

# Tax Exempt Entity Declaration and Signature for Electronic Filing

For calendar year 2021, or tax year beginning OCT 1, 2021,  
and ending SEP 30, 2022

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](http://www.irs.gov/Form8453TE) for the latest information.

Department of the Treasury  
Internal Revenue Service

Name of filer

**THE UNIVERSITY OF VERMONT MEDICAL CENTER**

EIN or SSN

**03-0219309**

## 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	1,927,049,540.
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** ▶ Judy Peek-Lee | 8/08/2023 ▶ VP / 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.

<b>ERO's Use Only</b>	ERO's signature	<u>Look from</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.

<b>Paid Preparer Use Only</b>	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](http://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>B</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	<b>C</b> Name of organization <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b> Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite <b>111 COLCHESTER AVENUE</b> City or town, state or province, country, and ZIP or foreign postal code <b>BURLINGTON, VT 05401</b> <b>F</b> Name and address of principal officer: <b>DR. STEPHEN M. LEFFLER</b> <b>SAME AS C ABOVE</b>	<b>D</b> Employer identification number <b>03-0219309</b> <b>E</b> Telephone number <b>802-847-5959</b> <b>G</b> Gross receipts \$ <b>2,018,800,181.</b> <b>H(a)</b> Is this a group return for subordinates? ..... <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>H(b)</b> Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. See instructions <b>H(c)</b> Group exemption number ▶
<b>I</b> 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		
<b>J</b> Website: ▶ <b>WWW.UVMHEALTH.ORG/MEDCENTER</b>		
<b>K</b> Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		
<b>L</b> Year of formation: <b>1968</b>		<b>M</b> State of legal domicile: <b>VT</b>

**Part I Summary**

	<b>1</b>	Briefly describe the organization's mission or most significant activities: <b>TO IMPROVE THE HEALTH OF THE PEOPLE IN THE COMMUNITIES WE SERVE BY INTEGRATING PATIENT CARE,</b>		
	<b>2</b>	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
<b>Activities &amp; Governance</b>	<b>3</b>	Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>17</b>
	<b>4</b>	Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>14</b>
	<b>5</b>	Total number of individuals employed in calendar year 2021 (Part V, line 2a)	<b>5</b>	<b>9644</b>
	<b>6</b>	Total number of volunteers (estimate if necessary)	<b>6</b>	<b>315</b>
	<b>7a</b>	Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>51,821.</b>
	<b>7b</b>	Net unrelated business taxable income from Form 990-T, Part I, line 11	<b>7b</b>	<b>0.</b>
	<b>Revenue</b>	<b>8</b>	Contributions and grants (Part VIII, line 1h)	<b>Prior Year</b>
<b>9</b>		Program service revenue (Part VIII, line 2g)	<b>101,361,434.</b>	<b>42,272,788.</b>
<b>10</b>		Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<b>1552052488.</b>	<b>1822665025.</b>
<b>11</b>		Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<b>32,202,392.</b>	<b>61,896,472.</b>
<b>12</b>		Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<b>446,754.</b>	<b>215,255.</b>
<b>12</b>			<b>1686063068.</b>	<b>1927049540.</b>
<b>Expenses</b>	<b>13</b>	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<b>2,128,997.</b>	<b>2,447,635.</b>
	<b>14</b>	Benefits paid to or for members (Part IX, column (A), line 4)	<b>0.</b>	<b>0.</b>
	<b>15</b>	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<b>933,449,125.</b>	<b>1097221460.</b>
	<b>16a</b>	Professional fundraising fees (Part IX, column (A), line 11e)	<b>0.</b>	<b>0.</b>
	<b>16b</b>	Total fundraising expenses (Part IX, column (D), line 25) ▶ <b>4,715,699.</b>		
	<b>17</b>	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<b>685,264,831.</b>	<b>811,538,436.</b>
	<b>18</b>	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<b>1620842953.</b>	<b>1911207531.</b>
	<b>19</b>	Revenue less expenses. Subtract line 18 from line 12	<b>65,220,115.</b>	<b>15,842,009.</b>
<b>Net Assets or Fund Balances</b>	<b>20</b>	Total assets (Part X, line 16)	<b>Beginning of Current Year</b>	<b>End of Year</b>
	<b>21</b>	Total liabilities (Part X, line 26)	<b>1918641832.</b>	<b>1619652702.</b>
	<b>22</b>	Net assets or fund balances. Subtract line 21 from line 20	<b>764,600,395.</b>	<b>666,675,276.</b>
	<b>22</b>		<b>1154041437.</b>	<b>952,977,426.</b>

**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.

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

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: SEE SCHEDULE O

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [ ] Yes [X] No

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 \$ 728,394,296. including grants of \$ 1,156,411. ) (Revenue \$ 861,137,681. ) OUTPATIENT SERVICES. FOR MORE INFORMATION, SEE SCHEDULE O.

4b (Code: ) (Expenses \$ 517,575,425. including grants of \$ 821,712. ) (Revenue \$ 611,898,945. ) INPATIENT SERVICES. FOR MORE INFORMATION, SEE SCHEDULE O.

4c (Code: ) (Expenses \$ 295,733,582. including grants of \$ 469,512. ) (Revenue \$ 349,628,399. ) PROFESSIONAL SERVICES. FOR MORE INFORMATION, SEE SCHEDULE O.

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

4e Total program service expenses 1,541,703,303.

**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 <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <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
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> .....	X	
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> .....	X	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> .....	X	
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? .....		X
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? .....		X
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....		X
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> .....		X
<b>b</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
<b>26</b> Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part II</i> .....		X
<b>27</b> Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i> .....		X
<b>28</b> 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):		
<b>a</b> A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV</i> .....	X	
<b>b</b> A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV</i> .....	X	
<b>c</b> 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
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> .....	X	
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> .....	X	
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> .....		X
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> .....		X
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> .....	X	
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> .....	X	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)? .....	X	
<b>b</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	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> .....		X
<b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> .....		X
<b>38</b> 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
<b>1a</b> Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable .....		
<b>b</b> Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable .....		
<b>c</b> 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 columns. Includes questions 2a through 17 regarding employee counts, tax filings, and organizational compliance.

