

Tax Exempt Entity Declaration and Signature for Electronic Filing

For calendar year 2021, or tax year beginning OCT 1, 2021,
and ending SEP 30, 20 22

For use with Forms 990, 990-EZ, 990-PF, 990-T, 1120-POL, 4720, 8868, 5227, 5330, and 8038-CP

2021

▶ Go to www.irs.gov/Form8453TE for the latest information.

Department of the Treasury
Internal Revenue Service

Name of filer

PORTER HOSPITAL, INC.

EIN or SSN

03-0181058

Part I Type of Return and Return Information

Check the box for the type of return being filed with Form 8453-TE and enter the applicable amount, if any, from the return. Form 8038-CP and Form 5330 filers may enter dollars and cents. For all other forms, enter whole dollars only. If you check the box on line 1a, 2a, 3a, 4a, 5a, 6a, 7a, 8a, 9a, or 10a below, and the amount on that line of the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, 5b, 6b, 7b, 8b, 9b, or 10b, whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a Form 990 check here	<input checked="" type="checkbox"/>	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	106,999,340.
2a Form 990-EZ check here	<input type="checkbox"/>	b Total revenue, if any (Form 990-EZ, line 9)	2b	
3a Form 1120-POL check here	<input type="checkbox"/>	b Total tax (Form 1120-POL, line 22)	3b	
4a Form 990-PF check here	<input type="checkbox"/>	b Tax based on investment income (Form 990-PF, Part V, line 5)	4b	
5a Form 8868 check here	<input type="checkbox"/>	b Balance due (Form 8868, line 3c)	5b	
6a Form 990-T check here	<input type="checkbox"/>	b Total tax (Form 990-T, Part III, line 4)	6b	
7a Form 4720 check here	<input type="checkbox"/>	b Total tax (Form 4720, Part III, line 1)	7b	
8a Form 5227 check here	<input type="checkbox"/>	b FMV of assets at end of tax year (Form 5227, Item D)	8b	
9a Form 5330 check here	<input type="checkbox"/>	b Tax due (Form 5330, Part II, line 19)	9b	
10a Form 8038-CP check here	<input type="checkbox"/>	b Amount of credit payment requested (Form 8038-CP, Part III, line 22)	10b	

Part II Declaration of Officer or Person Subject to Tax

11a I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.

b If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named entity or I am the person subject to tax with respect to (name of entity) _____, (EIN) _____, and that I have examined a copy of the 2021 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund.

Sign Here ▶ Scott A Comeau | 8-4-2023 | **CFO**
Signature of officer or person subject to tax | Date | Title, if applicable

Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above return and that the entries on Form 8453-TE are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The entity officer or person subject to tax will have signed this form before I submit the return. I will give a copy of all forms and information to be filed with the IRS to the officer or person subject to tax, and have followed all other requirements in Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only	ERO's signature	<u>Scott A Comeau</u>	Date	8-1-2023	Check if also paid preparer	<input type="checkbox"/>	Check if self-employed	<input type="checkbox"/>	ERO's SSN or PTIN	P01257831	
	Firm's name (or yours if self-employed), address, and ZIP code	UNIVERSITY OF VERMONT MEDICAL CENTER 111 COLCHESTER AVE BURLINGTON, VT 05401							EIN	03-0219309	Phone no.

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer Use Only	Print/Type preparer's name	<u>Paul J Tanis</u>	Preparer's signature	<u>Paul J Tanis</u>	Date	08/09/2023	Check if self-employed	<input type="checkbox"/>	PTIN	P01441612
	Firm's name	PWC US TAX LLP							Firm's EIN	92-0460586
	Firm's address	101 SEAPORT BLVD., BOSTON, MA 02210							Phone no.	617-530-5000

LHA For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Form **8453-TE** (2021)

Form **990**

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

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

2021

Department of the Treasury
Internal Revenue Service

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.

Open to Public Inspection

A For the 2021 calendar year, or tax year beginning **OCT 1, 2021** and ending **SEP 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 PORTER HOSPITAL, INC.		D Employer identification number 03-0181058
	Doing business as		E Telephone number 802-388-4701
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	G Gross receipts \$ 112,024,240.
	115 PORTER DRIVE		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	City or town, state or province, country, and ZIP or foreign postal code MIDDLEBURY, VT 05753		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No
F Name and address of principal officer: TOM THOMPSON SAME AS C ABOVE			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.PORTERMEDICAL.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: 1941 M State of legal domicile: VT

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: OPERATION OF A CRITICAL ACCESS HOSPITAL, IN LINE WITH OUR MISSION TO IMPROVE THE HEALTH OF OUR		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	17
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	13
	5 Total number of individuals employed in calendar year 2021 (Part V, line 2a)	5	680
	6 Total number of volunteers (estimate if necessary)	6	40
	7 a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.	
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year 2,157,545.	Current Year 4,426,280.
	9 Program service revenue (Part VIII, line 2g)	96,925,189.	100,695,971.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	607,439.	927,280.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	18,284.	949,809.
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	99,708,457.	106,999,340.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.	54,369.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	56,506,626.	65,429,255.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
	b Total fundraising expenses (Part IX, column (D), line 25)	77,904.	
	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	35,101,395.	36,573,454.
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	91,608,021.	102,057,078.	
19 Revenue less expenses. Subtract line 18 from line 12	8,100,436.	4,942,262.	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year 83,460,872.	End of Year 76,238,721.
	21 Total liabilities (Part X, line 26)	28,415,891.	22,549,146.
	22 Net assets or fund balances. Subtract line 21 from line 20	55,044,981.	53,689,575.

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	
	SCOTT COMEAU, CFO Type or print name and title			
Paid Preparer Use Only	Print/Type preparer's name PAUL J TANIS	Preparer's signature	Date	Check if self-employed <input type="checkbox"/> PTIN P01441612
	Firm's name PWC US TAX LLP	Firm's EIN 92-0460586	Phone no. 617-530-5000	
	Firm's address 101 SEAPORT BLVD. BOSTON, MA 02210			

May the IRS discuss this return with the preparer shown above? See instructions Yes No

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: OPERATION OF A CRITICAL ACCESS HOSPITAL, IN LINE WITH OUR MISSION TO IMPROVE THE HEALTH OF OUR COMMUNITY, ONE PERSON AT A TIME.

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

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses.

4a (Code:) (Expenses \$ 84,465,867. including grants of \$ 54,369.) (Revenue \$ 101,424,664.) PORTER HOSPITAL, INC. ("PORTER") OPERATES A NOT-FOR PROFIT CRITICAL ACCESS HOSPITAL WITH PATIENT CARE SERVICES INCLUDING EMERGENCY ROOM, MATERNITY AND MEDICAL/SURGICAL INPATIENT AND OUTPATIENT CARE, AND ANCILLARY SERVICES INCLUDING REHABILITATION, LABORATORY TESTING, AND DIAGNOSTIC IMAGING SERVICES. AS A CRITICAL ACCESS HOSPITAL, PORTER STAFFS A TOTAL OF 25 BEDS. OF THE 25 BEDS, SIX BEDS ARE LOCATED IN THE MATERNITY UNIT, AND THE REMAINING BEDS ARE LOCATED ON THE MEDICAL/SURGICAL UNIT. PORTER RECORDED APPROXIMATELY 6,064 INPATIENT DAYS DURING THE YEAR. EMERGENCY ROOM VISITS TOTALED 12,841 FOR THE YEAR. SURGERIES FOR THE YEAR TOTALED 4,821. SUPPORT SERVICES FOR BOTH INPATIENTS AND OUTPATIENTS INCLUDE BUT ARE NOT LIMITED TO LABORATORY, DIAGNOSTIC IMAGING SERVICES, CARDIAC SERVICES, AND REHABILITATION

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4d Other program services (Describe on Schedule O.) (Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 84,465,867.

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>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions	X	
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>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	X	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		X
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>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
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>	X	
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments - other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	X	
c Did the organization report an amount for investments - program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>		X
d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>		X
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	X	
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>		X
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>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		X
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I.</i> See instructions		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>		X
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>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	X	

Part IV Checklist of Required Schedules (continued)

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

Note: All Form 990 filers are required to complete Schedule O

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

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

Table with columns for question number, question text, and Yes/No response boxes. Includes questions 2a through 17 regarding employee counts, tax returns, unrelated business income, foreign accounts, prohibited transactions, and charitable contributions.

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 (17), 1b (13), 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 NONE
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

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See 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 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) TOM THOMPSON PRESIDENT & COO	10.00 40.00			X				0.	483,330.	48,416.
(2) DR. ELYA VASILOU DIRECTOR	1.00 44.00	X						0.	440,002.	49,887.
(3) DR. ANDREW MAHONEY DIRECTOR	1.00 44.00	X						0.	324,592.	59,247.
(4) DR. KRISTOFER ANDERSON DIRECTOR	1.00 44.00	X						0.	346,235.	32,054.
(5) ERIC BERG CRNA	40.00 0.00					X		308,623.	0.	14,143.
(6) AMY BISHOP CRNA	40.00 0.00					X		274,171.	0.	43,425.
(7) WILLIAM HARRINGTON CRNA	40.00 0.00					X		299,211.	0.	11,005.
(8) DAVID J. MYERS CRNA	40.00 0.00					X		190,640.	0.	34,977.
(9) RENEE MOSIER PHARMACY DIR	40.00 0.00					X		180,187.	0.	32,922.
(10) MICHAEL LEYDEN AVP OPERATIONS	30.00 10.00				X			0.	176,912.	30,760.
(11) LINDA HAVEY AVP OPERATIONS	30.00 10.00				X			0.	185,973.	7,499.
(12) SCOTT COMEAU CFO	25.00 25.00			X				0.	126,103.	20,030.
(13) JUDY PEEK-LEE FMR INTERIM CFO	0.00 50.00					X		0.	138,158.	2,426.
(14) DR. LINN LARSON DIRECTOR	1.00 2.00	X						8,255.	0.	0.
(15) DR. AMY GREGORY DIRECTOR (PART YR)	1.00 2.00	X						0.	0.	0.
(16) MAUREEN MCLAUGHIN TREASURER (PART YR)	1.00 2.00	X		X				0.	0.	0.
(17) HELENA VAN VOORST DIRECTOR	1.00 2.00	X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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			
(18) DEBRA STENNER DIRECTOR	1.00 2.00	X						0.	0.	0.
(19) SARAH RAY DIRECTOR	1.00 2.00	X						0.	0.	0.
(20) CHERYL MULLINS DIRECTOR	1.00 2.00	X						0.	0.	0.
(21) NICHOLAS LOVEJOY DIRECTOR / SECRETARY	1.00 2.00	X		X				0.	0.	0.
(22) ANNE COLLINS DIRECTOR	1.00 2.00	X						0.	0.	0.
(23) JUDSON BARTLETT VICE CHAIR	1.00 2.00	X		X				0.	0.	0.
(24) GRETCHEN AYER DIRECTOR	1.00 2.00	X						0.	0.	0.
(25) MATTHEW CURRAN TREASURER	1.00 2.00	X		X				0.	0.	0.
(26) LINDA SCHIFFER CHAIR	1.00 2.00	X		X				0.	0.	0.
1b Subtotal								1,261,087.	2,221,305.	386,791.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								1,261,087.	2,221,305.	386,791.

