIP; THE UNINSURED AND UNDERINSURED PATIENTS WHO ARE

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.

IDENTIFIED ARE ACTIVELY COUNSELED WITH HELP FOR GOVERNMENT AND EXCHANGE PROGRAMS AS WELL AS ASSISTANCE IN THE CENTRAL VERMONT MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM.

PART V, SECTION B, 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 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:

TO QUALIFY FOR FINANCIAL ASSISTANCE, AN ELIGIBLE PATIENT MUST PASS BOTH AN INCOME AND ASSETS TEST. INCOME IS SET AT A MAXIMUM OF 400% OF FEDERAL POVERTY LEVEL GUIDELINES ("FPLG") AND THE ASSETS TEST IS SET AT \$50,000 LIQUID ASSETS, AS FURTHER DEFINED AND DESCRIBED IN THE POLICY. ASSISTANCE IS GRANTED BASED UPON THE PATIENT'S INCOME FPLG.

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.

PART I, LINE 7:

CENTRAL VERMONT MEDICAL CENTER UTILIZED THE AXIOM COST ACCOUNTING SYSTEM TO CALCULATE THE AMOUNTS REPORTED IN THE TABLE ON LINE 7. THE COST ACCOUNTING SYSTEM ADDRESSES ALL PATIENT SEGMENTS, INCLUDING, BUT NOT LIMITED TO, INPATIENT, OUTPATIENT, EMERGENCY ROOM, PRIVATE INSURANCE, MEDICAID, MEDICARE, UNINSURED AND SELF PAY. THE COST-TO-CHARGE RATIO DERIVED FROM WORKSHEET 2 WAS ALSO UTILIZED FOR SOME OF THE FIGURES REPORTED IN THE TABLE ON LINE 7. THE CENTRAL VERMONT MEDICAL CENTER'S ANNUAL MEDICAID PROVIDER TAX IS ASSESSED ON VERMONT ACUTE CARE HOSPITALS BY THE STATE OF VERMONT. THE TAX ASSESSMENT IS CALCULATED AS 6% OF A HOSPITAL'S BASE YEAR NET PATIENT CARE REVENUE.

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.

PART I, LINE 7, COLUMN (F):

THE AMOUNT OF BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25,
BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE AMOUNT REPORTED ON LINE
7(F) IS \$0. PATIENT-RELATED BAD DEBT IN THE AMOUNT OF \$7,540,979 IS
NETTED FROM PATIENT REVENUE IN PART VIII, LINE 2.

PART III, LINE 2:

CENTRAL VERMONT MEDICAL CENTER'S FINANCIAL STATEMENTS INCLUDE A FOOTNOTE
DESCRIBING BAD DEBT EXPENSE. RECEIVABLES ARE REPORTED NET OF AN ALLOWANCE
FOR DOUBTFUL ACCOUNTS. THE PROVISION FOR PATIENT RELATED BAD DEBT IS
REPORTED AS A DEDUCTION FROM GROSS REVENUE. THIS EXPENSE IS DETERMINED AS
A PERCENTAGE OF GROSS PATIENT SERVICE REVENUE BASED ON ACTUAL WRITE-OFF
HISTORY, REVIEWED ON A QUARTERLY BASIS AND ADJUSTED ON A SEMI-ANNUAL
BASIS.

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.

PART III, LINE 3:

DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE NETTED AGAINST THE TOTAL GROSS CHARGES WHEN DETERMINING BAD DEBT EXPENSE. THE \$150,820 REFLECTS THE ADJUSTED BAD DEBT EXPENSE FOR ALL PATIENTS WHO SUBMITTED AN INITIAL APPLICATION, BUT UPON FOLLOW-UP, DID NOT RESPOND TO REQUESTS FOR ADDITIONAL INFORMATION OR SUPPORTING DOCUMENTATION.

PART III, LINE 4:

PLEASE REFERENCE FOOTNOTE NUMBER 4 ON PAGES 22-27 IN THE FISCAL YEAR 2022 AUDITED CONSOLIDATED FINANCIAL STATEMENTS.

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.

PART III, LINE 8:

THE AMOUNT REPORTED IN PART III, LINE 6, MEDICARE ALLOWABLE COSTS OF CARE, IS DERIVED FROM CENTRAL VERMONT MEDICAL CENTER'S FYE 9/30/22 MEDICARE COST REPORT, WORKSHEET D-1, COMPUTATION OF INPATIENT OPERATING COSTS, WORKSHEET E PART B, CALCULATION OF OUTPATIENT SETTLEMENT, AND WORKSHEET I-4, COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS. WHILE CVMC HAS HISTORICALLY FOLLOWED THE CATHOLIC HOSPITAL ASSOCIATION'S GUIDANCE AND HAS NOT CONSIDERED ANY MEDICARE SHORTFALL (REPORTED IN PART III, LINE 7) AS A COMMUNITY BENEFIT, IT IS LIKELY THAT SOME PORTION OF MEDICARE PATIENTS WOULD HAVE QUALIFIED FOR CHARITY CARE UNDER OUR POLICIES IN THE ABSENCE OF MEDICARE COVERAGE, SUCH THAT SHORTFALLS ASSOCIATED WITH THOSE PATIENTS WOULD OTHERWISE HAVE BEEN INCLUDED IN OUR COMMUNITY BENEFITS.

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.

PART III, LINE 9B:

THE COLLECTION PROCESS IN PLACE AT CENTRAL VERMONT MEDICAL CENTER (CVMC) INCLUDES GENERATION OF MONTHLY STATEMENTS, FOLLOWED BY A PRE-COLLECTION LETTER OVER THE COURSE OF 120 DAYS. IN THE CASE OF UNDELIVERABLE MAIL, EFFORTS WILL BE MADE TO REACH THE PATIENT BY TELEPHONE. IF A NEW BILLING ADDRESS IS OBTAINED, THE 120 DAY WINDOW WILL BEGIN AGAIN. IF NO CONTACT CAN BE MADE AND PAYMENT IS NOT RECEIVED WITHIN THE REVISED 120 DAY WINDOW, THE ACCOUNT WILL BE REFERRED TO A COLLECTION AGENCY. IF CONTACT IS MADE, THE PATIENT WILL BE OFFERED A BUDGET PLAN. ALL STATEMENTS, LETTERS AND CONTACT WILL INCLUDE THE FACT THAT FINANCIAL ASSISTANCE IS AVAILABLE.