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 Enter the number of voting members... 17; 1b Enter the number of voting members included... 14; 2 Did any officer, director, trustee, or key employee have a family relationship... X; 3 Did the organization delegate control over management duties... X; 4 Did the organization make any significant changes to its governing documents... X; 5 Did the organization become aware during the year of a significant diversion of the organization's assets... X; 6 Did the organization have members or stockholders... X; 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body... X; 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body... X; 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: a The governing body... X; b Each committee with authority to act on behalf of the governing body... X; 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses on Schedule O... 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 Did the organization have local chapters, branches, or affiliates... X; 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? X; 11b Describe on Schedule O the process, if any, used by the organization to review this Form 990.; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13... X; 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? X; 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done... X; 13 Did the organization have a written whistleblower policy? X; 14 Did the organization have a written document retention and destruction policy? X; 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? a The organization's CEO, Executive Director, or top management official... X; b Other officers or key employees of the organization... X; 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? X; 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed NY, VT
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
[ ] Own website [ ] Another's website [X] Upon request [ ] Other (explain on Schedule O)
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
JUDY PEEK-LEE - 802-847-1104
111 COLCHESTER AVENUE, BURLINGTON, VT 05401

**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) DR. JOHN BRUMSTED PRES/CEO OF UVMHN	8.00 42.00	X		X				2,098,354.	0.	66,714.
(2) ALFRED GOBEILLE EXEC VP NETWORK HOSP OPS	13.00 37.00					X		813,757.	0.	120,324.
(3) DR. STEPHEN M. LEFFLER PRES & COO	43.00 7.00			X				863,345.	0.	64,044.
(4) RICHARD VINCENT SVP/CFO (TIL 10/21); NTKW CFO	10.00 40.00			X				752,772.	0.	57,803.
(5) DR. DOUGLAS GENTILE SVP, NETWORK IT	13.00 37.00				X			577,476.	0.	88,736.
(6) JERALD NOVAK NETWORK CHIEF PEOPLE OFFICER	8.00 42.00				X			576,990.	0.	50,643.
(7) ERIC MILLER, ESQ SVP, NETWORK GEN COUNSEL	8.00 42.00				X			531,489.	0.	79,454.
(8) DR. ISABELLE DESJARDINS CHIEF MEDICAL OFFICER	50.00 0.00				X			548,466.	0.	57,593.
(9) DIANA SCALISE SVP, HIGH VALUE CARE (TIL 6/22)	8.00 42.00					X		549,256.	0.	40,857.
(10) DR. CLAUDE DESCHAMPS PRES/CEO OF UVMHN MG (TIL 9/21)	10.00 40.00				X			518,015.	0.	30,310.
(11) CHARLES M. MICELI NETWORK CHIEF SUPPLY CHAIN	13.00 37.00				X			471,126.	0.	49,935.
(12) DR. HOWARD M. SCHAPIRO SVP CHIEF POP HEAL & QUAL (TIL 6/21)	10.00 40.00				X			476,171.	0.	36,903.
(13) LISA L. GOODRICH VP MEDICAL GROUP OPS	5.00 45.00				X			426,340.	0.	66,048.
(14) REBECCA FREEMAN NETWORK VP HEALTH INFORMATICS	12.00 38.00					X		411,212.	0.	44,219.
(15) RAY KELLER NETWORK CHIEF MEDICAL INFO	12.00 38.00					X		409,833.	0.	39,369.
(16) MARY BROADWORTH VP, HUMAN RESOURCES	50.00 0.00					X		398,568.	0.	36,786.
(17) MARC STANISLAS NETWORK VP TREASURY & FIN	13.00 37.00				X			352,313.	0.	58,858.



**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) MARGARET GAGNE CHIEF NURSING OFFICER	50.00 0.00				X			333,698.	0.	59,637.
(19) CHRISTINA OLIVER VP CLINICAL SERVICES	50.00 0.00				X			337,782.	0.	55,214.
(20) THERESA ALBERGHINI DIPALMA NETWORK SVP EXTERN RELAT (TIL 6/21)	13.00 37.00				X			311,431.	0.	26,512.
(21) ADAM P. BUCKLEY FMR NETWORK CIO	0.00 0.00						X	271,134.	0.	0.
(22) TODD KEATING FMR NETWORK CFO	10.00 40.00				X			196,134.	0.	16,283.
(23) LAURIE A. GUNN FMR VP EMPL PAT & FAM EXP	0.00 0.00						X	192,004.	0.	0.
(24) JUDY PEEK-LEE SVP/CFO (AS OF 10/21)	45.00 5.00			X				138,158.	0.	2,426.
(25) DR. MARTIN LEWINTER TRUSTEE	2.00 33.00	X						132,864.	0.	33.
(26) DR. VIRGINIA HOOD TRUSTEE	2.00 33.00	X						0.	64,508.	33.
<b>1b Subtotal</b>								12,688,688.	64,508.	114,873.
<b>c Total from continuation sheets to Part VII, Section A</b>								0.	0.	0.
<b>d Total (add lines 1b and 1c)</b>								12,688,688.	64,508.	114,873.

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 980

	Yes	No
3 Did the organization list any <b>former</b> officer, director, trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>		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 30384-4678	TRAVELING NURSING SERVICES	46,611,387.
TEGRIA SERVICES GROUP 720 COOL SPRINGS BLVD, FRANKLIN, TN 37067	CONSULTING SERVICES	12,962,166.
FREEDOM HEALTHCARE STAFFING 2851 S PARKER RD STE 1100, AURORA, CO 80014	TRAVELING NURSING SERVICES	7,226,415.
FARRINGTON CONSTRUCTION CO 4788 SPEAR STREET, SHELBURNE, VT 05482	CONSTRUCTION	6,316,655.
MCKINSEY & COMPANY INC 175 GREENWICH STREET, NEW YORK, NY 10007	CONSULTING SERVICES	4,375,000.

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 210

SEE PART VII, SECTION A CONTINUATION SHEETS

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

Table with 6 main columns: (A) Name and title, (B) Average hours per week, (C) Position (check all that apply), (D) Reportable compensation from the organization, (E) Reportable compensation from related organizations, (F) Estimated amount of other compensation. Rows list individuals like ALYSON RICHARDS, DR. RICHARD PAGE, HAL COLSTON, etc.