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 **37**

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
CROSS COUNTRY STAFFING INC. PO BOX 404678, ATLANTA, GA 30384-4768	TRAVELING NURSING SERVICES	7,443,090.
MEDICAL SOLUTIONS PO BOX 850737, MINNEAPOLIS, MN 55485-0737	TRAVELING NURSING SERVICES	1,996,938.
ALLIANCE HEALTHCARE SERVICES INC. PO BOX 735714, DALLAS, TX 75373-5714	RADIOLOGY SERVICES	1,197,110.
MAYO COLLABORATIVE SERVICES INC. PO BOX 9146, MINNEAPOLIS, MN 55480-9146	LABORATORY SERVICES	643,303.
MIDDLEBURY REGIONAL EMS INC. PO BOX 8648, ESSEX JUNCTION, VT 05452	AMBULANCE / TRANSPORT SERVICES	349,373.

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **41**

SEE PART VII, SECTION A CONTINUATION SHEETS

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 line)	(C) Position (check all that apply)						(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			
(27) SIVAN COTEL DIRECTOR / CHAIR (PT YR)	1.00 4.00	X		X				0.	0.	0.
(28) AMEY RYAN DIRECTOR	1.00 2.00	X						0.	0.	0.
(29) RICHARD FOOTE DIRECTOR	1.00 2.00	X						0.	0.	0.
Total to Part VII, Section A, line 1c										

Part VIII Statement of Revenue

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

			(A)	(B)	(C)	(D)	
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	83,202.				
	e Government grants (contributions)	1e	3,518,623.				
	f All other contributions, gifts, grants, and similar amounts not included above ...	1f	824,455.				
	g Noncash contributions included in lines 1a-1f	1g	\$				
	h Total. Add lines 1a-1f			4,426,280.			
Program Service Revenue	2 a PATIENT SERVICE REVENUE	Business Code	900099	77,563,891.	77563891.		
	b FIXED PROSPECTIVE PAYMENTS		900099	20,810,103.	20810103.		
	c PATIENT SERVICES - PHARMACY		446110	1,510,708.	1,510,708.		
	d DSH REVENUE		900099	811,269.	811,269.		
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			100695971.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			476,934.		476,934.	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	6a	(i) Real	11,659.			
			(ii) Personal				
	b Less: rental expenses ...	6b		0.			
	c Rental income or (loss)	6c		11,659.			
	d Net rental income or (loss)			11,659.		11,659.	
	7 a Gross amount from sales of assets other than inventory	7a	(i) Securities	5,475,246.			
			(ii) Other				
	b Less: cost or other basis and sales expenses	7b		5,009,634.	15,266.		
c Gain or (loss)	7c		465,612.	-15,266.			
d Net gain or (loss)			450,346.		450,346.		
8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a						
b Less: direct expenses	8b						
c Net income or (loss) from fundraising events							
9 a Gross income from gaming activities. See Part IV, line 19	9a						
b Less: direct expenses	9b						
c Net income or (loss) from gaming activities							
10 a Gross sales of inventory, less returns and allowances	10a						
b Less: cost of goods sold	10b						
c Net income or (loss) from sales of inventory							
Miscellaneous Revenue	11 a OTHER MISC REVENUE	Business Code	900099	728,693.	728,693.		
	b CAFETERIA		900099	209,457.		209,457.	
	c						
	d All other revenue						
	e Total. Add lines 11a-11d			938,150.			
12 Total revenue. See instructions			106999340.	101424664.	0.	1148396.	

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	54,369.	54,369.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	6,974.		6,974.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	55,200,097.	49,172,196.	6,027,901.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	2,174,686.	1,898,837.	275,849.	
9 Other employee benefits	5,266,957.	4,366,321.	900,636.	
10 Payroll taxes	2,780,541.	2,383,217.	397,324.	
11 Fees for services (nonemployees):				
a Management				
b Legal	83,978.		83,978.	
c Accounting	60,524.		60,524.	
d Lobbying	9,011.		9,011.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	15,120.		15,120.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	11,537,277.	5,899,577.	5,561,554.	76,146.
12 Advertising and promotion	125,722.	75,285.	50,437.	
13 Office expenses	10,811,411.	10,254,988.	556,423.	
14 Information technology	1,520,195.	24,603.	1,495,592.	
15 Royalties				
16 Occupancy	1,867,989.	726,389.	1,141,600.	
17 Travel	81,318.	66,728.	14,590.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	201,211.	193,369.	7,842.	
20 Interest	271,600.	226,134.	45,466.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	2,929,571.	2,437,403.	490,410.	1,758.
23 Insurance	319,356.	238,457.	80,899.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a MEDICARE PROVIDER TAX	5,587,514.	5,587,514.		
b LEASED EQUIPMENT	473,322.	388,134.	85,188.	
c BOOKS, DUES & SUBSCRIPT	203,556.	37,175.	166,381.	
d FREIGHT	127,991.	123,836.	4,155.	
e All other expenses	346,788.	311,335.	35,453.	
25 Total functional expenses. Add lines 1 through 24e	102,057,078.	84,465,867.	17,513,307.	77,904.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				
Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	79,971.	1	19,595.
	2 Savings and temporary cash investments	30,901,493.	2	7,666,579.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	14,155,944.	4	17,034,121.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	2,167,561.	8	2,435,609.
	9 Prepaid expenses and deferred charges	481,697.	9	1,362,795.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 60,077,676.		
	b Less: accumulated depreciation	10b 46,163,640.	10c	13,914,036.
	11 Investments - publicly traded securities	11,826,884.	11	27,790,928.
	12 Investments - other securities. See Part IV, line 11	4,993,379.	12	4,793,323.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	3,291,260.	15	1,221,735.
16 Total assets. Add lines 1 through 15 (must equal line 33)	83,460,872.	16	76,238,721.	
Liabilities	17 Accounts payable and accrued expenses	8,482,999.	17	10,139,416.
	18 Grants payable		18	
	19 Deferred revenue		19	3,447.
	20 Tax-exempt bond liabilities	9,530,945.	20	8,965,927.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	10,401,947.	25	3,440,356.
	26 Total liabilities. Add lines 17 through 25	28,415,891.	26	22,549,146.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	49,584,235.	27	47,932,940.
	28 Net assets with donor restrictions	5,460,746.	28	5,756,635.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	55,044,981.	32	53,689,575.
	33 Total liabilities and net assets/fund balances	83,460,872.	33	76,238,721.

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	106,999,340.
2	Total expenses (must equal Part IX, column (A), line 25)	2	102,057,078.
3	Revenue less expenses. Subtract line 2 from line 1	3	4,942,262.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	55,044,981.
5	Net unrealized gains (losses) on investments	5	-6,173,632.
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	-124,036.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	53,689,575.

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		

Form 990 (2021)

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 **PORTER HOSPITAL, INC.** Employer identification number **03-0181058**

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		
Total						

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 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 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge ...						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources ...						
9 Net income from unrelated business activities, whether or not the business is regularly carried on ...						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 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						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2020 Schedule A, Part II, line 14	15	%
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		<input type="checkbox"/>
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		<input type="checkbox"/>
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		<input type="checkbox"/>
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		<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions		<input type="checkbox"/>

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

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

Section A. Public Support

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 Gross receipts from admissions; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 8 Public support.

Section B. Total Support

Table with 7 columns: (a) 2017, (b) 2018, (c) 2019, (d) 2020, (e) 2021, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 10b Unrelated business taxable income; 11 Net income from unrelated business activities not included on line 10b; 12 Other income; 13 Total support.

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

Table with 2 columns: Description, Percentage. Row 15: Public support percentage for 2021 (line 8, column (f), divided by line 13, column (f)) 15 %; Row 16: Public support percentage from 2020 Schedule A, Part III, line 15 16 %

Section D. Computation of Investment Income Percentage

Table with 2 columns: Description, Percentage. Row 17: Investment income percentage for 2021 (line 10c, column (f), divided by line 13, column (f)) 17 %; Row 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)

Table with 3 columns: Question, Yes, No. Contains questions 11a, 11b, 11c regarding gifts and contributions.

Section B. Type I Supporting Organizations

Table with 3 columns: Question, Yes, No. Contains questions 1 and 2 regarding governing body powers and organization benefits.

Section C. Type II Supporting Organizations

Table with 3 columns: Question, Yes, No. Contains question 1 regarding directors or trustees of supported organizations.

Section D. All Type III Supporting Organizations

Table with 3 columns: Question, Yes, No. Contains questions 1, 2, 3 regarding support provided, officers, and significant voice.

Section E. Type III Functionally Integrated Supporting Organizations

Table with 3 columns: Question, Yes, No. Contains questions 1-3 regarding the Integral Part Test and Activities Test.

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 - <i>provide details in Part VI</i>)	5
6	Other distributions (<i>describe in Part VI</i>). 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 (<i>provide details in Part VI</i>). 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 - <i>explain in Part VI</i>). 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, <i>explain in Part VI</i> . See instructions.			
6 Remaining underdistributions for 2021. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . 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			

Part VI

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

Horizontal lines for supplemental information input.

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

PORTER HOSPITAL, INC.

Employer identification number

03-0181058

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 PORTER HOSPITAL, INC.	Employer identification number 03-0181058
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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	_____ _____ _____	\$ <u>502,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	_____ _____ _____	\$ <u>83,202.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	_____ _____ _____	\$ <u>13,955.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	_____ _____ _____	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	_____ _____ _____	\$ <u>5,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization PORTER HOSPITAL, INC.	Employer identification number 03-0181058
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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 PORTER HOSPITAL, INC.	Employer identification number 03-0181058
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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 info. once.) ▶ \$ _____
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	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
(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

Department of the Treasury
Internal Revenue Service

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.**

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 PORTER HOSPITAL, INC.	Employer identification number 03-0181058
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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.
- 2 Political campaign activity expenditures ▶ \$ _____
- 3 Volunteer hours for political campaign activities

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-.

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.			
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)).

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		9,011.
j Total. Add lines 1c through 1i			9,011.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE ORGANIZATION PAYS DUES TO THE VERMONT ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS, A PORTION OF WHICH IS ATTRIBUTABLE TO LOBBYING EXPENSES.