REASONABLE EFFORTS WILL BE MADE TO DETERMINE IF A PATIENT IS ELIGIBLE FOR FINANCIAL ASSISTANCE PRIOR TO BALANCE TRANSFER TO COLLECTIONS. REASONABLE EFFORTS MAY INCLUDE THE USE OF PRESUMPTIVE SCORING, THE NOTIFICATION AND PROCESSING OF APPLICATIONS AND NOTIFICATION BEFORE, DURING AND AFTER CARE.

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.

CVMC WILL PROCESS APPLICATIONS SUBMITTED BY INDIVIDUALS DURING THE APPLICATION PERIOD WHICH BEGINS ON THE DATE A BILLING STATEMENT FOR THE PATIENT BALANCE OF CARE IS PRESENTED AND ENDS 240 DAYS LATER. IF AT THE END OF THE 120 NOTIFICATION PERIOD AND ACCOUNT HAS BEEN REFERRED TO A COLLECTION AGENCY AND AN APPLICATION IS RECEIVED AND GRANTED WITHIN THE 240 DAY APPLICATION PERIOD, ACCOUNTS SHALL BE RECALLED FROM THE AGENCY AND PROCESSED UNDER THE FINANCIAL ASSISTANCE PROGRAM.

NEEDS ASSESSMENT

PART VI, LINE 2

THE COMPREHENSIVE 2022 CHNA INCLUDED AN IN-DEPTH REVIEW OF PRIMARY AND SECONDARY DATA, HEALTH TRENDS, SOCIO-ECONOMIC STATISTICS, STAKEHOLDER PERCEPTIONS AND OTHER INFORMATION. CVMC AND THRIVE ANALYZED THE DATA TO ALIGN WITH THE VERMONT DEPARTMENT OF HEALTH STATE HEALTH IMPROVEMENT PLAN (SHIP) TO INFORM COMMUNITY HEALTH PLANNING. PRIMARY STUDY METHODS WERE USED TO SOLICIT INPUT FROM HEALTH CARE CONSUMERS AND KEY COMMUNITY

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.

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 2022 CHNA WITH WIDE PARTICIPATION FROM NEARLY 1,500 COMMUNITY STAKEHOLDERS WHO PARTICIPATED IN SURVEYS, FOCUS GROUPS, PLANNING MEETINGS, AND OTHER DIALOGUE.

IN ADDITION TO THE TRIENNIAL CHNA, CVMC REGULARLY MONITORS THE HEALTH NEEDS OF THE CENTRAL VERMONT COMMUNITY, THROUGH THRIVE, THE REGIONAL ACCOUNTABLE COMMUNITY FOR HEALTH (ACH). THRIVE MEMBERS HOLD REGULAR MEETINGS TO SUPPORT THE INTEGRATION OF HIGH-QUALITY MEDICAL CARE, MENTAL HEALTH AND SUBSTANCE USE TREATMENT SERVICES, AND SOCIAL SERVICES, BOTH GOVERNMENTAL AND NON-GOVERNMENTAL, FOR THOSE IN NEED OF CARE. THRIVE ALSO STRIVES TO SUPPORT COMMUNITY WIDE PREVENTION EFFORTS ACROSS ITS DEFINED DEOGRAPHIC AREA TO REDUCE DISPARITIES IN THE DISTRIBUTION OF HEALTH AND WELLNESS.

THE FOLLOWING ORGANIZATIONS AND AGENCIES ARE COLLECTIVELY REFERRED TO AS

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.

THE LEADERSHIP PARTNERS TEAM OF THRIVE:

- BLUECROSS/BLUESHIELD OF VERMONT
- CAPSTONE COMMUNITY ACTION
- CENTRAL VERMONT COUNCIL ON AGING
- CENTRAL VERMONT HOME HEALTH & HOSPICE
- CENTRAL VERMONT MEDICAL CENTER
- CENTRAL VERMONT REGIONAL PLANNING COMMISSION
- DOWNSTREET HOUSING & COMMUNITY DEVELOPMENT
- FAMILY CENTER OF WASHINGTON COUNTY
- GOOD SAMARITAN HAVEN
- GREEN MOUNTAIN UNITED WAY
- ONECARE VERMONT
- PEOPLE'S HEALTH & WELLNESS CLINIC
- VERMONT AGENCY OF HUMAN SERVICES
- VERMONT DEPARTMENT OF HEALTH
- VERMONT FOODBANK
- WASHINGTON COUNTY MENTAL HEALTH SERVICES

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.

THE COMMUNITY HEALTH NEEDS ASSESSMENT IS AVAILABLE AT THE FOLLOWING WEB

ADDRESS:

[HTTPS://WWW.CVMC.ORG/ABOUT-CVMC/COMMUNITY/COMMUNITY-HEALTH-NEEDS-ASSESSMEN](https://www.cvmc.org/about-cvmc/community/community-health-needs-assessment)

T

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE: CENTRAL VERMONT MEDICAL CENTER UTILIZES A VARIETY OF METHODS TO INFORM, EDUCATE AND ASSIST PATIENTS IN IDENTIFYING PAYMENT SOURCES, INCLUDING STATE / FEDERAL PROGRAMS AS WELL AS OUR PATIENT ASSISTANCE PROGRAM.

INFORM & EDUCATE:

PATIENT EDUCATION IS PROVIDED ACROSS THE CONTINUUM OF CARE. PATIENT BENEFIT ADVISORS, FINANCIAL ADVOCATES, REGISTRARS, CASE MANAGERS, SOCIAL WORKERS AND CUSTOMER SERVICE REPRESENTATIVES ACTIVELY INFORM AND EDUCATE PATIENTS ON THE PROGRAM, GUIDELINES, REQUIREMENTS FROM:

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.

- PRE-ARRIVAL SCREENING/REGISTRATION TO POINT OF SALE EDUCATION AT

REGISTRATION

- AT THE BEDSIDE OF AN INPATIENT OR OBSERVATION PATIENT- AFTER DISCHARGE

WITH CONTINUED FOLLOW-UP BY FINANCIAL ADVOCATES AND - DURING THE SELF-PAY

BILLING FOLLOW-UP PROCESS.