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	<b>1 a</b>	Federated campaigns	<b>1a</b>				
	<b>b</b>	Membership dues	<b>1b</b>				
	<b>c</b>	Fundraising events	<b>1c</b>	151,391.			
	<b>d</b>	Related organizations	<b>1d</b>	333,300.			
	<b>e</b>	Government grants (contributions)	<b>1e</b>	30,331,055.			
	<b>f</b>	All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	11,457,042.			
	<b>g</b>	Noncash contributions included in lines 1a-1f	<b>1g</b>	\$ 97,494.			
	<b>h</b>	<b>Total.</b> Add lines 1a-1f		42,272,788.			
	Program Service Revenue	<b>2 a</b>	PATIENT SERVICES	<b>Business Code</b>	900099	1309866241.	1309866241
<b>b</b>		PATIENT SERVICES - PHARMACY		446110	198770159.	198770159.	
<b>c</b>		FIXED PROSPECTIVE PAYMENTS		900099	185071892.	185071892.	
<b>d</b>		INSTITUTIONAL SERVICES REVENUE		900099	13,234,865.	13234865.	
<b>e</b>		CAFETERIA		909009	4,907,768.	4,907,768.	
<b>f</b>		All other program service revenue		900099	110814100.	110814100.	
<b>g</b>		<b>Total.</b> Add lines 2a-2f			1822665025.		
Other Revenue		<b>3</b>	Investment income (including dividends, interest, and other similar amounts)			15,134,470.	51,821.
	<b>4</b>	Income from investment of tax-exempt bond proceeds			8,432,878.		8432878.
	<b>5</b>	Royalties					
	<b>6 a</b>	Gross rents	(i) Real	1,074,089.			
			(ii) Personal				
			<b>6a</b>	1,074,089.			
	<b>b</b>	Less: rental expenses	<b>6b</b>	862,161.			
	<b>c</b>	Rental income or (loss)	<b>6c</b>	211,928.			
	<b>d</b>	Net rental income or (loss)			211,928.		211,928.
	<b>7 a</b>	Gross amount from sales of assets other than inventory	(i) Securities	128,771,643.	411,204.		
			(ii) Other				
			<b>7a</b>	128,771,643.	411,204.		
			<b>b</b>	Less: cost or other basis and sales expenses	<b>7b</b>	90,474,970.	378,753.
	<b>c</b>	Gain or (loss)	<b>7c</b>	38,296,673.	32,451.		
<b>d</b>	Net gain or (loss)			38,329,124.		38329124.	
<b>8 a</b>	Gross income from fundraising events (not including \$ 151,391. of contributions reported on line 1c). See Part IV, line 18	<b>8a</b>	38,084.				
		<b>b</b>	Less: direct expenses	<b>8b</b>	34,757.		
		<b>c</b>	Net income or (loss) from fundraising events			3,327.	
<b>9 a</b>	Gross income from gaming activities. See Part IV, line 19	<b>9a</b>					
		<b>b</b>	Less: direct expenses	<b>9b</b>			
		<b>c</b>	Net income or (loss) from gaming activities				
<b>10 a</b>	Gross sales of inventory, less returns and allowances	<b>10a</b>					
		<b>b</b>	Less: cost of goods sold	<b>10b</b>			
		<b>c</b>	Net income or (loss) from sales of inventory				
Miscellaneous Revenue	<b>11 a</b>		<b>Business Code</b>				
	<b>b</b>						
	<b>c</b>						
	<b>d</b>	All other revenue					
	<b>e</b>	<b>Total.</b> Add lines 11a-11d					
<b>12</b>	<b>Total revenue.</b> See instructions			1927049540.	1822665025	51,821.	62059906.

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	2,059,617.	2,059,617.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	388,018.	388,018.		
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	9,527,725.		9,527,725.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	182,913.	182,913.		
7 Other salaries and wages	875,386,377.	738,128,618.	135,690,208.	1,567,551.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	48,243,638.	41,809,808.	6,355,453.	78,377.
9 Other employee benefits	114,805,517.	88,143,397.	26,357,418.	304,702.
10 Payroll taxes	49,075,290.	41,394,458.	7,591,662.	89,170.
11 Fees for services (nonemployees):				
a Management				
b Legal	6,043,778.		6,043,778.	
c Accounting	1,644,879.	129,713.	1,515,166.	
d Lobbying	144,000.		144,000.	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	1,035,217.		1,035,217.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	71,321,588.	34,013,668.	35,871,109.	1,436,811.
12 Advertising and promotion	766,678.	60,104.	705,224.	1,350.
13 Office expenses	390,030,293.	371,785,538.	18,005,844.	238,911.
14 Information technology	41,029,136.	2,750,881.	38,266,081.	12,174.
15 Royalties				
16 Occupancy	32,287,569.	11,992,506.	20,135,187.	159,876.
17 Travel	1,551,951.	840,982.	648,058.	62,911.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	4,769,383.	4,521,780.	242,094.	5,509.
20 Interest	16,144,190.	8,601,966.	7,542,224.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	68,497,263.	36,620,232.	31,877,031.	
23 Insurance	10,067,064.	7,485,913.	2,581,151.	
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 <b>PROVIDER TAX</b>	85,420,044.	85,420,044.		
b <b>AFFILIATION COMMITMENT</b>	27,529,803.	27,529,803.		
c <b>ACADEMIC SUPPORT PAYMEN</b>	15,136,742.	5,280,502.	9,856,240.	
d <b>PARKING</b>	4,481,456.	3,644,889.	826,850.	9,717.
e All other expenses	33,637,402.	28,917,953.	3,970,809.	748,640.
<b>25 Total functional expenses.</b> Add lines 1 through 24e	1911207531.	1541703303.	364,788,529.	4,715,699.
<b>26 Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here  if following SOP 98-2 (ASC 958-720)

**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
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	3,793,274.	<b>1</b>	10,410,739.
	<b>2</b> Savings and temporary cash investments .....	198,237,514.	<b>2</b>	121,533,240.
	<b>3</b> Pledges and grants receivable, net .....	2,486,296.	<b>3</b>	2,147,119.
	<b>4</b> Accounts receivable, net .....	232,466,164.	<b>4</b>	232,982,462.
	<b>5</b> 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 .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....	20,589,962.	<b>7</b>	15,009,330.
	<b>8</b> Inventories for sale or use .....	53,741,872.	<b>8</b>	58,162,318.
	<b>9</b> Prepaid expenses and deferred charges .....	39,478,455.	<b>9</b>	42,240,115.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 1429983373.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 822,672,122.	<b>10c</b>	607,311,251.
	<b>11</b> Investments - publicly traded securities .....		<b>11</b>	
	<b>12</b> Investments - other securities. See Part IV, line 11 .....	699,814,899.	<b>12</b>	489,767,502.
	<b>13</b> Investments - program-related. See Part IV, line 11 .....	3,196,645.	<b>13</b>	
	<b>14</b> Intangible assets .....		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 .....	42,715,044.	<b>15</b>	40,088,626.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	1918641832.	<b>16</b>	1619652702.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	170,752,728.	<b>17</b>	190,280,584.
	<b>18</b> Grants payable .....	6,690,985.	<b>18</b>	5,816,466.
	<b>19</b> Deferred revenue .....		<b>19</b>	
	<b>20</b> Tax-exempt bond liabilities .....	340,112,500.	<b>20</b>	333,807,500.
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....	97,121,099.	<b>23</b>	82,156,831.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	149,923,083.	<b>25</b>	54,613,895.
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	764,600,395.	<b>26</b>	666,675,276.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions .....	1062943590.	<b>27</b>	875,557,261.
	<b>28</b> Net assets with donor restrictions .....	91,097,847.	<b>28</b>	77,420,165.
	<b>Organizations that do not follow FASB ASC 958, check here</b> <input type="checkbox"/> <b>and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds .....		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>31</b>	
	<b>32</b> Total net assets or fund balances .....	1154041437.	<b>32</b>	952,977,426.
	<b>33</b> Total liabilities and net assets/fund balances .....	1918641832.	<b>33</b>	1619652702.