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

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

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

OMB No. 1545-0047

2021

Open to Public Inspection

Name of the organization PORTER HOSPITAL, INC. Employer identification number 03-0181058

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: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two Yes/No questions regarding donor property and grant fund usage.

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include purpose(s) of conservation easements, a table for lines 2a-2d (Total number, acreage, certified historic structures, and National Register listings), and questions about monitoring, expenses, and reporting requirements.

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: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include questions about reporting requirements for art and historical treasures, and a table for revenue and assets included in Form 990.

LHA 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	5,111,060.	3,965,823.	3,834,593.	3,801,633.	3,685,569.
b Contributions					
c Net investment earnings, gains, and losses	215,550.	1,546,430.	518,448.	416,015.	508,630.
d Grants or scholarships					
e Other expenditures for facilities and programs	415,605.	401,193.	387,218.	383,055.	392,566.
f Administrative expenses					
g End of year balance	4,911,005.	5,111,060.	3,965,823.	3,834,593.	3,801,633.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment 0.0000 %
 - b Permanent endowment 100 %
 - c Term endowment 0.0000 %
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- | | Yes | No |
|---|-----|----|
| (i) Unrelated organizations | X | |
| (ii) Related organizations | | X |
| b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R? <input type="checkbox"/> | 3b | |
- 4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings		28,987,420.	19,921,447.	9,065,973.
c Leasehold improvements				
d Equipment		28,557,131.	24,640,060.	3,917,071.
e Other		2,533,125.	1,602,133.	930,992.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				13,914,036.

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		
(B) PERPETUAL TRUSTS	4,793,323.	END-OF-YEAR MARKET VALUE
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶	4,793,323.	

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. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

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

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

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) ESTIMATED THIRD PARTY SETTLEMENTS	740,297.
(3) LIABILITY FOR PENSION BENEFITS	1,446,309.
(4) RT OF USE OPERATING LEASE	
(5) OBLIGATION	1,239,864.
(6) CONTRACT LIABILITIES	13,886.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	3,440,356.

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.

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

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

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

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

Part XIII Supplemental Information.

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

PART V, LINE 4:

INCOME FROM ENDOWMENTS HELD AND ADMINISTERED BY MIDDLEBURY COLLEGE
 SUPPORTS THE ORGANIZATION'S MISSION BY PROVIDING FUNDS FOR CHARITY CARE
 AND ADDITIONALLY OFFSETS A PORTION OF THE ORGANIZATION'S OPERATING
 EXPENSES.

PART X, LINE 2:

PORTER HOSPITAL, INC. IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS
 FOR THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK"). PAGE
 18 OF THE CONSOLIDATED FINANCIAL STATEMENTS CONTAINS A FOOTNOTE INDICATING
 THAT NO PROVISION FOR FEDERAL INCOME TAXES HAS BEEN RECORDED.

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2021

Open to Public Inspection

Name of the organization **PORTER HOSPITAL, INC.** Employer identification number **03-0181058**

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"/>	
b 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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	<input checked="" type="checkbox"/>	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>360</u> %		
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?		<input checked="" type="checkbox"/>
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?		

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

7 Financial Assistance and Certain Other Community Benefits at Cost

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			762,022.		762,022.	.75%
b Medicaid (from Worksheet 3, column a)			12714349.	2913948.	9800401.	9.60%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			13476371.	2913948.	10562423.	10.35%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			855,049.	677,862.	177,187.	.17%
f Health professions education (from Worksheet 5)			77,205.		77,205.	.08%
g Subsidized health services (from Worksheet 6)			6815697.	5028139.	1787558.	1.75%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			54,369.		54,369.	.05%
j Total. Other Benefits			7802320.	5706001.	2096319.	2.05%
k Total. Add lines 7d and 7j			21278691.	8619949.	12658742.	12.40%

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	16,141,839.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	21,033,121.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-4,891,282.
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 checked="" type="checkbox"/> Cost accounting system <input 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?	9a	X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	X	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities

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

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)

1 PORTER HOSPITAL, INC.
115 PORTER DRIVE
MIDDLEBURY, VT 05753
WWW.PORTERMEDICAL.ORG
899

Table with columns: Licensed hospital, gen. medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1 contains 'X' marks in the first four columns.

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 PORTER HOSPITAL, INC.

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	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input checked="" type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>20</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?	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SECTION C</u>		
b <input type="checkbox"/> Other website (list url):		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>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 PART V, 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 PORTER HOSPITAL, INC.

		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?	X	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>360</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 type="checkbox"/> Residency		
h	<input checked="" 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?	X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	<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?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Schedule H (Form 990) 2021

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group PORTER HOSPITAL, INC.

	Yes	No
<p>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?</p>	X	
<p>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:</p> <p>a <input type="checkbox"/> Reporting to credit agency(ies)</p> <p>b <input type="checkbox"/> Selling an individual's debt to another party</p> <p>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</p> <p>d <input type="checkbox"/> Actions that require a legal or judicial process</p> <p>e <input type="checkbox"/> Other similar actions (describe in Section C)</p> <p>f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted</p>		
<p>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?</p> <p>If "Yes," check all actions in which the hospital facility or a third party engaged:</p> <p>a <input type="checkbox"/> Reporting to credit agency(ies)</p> <p>b <input type="checkbox"/> Selling an individual's debt to another party</p> <p>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</p> <p>d <input type="checkbox"/> Actions that require a legal or judicial process</p> <p>e <input type="checkbox"/> Other similar actions (describe in Section C)</p>		X
<p>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):</p> <p>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)</p> <p>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)</p> <p>c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)</p> <p>d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)</p> <p>e <input checked="" type="checkbox"/> Other (describe in Section C)</p> <p>f <input type="checkbox"/> None of these efforts were made</p>		

Policy Relating to Emergency Medical Care

<p>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?</p> <p>If "No," indicate why:</p> <p>a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions</p> <p>b <input type="checkbox"/> The hospital facility's policy was not in writing</p> <p>c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)</p> <p>d <input type="checkbox"/> Other (describe in Section C)</p>	X	
--	----------	--

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 PORTER HOSPITAL, INC.

		Yes	No		
<p>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.</p> <p>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</p> <p>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</p> <p>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</p> <p>d <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method</p>					
<p>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?</p> <p>If "Yes," explain in Section C.</p>		23	X		
<p>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?</p> <p>If "Yes," explain in Section C.</p>		24	X		

Schedule H (Form 990) 2021

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.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 3J: THE CHNA CONDUCTED IN FY 2021 / TY 2020

CONTAINS INFORMATION AND ANALYSIS THAT EXTENDS BEYOND THE SUBJECTS

DESCRIBED IN PART V, LINE 3, INCLUDING BUT NOT LIMITED TO: SECONDARY DATA

SOURCES, MORTALITY STATISTICS, KEY HEALTH AND WELLBEING INDICATORS AND

THEIR SOURCES, AND A DISCUSSION OF THE IMPACT OF COVID-19 ON THE

COMMUNITY.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 5: THE CHNA DATA COLLECTION PROCESS CONSISTED OF

A CHNA SURVEY COMPLETED BY 761 RESPONDENTS, FIVE SEPARATE FOCUS GROUP

SESSIONS IN WHICH 14 PERSONS PARTICIPATED, AND STAKEHOLDER INTERVIEWS WITH

33 REPRESENTATIVES FROM 23 COMMUNITY ORGANIZATIONS.

THE SURVEYS WERE CONDUCTED IN FEBRUARY AND MARCH 2021 AND WERE PRIMARILY

COLLECTED ONLINE. THE SURVEY WAS MADE AVAILABLE IN ENGLISH AND IN

SPANISH. THE SURVEYS WERE PUBLICIZED THROUGH ELECTRONIC MAILING LISTS,

ONLINE COMMUNITY MESSAGE BOARDS, SOCIAL MEDIA, AND THE PORTER HOSPITAL

WEBSITE. HOWEVER, PAPER SURVEYS WERE MADE AVAILABLE BY REQUEST AND

DISTRIBUTED LOCALLY AT OPEN DOOR CLINIC AND MIDDLEBURY LAUNDROMAT. PAPER

SURVEYS WERE ALSO OFFERED TO INDIVIDUALS WHO RECEIVED HOME-BOUND COVID-19

VACCINATIONS.

FOCUS GROUPS WERE HELD IN MAY 2021. PARTICIPANTS WERE RECRUITED VIA

FLYERS SENT TO COMMUNITY PARTNERS, THROUGH COMMUNITY MEMBERS IDENTIFIED BY

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.

COMMUNITY PARTNERS, AND VIA ONLINE MESSAGE BOARDS. FOCUS GROUP DISCUSSIONS WERE GUIDED BY AN IN-DEPTH QUESTIONNAIRE, A COPY OF WHICH IS INCLUDED AS AN APPENDIX TO THE CHNA.

CROSS-SECTOR STAKEHOLDERS WERE INTERVIEWED AT EXISTING MEETINGS SUCH AS THAT OF THE COMMUNITY HEALTH ACTION TEAM, BUILDING BRIGHT FUTURES GROUP, SUBSTANCE USE TREATMENT AND RECOVERY COMMITTEE, OR WERE CONDUCTED SEPARATELY TO INTERESTED INDIVIDUALS. STAKEHOLDER ORGANIZATIONS REPRESENTED MANY ASPECTS OF THE COMMUNITY AND INCLUDED: PARENT CHILD CENTER, BUILDING BRIGHT FUTURES, UNITED WAY OF ADDISON COUNTY, MARY HOGAN, MARY JOHNSON, ADDISON COUNTY SCHOOL DISTRICTS, END OF LIFE SERVICES, ADDISON COUNTY HOME HEALTH AND HOSPICE, COUNSELING SERVICES OF ADDISON COUNTY, FIELD SERVICES, PRIVATE PT PRACTICE, MOUNTAIN HEALTH CENTER, GIVING FRIDGE, TURNING POINT CENTER, DEPARTMENT FOR CHILDREN AND FAMILIES, VERMONT DEPARTMENT OF HEALTH, RESIDENCE AT OTTER CREEK, SAVIDA, BRISTOL FAMILY CENTER, PREGNANCY RESOURCE CENTER, NORTHERN LIGHTS AT CCV, AND MOUNT ABRAHAM UNIFIED SCHOOL DISTRICT.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 6B: THE TY 2020/FY 2021 CHNA WAS CONDUCTED WITH THE ASSISTANCE OF COMMUNITY ORGANIZATIONS SUCH AS UNITED WAY OF ADDISON COUNTY, THE DEPARTMENT OF HEALTH, MIDDLEBURY COLLEGE, BLUEPRINT FOR HEALTH, AND ADDISON COUNTY HOME HEALTH AND HOSPICE, ALL OF WHICH CONTRIBUTED MEMBERS TO THE CHNA STEERING COMMITTEE. ADDITIONALLY, MIDDLEBURY COLLEGE STUDENTS SERVED IMPORTANT ROLES IN THE AREAS OF DATA COLLECTION AND ANALYSIS. FINALLY, THE LOCAL ORGANIZATIONS LISTED IN THE