PATIENTS ARE INFORMED OF THE PROGRAM, APPLICATIONS AND ASSISTANCE WITH

COMPLETION ARE PROVIDED WITH FINANCIAL ADVOCATES ALSO PROVIDING EDUCATION

AND ASSISTANCE FOR MEDICAID AND HEALTH INFORMATION EXCHANGE PROGRAMS,

ALONG WITH ASSISTANCE IN APPLYING FOR THE UVM MEDICAL CENTER FINANCIAL

ASSISTANCE PROGRAM. PATIENTS ARE ROUTINELY REFERRED TO ADVOCATES AND

ADVISORS IN ADVANCE OF SERVICE WITH ADVOCATES ACTIVELY ASSISTING PATIENTS

WHOM ARE ADMITTED TO THE ORGANIZATION URGENTLY OR EMERGENTLY. POLICIES,

SUMMARIES AND APPLICATIONS ARE AVAILABLE AT ALL REGISTRATION LOCATIONS,

THEY ARE REFERENCED IN ALL INTERVIEW PROCESSES AND FURTHER AVAILABLE IN

THE WAITING AREAS. OUR ORGANIZATIONAL WEBSITES PROVIDE EDUCATION,

APPLICATIONS, POLICIES, SUMMARIES, AND FAQ DOCUMENTS ALONG WITH CONTACT

INFORMATION AS A PASSIVE MEANS OF COMMUNICATION IN ADDITION TO THE ACTIVE

EDUCATION REFERENCED PREVIOUSLY. OUR BILLING STATEMENTS REFLECT FINANCIAL

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.

ASSISTANCE HELP AND OUR COMMUNITY BENEFIT TEAM EDUCATE WITHIN THE
COMMUNITY ON OUR PROGRAMS. APPLICATIONS AND INFORMATION ARE ADDITIONALLY
AVAILABLE IN THE LOCAL COMMUNITY HEALTH CENTERS.

ASSIST:

- ALL INPATIENT AND OUTPATIENT PROCEDURES ARE FINANCIALLY SCREENED TO IDENTIFY THE UNDERINSURED OR UNINSURED PATIENT POPULATION. PRIOR TO SERVICE, CONCURRENT WITH SERVICE AND POST SERVICE, OUR PATIENT FINANCIAL COUNSELORS WILL CALL AND/OR MEET WITH PATIENTS AND FAMILIES TO EDUCATE THEM ON THE AVAILABLE PROGRAMS AND WHERE APPLICABLE, ASSIST IN THE APPLICATION PROCESS. THIS INCLUDES STATE AND FEDERAL AID APPLICATIONS AND THE CENTRAL VERMONT MEDICAL CENTER CHARITY APPLICATION PROCESS.
- OUR FINANCIAL COUNSELORS /ADVOCATES HAVE BEEN CERTIFIED AS ASSISTERS IN THE PROCESS FOR HEALTH EXCHANGE INSURANCE, MEDICAID AND THE FINANCIAL ASSISTANCE PROGRAMS. COUNSELORS WILL ADDITIONALLY MEET WITH PATIENTS AT THE BEDSIDE TO HELP COMPLETE THE APPLICATIONS, PROVIDE DETAILS ON SUPPORTING DOCUMENTATION NEEDS AND FACILITATE AND EXPEDITE THE REVIEW PROCESS UNTIL A NOTICE OF DECISION HAS BEEN RECEIVED. PROCESS UNTIL A NOTICE OF DECISION HAS BEEN RECEIVED.

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.

COMMUNITY INFORMATION

PART VI, LINE 4

COMMUNITY INFORMATION: CENTRAL VERMONT MEDICAL CENTER PRIMARILY SERVES RESIDENTS OF WASHINGTON COUNTY AND NEIGHBORING COMMUNITIES IN CALEDONIA, CHITTENDEN, LAMOILLE, AND ORANGE COUNTIES.

DEMOGRAPHICS:

-SINCE 2010, VERMONT SAW A SMALLER INCREASE IN POPULATION (+2.8%) THAN US OVERALL (+7.4%). THE WASHINGTON COUNTY POPULATION WAS GENERALLY STAGNANT, INCREASINGLY 0.5% OR 273 PEOPLE FROM 2010, ENDING WITH A POPULATION OF 59,807.

-FROM 2010 TO 2020, THE WHITE POPULATION DECLINES -5.3%. THE LARGEST POPULATION INCREASES WERE SEEN AMONG MULTIRACIAL (+2,642 PEOPLE) AND OTHER RACE (+316 PEOPLE) INDIVIDUALS. DESPITE INCREASING DIVERSITY, THE WHITE POPULATION IN WASHINGTON COUNTY IS APPROXIMATELY 90% OF RESIDENTS.

-APPROXIMATELY 19% OF WASHINGTON COUNTY AND VERMONT RESIDENTS ARE AGED 65 OR OLDER COMPARED TO 15.6% NATIONWIDE. THE YOUTH POPULATION UNDER AGE 18

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.

IS PROPORTIONATELY SMALLER IN WASHINGTON COUNTY AND VERMONT THAN THE NATION, ESTIMATED AT 19% VERSUS 22.6%.

-APPROXIMATELY 11% OF VERMONT AND WASHINGTON COUNTY RESIDENTS LIVE IN POVERTY COMPARED TO 13.4% NATIONALLY.

-WITHIN WASHINGTON COUNTY, CHILDHOOD POVERTY IS HIGHER IN THE CABOT ZIP CODE 05647 (33.5%), WATERBURY CENTER ZIP CODE 05677 (27.0%), AND BARRE ZIP CODE 05641 (24.8%).

-SINCE THE 2019 CHNA THE WASHINGTON COUNTY, POVERTY DECLINES FOR WHITE, BLACK/AFRICAN AMERICAN, AND LATINX RESIDENTS BUT INCREASED FOR ASIAN AND MULTIRACIAL RESIDENTS. NOTABLE, THE PROPORTION OF ASIAN RESIDENTS LIVING IN POVERTY INCREASED FROM 13.6% TO 22.4%.