**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	1,927,049,540.
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,911,207,531.
3	Revenue less expenses. Subtract line 2 from line 1	3	15,842,009.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	1,154,041,437.
5	Net unrealized gains (losses) on investments	5	-181,252,097.
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	-35,653,923.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	952,977,426.

**Part XII Financial Statements and Reporting**

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

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

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

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 THE UNIVERSITY OF VERMONT MEDICAL CENTER Employer identification number 03-0219309

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).
3 X 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).
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).
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).
8 A community trust described in section 170(b)(1)(A)(vi).
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.
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...
11 An organization organized and operated exclusively to test for public safety.
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...
a Type I. A supporting organization operated, supervised, or controlled by its supported organization(s)...
b Type II. A supporting organization supervised or controlled in connection with its supported organization(s)...
c Type III functionally integrated. A supporting organization operated in connection with, and functionally integrated with, its supported organization(s)...
d Type III non-functionally integrated. A supporting organization operated in connection with its supported organization(s) that is not functionally integrated...
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).

Table with 6 columns: (i) Name of supported organization, (ii) EIN, (iii) Type of organization, (iv) Is the organization listed in your governing document?, (v) Amount of monetary support, (vi) Amount of other support. Includes a Total row at the bottom.

**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
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> 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) .....						
<b>6 Public support.</b> 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
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First 5 years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> .....						<input type="checkbox"/>

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

<b>14</b> Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2020 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2021.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 33 1/3% support test - 2020.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>17a 10% -facts-and-circumstances test - 2021.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>b 10% -facts-and-circumstances test - 2020.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....		<input type="checkbox"/>
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions .....		<input type="checkbox"/>



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

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

**Section A. Public Support**

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

**Section B. Total Support**

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

**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**

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

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

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

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

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

**Section E. Type III Functionally Integrated Supporting Organizations**

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

**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.

<b>Section A - Adjusted Net Income</b>		(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	<b>Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	8	

<b>Section B - Minimum Asset Amount</b>		(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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> 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	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	

<b>Section C - Distributable Amount</b>			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	<b>Distributable Amount.</b> 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)

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

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

Schedule A (Form 990) 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.)

Area with horizontal lines for providing supplemental information.

**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](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2021**

Name of the organization

**THE UNIVERSITY OF VERMONT MEDICAL CENTER**

Employer identification number

**03-0219309**

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  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
<u>1</u>	 <hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>2</u>	 <hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>3</u>	 <hr/> <hr/> <hr/>	\$ <u>50,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>4</u>	 <hr/> <hr/> <hr/>	\$ <u>361,431.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>5</u>	 <hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
<u>6</u>	 <hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
7	 <hr/> <hr/> <hr/>	\$ <u>410,475.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
8	 <hr/> <hr/> <hr/>	\$ <u>5,328.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
9	 <hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
10	 <hr/> <hr/> <hr/>	\$ <u>40,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
11	 <hr/> <hr/> <hr/>	\$ <u>8,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
12	 <hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
13	 <hr/> <hr/> <hr/>	\$ <u>9,290.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
14	 <hr/> <hr/> <hr/>	\$ <u>5,039.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
15	 <hr/> <hr/> <hr/>	\$ <u>147,772.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
16	 <hr/> <hr/> <hr/>	\$ <u>17,480.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
17	 <hr/> <hr/> <hr/>	\$ <u>5,400.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
18	 <hr/> <hr/> <hr/>	\$ <u>42,520.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
19	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
20	<hr/> <hr/> <hr/>	\$ 81,592.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
21	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
22	<hr/> <hr/> <hr/>	\$ 6,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
23	<hr/> <hr/> <hr/>	\$ 6,002.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
24	<hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
25	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
26	 <hr/> <hr/> <hr/>	\$ 20,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
27	 <hr/> <hr/> <hr/>	\$ 45,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
28	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
29	 <hr/> <hr/> <hr/>	\$ 20,901.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
30	 <hr/> <hr/> <hr/>	\$ 10,100.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
31	 <hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
32	 <hr/> <hr/> <hr/>	\$ <u>5,182.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
33	 <hr/> <hr/> <hr/>	\$ <u>52,380.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
34	 <hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
35	 <hr/> <hr/> <hr/>	\$ <u>9,105.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
36	 <hr/> <hr/> <hr/>	\$ <u>60,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
37	 <hr/> <hr/> <hr/>	\$ <u>15,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
38	 <hr/> <hr/> <hr/>	\$ <u>18,259.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
39	 <hr/> <hr/> <hr/>	\$ <u>33,150.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
40	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
41	 <hr/> <hr/> <hr/>	\$ <u>29,432.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
42	 <hr/> <hr/> <hr/>	\$ <u>433,005.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
43	 <hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
44	 <hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
45	 <hr/> <hr/> <hr/>	\$ <u>8,300.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
46	 <hr/> <hr/> <hr/>	\$ <u>5,200.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
47	 <hr/> <hr/> <hr/>	\$ <u>6,603.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
48	 <hr/> <hr/> <hr/>	\$ <u>19,375.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
49	 <hr/> <hr/> <hr/>	\$ <u>75,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
50	 <hr/> <hr/> <hr/>	\$ <u>24,380.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
51	 <hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
52	 <hr/> <hr/> <hr/>	\$ <u>150,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
53	 <hr/> <hr/> <hr/>	\$ <u>51,261.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
54	 <hr/> <hr/> <hr/>	\$ <u>11,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
55	 <hr/> <hr/> <hr/>	\$ <u>6,280.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
56	 <hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
57	 <hr/> <hr/> <hr/>	\$ <u>5,094.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
58	 <hr/> <hr/> <hr/>	\$ <u>4,480.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
59	 <hr/> <hr/> <hr/>	\$ <u>7,500.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
60	 <hr/> <hr/> <hr/>	\$ <u>114,175.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
61	 <hr/> <hr/> <hr/>	\$ <u>20,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
62	 <hr/> <hr/> <hr/>	\$ <u>100,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
63	 <hr/> <hr/> <hr/>	\$ <u>30,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
64	 <hr/> <hr/> <hr/>	\$ <u>30,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
65	 <hr/> <hr/> <hr/>	\$ <u>101,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
66	 <hr/> <hr/> <hr/>	\$ <u>10,000.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
67	 <hr/> <hr/> <hr/>	\$ 333,300.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
68	 <hr/> <hr/> <hr/>	\$ 278,539.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
69	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
70	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
71	 <hr/> <hr/> <hr/>	\$ 10,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
72	 <hr/> <hr/> <hr/>	\$ 5,500.	Person <input checked="" type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
73	 <hr/> <hr/> <hr/>	\$ <u>11,576.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
74	 <hr/> <hr/> <hr/>	\$ <u>17,935.</u>	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
75	 <hr/> <hr/> <hr/>	\$ <u>27,685.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
76	 <hr/> <hr/> <hr/>	\$ <u>5,085.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
77	 <hr/> <hr/> <hr/>	\$ <u>15,454.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
78	 <hr/> <hr/> <hr/>	\$ <u>25,977.</u>	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
73	CHILDREN'S TOYS _____ _____ _____	\$ <u>576.</u>	<u>12/06/21</u>
74	CHOCOLATES _____ _____ _____	\$ <u>3,000.</u>	<u>05/06/22</u>
75	SHARES OF STOCK _____ _____ _____	\$ <u>27,685.</u>	<u>12/10/21</u>
76	SHARES OF STOCK _____ _____ _____	\$ <u>5,085.</u>	<u>12/28/21</u>
77	SHARES OF STOCK _____ _____ _____	\$ <u>15,454.</u>	<u>12/17/21</u>
78	SHARES OF STOCK _____ _____ _____	\$ <u>25,977.</u>	<u>04/19/22</u>