Part V Facility Information (continued)

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

PREVIOUS DISCLOSURE CONTRIBUTED TO THE STAKEHOLDER MEETINGS.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 11: PARTICIPANTS IN THE CHNA DATA COLLECTION

PROCESSES DESCRIBED ABOVE IDENTIFIED CONCERNS AROUND THE FOLLOWING AREAS:

SUBSTANCE ABUSE, INCLUDING CONCERNS ABOUT STIGMA SURROUNDING TREATMENT, AS WELL AS THE AVAILABILITY AND AFFORDABILITY OF TREATMENT;

HEALTHY EATING, PRIMARILY CONCERNED AROUND AFFORDABILITY OF HEALTHY FOODS;

MENTAL HEALTH, INCLUDING CONCERNS ABOUT AFFORDABILITY AND A NEED FOR MORE RESOURCES SUCH AS MENTAL HEALTH CLINICIANS;

HEALTH CARE, INCLUDING CONCERNS ABOUT AFFORDABILITY, THE NEED FOR MORE PRIMARY CARE PROVIDERS, AND WELLNESS CENTERED CARE, AS WELL AS BARRIERS SUCH AS TRANSPORTATION AND LACK OF HEALTH INSURANCE

ENVIRONMENTAL ISSUES SUCH AS CLIMATE CHANGE AND STREET SAFETY; AND

HOUSING, INCLUDING LACK OF AFFORDABLE UNITS, SPACE TO RENT, SOBER HOUSING, AND HOUSING FOR ELDERS.

A COMMUNITY MEETING WAS HELD TO PRESENT THE INFORMATION FROM THE CHNA SURVEY, FOCUS GROUPS, AND STAKEHOLDER MEETINGS WHERE 32 COMMUNITY LEADERS WERE PRESENT. ONCE THE INFORMATION WAS PRESENTED, LEADERS BROKE OUT INTO

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.

GROUPS TO IDENTIFY THE TOP THREE PRIORITIES TO BE ADDRESSED IN THE IMPLEMENTATION STRATEGY. THE TOP THREE PRIORITIES SELECTED WERE ACCESS TO MENTAL HEALTH SERVICES (72%), ACCESS TO HEALTHCARE SERVICES (60%), AND HOUSING (44%). THE IMPLEMENTATION STRATEGY CONTAINS THE FOLLOWING OBJECTIVES WITH RESPECT TO THESE PRIORITIES AND CONTAINS METRICS AND BENCHMARKS TO ESTABLISH PROGRESS.

ACCESS TO MENTAL HEALTH SERVICES:

- ADVANCE MENTAL WELLNESS THROUGH EQUITABLE ACCESS TO A TIMELY, RESPONSIVE, AND INTEGRATED SYSTEM;
- STRONG CROSS-ORGANIZATION COMMITMENT AND ENGAGEMENT TO INCREASE ACCESS TO MENTAL HEALTH CARE; AND
- CULTIVATE RESILIENT COMMUNITIES TO SUPPORT MENTAL AND SOCIAL WELLBEING.

ACCESS TO HEALTHCARE SERVICES:

- ENHANCE USE OF TECHNOLOGY AND ELECTRONIC HEALTH RECORD SYSTEMS TO IMPROVE ACCESS, EFFECTIVENESS, OUTREACH, AND OVERALL QUALITY OF CARE;
- EXPAND WORKFORCE RECRUITMENT AND RETENTION EFFORTS TO INCREASE CAPACITY;
- REIMAGINE HEALTH CARE TO INCREASE ACCESS TO SERVICES; AND
- IMPROVE EQUITY IN THE HEALTH CARE SYSTEM BY DEVELOPING A COLLECTIVE APPROACH AND COORDINATED IMPACT WITHIN THE COMMUNITY.

HOUSING:

- STRONG CROSS-ORGANIZATIONAL COMMITMENT AND ENGAGEMENT TO EXPAND OPPORTUNITIES FOR AFFORDABLE AND QUALITY HOUSING IN ADDISON COUNTY;
- REDUCE DISPLACEMENT AND HOMELESSNESS IN ADDISON COUNTY; AND

Part V Facility Information (continued)

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

- PROMOTE A SAFE ENVIRONMENT FOR YOUTH, FAMILIES, AND OLDER VERMONTERS IN THE HOME SETTING.

GIVEN THE NUMBER OF INDIVIDUALS AND ORGANIZATIONS INCLUDED IN THE CHNA PROCESS AND THE VAST ARRAY OF VIEWPOINTS REPRESENTED, THE ORGANIZATION WAS UNABLE TO ADDRESS ALL OF THE NEEDS IDENTIFIED THROUGHOUT THE CHNA PROCESS. THE GROUP THEREFORE FOCUSED IMPLEMENTATION EFFORTS ON THE TOP THREE NEEDS AS DETERMINED BY CONSENSUS AT THE COMMUNITY MEETING DESCRIBED ABOVE.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 13H: PATIENTS WHOSE FAMILY INCOME IS ABOVE 360% OF THE FEDERAL POVERTY GUIDELINES MAY BE ELIGIBLE TO RECEIVE ASSISTANCE ON A CASE-BY-CASE BASIS BASED ON THEIR SPECIFIC CIRCUMSTANCES AT THE DISCRETION OF PORTER HOSPITAL.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 15E: ELIGIBILITY VERIFICATION MAY INCLUDE WRITTEN DOCUMENTATION FROM THE OPEN DOOR CLINIC (A LOCAL, FREE HEALTH CLINIC FOR UNINSURED AND UNDER-INSURED ADULTS IN ADDISON COUNTY, VERMONT) OF FINANCIAL INFORMATION IN LIEU OF INCOME VERIFICATION.

WHILE THE FINANCIAL ASSISTANCE POLICY DOES NOT PROVIDE A LIST OF "EXTERNAL" CONTACT INFORMATION FOR ORGANIZATIONS AGENCIES WHO MAY ASSIST PATIENTS IN THE APPLICATION PROCESS, APPLICATION COMPLETION AID IS WELL PUBLISHED WITH MULTIPLE INTERNAL, ORGANIZATIONAL AND PROVIDED BY STAFF

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.

MEMBERS AVAILABLE TO ASSIST OUR PATIENTS. IT IS ALSO IMPORTANT TO NOTE, WHENEVER POSSIBLE, 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 UNDER THE FINANCIAL ASSISTANCE PROGRAM.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 16J: PORTER HOSPITAL MAKES ADDITIONAL EFFORTS TO ENGAGE PATIENTS IN FINANCIAL COUNSELING AND DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE AS FOLLOWS:

- SIGNAGE HAS BEEN POSTED IN ALL WAITING AREAS OF THE ORGANIZATION REGARDING FINANCIAL ASSISTANCE BEING OFFERED.
- NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE HAS BEEN ADDED TO THE PATIENT PORTAL ALONG WITH A PHONE NUMBER FOR ASSISTANCE ALONG WITH OUR WEBSITE ADDRESS FOR APPLICATION.
- OUTPATIENT PREREGISTRATION CALLS NOTIFY PATIENTS OF AVAILABILITY OF FINANCIAL ASSISTANCE.
- REGISTRATION AREAS NOTIFY PATIENTS OF AVAILABILITY OF FINANCIAL ASSISTANCE AS WELL AS HAVING APPLICATIONS READILY AVAILABLE.
- EVERY STATEMENT HAS THE NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE ALONG WITH A PHONE NUMBER TO CALL FOR ASSISTANCE AND A WEBSITE TO VISIT FOR AN APPLICATION.
- THE UVMHN CUSTOMER SERVICE DEPARTMENT MAKES A REASONABLE EFFORT TO CALL PATIENTS FOR COLLECTIONS OF SELF-PAY BALANCES AND NOTIFICATION OF FINANCIAL ASSISTANCE.

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.

PORTER HOSPITAL, INC.:

PART V, SECTION B, LINE 20E: (ALSO APPLICABLE TO LINE 20A) PORTER HOSPITAL DOES NOT TAKE ANY EXTRAORDINARY COLLECTION ACTIONS.

PART V, SECTION B, LINES 7A, 10A, AND 16A-16C: HOSPITAL FACILITY'S WEBSITE CHNA AND IMPLEMENTATION STRATEGY:

WWW.PORTERMEDICAL.ORG/ABOUT/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/

FINANCIAL ASSISTANCE POLICY, FAP APPLICATION, AND PLAIN LANGUAGE

SUMMARY:

WWW.PORTERMEDICAL.ORG/PATIENTS-VISITORS/PATIENT-FINANCIAL-SERVICES/

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? 10

Name and address	Type of Facility (describe)
1 UVMHN-PMC ORTHOPEDICS 2436 EXCHANGE STREET MIDDLEBURY, VT 05753	PHYSICIAN CLINIC
2 UVMHN-PMC PRIMARY CARE-MIDDLEBURY 82 CATAMOUNT PARK MIDDLEBURY, VT 05753	FAMILY PHYSICIAN CLINIC
3 UVMHN-PMC PRIMARY CARE-VERGENNES 10 NORTH STREET VERGENNES, VT 05491	FAMILY PHYSICIAN CLINIC
4 UVMHN-PMC PEDIATRIC PRIMARY CARE 1330 EXCHANGE STREET, #201 MIDDLEBURY, VT 05753	PHYSICIAN CLINIC
5 UVMHN-PMC PRIMARY CARE-BRANDON 61 COURT DRIVE BRANDON, VT 05733	FAMILY PHYSICIAN CLINIC
6 UVMHN-PMC EAR, NOSE & THROAT 1330 EXCHANGE STREET, #202 MIDDLEBURY, VT 05753	PHYSICIAN CLINIC
7 UVMHN-PMC PRIMARY CARE-BRISTOL 61 PINE STREET BRISTOL, VT 05443	PHYSICIAN CLINIC
8 UVMHN-PMC CARDIOLOGY 115 PORTER DRIVE MIDDLEBURY, VT 05753	PHYSICIAN CLINIC
9 UVMHN-PMC PODIATRY 76 COURT STREET MIDDLEBURY, VT 05753	PHYSICIAN CLINIC
10 UVMHN-PMC WOMEN'S HEALTH 116 PORTER DRIVE MIDDLEBURY, VT 05753	PHYSICIAN CLINIC

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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 3C:

ALL UNINSURED PATIENTS AND PATIENTS HAVING A BALANCE AFTER INSURANCE ARE ELIGIBLE TO SUBMIT A FINANCIAL ASSISTANCE APPLICATION. IN ADDITION TO THE INCOME TEST BASED ON FEDERAL POVERTY GUIDELINES DESCRIBED IN SCHEDULE H, PART I, ELIGIBILITY IS PREDICATED UPON AN ASSET LEVEL WITHIN THE LIMITATIONS SET FORTH BY THE CMS MEDICARE LOW INCOME BENEFICIARY LIMITS. ADDITIONALLY, CATASTROPHIC FINANCIAL ASSISTANCE IS AVAILABLE TO THE MEDICALLY INDIGENT. FINALLY, PATIENTS WHOSE FAMILY INCOME IS ABOVE 360% OF THE FEDERAL POVERTY GUIDELINES, OR WHO OTHERWISE DO NOT QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE TESTS DESCRIBED ABOVE, WERE ELIGIBLE TO RECEIVE ASSISTANCE ON A CASE-BY-CASE BASIS BASED ON THEIR SPECIFIC CIRCUMSTANCES AT THE THE DISCRETION OF PORTER HOSPITAL.