-IN WASHINGTON COUNTY, THE PERCENTAGE OF BLACK/AFRICAN AMERICAN RESIDENTS LIVING IN PVOVERTY (13.5%) DECLINED AND IS ONLY SLIGHTLY HIGHER THAN THE PERCENTAGE FOR WHITE RESIDENTS (10.1%), BUT THE MEDIAN HOUSEHOLD INCOME FOR BLACK/AFRICAN AMERICANS (\$27,273) IS LESS THAN HALF THE MEDIAN INCOME FOR WHITES (\$63,454).

-APPROXIMATELY 29% OF HOMEOWNERS IN WASHINGTON COUNTY ARE CONSIDERED HOUSING COST BURDENED, A DECREASE FROM THE 2019 CHNA FINDING (31.2%) AND

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.

A SIMILAR PROPORTION AS THE STATE AND NATION OVERALL.

-THE PERCENTAGE OF RENTERS COST BURDENED BY THEIR MONTHLY RENT EXPENSE DECLINED FROM THE 2019 CHNA, FROM 47.3% TO 42.9%, BUT STILL REPRESENTS MORE THAN 1 IN 4 RENTAL HOUSEHOLDS.

-AS OF 2019, 12% OF VERMONT ADULTS HAD A CURRENT ASTHMA DIAGNOSIS COMPARED TO 8.9% NATIONALLY. WITHIN WASHINGTON COUNTY, AN ESTIMATED 10.7% OF ADULTS HAD AN ASTHMA DIAGNOSIS.

ACCESS TO HEALTH CARE:

-WASHINGTON COUNTY CONTINUES TO HAVE A LOWER PERCENTAGE OF UNINSURED RESIDENTS THAN THE STATE AND NATION AND MEETS THE HP2030 GOAL OF 92.1% INSURED RESIDENTS.

-CONSISTENT WITH PRIOR YEARS OF DATA, 25.5% OF RESIDENTS HAVE MEDICAID INSURANCE (ALONE OR IN COMBINATION WITH OTHER INSURANCE). THE PERCENTAGE OF MEDICARE INSURED RESIDENTS INCREASED SLIGHTLY FROM THE 2019 CHNA FROM 19.7% TO 20.9%, A FINDING CONSISTENT WITH THE COUNTY'S AGING DEMOGRAPHIC.

-WASHINGTON COUNTY HAS LOW UNINSURED PERCENTAGES ACROSS ALL REPORTED RACIAL AND ETHNIC GROUPS, EXCLUDING ASIANS. THE PERCENTAGE OF UNINSURED

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.

WASHINGTON COUNTY ASIAN RESIDENTS (13.2%) MORE THAN TRIPLED FROM FIVE YEARS AGO (3.8%) AND IS MORE THAN DOUBLE THE STATEWIDE PERCENTAGE (4.8%).

-WASHINGTON COUNTY HAS MORE PRIMARY CARE PROVIDERS THAN THE STATE, AND THE RATE OF PROVIDERS INCREASED FROM THE 2019 CHNA, FROM 102.4 TO 106.6 PER 100,000. DESPITE HAVING BETTER AVAILABILITY OF PRIMARY CARE PROVIDERS, BOTH WASHINGTON COUNTY AND VERMONT OVERALL HAVE SLIGHTLY LOWER PERCENTAGES OF ADULTS ACCESSING ROUTINE CARE (72%-72.5%) COMPARED TO THE NATION (75%)

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

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.

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)
- 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

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.

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 2020, OVER 50 PRIMARY CARE PROVIDERS WERE ALL PART OF A RECOGNIZED NATIONAL COMMITTEE FOR QUALITY ASSURANCE, PATIENT 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.

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.

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

AFFILIATED HEALTH CARE SYSTEM:

AS OF OCTOBER 1, 2011, CENTRAL VERMONT MEDICAL CENTER, INC. (CVMC) AND
THE UNIVERSITY OF VERMONT MEDICAL CENTER (UVMC) BECAME MEMBERS OF THE
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.

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.

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

THE CENTRAL VERMONT MEDICAL FILES A COMMUNITY BENEFIT REPORT WITH THE
STATE OF VERMONT.

**SCHEDULE I
(Form 990)**

**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.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 990.

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

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? 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 51 CHURCH ST BARRE, VT 05641	03-0343290	501(C)(3)	45,000.				HEALTH CARE FOR THE SVCS TO UNINSURED
(2) CAPSTONE COMMUNITY ACTION 20 GABLE PLACE BARRE, VT 05641	03-0216254	501(C)(3)	15,000.				FUEL YOUR NEIGHBORS
(3) DOWNSTREET HOUSING & COMMUNITY DEVELOPMENT 22 KEITH AVE, SUITE 100 BARRE, VT 05641	22-2843473	501(C)(3)	17,500.				COMMUNITY BENEFIT AWARD
(4) FAMILY CENTER OF WASHINGTON COUNTY 383 SHERWOOD DR MONTPELIER, VT 05602	22-2652676	501(C)(3)	15,000.				COMMUNITY BENEFIT AW
(5) GREEN MOUNTAIN UNITED WAY 652 GRANGER ROAD BARRE, VT 05641	03-0261384	501(C)(3)	17,500.				COMMUNITY BENEFIT AW
(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 ▶ 5

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

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

Schedule I (Form 990) 2021

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

2021

**Open to Public
Inspection**

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|--|--|
| <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
 - b** Participate in or receive payment from a supplemental nonqualified retirement plan?
 - c** Participate in or receive payment from an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III.