Name of organization  <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number  <b>03-0219309</b>
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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
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
<b>(e) Transfer of gift</b>			
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](http://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 <b>THE UNIVERSITY OF VERMONT MEDICAL CENTER</b>	Employer identification number <b>03-0219309</b>
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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-.

**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.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
<b>1a</b>	Total lobbying expenditures to influence public opinion (grassroots lobbying) .....														
<b>b</b>	Total lobbying expenditures to influence a legislative body (direct lobbying) .....														
<b>c</b>	Total lobbying expenditures (add lines 1a and 1b) .....														
<b>d</b>	Other exempt purpose expenditures .....														
<b>e</b>	Total exempt purpose expenditures (add lines 1c and 1d) .....														
<b>f</b>	Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
<b>g</b>	Grassroots nontaxable amount (enter 25% of line 1f) .....														
<b>h</b>	Subtract line 1g from line 1a. If zero or less, enter -0- .....														
<b>i</b>	Subtract line 1f from line 1c. If zero or less, enter -0- .....														
<b>j</b>	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? .....														

Yes  No

**4-Year Averaging Period Under Section 501(h)**  
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

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



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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
<b>1</b> 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:			
<b>a</b> Volunteers? .....		X	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)? ..	X		
<b>c</b> Media advertisements? .....		X	
<b>d</b> Mailings to members, legislators, or the public? .....		X	
<b>e</b> Publications, or published or broadcast statements? .....		X	
<b>f</b> Grants to other organizations for lobbying purposes? .....		X	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body? .....	X		88,361.
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means? .....		X	
<b>i</b> Other activities? .....	X		302,874.
<b>j</b> Total. Add lines 1c through 1i .....			391,235.
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)? .....		X	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912 .....			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912 .....			
<b>d</b> 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
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members? .....	1	
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less? .....	2	
<b>3</b> 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."**

<b>1</b> Dues, assessments and similar amounts from members .....	1	
<b>2</b> Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
<b>a</b> Current year .....	2a	
<b>b</b> Carryover from last year .....	2b	
<b>c</b> Total .....	2c	
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .....	3	
<b>4</b> 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	
<b>5</b> 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.

**LOBBYING ACTIVITY**

**SCHEDULE C, PART II-B**

THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. ("UVMCM") REGULARLY MONITORS THE WORK OF THE VERMONT STATE GOVERNMENT AND THE NEW YORK STATE GOVERNMENT TO IDENTIFY ISSUES THAT DIRECTLY AFFECT THE ORGANIZATION AND THE MEMBER ORGANIZATIONS OF THE UNIVERSITY OF VERMONT HEALTH NETWORK.

**Part IV** Supplemental Information (continued)

COSTS ASSOCIATED WITH THESE ACTIVITIES INCLUDE CONSULTING AND STAFF COSTS AND ARE REPORTED ON LINE G. UVMMC ALSO BELONGS TO ORGANIZATIONS THAT LOBBY ON BEHALF OF THEIR MEMBERS. THESE COSTS ARE INCLUDED ON LINE I. THE LOBBYING ACTIVITIES ENGAGED IN BY UVMMC BENEFIT THE MEMBER ORGANIZATIONS OF THE UVM HEALTH NETWORK LOCATED IN VERMONT AND NORTHERN NEW YORK STATE.

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 THE UNIVERSITY OF VERMONT MEDICAL CENTER Employer identification number 03-0219309

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

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?, 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year, 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year, 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?, 6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year, 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?, 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

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

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

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	49,645,475.	42,096,683.	39,461,641.	38,361,267.	36,335,521.
b Contributions	513,348.	215,486.	253,817.	83,106.	214,155.
c Net investment earnings, gains, and losses	-6,967,361.	9,972,688.	3,640,535.	2,419,332.	3,203,413.
d Grants or scholarships					
e Other expenditures for facilities and programs	790,426.	2,639,382.	1,259,310.	1,402,064.	1,391,822.
f Administrative expenses					
g End of year balance	42,401,036.	49,645,475.	42,096,683.	39,461,641.	38,361,267.

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment  \_\_\_\_\_ %
  - b Permanent endowment  46.6200 %
  - c Term endowment  53.3800 %
- 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		26,043,783.		26,043,783.
b Buildings		775,611,842.	378,730,495.	396,881,347.
c Leasehold improvements		79,366,186.	56,101,569.	23,264,617.
d Equipment		527,390,955.	382,622,570.	144,768,385.
e Other		21,570,607.	5,217,488.	16,353,119.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				607,311,251.

**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) HEALTH NETWORK INVESTMENT		
(C) POOL	489,767,502.	END-OF-YEAR MARKET VALUE
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	489,767,502.	

**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)		
<b>Total.</b> (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)	
<b>Total.</b> (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) ASSET RETIREMENT OBLIGATION	2,217,702.
(3) ESTIMATED CLAIMS	7,404,637.
(4) SWAP LIABILITY	3,158,200.
(5) ESTIMATED 3RD PARTY BILLINGS	10,674,596.
(6) OP LEASE RT OF USE LIABILITY	30,051,495.
(7) FNCE LEASE RT OF USE LIABILITY	960,050.
(8) POST RETIRMENT HEALTH BEN	147,215.
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	54,613,895.

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.

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

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

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

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

**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:**

THE FUNDS, AND ALL NET EARNINGS IN ADDITION THERETO, ARE HELD TO BENEFIT CHARITY, EDUCATION, RESEARCH AND CHILDREN'S PROGRAMS.

**PART X, LINE 2:**

THE UNIVERSITY OF VERMONT MEDICAL CENTER, 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 G  
(Form 990)**

**Supplemental Information Regarding Fundraising or Gaming Activities**  
Complete if the organization answered "Yes" on Form 990, Part IV, line 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a.