PART I, LINE 7:

THE ORGANIZATION USED A COST-TO-CHARGE RATIO FOR THE PURPOSES OF CALCULATING AMOUNTS ON LINES 7A AND 7B. AN ACTUAL COSTING METHOD WAS USED TO CALCULATE AMOUNTS ON LINES 7E, 7F, 7G AND 7I.

Part VI Supplemental Information (Continuation)

PART I, LINE 7G:

SUBSIDIZED HEALTH SERVICES PROVIDED DESPITE A LOSS TO THE ORGANIZATION INCLUDED SERVICES PROVIDED TO PUBLIC AGENCIES AS WELL AS DEPARTMENTS MEETING NEEDS THAT ARE NOT OTHERWISE AVAILABLE IN THE COMMUNITY SUCH AS DELIVERY, NEWBORN AND POSTPARTUM SERVICES, AND SERVICES RELATED TO MENTAL HEALTH. DUE TO A CHANGE IN THE ORGANIZATION'S MEDICAL RECORDS AND BILLING SYSTEM, EXPENSE DATA FOR THESE SERVICES IS ONLY AVAILABLE FOR THE PERIOD FROM 11/6/2021 THROUGH 9/30/2022. THESE AMOUNTS ARE REPORTED ON SCH H, PART I, LINE 7G. ACTUAL EXPENSES FOR THE ENTIRE YEAR (10/1/2021-9/30/2022) CANNOT BE ACCURATELY ASCERTAINED, BUT THEY ARE MOST LIKELY HIGHER THAN THOSE REPORTED.

PART I, LN 7 COL(F):

THE PROVISION FOR BAD DEBT SUBTRACTED FOR PURPOSES OF OF CALCULATING THE AMOUNT REPORTED ON LINE 7(F) IS \$0. BAD DEBT IS DEDUCTED FROM PATIENT SERVICE REVENUE REPORTED ON FORM 990, PART VIII.

PART III, LINE 2:

THE ORGANIZATION USED THE COST-TO-CHARGE RATIO AS ITS COSTING METHODOLOGY TO CALCULATE BAD DEBT EXPENSE AT COST.

PART III, LINE 3:

DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE NETTED AGAINST THE TOTAL GROSS CHARGES WHEN DETERMINING BAD DEBT EXPENSE. THE \$27,949 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. PORTER HOSPITAL HAS A DATABASE WHICH TRACKS ALL APPLICATIONS AND THEIR STATUS; A QUERY EXTRACTED

Part VI Supplemental Information (Continuation)

ALL INCOMPLETE/NON RESPONSIVE ARCHIVED APPLICATIONS PROVIDING A LIST OF PATIENTS & DEPENDENTS. SUBSEQUENTLY, A QUERY OF ASSOCIATED PATIENT SERVICES FROM 10/1/21-9/30/22 FOR "SELF-PAY" AND COLLECTION ACCOUNTS WAS EXTRACTED FROM THE BILLING SYSTEM.

PART III, LINE 4:

THE ORGANIZATION'S BAD DEBT EXPENSE IS ADDRESSED ON PAGE 27 IN FOOTNOTE 5 OF ITS MOST RECENT AUDITED FINANCIAL STATEMENTS.

PART III, LINE 8:

THE AMOUNT REPORTED IN PART III, LINE 6, MEDICARE ALLOWABLE COSTS OF CARE, IS DERIVED FROM PORTER HOSPITAL'S FYE 9/30/22 MEDICARE COST REPORT, WORKSHEETS E-1 THROUGH E-3. WHILE PORTER HOSPITAL HAS 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 III, LINE 9B:

THE ORGANIZATION'S WRITTEN DEBT COLLECTION POLICY PROVIDES THAT PATIENTS INDICATING AN INABILITY TO MEET THEIR FINANCIAL OBLIGATIONS ARE TO BE REFERRED TO THE PATIENT FINANCIAL ADVOCATE. THE POLICY PROVIDES FURTHER THAT PATIENTS WHO APPLY UNDER THE FINANCIAL ASSISTANCE POLICY ARE NOT CHARGED MORE THAN AMOUNTS GENERALLY BILLED AND QUALIFY FOR A SLIDING SCALE DISCOUNT. THE BILLING AND COLLECTIONS PROCESS IS EXTENDED FOR UP TO THE LATTER OF 240 DAYS OR SIX WEEKS AFTER A PATIENT HAS REQUESTED A FINANCIAL

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

ASSISTANCE APPLICATION FOR PATIENTS REQUESTING A FINANCIAL ASSISTANCE APPLICATION. ONCE A PATIENT IS DETERMINED ELIGIBLE FOR FINANCIAL ASSISTANCE, ALL PAYMENTS MADE IN EXCESS OF THE FAP-ELIGIBLE AMOUNT ARE FUNDED AND THE FAP-ELIGIBLE AMOUNT IS NOT PURSUED.

PART VI, LINE 2:

PORTER HOSPITAL PARTNERS WITH A NUMBER OF COMMUNITY HEALTH RESOURCE GROUPS INCLUDING MY HEALTHY VERMONT, THE VERMONT PUBLIC HEALTH INSTITUTE, AND THE VERMONT DEPARTMENT OF HEALTH DISTRICT OFFICES TO ADDRESS THE NEEDS OF ADDISON COUNTY, VERMONT AND SURROUNDING AREAS. RECENT COLLABORATIONS HAVE INCLUDED A FOOD BAGS PROJECT PILOTED AT PORTER WOMEN'S HEALTH, AND ADMINISTRATION OF VERMONT COMMUNITY HEALTH PARTNERSHIP GRANTS.

ADDITIONALLY, PORTER HOSPITAL OFFERS FREE TO THE COMMUNITY A WIDE RANGE OF HEALTH, PREVENTION AND WELLNESS PROGRAMS DESIGNED TO ADDRESS THE HEALTH CARE NEEDS OF THE COMMUNITY AND LIMIT THE NEED FOR MORE EXPENSIVE ACUTE CARE. CURRENT PROGRAMS ARE LISTED AT THE PORTER WEBSITE AT WWW.PORTERMEDICAL.ORG/CATEGORY/CLASSES-EVENTS. FINALLY, PORTER HOSPITAL HAS A COMMUNITY DEVELOPMENT COUNCIL THAT CONSISTS OF COMMUNITY MEMBERS AND PORTER STAFF WORKING TOGETHER TO DRIVE COMMUNITY ENGAGEMENT AND CREATE OPPORTUNITIES TO SUPPORT PORTER AND EXPAND PATIENT ACCESS.

PART VI, LINE 3:

PORTER HOSPITAL ("PORTER") UTILIZES A VARIETY OF METHODS TO INFORM, EDUCATE, AND ASSIST PAYMENTS IN IDENTIFYING PAYMENT SOURCES, INCLUDING STATE / FEDERAL PROGRAMS AND ITS FINANCIAL ASSISTANCE POLICY.

PORTER WIDELY PUBLICIZES ITS FINANCIAL ASSISTANCE POLICY ON ITS WEBSITE, WHICH INCLUDES THE POLICY, THE APPLICATION, AND PLAIN LANGUAGE SUMMARY IN

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

BOTH ENGLISH AND SPANISH. PAPER COPIES ARE AVAILABLE WITHOUT CHARGE AT LOCATIONS THROUGHOUT THE HOSPITAL INCLUDING BUT NOT LIMITED TO REGISTRATIONS DESKS IN THE ER AS WELL AS OFFSITE LOCATIONS. INDIVIDUALS ARE NOTIFIED ABOUT THE FAP WITH BILLING NOTICES AND OTHER BROCHURES PLACED THROUGHOUT PORTER FACILITIES.

PORTER MAINTAINS ITS OWN HEALTH ASSISTANCE PROGRAM TO HELP ELIGIBLE LOW AND MIDDLE INCOME FAMILIES OBTAIN PRESCRIPTION MEDICATIONS, EYEGLASSES, AND MEDICAL EQUIPMENT AT NO COST. THE HEALTH ASSISTANCE PROGRAM ALSO PROVIDES ASSISTANCE WITH ENROLLMENT IN STATE AND FEDERAL PROGRAMS, INCLUDING OBTAINING INSURANCE THROUGH THE VERMONT HEALTH CONNECT EXCHANGE, AND PROVIDES ADVOCACY AND SUPPORT WITH OBTAINING OTHER HEALTH CARE RELATED RESOURCES.

ADDITIONALLY, PORTER'S OFFICE OF PATIENT AND FAMILY ADVOCACY IS AVAILABLE TO HELP WITH CONCERNS ABOUT DELIVERY OF CARE, INCLUDING BUT NOT LIMITED TO COSTS.

PART VI, LINE 4:

ADDISON COUNTY IS LOCATED IN THE LOWER CHAMPLAIN VALLEY OF VERMONT WITH LAKE CHAMPLAIN AND THE ADIRONDACKS TO THE WEST AND THE GREEN MOUNTAINS TO THE EAST. THE UNIQUE LANDSCAPE OF ADDISON COUNTY, THE FARMLANDS OF THE CHAMPLAIN VALLEY, AND THE PREDOMINATELY WOODED SETTINGS NEAR THE GREEN MOUNTAINS PROMOTE A BLEND OF LIGHT INDUSTRY AND FARMING. THE MAJOR EMPLOYERS IN THE COUNTY INCLUDE MIDDLEBURY COLLEGE, PORTER MEDICAL CENTER (AND ITS AFFILIATES INCLUDING PORTER HOSPITAL), AND COLLINS AEROSPACE.