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1a		
1b		
2		
3		
4a	X	
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

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

Schedule J (Form 990) 2021

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

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

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

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JOHN BRUMSTED, MD TRUSTEE	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	1,089,798.	357,989.	650,567.	34,800.	31,914.	2,165,068.
2 JEREMIAH ECKHAUS, MD TRUSTEE, UNTIL 10/2021	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	257,084.	NONE	14,265.	16,573.	30,904.	318,826.
3 ANNA T. NOONAN TRUSTEE, PRESIDENT/COO	(i)	348,190.	97,472.	30,214.	67,031.	38,707.	581,614.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE
4 MATTHEW CHOATE VP PATIENT CARE SERVICES	(i)	226,688.	34,067.	824.	15,972.	25,083.	302,634.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE
5 CHRISTOPHER MERIAM, MD TRUSTEE, PRESIDENT MED STAFF	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	488,786.	NONE	88,412.	17,400.	38,091.	632,689.
6 ROBERT PATTERSON VP OF HR & CLINICAL OPERATIONS	(i)	213,142.	35,022.	29,890.	16,935.	32,960.	327,949.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE
7 JAMES ALVAREZ VP SUPPORT SERVICES	(i)	239,280.	35,332.	15,688.	11,709.	23,835.	325,844.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE
8 PATRICIA FISHER, MD FORMER CHIEF MED OFFICER	(i)	156,756.	NONE	149,016.	12,364.	12,225.	330,361.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE
9 TODD KEATING FORMER INTERIM TREASURER	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	167,192.	NONE	28,942.	15,047.	1,236.	212,417.
10 KIMBERLY PATNAUDE TREASURER, CFO	(i)	210,247.	46,232.	763.	NONE	19,823.	277,065.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE
11 CHRISTIAN BEAN, MD PHYSICIAN	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	539,261.	NONE	56,733.	17,400.	35,894.	649,288.
12 JOHN BEGLY, MD PHYSICIAN	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	462,806.	11,800.	63,671.	17,400.	38,880.	594,557.
13 DAVID OSPINA, MD PHYSICIAN	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	351,295.	25,926.	22,960.	17,400.	34,801.	452,382.
14 STEFAN LISCHKE, MD PHYSICIAN	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	338,268.	37,119.	20,639.	17,400.	15,621.	429,047.
15 SARA GRAVES, MD PHYSICIAN	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	524,378.	NONE	61,097.	17,400.	32,951.	635,826.
16 ANNA HANKINS, MD TRUSTEE, PRES-ELECT MED STAFF	(i)	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	211,436.	NONE	45,172.	15,794.	31,363.	303,765.

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

CVMC RECEIVES GUIDANCE REGARDING ITS PRESIDENT'S COMPENSATION FROM THE
UVM HEALTH NETWORK COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES, 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 2021, PATRICIA FISHER RECEIVED \$102,445 IN SEVERANCE
PAYMENTS AFTER HER DEPARTURE IN APRIL 2021.

Part III Supplemental Information

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

SCHEDULE J, PART I, LINE 4B

THE UNIVERSITY OF VERMONT HEALTH NETWORK, BY AND THROUGH ITS AFFILIATED SUBSIDIARIES, MAINTAINS A SUPPLEMENTAL RETIREMENT BENEFIT PLAN (SRP) UNDER CONTRACTUAL ARRANGEMENTS WITH SEVERAL PERSONS LISTED ON FORM 990, PART VII, SECTION A, LINE 1A. PURSUANT TO THE TERMS OF THE SRP, ANNUAL CREDITS WERE MADE EQUAL TO A FIXED PERCENTAGE OF BASE SALARY. THE FOLLOWING PERSONS PARTICIPATED IN THE SRP IN CALENDAR YEAR 2021, AND THEIR RESPECTIVE FIXED PERCENTAGE IS DESIGNATED IN PARENTHESES: ANNA T. NOONAN (8.68%). DEFERRED AMOUNTS VEST ON THE EARLIER OF: (I) JANUARY 1 OF THE THIRD PLAN YEAR AFTER THE PLAN YEAR FOR WHICH THE ACCOUNT WAS CREATED; OR (II) THE PARTICIPANT'S 65TH BIRTHDAY.

UNTIL 9/31/2021, THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. MAINTAINED A SEPARATE SRP PURSUANT TO A CONTRACTUAL ARRANGEMENT WITH NETWORK PRESIDENT AND CEO JOHN BRUMSTED, UNDER WHICH UVM MEDICAL CENTER MADE ANNUAL CREDITS EQUAL TO 15% OF THE CEO'S BASE SALARY. UPON TERMINATION OF THE SRP, DR. BRUMSTED RECEIVED A DISTRIBUTION AS DESCRIBED

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.

IN SCH J, PART II, COL B(III).

FOR THE PLANS NOTED ABOVE, THE AMOUNT DEFERRED FOR CALENDAR YEAR 2021 IS INCLUDED ON SCHEDULE J, PART II, COLUMN C. AMOUNTS DEFERRED REMAIN SUBJECT TO FORFEITURE IF CERTAIN CONDITIONS ARE NOT MET.

SCHEDULE J, PART I, LINE 7

CENTRAL VERMONT MEDICAL CENTER, INC (CVMC) HAS AN ANNUAL PERFORMANCE INCENTIVE PLAN. PERFORMANCE TARGETS AND PAYOUT METRICS ARE ESTABLISHED AND APPROVED BY THE UVM HEALTH NETWORK COMPENSATION COMMITTEE AT THE BEGINNING OF EACH PERFORMANCE CYCLE.

**SCHEDULE L
(Form 990)**

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

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

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

OMB No. 1545-0047

2021

**Open To Public
Inspection**

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

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ \$ _____

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ \$ _____

Part II Loans to and/or From Interested Persons.
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

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

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SUBSTANTIAL DONOR	SUBSTANTIAL CONTRIBUTOR	328,173.	SERVICES		X
(2) SUBSTANTIAL DONOR	SUBSTANTIAL CONTRIBUTOR	663,364.	SERVICES		X
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

22-2547186

DESCRIPTION OF THE ORGANIZATION'S MISSION

FORM 990, PART III, LINE 1

CENTRAL VERMONT MEDICAL CENTER IS THE PRIMARY HEALTH CARE PROVIDER
SERVING MORE THAN 69,000 PEOPLE WHO LIVE, AND WORK, AND PLAY IN THE 26
COMMUNITIES OF CENTRAL VERMONT.