OMB No. 1545-0047

**2021**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization: **THE UNIVERSITY OF VERMONT MEDICAL CENTER**  
Employer identification number: **03-0219309**

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

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

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

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

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

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col. (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
<b>Total</b>						

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



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

		(a) Event #1	(b) Event #2	(c) Other events	(d) Total events (add col. (a) through col. (c))
		GOLF TOURNAMENT		NONE	
		(event type)	(event type)	(total number)	
Revenue	1	Gross receipts	189,475.		189,475.
	2	Less: Contributions	151,391.		151,391.
	3	Gross income (line 1 minus line 2)	38,084.		38,084.
Direct Expenses	4	Cash prizes			
	5	Noncash prizes			
	6	Rent/facility costs	20,740.		20,740.
	7	Food and beverages	9,096.		9,096.
	8	Entertainment			
	9	Other direct expenses	4,921.		4,921.
	10	Direct expense summary. Add lines 4 through 9 in column (d)			
11	Net income summary. Subtract line 10 from line 3, column (d)				3,327.

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

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

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

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

b If "No," explain: \_\_\_\_\_

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

b If "Yes," explain: \_\_\_\_\_

11 Does the organization conduct gaming activities with nonmembers?  Yes  No

12 Is the organization a grantor, beneficiary or trustee of a trust, or a member of a partnership or other entity formed to administer charitable gaming?  Yes  No

13 Indicate the percentage of gaming activity conducted in:

a The organization's facility	13a	%
b An outside facility	13b	%

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

Name ► \_\_\_\_\_

Address ► \_\_\_\_\_

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

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

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

Name ► \_\_\_\_\_

Address ► \_\_\_\_\_

16 Gaming manager information:

Name ► \_\_\_\_\_

Gaming manager compensation ► \$ \_\_\_\_\_

Description of services provided ► \_\_\_\_\_

\_\_\_\_\_

Director/officer       Employee       Independent contractor

17 Mandatory distributions:

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

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

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

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

OMB No. 1545-0047

**2021**

Open to Public Inspection

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a .....	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," was it a written policy? .....	<input checked="" type="checkbox"/>	
<b>2</b> 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		
<b>3</b> 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.		
<b>a</b> 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>b</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 checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
<b>c</b> 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.		
<b>4</b> 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"/>	
<b>5a</b> 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>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
<b>c</b> 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?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

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
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1) .....			14650421.	1418034.	13232387.	.69%
<b>b</b> Medicaid (from Worksheet 3, column a) .....		51,367	326551222	150863228	175687994	9.19%
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) .....						
<b>d Total.</b> Financial Assistance and Means-Tested Government Programs .....		51,367	341201643	152281262	188920381	9.88%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .....			3803098.		3803098.	.20%
<b>f</b> Health professions education (from Worksheet 5) .....			91571938.	65183420.	26388518.	1.38%
<b>g</b> Subsidized health services (from Worksheet 6) .....			263076830	205701318	57375512.	3.00%
<b>h</b> Research (from Worksheet 7) .....			6405129.	6405129.		
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....			2645594.		2645594.	.14%
<b>j Total.</b> Other Benefits .....			367502589	277289867	90212722.	4.72%
<b>k Total.</b> Add lines 7d and 7j .....		51,367	708704232	429571129	279133103	14.60%

**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						
<b>10 Total</b>						

**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	36,711,036.
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	363,307.
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	251,258,939.
6 Enter Medicare allowable costs of care relating to payments on line 5 .....	6	367,227,375.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) .....	7	-115968436.
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="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 UNIVERSITY OF VERMONT MEDICAL CENTER
111 COLCHESTER AVE
BURLINGTON, VT 05401
WWW.UVMHEALTH.ORG
860

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 eight 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 UNIVERSITY OF VERMONT MEDICAL CENTER

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

	Yes	No
<b>Community Health Needs Assessment</b>		
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: <u>20 21</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: <u>20 22</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 UNIVERSITY OF VERMONT MEDICAL CENTER

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:		
<b>a</b> <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>400</u> %		
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Asset level		
<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input checked="" type="checkbox"/> Underinsurance status		
<b>g</b> <input checked="" type="checkbox"/> Residency		
<b>h</b> <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>X</b>	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>X</b>	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>16</b> Was widely publicized within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, SECTION C</u>		
<b>c</b> <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>		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b> <input 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)		
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <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		
<b>j</b> <input checked="" type="checkbox"/> Other (describe in Section C)		



**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group UNIVERSITY OF VERMONT MEDICAL CENTER

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

**Policy Relating to Emergency Medical Care**

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

		Yes	No
<b>22</b>	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.		
	<b>a</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
	<b>b</b> <input 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		
	<b>c</b> <input checked="" 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		
<b>d</b> <input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method			
<b>23</b>	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? ..... If "Yes," explain in Section C.		<b>X</b>
<b>24</b>	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? ..... If "Yes," explain in Section C.		<b>X</b>

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.

UNIVERSITY OF VERMONT MEDICAL CENTER:

PART V, SECTION B, LINE 3J: THE CHNA CONDUCTED IN FY 2022 / TY 2021

CONTAINS INFORMATION AND ANALYSIS THAT EXTENDS BEYOND THE SUBJECTS

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

SOURCES LISTING; KEY HEALTH AND WELLBEING INDICATORS AND THEIR SOURCES; A

DESCRIPTION OF A NUMBER OF ONGOING PROGRAMS AND FUNDING THAT HAVE OCCURRED

AS A RESULT OF THE CHNA PROCESS; AND UPDATES ON INITIATIVES RELATED TO THE

PRIOR CHNA. AT PAGE 80, THE CHNA ALSO CONTAINS AN INDEX OF KEY SCHEDULE H

REQUIREMENTS AND INFORMATION ABOUT WHERE THOSE ITEMS ARE ADDRESSED WITHIN

THE CHNA.