PORTER HOSPITAL SERVES 36,777 RESIDENTS LOCATED IN ADDISON COUNTY,

Part VI Supplemental Information (Continuation)

VERMONT, WHICH COMPRISES APPROXIMATELY 6% OF THE STATE'S TOTAL POPULATION. AS OF 2019, A VAST MAJORITY (94.5%) OF ADDISON COUNTY RESIDENTS WERE WHITE, NON-HISPANIC. HISPANIC OR LATINO RESIDENTS ARE ADDISON COUNTY'S MORE PREVALENT MINORITY POPULATION AT 2.3%.

THE US CENSUS BUREAU ESTIMATES THAT 4.7% OF ADDISON COUNTY RESIDENTS UNDER THE AGE OF 65 WERE UNINSURED IN 2019. 93.5% OF THE POPULATION HAS A HIGH SCHOOL DIPLOMA OR HIGHER, 39.6% OF THE POPULATION HAS A BACHELOR'S DEGREE OR HIGHER, AND 7.9% OF THE POPULATION IS UNDER THE FEDERAL POVERTY LEVEL. THE MEDIAN HOUSEHOLD INCOME AS OF 2019 WAS \$68,825.

PART VI, LINE 5:

IN ADDITION TO THE COLLABORATIONS AND PARTNERSHIPS DESCRIBED PREVIOUSLY:

PORTER HOSPITAL ("PORTER") PROVIDES RENT-FREE CLINIC SPACE AND VOUCHERS FOR NO-COST ANCILLARY SERVICES TO THE LOCAL OPEN DOOR CLINIC IN ITS ROLE AS A CATALYST IN THE DELIVERY OF HEALTH CARE SERVICES TO ITS ENTIRE COMMUNITY.

PORTER OFFERS FREE AND LOW COST COMMUNITY EDUCATION PROGRAMS ON HEALTH CARE TOPICS INCLUDING MEMORY LOSS, DEMENTIA, BREAST CANCER SCREENING, BASIC DIABETES, CPR, SMOKING CESSATION, NUTRITION, PHYSICAL FITNESS, PARENTING, PRENATAL EXERCISE AND BREASTFEEDING.

A MAJORITY OF THE GOVERNING BODY IS COMPRISED OF PERSONS WHO RESIDE IN ITS SERVICE AREA AND WHO ARE NEITHER EMPLOYEES NOR CONTRACTORS OF PORTER NOR FAMILY MEMBERS THEREOF. MEDICAL STAFF PRIVILEGES ARE EXTENDED TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY.

Part VI Supplemental Information (Continuation)

SURPLUS FUNDS ARE INVESTED IN TECHNOLOGY, FACILITIES AND PROGRAMS.

PART VI, LINE 6:

ON APRIL 1, 2017, THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVMHN") BECAME THE SOLE MEMBER OF PORTER MEDICAL CENTER, INC., THE PARENT ORGANIZATION FOR BOTH PORTER HOSPITAL AND HELEN PORTER NURSING HOME, INC. WITH SIX HOSPITALS ACROSS VERMONT AND NORTHERN NEW YORK, AS WELL AS A MEDICAL GROUP, AND AFFILIATED CLINICS, NURSING HOMES, AND NON-HOSPITAL FACILITIES, UVMHN COMPRISES AN INTEGRATED SYSTEM OF CARE SERVING ITS COMMUNITIES. UVMHN CARRIES OUT CENTRALIZED ACTIVITIES FOR THE BENEFIT OF PATIENTS OF ALL 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, AND COLLABORATIVE EFFORTS. PORTER HOSPITAL REGULARLY PARTNERS WITH OTHER ORGANIZATIONS AND PROVIDERS TO HELP MEET THE NEEDS OF ITS COMMUNITY. THIS INCLUDES WORKING WITH OTHER ORGANIZED SYSTEMS OF CARE (LIKE HOME HEALTH AGENCIES AND PHYSICIAN PRACTICES), AS WELL AS COMMUNITY-BASED ORGANIZATIONS WHOSE MISSIONS ARE SIMILAR. FOR EXAMPLE, PORTER HOSPITAL COLLABORATES WITH COMMUNITY PARTNERS TO REGULARLY ASSESS COMMUNITY AND HEALTH CARE NEEDS, WHICH HELPS GUIDE THE ORGANIZATION'S PRIORITIES.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

VT

**SCHEDULE I
(Form 990)**

Department of the Treasury
Internal Revenue Service

**Grants and Other Assistance to Organizations,
Governments, and Individuals in the United States**
Complete if the organization answered "Yes" on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization **PORTER HOSPITAL, INC.** Employer identification number **03-0181058**

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 noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
HUDSON HEADWATERS HEALTH NETWORK 9 CAREY ROAD QUEENSBURY, NY 12804	14-1628237	501(C)(3)	14,700.	0.			COMMUNITY HEALTH IMPROVEMENT

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

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

LHA 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 noncash assistance

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

PART I, LINE 2:

IN FY 2021-2022, THE ORGANIZATION RELIED ON THE UVM HEALTH NETWORK AND ITS
 AFFILIATED ORGANIZATIONS FOR SELECTION AND MONITORING OF THE GRANT TO
 HUDSON HEADWATERS HEALTH NETWORK DESCRIBED IN SCH I, PART II. THE
 REMAINING GRANTS IN SMALLER AMOUNTS WERE MADE FOR COMMUNITY BENEFIT AS
 SELECTED BY THE ORGANIZATION'S COMMUNITY BENEFIT STAFF. THE ORGANIZATION
 HAS MORE RECENTLY IMPLEMENTED SOFTWARE FOR THE PURPOSES OF MONITORING
 GRANTS AND THE USE OF GRANT FUNDS.

**SCHEDULE J
(Form 990)**

Compensation Information

OMB No. 1545-0047

2021

Open to Public Inspection

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.

Department of the Treasury
Internal Revenue Service

Name of the organization: **PORTER HOSPITAL, INC.**
 Employer identification number: **03-0181058**

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 checked="" 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
1b		X
2		X
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

LHA 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) TOM THOMPSON PRESIDENT & COO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	332,859.	89,906.	60,565.	48,069.	347.	531,746.	0.
(2) DR. ELYA VASILOU DIRECTOR	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	405,722.	0.	34,280.	17,400.	32,487.	489,889.	0.
(3) DR. ANDREW MAHONEY DIRECTOR	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	311,059.	0.	13,533.	26,100.	33,147.	383,839.	0.
(4) DR. KRISTOFER ANDERSON DIRECTOR	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	345,075.	0.	1,160.	17,400.	14,654.	378,289.	0.
(5) ERIC BERG CRNA	(i)	303,599.	0.	5,024.	12,075.	2,068.	322,766.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) AMY BISHOP CRNA	(i)	269,330.	0.	4,841.	8,530.	34,895.	317,596.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) WILLIAM HARRINGTON CRNA	(i)	279,330.	15,000.	4,881.	9,022.	1,983.	310,216.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) DAVID J. MYERS CRNA	(i)	186,120.	0.	4,520.	5,661.	29,316.	225,617.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) RENEE MOSIER PHARMACY DIR	(i)	179,953.	0.	234.	7,053.	25,869.	213,109.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) MICHAEL LEYDEN AVP OPERATIONS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	160,471.	13,780.	2,661.	5,477.	25,283.	207,672.	0.
(11) LINDA HAVEY AVP OPERATIONS	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	171,850.	13,780.	343.	5,500.	1,999.	193,472.	0.
(12) JUDY PEEK-LEE FMR INTERIM CFO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	80,365.	56,507.	1,286.	0.	2,426.	140,584.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 1A:

PRESIDENT AND COO TOM THOMPSON RECEIVED COMPENSATION OF \$1,400 TO COVER TAX PREPARATION AND FINANCIAL ADVISORY SERVICES.

PART I, LINE 1B:

WHILE THERE IS NO ORGANIZATION-WIDE WRITTEN POLICY REGARDING SUCH PAYMENTS, THE AMOUNT IS PROVIDED BY CONTRACT, WHICH IS SUBJECT TO ANNUAL REVIEW. PERSONAL SERVICE COMPENSATION IS INCLUDED IN FORM W-2 AS TAXABLE INCOME. NO REIMBURSEMENT IS MADE UNDER AN ACCOUNTABLE PLAN AND THE COMPENSATION IS OFFERED ON A TAXABLE BASIS. THEREFORE, SUBSTANTIATION OF EXPENSE IS NOT REQUIRED.

PART I, LINE 3:

PORTER HOSPITAL CENTER RELIED ON THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK"), PARENT OF PORTER HOSPITAL'S PARENT ORGANIZATION, PORTER MEDICAL CENTER, TO ESTABLISH SENIOR EXECUTIVE COMPENSATION.

UVM HEALTH NETWORK UTILIZED THE FOLLOWING METHODS TO ESTABLISH COMPENSATION:

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.

- COMPENSATION COMMITTEE

- INDEPENDENT COMPENSATION CONSULTANT

- COMPENSATION SURVEY OR STUDY

- APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE

PART I, LINE 4B:

PORTER MEDICAL CENTER, PARENT ORGANIZATION OF PORTER HOSPITAL, MAINTAINS A SUPPLEMENTAL RETIREMENT BENEFIT PLAN (SRP) UNDER CONTRACTUAL ARRANGEMENT WITH PRESIDENT AND COO TOM THOMPSON. PURSUANT TO THE TERMS OF THE SRP, PORTER MEDICAL CENTER MAKES ANNUAL CREDITS EQUAL TO 8.68% OF BASE SALARY.

AMOUNTS DEFERRED DURING CALENDAR YEAR 2021 ARE INCLUDED ON SCHEDULE J, PART II, COLUMN C. AMOUNTS DEFERRED REMAIN SUBJECT TO FORFEITURE IF CERTAIN CONDITIONS ARE NOT MET.

PART I, LINE 7:

PORTER HOSPITAL PAID AWARDS TO CERTAIN MEMBERS OF UPPER MANAGEMENT (OFFICERS, VICE PRESIDENTS, PHYSICIAN CHAIRS AND SENIOR EXECUTIVES) THROUGH ITS ANNUAL VARIABLE PAY PLAN AS THE PLAN'S PERFORMANCE MEASURES WERE MET.

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.

THE MEASURES WERE REVIEWED AND APPROVED BY THE COMPENSATION COMMITTEE OF
THE BOARD OF TRUSTEES. THESE MEASURES INCLUDED FINANCIAL, POPULATION HEALTH
& QUALITY, AND OPERATIONAL RELATED METRICS.

ADDITIONALLY, CERTAIN EMPLOYEEES OF THE ORGANIZATION WERE ELIGIBLE TO
RECEIVE DISCRETIONARY BONUSES FOR TAKING ON EXTRA RESPONSIBILITIES.