CENTRAL VERMONT MEDICAL CENTER HOSPITAL PROVIDES 24-HOUR EMERGENCY CARE,
WITH A FULL SPECTRUM OF INPATIENT (LICENSED FOR 122 BEDS) AND OUTPATIENT
SERVICES, CLOSE TO HOME. CENTRAL VERMONT MEDICAL CENTER NAMED ONE OF THE
NATION'S TOP 100 RURAL & COMMUNITY HOSPITALS BY THE NATIONAL RURAL HEALTH
ASSOCIATION (NRHA). TOP 100 RURAL COMMUNITY HOSPITALS ARE THOSE ACHIEVING
SUCCESS IN OVERALL PERFORMANCE BASED ON A COMPOSITE RATING FROM EIGHT
INDICATORS OF STRENGTH - INPATIENT MARKET SHARE, OUTPATIENT MARKET SHARE,
QUALITY, OUTCOMES, PATIENT PERSPECTIVES, COSTS, CHARGES AND FINANCIAL
STABILITY. IN ADDITION, CENTRAL VERMONT MEDICAL CENTER HOSPITAL HAS
RECEIVED FIVE STAR CMS HOSPITAL CARE RATINGS FOR THREE YEARS IN A ROW
2020-2022 AND IS A HIGH PERFORMING HOSPITAL OF THE US NEWS FOR COPD,
PNEUMONIA, AND HIP FRACTURE FOR 2022-23.

THE CENTRAL VERMONT MEDICAL CENTER PROFESSIONAL STAFF INCLUDES OVER 175
PHYSICIANS AND 70 ADVANCED PRACTICE PROVIDERS REPRESENTING 25 MEDICAL
SPECIALTIES.

CENTRAL VERMONT MEDICAL CENTER'S WOODRIDGE REHABILITATION AND NURSING IS
A LONG-TERM AND SHORT-TERM FACILITY ON OUR MAIN CAMPUS LICENSED FOR 153

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

22-2547186

SKILLED NURSING BEDS. CVMC WOODRIDGE REHABILITATION AND NURSING EARNED BEST NURSING HOMES STATUS BY ACHIEVING A RATING OF "HIGH PERFORMING," THE HIGHEST POSSIBLE RATING, FOR SHORT-TERM REHABILITATION. U.S. NEWS GIVES THE DESIGNATION OF BEST NURSING HOME ONLY TO THOSE HOMES THAT SATISFY U.S. NEWS'S ASSESSMENT OF THE APPROPRIATE USE OF KEY SERVICES AND CONSISTENT PERFORMANCE IN QUALITY MEASURES.

COMBINED AS CENTRAL VERMONT MEDICAL CENTER (HOSPITAL, 28 MEDICAL PRACTICES, AND WOODRIDGE REHABILITATION AND NURSING) ARE A CRITICAL SOURCE OF HIGH QUALITY CARE, CLOSE TO HOME.

WITH OVER 1,700 EMPLOYEES (FROM WASHINGTON, ORANGE, LAMOILLE, CHITTENDEN COUNTIES AND MORE), CENTRAL VERMONT MEDICAL CENTER IS THE LARGEST PRIVATE EMPLOYER IN CENTRAL VERMONT.

GOVERNING BODY AND MANAGEMENT

FORM 990, PART VI, LINE 2

THERE IS A BUSINESS RELATIONSHIP BETWEEN DR. JOHN BRUMSTED AN OFFICER OF THE UNIVERSITY OF VERMONT MEDICAL CENTER (UVMC), DR. JEREMIAH ECKHAUS AN OFFICER OF CENTRAL VERMONT MEDICAL CENTER, INC. (CVMC), DR. ANNA HANKINS, AN OFFICER OF CVMC, DR. CHRISTOPHER MERIAM AN OFFICER OF CVMC AND TODD KEATING, FORMER INTERIM TREASURER, CFO OF 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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

22-2547186

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 MGMT &/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 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 EXECUTIVE COMMITTEE AND MAKES AVAILABLE TO THE EXECUTIVE COMMITTEE THE FORM 990 ALONG WITH HIGHLIGHTS OF ALL SIGNIFICANT PARTS OF THE FORM 990. THE COMPLETED FORM 990 IS PROVIDED TO ALL MEMBERS OF THE BOARD OF TRUSTEES PRIOR TO THE FORM BEING FILED WITH THE IRS.

DESCRIPTION OF PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST

FORM 990, PART VI, LINE 12C

THE ORGANIZATION REGULARLY MONITORS AND ENFORCES COMPLIANCE WITH THE UVM HEALTH NETWORK'S (UVMHN) CONFLICT OF INTEREST POLICY, WHICH IT HAS ADOPTED. IN ACCORDANCE WITH THE POLICY, TRUSTEES, OFFICERS, KEY

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

22-2547186

EMPLOYEES AND PHYSICIANS ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE AND CERTIFICATION UPON HIRING, AT LEAST ANNUALLY, PRIOR TO PARTICIPATING IN ANY DECISION THAT MAY BE AFFECTED BY A PERSONAL INTEREST, AND WHENEVER A POTENTIALLY CONFLICTING INTEREST FIRST ARISES.

CONFLICT OF INTEREST DISCLOSURES AND CERTIFICATIONS ARE REGULARLY REVIEWED BY THE GENERAL COUNSEL. THE CONFLICT OF INTEREST POLICY IS ENFORCED BY THE OFFICE OF GENERAL COUNSEL AND OVERSEEN BY A FIVE-PERSON CONFLICT OF INTEREST COMMITTEE. THE GENERAL COUNSEL REPORTS AT LEAST QUARTERLY ON CONFLICT OF INTEREST ISSUES TO THE AUDIT COMMITTEE OF THE BOARD OF TRUSTEES. CONFLICTS OF INTEREST ARE MANAGED IN ACCORDANCE WITH THE POLICY, WHICH PROVIDES FOR A VARIETY OF REMEDIES TO ADDRESS CONFLICTS OF INTEREST. IN ADDITION, "DISQUALIFIED PERSONS", CONSISTING OF TRUSTEES, OFFICERS AND KEY EMPLOYEES ARE SUBJECT TO SPECIAL PROCEDURES TO COMPLY WITH THE INTERMEDIATE SANCTION RULES, AS OUTLINED IN THE CONFLICT OF INTEREST POLICY. REMEDIES TO ADDRESS CONFLICTS OF INTEREST MAY INCLUDE THE FOLLOWING: RECUSAL FROM DECISION MAKING, DISCLOSURE TO APPROPRIATE PARTIES, COMMITTEE PARTICIPATION LIMITS AND REQUESTED DIVESTITURE. AN APPEALS PROCESS EXISTS SHOULD THE INDIVIDUAL REQUEST A SECONDARY REVIEW BE PERFORMED.