UNIVERSITY OF VERMONT MEDICAL CENTER:

PART V, SECTION B, LINE 5: THE UNIVERSITY OF VERMONT MEDICAL CENTER

("UVMC") AND 37 MEMBERS OF THE 2022 CHNA STEERING COMMITTEE COLLABORATED

ON THE 2022 CHNA FOR THE DESIGNATED HEALTH SERVICE AREA OF CHITTENDEN AND

GRAND ISLE COUNTIES. THE STEERING COMMITTEE MEMBERS INCLUDED

REPRESENTATIVES FROM UVMC AS WELL AS COMMUNITY PARTNERS SUCH AS

COMMUNITY-BASED ORGANIZATIONS, LOCAL AND REGIONAL INSTITUTIONS, AND STATE

AGENCIES INCLUDING: BUILDING BRIGHT FUTURES, LAKE CHAMPLAIN CHAMBER OF

COMMERCE; VERMONT DEPARTMENT OF HEALTH; VERMONT AGENCY OF HUMAN SERVICES;

ABENAKI NATION OF MISSISQUOI; CENTER FOR HEALTH & LEARNING; HUNGER FREE

VERMONT; COMMUNITY HEALTH CENTERS OF BURLINGTON; CHAMPLAIN HOUSING TRUST;

CITY OF BURLINGTON (RACIAL EQUITY, INCLUSION & BELONGING OFFICE); HOWARD

CENTER; CHITTENDEN COUNTY REGIONAL PLANNING COMMISSION; SASH AT CATHEDRAL

SQUARE; PRIDE CENTER OF VERMONT; WINOOSKI HIGH SCHOOL; US COMMITTEE FOR

**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.

REFUGEES AND IMMIGRANTS VERMONT; VERMONT PUBLIC HEALTH INSTITUTE; UNITED WAY OF NORTHWEST VERMONT MERCY CONNECTIONS; CHAMPLAIN ISLANDERS DEVELOPING ESSENTIAL RESOURCES; MENTAL HEALTH FIRST BTV; CHAMPLAIN VALLEY SUPERINTENDENTS ASSOCIATION; ASSOCIATION OF AFRICANS LIVING IN VERMONT; AND THE CHAMPLAIN VALLEY OFFICE OF ECONOMIC OPPORTUNITY.

THE CHNA PURSUED INPUT FROM PERSONS REPRESENTING BROAD INTERESTS OF THE COMMUNITY, INCLUDING BUT NOT LIMITED TO 32 INTERVIEWS WITH COMMUNITY LEADERS INCLUDING MEMBERS OF THE ABOVE-MENTIONED ORGANIZATIONS (JULY 2021); A COMMUNITY SURVEY COMPLETED BY 3,771 COMMUNITY MEMBERS ACROSS A WIDE RANGE OF BACKGROUNDS (SEPTEMBER AND OCTOBER 2021); 5 FOCUS GROUPS (NOVEMBER 2021), AND COMMUNITY HEALTH PRIORITY SESSIONS INVOLVING 140 PARTICIPANTS FROM 57 ORGANIZATIONS AND AGENCIES (JANUARY 2022). THE CHNA ALSO GATHERED SECONDARY DATA ON 70+ POPULATION-LEVEL HEALTH AND WELLBEING INDICATORS.

TWO VIRTUAL SESSIONS WERE HELD IN JANUARY 2022 TO ENGAGE COMMUNITY LEADERS AND CHAMPIONS IN PRIORITIZING HEALTH PRIORITIES THAT EMERGED FROM THE DATA GATHERING PHASE (NAMELY, ACCESSIBLE AND COORDINATED CARE, CULTURAL HUMILITY AND INCLUSIVE CARE, FOOD ACCESS AND SECURITY, HOUSING, MENTAL HEALTH AND WELLBEING, AND WORKFORCE DEVELOPMENT). 140 PARTICIPANTS FROM 57 DIFFERENT ORGANIZATIONS AND AGENCIES PARTICIPATED AND PROVIDED RATINGS BY THREE CRITERIA: IMPACT, COMMUNITY READINESS, AND EQUITY.

THE DATA GATHERING AND COMMUNITY ENGAGEMENT ACTIVITIES PROVIDED INSIGHTS INTO THE UNIQUE EXPERIENCES AND PERSPECTIVES OF POPULATIONS WHO HAVE BEEN HISTORICALLY UNDER OR UNREPRESENTED. POPULATIONS OF FOCUS INCLUDED:

**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.

BLACK, NATIVE AMERICAN, AND PEOPLE OF COLOR; PEOPLE WHO ARE NON-BINARY, GENDERQUEER, FLUID, AND TRANSGENDER; PEOPLE WITH LIMITED ENGLISH PROFICIENCY (LEP); PEOPLE WITH DISABILITIES; PEOPLE WHO ARE LGBTQ+; OLDER ADULTS OVER 65 YEARS OF AGE; REFUGEES & NEWLY IMMIGRATED INDIVIDUALS; PEOPLE EXPERIENCING POVERTY OR LOWER SOCIO-ECONOMIC STATUS; AND YOUTH.

UNIVERSITY OF VERMONT MEDICAL CENTER:

PART V, SECTION B, LINE 6B: THE 2022 CHNA PROJECT TEAM INCLUDED MEMBERS OF THE UVMC, COMMUNITY BENEFITS TEAM AS WELL AS THE REPRESENTATIVES FROM THE CENTER FOR RURAL STUDIES AT THE CENTRAL VERMONT. AS DISCUSSED ABOVE, THE CHNA PROJECT WAS ALSO GUIDED BY A STEERING COMMITTEE THAT INCLUDED MEMBERS OF COMMUNITY-BASED ORGANIZATIONS, LOCAL AND REGIONAL INSTITUTIONS, AND STATE AGENCIES INCLUDING: BUILDING BRIGHT FUTURES, LAKE CHAMPLAIN CHAMBER OF COMMERCE; VERMONT DEPARTMENT OF HEALTH; VERMONT AGENCY OF HUMAN SERVICES; ABENAKI NATION OF MISSISQUOI; CENTER FOR HEALTH & LEARNING; HUNGER FREE VERMONT; COMMUNITY HEALTH CENTERS OF BURLINGTON; CHAMPLAIN HOUSING TRUST; CITY OF BURLINGTON (RACIAL EQUITY, INCLUSION & BELONGING OFFICE); HOWARD CENTER; CHITTENDEN COUNTY REGIONAL PLANNING COMMISSION; SASH AT CATHEDRAL SQUARE; PRIDE CENTER OF VERMONT; WINOOSKI HIGH SCHOOL; US COMMITTEE FOR REFUGEES AND IMMIGRANTS VERMONT; VERMONT PUBLIC HEALTH INSTITUTE; UNITED WAY OF NORTHWEST VERMONT MERCY CONNECTIONS; CHAMPLAIN ISLANDERS DEVELOPING ESSENTIAL RESOURCES; MENTAL HEALTH FIRST BTV; CHAMPLAIN VALLEY SUPERINTENDENTS ASSOCIATION; ASSOCIATION OF AFRICANS LIVING IN VERMONT; AND THE CHAMPLAIN VALLEY OFFICE OF ECONOMIC OPPORTUNITY.

**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.

UNIVERSITY OF VERMONT MEDICAL CENTER:

PART V, SECTION B, LINE 11: THE UNIVERSITY OF VERMONT MEDICAL CENTER'S CHNA IDENTIFIED THE FOLLOWING PRIORITIES AND SETS OUT ACTION PLANS FOR EACH PRIORITY WITH TOP STRATEGIES AS DISCUSSED BELOW.