FORM 990, PART VII, SECTION A, LINE 5

JUDY PEEK-LEE RECEIVED OR ACCRUED COMPENSATION FROM KORN FERRY, AN
UNRELATED MANAGEMENT CONSULTING FIRM, FOR SERVICES RENDERED TO THE
ORGANIZATION AS INTERIM CFO OF PORTER MEDICAL CENTER, PRIOR TO HER
EMPLOYMENT WITH THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC., A
RELATED ORGANIZATION. THE TOTAL AMOUNT CHARGED TO PORTER MEDICAL
CENTER FOR SUCH SERVICES DURING CY 2021 WAS \$132,298. THIS AMOUNT IS
NOT INCLUDED IN THE COMPENSATION AMOUNTS REPORTED IN FORM 990, PART
VII, SECTION A OR SCHEDULE J, PART II, AS THOSE AMOUNTS REPRESENT
COMPENSATION PAID BY THE UNIVERSITY OF VERMONT MEDICAL CENTER FOR HER
SERVICES AS AN EMPLOYEE.

Supplemental Information on Tax-Exempt Bonds

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**
▶ **Attach to Form 990.** ▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization **PORTER HOSPITAL, INC.** Employer identification number **03-0181058**

Part I	Bond Issues	SEE PART VI FOR COLUMN (A) CONTINUATIONS												
		(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing		
								Yes	No	Yes	No	Yes	No	
	A	VERMONT EDUCATIONAL HEALTH BUILDINGS AND FIN	23-7154467	NONEAVAIL	08/06/15	12650000.	REFUND 2006 SERIES A BONDS		X		X			X
	B													
	C													
	D													

Part II	Proceeds								
		A		B		C		D	
1	Amount of bonds retired	3,684,186.							
2	Amount of bonds legally defeased								
3	Total proceeds of issue	12,650,000.							
4	Gross proceeds in reserve funds								
5	Capitalized interest from proceeds								
6	Proceeds in refunding escrows								
7	Issuance costs from proceeds	138,787.							
8	Credit enhancement from proceeds								
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds								
11	Other spent proceeds	12,511,213.							
12	Other unspent proceeds								
13	Year of substantial completion	2015							
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X							
15	Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X						
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property? ...								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test?		X						
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?		X						

Part IV Arbitrage								
	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X						
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X						
b Exception to rebate?	X							
c No rebate due?		X						
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X						

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X						
7 Has the organization established written procedures to monitor the requirements of section 148?		X						

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?		X						

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions.

SCHEDULE K, PART I, BOND ISSUES:

(A) ISSUER NAME: VERMONT EDUCATIONAL HEALTH BUILDINGS AND FINANCING AGENCY

SCHEDULE K, PART I, COL (C) CUSIP #

BECAUSE THE BONDS ARE HELD BY A PRIVATE FINANCIAL INSTITUTION AND WERE NEVER OFFERED TO THE PUBLIC, A CUSIP NUMBER WAS NOT ASSIGNED.

**SCHEDULE O
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2021

Open to Public
Inspection

Name of the organization

PORTER HOSPITAL, INC.

Employer identification number

03-0181058

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

COMMUNITY, ONE PERSON AT A TIME.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

FACILITIES. IMAGING INCLUDES RADIOLOGY, NUCLEAR MEDICINE, MRI,
ULTRASOUND, AND CT SCAN. PORTER PROVIDES FREE CARE TO PATIENTS WHO MEET
CERTAIN CRITERIA. PORTER PROVIDES A NUMBER OF COMMUNITY HEALTH OUTREACH
PROGRAMS TO THE GENERAL PUBLIC FOR FREE. THE PROGRAMS INCLUDE BUT ARE
NOT LIMITED TO DIABETES EDUCATION, BREAST CANCER SCREENING, PRENATAL
CLASSES, BREASTFEEDING CLASSES, AND CPR COURSES. PORTER PROVIDES
CLINICAL OFFICE SPACE TO THE OPEN DOOR CLINIC, WHICH PROVIDES ACCESS TO
FREE QUALITY HEALTHCARE SERVICES TO THOSE WHO ARE UNINSURED OR
UNDERINSURED UNTIL A PERMANENT HEALTH CARE PROVIDER CAN BE ESTABLISHED.
FINALLY, PORTER HAS PARTNERED WITH LOCAL CAREER CENTERS, AS WELL AS
COLLEGES TO PROVIDED CLINICAL EXPOSURE TO THEIR STUDENTS WITH GOALS OF
DEVELOPING FUTURE HEALTHCARE WORKERS FOR THE COMMUNITY.

FORM 990, PART VI, SECTION A, LINE 2:

THE GOVERNING BODY FOR PORTER HOSPITAL, INC. IS IDENTICAL TO THAT OF HELEN
PORTER NURSING HOME, INC. AS WELL AS THEIR PARENT ORGANIZATION, PORTER
MEDICAL CENTER. TOM THOMPSON, MICHAEL LEYDEN, LINDA HAVEY, AND SCOTT
COMEAU HAD AN EMPLOYMENT RELATIONSHIP WITH PORTER MEDICAL CENTER.

FORM 990, PART VI, SECTION A, LINE 6:

PORTER MEDICAL CENTER, INC. IS THE SOLE MEMBER OF THE ORGANIZATION.

Name of the organization PORTER HOSPITAL, INC.	Employer identification number 03-0181058
---	--

FORM 990, PART VI, SECTION A, LINE 7A:

THE GOVERNING BODY OF PORTER HOSPITAL, INC. IS IDENTICAL TO THAT OF ITS PARENT ORGANIZATION, PORTER MEDICAL CENTER, INC. THE UNIVERSITY OF VERMONT HEALTH NETWORK, AS SOLE MEMBER OF PORTER MEDICAL CENTER, INC., HAS POWERS TO ELECT MEMBERS OF THE GOVERNING BODY.

FORM 990, PART VI, SECTION A, LINE 7B:

UVM HEALTH NETWORK HAS THE POWER TO APPROVE SIGNIFICANT CORPORATE ACTIONS, INCLUDING ANNUAL OPERATING AND CAPITAL BUDGETS, STRATEGIC PLANS, THE APPOINTMENT OF THE CEO, THE INCURRENCE OF LONG-TERM INDEBTEDNESS, AND AMENDMENTS TO THE ORGANIZATION'S BYLAWS AND ARTICLES OF ORGANIZATION. UVM 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.

FORM 990, PART VI, SECTION B, LINE 11B:

THE FORM 990 FOR PORTER HOSPITAL, INC. IS PREPARED BY UVM MEDICAL CENTER STAFF AND REVIEWED BY PRICEWATERHOUSECOOPERS (PWC). FOLLOWING OR CONCURRENT WITH PWC'S REVIEW, A DRAFT RETURN IS PRESENTED TO THE UVM HEALTH NETWORK AUDIT COMMITTEE AND MANAGEMENT FOR REVIEW AND COMMENT. THE COMPLETED FORM 990 IS PROVIDED TO ALL MEMBERS OF THE BOARD OF DIRECTORS PRIOR TO THE FORM BEING FILED WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C:

THE ORGANIZATION MONITORS AND ENFORCES COMPLIANCE WITH ITS CONFLICT OF INTEREST POLICY THROUGH ANNUAL QUESTIONNAIRES AND CERTIFICATIONS REQUIRED OF ALL TRUSTEES, OFFICERS, AND OTHER INDIVIDUALS IN A POSITION TO EXERCISE INFLUENCE OVER THE AFFAIRS OF THE ORGANIZATION, THROUGH ONGOING DUTIES TO

Name of the organization PORTER HOSPITAL, INC.	Employer identification number 03-0181058
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DISCLOSE TRANSACTIONS IN WHICH SUCH PERSONS HAVE A DIRECT OR INDIRECT FINANCIAL INTEREST, AND THROUGH ONGOING MONITORING EFFORTS BY THE ORGANIZATION'S CFO AND CONTROLLER.

WHEN A POTENTIAL CONFLICT IS DISCLOSED OR OTHERWISE IDENTIFIED, THE BOARD OR AFFECTED BOARD COMMITTEE IS CHARGED WITH DETERMINING WHETHER A CONFLICT OF INTEREST EXISTS, WITH THE INTERESTED PERSON BEING DISQUALIFIED FROM VOTING, PARTICIPATION, AND ATTENDANCE. IF THE BOARD OR BOARD COMMITTEE DETERMINES THAT A CONFLICT OF INTEREST DOES IN FACT EXIST, THEN SUCH PERSON IS RESTRICTED FROM PARTICIPATION IN ALL DELIBERATIONS PERTAINING TO THE PROPOSED TRANSACTION OR ARRANGEMENT AT ISSUE. THE REMAINING BOARD OR COMMITTEE MEMBERS MAY, AT THEIR DISCRETION, APPOINT A DISINTERESTED PERSON OR COMMITTEE TO INVESTIGATE ALTERNATIVES TO THE PROPOSED TRANSACTION OR ARRANGEMENT. THE MINUTES OF THE BOARD OR AFFECTED COMMITTEE SHALL CONTAIN THE NAME OF THE INTERESTED PERSON, THE NATURE OF THE INTEREST, ANY ACTION TAKEN TO DETERMINE WHETHER A CONFLICT WAS PRESENT, AND THE DECISION AS TO WHETHER A CONFLICT EXISTED. VIOLATIONS OF THE CONFLICT OF INTEREST POLICY ARE SUBJECT TO DISCIPLINARY AND CORRECTIVE ACTION INCLUDING BUT NOT LIMITED TO TERMINATION.

FORM 990, PART VI, SECTION B, LINE 15:

THE ORGANIZATION DELEGATES THE SETTING OF EXECUTIVE COMPENSATION TO THE UVM HEALTH NETWORK COMPENSATION COMMITTEE, AN INDEPENDENT COMMITTEE, UNDER PRINCIPLES DESCRIBED IN ITS CHARTER. THE UVM HEALTH NETWORK HAS ADOPTED A COMPENSATION PHILOSOPHY WHICH PROVIDES A FRAMEWORK FOR SETTING COMPENSATION FOR THE EXECUTIVES OF UVM HEALTH NETWORK AND ITS AFFILIATED MEMBER ORGANIZATIONS.

Name of the organization

PORTER HOSPITAL, INC.

Employer identification number

03-0181058

THE PARAMETERS OF THIS PHILOSOPHY INCLUDE UTILIZING APPROPRIATE NATIONAL AND REGIONAL PEER GROUPS. SALARIES ARE TARGETED AT THE 50TH PERCENTILE OF THE NATIONAL PEER GROUP, WITH PERFORMANCE BASED VARIABLE PAY OPPORTUNITIES TO ACHIEVE UP TO THE 65TH PERCENTILE, DEPENDING ON ORGANIZATION AND INDIVIDUAL RESULTS.