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

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

22-2547186

FORM 990, PART VI, LINES 15A & 15B

THE PROCESS FOR DETERMINING COMPENSATION FOR THE ORGANIZATION'S
PRESIDENT/COO IS HANDLED BY THE UVM HEALTH NETWORK (UVMHN) COMPENSATION
COMMITTEE. THE COMMITTEE MEETS ANNUALLY AND UTILIZES SURVEY DATA TO MAKE
A TOTAL COMPENSATION RECOMMENDATION. IF NECESSARY, THE UVMHN COMPENSATION
COMMITTEE WILL ENGAGE WITH AN INDEPENDENT CONSULTING FIRM, INTEGRATED
HEALTHCARE STRATEGIES (IHS)/GALLAGER, WITH NATIONAL EXPERTISE IN HEALTH
CARE COMPENSATION. THE UVMHN COMPENSATION COMMITTEE RECOMMENDS AND
APPROVES THE COMPENSATION.

AN ANALYSIS IS PERFORMED ANNUALLY BY THE UVMHN COMPENSATION COMMITTEE TO
EVALUATE CVMC SENIOR LEADERSHIP COMPENSATION. RECOMMENDATIONS ARE
REVIEWED BY THE PRESIDENT AND THE EXECUTIVE COMMITTEE OF THE CVMC BOARD
OF TRUSTEES. MARKET STUDY DATA COMES FROM, BUT IS NOT LIMITED TO, WILLIS
TOWERS WATSON, MERCER, GALLAGHER, AND SULLIVAN COTTER.

THE COMPENSATION OF OTHER KEY EMPLOYEES OF THE ORGANIZATION IS DETERMINED
THROUGH MARKET STUDY ANALYSIS PERFORMED BY THE UVMHN 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 FY2022 CAN ALSO
BE FOUND ON THE WEBSITE,

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Employer identification number

22-2547186

[HTTPS://WWW.CVMC.ORG/ABOUT-CVMC/REPORTS-AND-PUBLICATIONS](https://www.cvmc.org/about-cvmc/reports-and-publications)

COMPENSATION

FORM 990, PART VII

THREE PHYSICIANS SERVING AS BOARD MEMBERS, DR. MERIAM, DR. HANKINS, AND
DR. ECKHAUS, RECEIVE COMPENSATION FROM A RELATED ORGANIZATION (UVMMG) 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	\$(2,486,062)
TRANSFER OF NET ASSETS	499,563
ASSETS RELEASED FROM CAPITAL	19,630
OTHER CHANGES TO TEMP RESTRICTED ASSETS	(1,481,506)

TOTAL: \$(3,448,375)

CIRCULAR A-133 AUDIT

FORM 990, PART XII, LINE 3B:

DURING FY22, 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

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

FORM 990, PART III - PROGRAM SERVICE

=====

LINE 4A, PROGRAM SERVICE

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. 21,598 INPATIENT DAYS, MORE THAN 250,000 OUTPATIENT PROCEDURES, AND 25,530 EMERGENCY ROOM VISITS WERE RECORDED DURING FISCAL YEAR 2022. OUTPATIENT ANCILLARY SERVICE UNITS MAKE UP THE MAJORITY OF SERVICE VOLUME, INCLUDING 35,016 RADIOLOGY PROCEDURES, 483,831 LAB TESTS, 15,640 CARDIOLOGY TESTS, AND 150,221 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 2022 WAS 25,530. THE CANCER TREATMENT CENTER PROVIDED 4,292 ONCOLOGY AND RADIATION TREATMENTS. THE HOSPITAL ALSO HAS BEEN ACTIVE IN ITS OUTREACH TO CENTRAL VERMONT'S UNINSURED AND UNDER INSURED RESIDENTS.

LINE 4C, PROGRAM SERVICE

WOODRIDGE REHAB & NURSING IS A MEDICARE-CERTIFIED 153-LICENSED 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 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.

Name of the organization

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.**22-2547186**

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

NAME AND ADDRESS	DESCRIPTION OF SERVICES	COMPENSATION
MEDICAL SOLUTIONS 1010 NORTH 102ND STREET OMAHA, NE 68114	CLINICAL STAFFING	4,143,108.
AMN HEALTHCARE ALLIED, INC. PO BOX 281939 ATLANTA, GA 30384-1939	NURSE STAFFING	874,681.
CROSS COUNTRY STAFFING, INC. PO BOX 404674 ATLANTA, GA 30384-4678	CLINICAL STAFFING	781,131.
MARCAM ASSOCIATES PO BOX 60 ROCHESTER, NH 03866-0060	COLLECTION SERVICES	738,264.
CORE MEDICAL GROUP 655 SOUTH WILLOW ST, SUITE 128 MANCHESTER, NH 03103	CLINICAL STAFFING	726,742.

Name of the organization

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

FORM 990, PART IX - OTHER FEES

=====

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
-----	-----	-----	-----	-----
ALLOCATION OF SHARED SERV	6,365,701.		6,365,701.	
AGENCY FEES	1,692,991.	204,755.	1,488,236.	
LAUNDRY/LINENS/UNIFORMS	240,954.	240,954.		
TRAVELER EXPENSES	24,836,697.	24,827,991.	8,706.	
OTHER EXPENSES	7,566,015.	7,545,448.	20,188.	379.
TOTALS	----- 40,702,358. =====	----- 32,819,148. =====	----- 7,882,831. =====	----- 379. =====

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

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	No
SEE SUPPLEMENTAL PAGE							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) 2021

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

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

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

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

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

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

(A) NAME/ADDRESS/EIN	(B) PRIMARY ACTIVITY	(C) LEGAL DOMICILE	(D) DIRECT CONTROLLING	(E) ENTITY TYPE	(F) SHARE OF TOT INCOME	(G) SHARE OF EOY	(H) % OWNERSHIP	(I) SEC 512(B)(13) YES NO