COMPENSATION LEVELS ARE APPROVED BY THE NETWORK COMPENSATION COMMITTEE FOR THE UVM HEALTH NETWORK/DIRECT REPORTS AND THE AFFILIATED ORGANIZATIONS' CEOS. CALCULATIONS ARE PERFORMED USING THE SAME PHILOSOPHY FOR THE THIRD TIER OF LEADERSHIP, WITH THE EXCEPTION THAT THE LOCAL BOARDS APPROVE COMPENSATION FOR ALL NON-CEO POSITIONS. ALL ACTIONS TAKEN REGARDING EXECUTIVE COMPENSATION ARE CONTEMPORANEOUSLY DOCUMENTED BY THE APPROPRIATE ORGANIZATION. THIS REVIEW IS PERFORMED ANNUALLY.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART IX, LINE 11G, OTHER FEES:

NET ALLOCATION FOR HN SHARED SERVICES:

PROGRAM SERVICE EXPENSES	3,366,033.
MANAGEMENT AND GENERAL EXPENSES	4,519,372.
FUNDRAISING EXPENSES	76,146.
TOTAL EXPENSES	7,961,551.

COLLECTION SERVICES:

PROGRAM SERVICE EXPENSES	0.
MANAGEMENT AND GENERAL EXPENSES	410,139.

Name of the organization

PORTER HOSPITAL, INC.

Employer identification number

03-0181058

FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	410,139.
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GROUNDSKEEPING:

PROGRAM SERVICE EXPENSES	58,090.
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MANAGEMENT AND GENERAL EXPENSES	131,127.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	189,217.
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CONSULTING FEES:

PROGRAM SERVICE EXPENSES	1,275.
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MANAGEMENT AND GENERAL EXPENSES	136,280.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	137,555.
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FREIGHT:

PROGRAM SERVICE EXPENSES	72,236.
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MANAGEMENT AND GENERAL EXPENSES	1,608.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	73,844.
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ACO PARTICIPATION FEES:

PROGRAM SERVICE EXPENSES	54,583.
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MANAGEMENT AND GENERAL EXPENSES	0.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	54,583.
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HAZARDOUS WASTE DISPOSAL SERVICES:

Name of the organization PORTER HOSPITAL, INC.	Employer identification number 03-0181058
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PROGRAM SERVICE EXPENSES	36,707.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	36,707.

INTERPRETER SERVICES:

PROGRAM SERVICE EXPENSES	15,388.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	15,388.

OTHER PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	2,295,265.
MANAGEMENT AND GENERAL EXPENSES	363,028.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	2,658,293.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	11,537,277.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

TRANSFER OF NET ASSETS	-299,929.
OTHER COMPONENTS OF CURRENT PERIOD PENSION EXPENSE	209,722.
PENSION PLAN ADJUSTMENT	166,882.
CHANGE IN BENEFICIAL INTEREST IN PERPETUAL TRUSTS	-200,055.
ROUNDING VARIANCE	-656.
TOTAL TO FORM 990, PART XI, LINE 9	-124,036.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

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

OMB No. 1545-0047

2021

Open to Public Inspection

Name of the organization

PORTER HOSPITAL, INC.

Employer identification number

03-0181058

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

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

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

(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
THE UNIVERSITY OF VERMONT MEDICAL CENTER - 03-0219309, 111 COLCHESTER AVE, BURLINGTON, VT 05401	HOSPITAL	VERMONT	501(C)(3)	3	UVMHN	X	
UNIVERSITY OF VERMONT MED GROUP-NEW YORK - 20-3905216, 70 CONSTABLE STREET, MALONE, NY 12953	PHYSICIAN SVC	NEW YORK	501(C)(3)	3	UVMHNMG	X	
THE UNIVERSITY OF VERMONT MED CTR FDN INC - 26-3159849, 111 COLCHESTER AVE, BURLINGTON, VT 05401	FUNDRAISING	VERMONT	501(C)(3)	12A-I	UVMCMC	X	
UNIVERSITY OF VERMONT HEALTH NETWORK INC - 45-2880726, 111 COLCHESTER AVE, BURLINGTON, VT 05401	HOLDING COMPANY	VERMONT	501(C)(3)	12A-I	N/A		X

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

Schedule R (Form 990) 2021

Part II Continuation of Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
CENTRAL VERMONT MEDICAL CENTER - 22-2547186 130 FISHCHER ROAD BERLIN, VT 05602	HOSPITAL	VERMONT	501(C)(3)	3	UVMHN	X	
UNIVERSITY HEALTH CENTER - 03-0229931 111 COLCHESTER AVE BURLINGTON, VT 05401	HOSPITAL	VERMONT	501(C)(3)	12C-III-FI	UVMHNMG	X	
COMMUNITY PROVIDERS INC - 22-2544844 75 BEEKMAN STREET PLATTSBURGH, NY 01290	HEALTH SVC COOR	NEW YORK	501(C)(3)	12A-I	UVMHN	X	
CHAMPLAIN VALLEY PHYSICIANS HOSPITAL - 14-1338471, 75 BEEKMAN STREET, PLATTSBURGH, NY 12901	HOSPITAL	NEW YORK	501(C)(3)	3	UVMHN	X	
ELIZABETHTOWN COMMUNITY HOSPITAL - 14-1364513, 75 PARK STREET, ELIZABETHTOWN, NY 12932	HOSPITAL	NEW YORK	501(C)(3)	3	UVMHN	X	
EMERGENCY MEDICAL TRANSPORT OF CVPH, INC - 06-1718419, 75 BEEKMAN STREET, PLATTSBURGH, NY 12901	AMBULANCE SVC	NEW YORK	501(C)(3)	12B-II	CPI	X	
CVPH MEDICAL CENTER FOUNDATION - 14-1727048 75 BEEKMAN STREET PLATTSBURGH, NY 12901	HEALTH SVC SUPPORT	NEW YORK	501(C)(3)	12B-II	CVPH	X	
UNIVERSITY MEDICAL EDUCATION ASSOCIATES - 23-7107832, 89 BEAUMONT AVENUE, BURLINGTON, VT 05405	EDUCATIONAL	VERMONT	501(C)(3)	10	UVMHNMG	X	
ALICE HYDE MEDICAL CENTER - 15-0346515 133 PARK STREET MALONE, NY 12953	HOSPITAL	NEW YORK	501(C)(3)	3	UVMHN	X	
PORTER MEDICAL CENTER INC - 03-0310862 115 PORTER DRIVE MIDDLEBURY, VT 05753	SUPPORTING ORG	VERMONT	501(C)(3)	12B-II	UVMHN		X
HELEN PORTER NURSING HOME - 03-0306549 37 PORTER DRIVE MIDDLEBURY, VT 05753	NURSING HOME	VERMONT	501(C)(3)	3	PMC	X	
AUXILIARY OF PORTER MEDICAL CENTER - 23-7363227, 37 PORTER DRIVE, MIDDLEBURY, VT 05753	SUPPORTING ORG	VERMONT	501(C)(3)	12B-II	PMC	X	

Part II Continuation of Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
LAKE CHAMPLAIN PHYSICIAN SERVICES, P.C. - 27-3785445, 75 BEEKMAN STREET, PLATTSBURGH, NY 12901	PHYSICIAN SVC	NEW YORK	501(C)(3)	12A-I	CVPH	X	
THE UNIVERSITY OF VERMONT HEALTH NETWORK MEDICAL GROUP, INC. - 03-0225105, 111 COLCHESTER AVE, BURLINGTON, VT 05401	PHYSICIAN SVC	VERMONT	501(C)(3)	12A-I	UVMHN	X	
UVMHN HOME HEALTH & HOSPICE - 03-0179603 1110 PRIM ROAD COLCHESTER, VT 05446	HOME HEALTHCARE	VERMONT	501(C)(3)	10	UVMHN	X	
VMC INDEMNITY COMPANY, INC. - 83-1102018 95 ST. PAUL ST. BURLINGTON, VT 05401	INSURANCE	VERMONT	501(C)(3)	10	UVMHN	X	

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	
ADIRONDACK ACO, LLC - 46-2840926, 75 BEEKMAN STREET, PLATTSBURGH, NY 12901	ACCOUNTABLE CARE	NY	N/A	N/A	N/A	N/A		X	N/A		X	N/A

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
UVMHN VENTURES INC. - 04-3380045 111 COLCHESTER AVENUE BURLINGTON, VT 05401	HOLDING COMPANY	VT	N/A	C CORP	N/A	N/A	N/A		X
UVMHN CREDENTIALING & ENROLLMENT - 03-0333056, 111 COLCHESTER AVENUE, BURLINGTON, VT 05401	ADMIN SVC	VT	N/A	C CORP	N/A	N/A	N/A		X
CHARITABLE REMAINDER TRUSTS (6)	SUPPORT	VT	N/A	TRUST	N/A	N/A	N/A		X
PERPETUAL TRUSTS (10)	SUPPORT	VT	N/A	TRUST	N/A	N/A	N/A		X
CHARITABLE IRREVOCABLE TRUSTS (8)	SUPPORT	VT	N/A	TRUST	N/A	N/A	N/A		X

Part IV Continuation of Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
CHAMPLAIN VALLEY HEALTH NETWORK - 16-1586102 75 BEEKMAN STREET PLATTSBURGH, NY 12901	ADMIN SVC	NY	N/A	C CORP	N/A	N/A	N/A		X
MEDIQUEST INC - 14-1663061 P.O. BOX 1656 PLATTSBURGH, NY 12901	MED OFFICE LEASE	NY	N/A	C CORP	N/A	N/A	N/A		X
YANKEE MEDICAL, INC. - 03-0225363 276 NORTH AVENUE BURLINGTON, VT 05401	HOME MEDICAL EQUIPMENT	VT	N/A	C CORP	N/A	N/A	N/A		X

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

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

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

	Yes	No
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)		X
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) HELEN PORTER NURSING HOME, INC.	I	254,337.	FMV
(2) HELEN PORTER NURSING HOME, INC.	Q	6,174,675.	FMV
(3) PORTER MEDICAL CENTER, INC.	P	215,175.	FMV
(4) PORTER MEDICAL CENTER, INC.	K	84,720.	FMV
(5) UNIVERSITY OF VERMONT HEALTH NETWORK, INC.	P	7,961,551.	FMV
(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 sec. 501(c)(3) orgs.?		(f) Share of total income	(g) Share of end-of-year assets	(h) Dispropor- tionate 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	

Part VII Supplemental Information

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

Multiple horizontal lines for providing supplemental information.