CHARITABLE IRREVOCABLE TRUST (8)	SUPPORT	VT	UVMC/CVMC	TRUST				
UNIV OF VT MED CTR HEALTH VENT INC 111 COLCHESTER AVE BURLINGTON, VT 05401	COMPANY	VT	UVMC	C CORP				
CHARITABLE REMAINDER TRUST (6)	SUPPORT	VT	UVMC/CVMC	TRUST				
PERPETUAL TRUST (10)	SUPPORT	VT	UVMC	TRUST				
CHAMPLAIN VALLEY HEALTH NETWORK 75 BEEKMAN STREET PLATTSBURGH, NY 12901	ADMIN SERVICE	NY	N/A	C CORP				
MEDQUEST INC PO BOX 1656 PLATTSBURGH, NY 12901	LEASE	NY	N/A	C CORP				
YANKEE MEDICAL, INC. 276 NORTH AVENUE BURLINGTON, VT 05401	EQUIP	VT	UVMHN VENTURES	C CORP				
UVMHN CREDENTIALING & ENROLLMENT 111 COLCHESTER AVE BURLINGTON, VT 05401	ADMIN SVC	VT	UVMHN VENTURES	C CORP				

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

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) UNIVERSITY OF VERMONT MEDICAL CENTER	I	730,973.	FMV
(2) UNIVERSITY OF VERMONT MEDICAL CENTER	P	37,466,283.	FMV
(3) UNIVERSITY OF VERMONT MEDICAL CENTER	S	293,078.	FMV
(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.

Part VII Supplemental Information

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

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
UNIVERSITY OF VERMONT MEDICAL CENTER, INC 111 COLCHESTER AVE BURLINGTON, VT 05401 HOSPITAL	03-0219309	VT	501(C)(3)	3	UVMHN		X
UNIV OF VERMONT HEALTH NETWORK, INC. 111 COLCHESTER AVE BURLINGTON, VT 05401 HOLDING CO	45-2880726	VT	501(C)(3)	12A-I	N/A		X
UNIV OF VERMONT MEDICAL GROUP - NEW YORK 183 PARK STREET MALONE, NY 12953 PHYS SVCS	20-3905216	NY	501(C)(3)	3	UVMMG		X
UNIVERSITY OF VERMONT MEDICAL GROUP 111 COLCHESTER AVE BURLINGTON, VT 05401 PHYS SVCS	03-0225105	VT	501(C)(3)	12A-I	UVMHN		X
UNIV OF VERMONT MEDICAL CTR. FDN, INC. 111 COLCHESTER AVE BURLINGTON, VT 05401 FUNDRAISING	26-3159849	VT	501(C)(3)	12A-I	UVMMC		X
CENTRAL VERMONT HOSPITAL AUXILIARY 130 FISHER RD BERLIN, VT 05602 SERVICE	03-0264240	VT	501(C)(3)	12D-III-O	N/A		X
COMMUNITY PROVIDERS, INC. 75 BEEKMAN ST. PLATTSBURGH, NY 12901 HLTH SVC COOR	22-2544844	NY	501(C)(3)	12A-I	UVMHN		X
CHAMPLAIN VALLEY PHYSICIANS HOSPITAL 75 BEEKMAN STREET PLATTSBURGH, NY 12901 HOSPITAL	14-1338471	NY	501(C)(3)	3	CPI		X
ELIZABETHTOWN COMMUNITY HOSPITAL 75 PARK STREET ELIZABETHTOWN, NY 12932 HOSPITAL	14-1364513	NY	501(C)(3)	3	CPI		X
EMERGENCY MEDICAL TRANSPORT OF CVPH, INC 75 BEEKMAN ST PLATTSBURGH, NY 12901 AMBULANCE SVC	06-1718419	NY	501(C)(3)	12B-II	CPI		X

Part VII Supplemental Information

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

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512	
						YES	NO
CVPH MEDICAL CENTER FOUNDATION 75 BEEKMAN ST	14-1727048 PLATTSBURGH, NY 12901 HLTH SVC SUPP	NY	501(C)(3)	12B-II	CVPH		X
UNIVERSITY MEDICAL EDUCATION ASSOCIATES 89 BEAUMONT AVE	23-7107832 BURLINGTON, VT 05405 EDUCATIONAL	VT	501(C)(3)	11	UVMMG		X
UNIVERSITY HEALTH CENTER 111 COOLCHESTER AVE	03-0229931 BURLINGTON, VT 05401 HOSPITAL	VT	501(C)(3)	12C-III-FI	UVMMG		X
ALICE HYDE MEDICAL CENTER 133 PARK STREET	15-0346515 MALONE, NY 12953 HOSPITAL	NY	501(C)(3)	3	CPI		X
PORTER MEDICAL CENTER INC 115 PORTER DRIVE	03-0310862 MIDDLEBURY, VT 05753 SUPPTG ORG	VT	501(C)(3)	12-B,II	UVMHN		X
HELEN PORTER NURSING HOME 37 PORTER DRIVE	03-0306549 MIDDLEBURY, VT 05753 NURSING HOME	VT	501(C)(3)	3	PMC		X
AUXILIARY OF PORTER MEDICAL CENTER 37 PORTER DRIVE	23-7363227 MIDDLEBURY, VT 05753 SUPPORTG ORG	VT	501(C)(3)	12-B,II	PMC		X
PORTER HOSPITAL INC 37 PORTER DRIVE	03-0181058 MIDDLEBURY, VT 05753 HOSPITAL	VT	501(C)(3)	3	PMC		X
VMC INDEMNITY COMPANY, INC. 95 ST. PAUL ST.	83-1102018 BURLINGTON, VT 05401 INSURANCE	VT	501(C)(3)	12A-I	UVMHN		X
LAKE CHAMPLAIN PHYSICIANS SERVICES, P.C. 75 BEEKMAN STREET	27-3785445 PLATTSBURGH, NY 12901 PHYSICIAN SVC	NY	501(C)(3)	12A-I	CVPH		X

Part VII Supplemental Information

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

UVMHN HOME HEALTHCARE & HOSPICE	03-0179603						
1110 PRIM ROAD	COLCHESTER, VT 05446						
	HOME HEALTH	VT	501(C)(3)	10		UVMHN	X