ACCESSIBLE AND COORDINATED CARE

- EXPAND ACCESS BEYOND TRADITIONAL HOURS AND REDUCE WAIT TIMES
- IMPROVE COORDINATION OF CARE
- ADDRESS BARRIERS TO TREATMENT SUCH AS COMMUNICATION AND TRANSPORTATION LIMITATIONS

CULTURAL HUMILITY AND INCLUSIVE HEALTH CARE:

- INCREASE PROVIDER COMPETENCIES TO BETTER SERVE DIVERSE PATIENTS
- ESTABLISH TRUSTING RELATIONSHIPS WITH HISTORICALLY MARGINALIZED COMMUNITIES
- INVEST IN LANGUAGE ACCESS SERVICES, INCLUDING MEDICALLY TRAINED INTERPRETERS

FOOD ACCESS AND SECURITY

- INCREASE FOOD ACCESS AND MEAL DELIVERY PROGRAMS INCLUDING CULTURALLY APPROPRIATE FOODS AND SUPPORTING PROGRAMS FOR CHILDREN
- IMPLEMENT FOOD SECURITY SCREENINGS AND REFERRAL PROCESSES
- INCREASE ACCESS TO LOCAL GROWERS AND PROGRAMS THAT REDIRECT SURPLUS FOOD

HOUSING:

- EXPAND WRAP AROUND SERVICES FOR PEOPLE IN PERMANENT AND AFFORDABLE

**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.

**HOUSING**

- PROMOTE CULTURAL HUMILITY TRAINING FOR HOUSING SERVICES PROVIDERS
- DECREASE THE GAP IN LIVABLE WAGES AND HOUSING AFFORDABILITY

**MENTAL HEALTH AND WELLBEING:**

- SUPPORT CULTURAL CENTERS AND COMMUNITY GATHERING SPACES
- ENGAGE WITH YOUTH TO UNDERSTAND THEIR NEEDS AND INCREASE RESOURCES

**AVAILABLE FOR THEM**

- INTEGRATE MENTAL HEALTH SERVICES INTO ALL PEDIATRIC AND PRIMARY CARE

**CLINICS**

**WORKFORCE DEVELOPMENT**

- ADDRESS WAGE GAPS IN EDUCATION AND HELPING PROFESSIONS
- DIVERSIFY WORKFORCE AND INCREASE INVESTMENTS IN GROUPS ADDRESSING SOCIAL

**DETERMINANTS OF HEALTH**

- ADDRESS COST AND HOUSING STOCK LIMITATIONS THAT ARE A BARRIER TO

**RECRUITMENT AND RETENTION**

FOR EACH ENGAGEMENT WHEREIN COMMUNITY MEMBERS PARTICIPATED, A SURVEY WAS SHARED THAT ASKED PARTICIPANTS TO IDENTIFY THE TOP PRIORITIES. BASED ON COMMUNITY IMPUT, THE PRIORITIES THAT ADVANCED TO THE UVMC BOARD WERE INCLUSIVE CARE, HOUSING, AND MENTAL HEALTH AND WELLBEING. THE IMPLEMENTATION STRATEGY FOCUSES ON THESE TOP PRIORITIES, BUT INCLUDES COMMITMENTS RELATED TO THE REMAINING PRIORITIES WHERE THERE WAS DETERMINED TO BE A CLOSE RELATIONSHIP FOR EXAMPLE, THE IMPLEMENTATION STRATEGY CONTAINS COMMITMENTS RELATED TO HOUSING ON THE WORKFORCE AND WORKFORCE DEVELOPMENT, AS WELL AS COMMITMENTS RELATED TO COORDINATED HEALTH CARE

**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.

THAT ARE GEARED TOWARD PROMOTING INCLUSIVITY IN HEALTH CARE.

THE UVM MEDICAL CENTER'S STRATEGIES, INITIATIVES, AND FINANCIAL OUTLAYS TO PROMOTE THE PRIORITIES IDENTIFIED IN THE CHNA, AS WELL AS COMMUNITY HEALTH IN GENERAL, EXTEND BEYOND THE COMMITMENTS THAT ARE DISCUSSED IN THE IMPLEMENTATION STRATEGY. PRIORITIES AND INITIATIVES THAT WERE NOT IDENTIFIED AS TOP PRIORITIES BY COMMUNITY PARTICIPANTS CONTINUE TO GUIDE THE ACTIONS AND STRATEGIES OF FULL-TIME STAFF DEVOTED TO COMMUNITY BENEFIT. ADDITIONALLY, FINDINGS, DATA AND OTHER INFORMATION FROM THE CHNA CAN BE USED BY COMMUNITY PARTNERS TO DRIVE STRATEGY, GUIDE INVESTMENTS, AND INFORM DECISIONS.

UNIVERSITY OF VERMONT MEDICAL CENTER:

PART V, SECTION B, LINE 16J: IN ADDITION TO POSTING OUR GUIDELINES AND PLAIN LANGUAGE SUMMARY ONLINE, AT THE TIME OF SERVICE, REGISTRATION AND CHECK-IN STAFF PROVIDE A COPY OF THE PLAIN LANGUAGE SUMMARY TO ALL PATIENTS WHO HAVE OR WILL HAVE A BALANCE AND TO THOSE WHO EXPRESS FINANCIAL HARDSHIP. ADDITIONALLY, PLAIN LANGUAGE SUMMARIES ALONG WITH RACK CARDS REFERENCING OUR ASSISTANCE PROGRAM ARE PLACED IN ALL REGISTRATION WAITING ROOMS. FROM REGISTRATION, PATIENTS ARE ROUTINELY REFERRED TO OUR FINANCIAL ADVOCACY DEPARTMENT OR COMMUNITY HEALTH IMPROVEMENT. BOTH AREAS PROVIDE KNOWLEDGE AND ASSISTANCE IN THE APPLICATION PROCESS FOR CHARITY AND OTHER APPLICABLE FUNDING SOURCES. ADVOCATES ACTIVELY EDUCATE ALL INPATIENT, OBSERVATION AND OUTPATIENT INVASIVE SERVICE PATIENTS OF OUR PROGRAM, PRIOR TO OR CONCURRENT WITH THE PATIENTS' STAY, SUBSEQUENTLY AIDING IN THE APPLICATION PROCESS FOR STATE AID AND UVM MEDICAL CENTER'S



**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.

**FINANCIAL PROGRAM.**

**UNIVERSITY OF VERMONT MEDICAL CENTER:**

**PART V, SECTION B, LINE 20E: (ALSO APPLICABLE TO LINE 20A) THE UNIVERSITY OF VERMONT MEDICAL CENTER'S BAD DEBT POLICY PROVIDES THAT UVMC SHALL NOT TAKE ANY EXTRAORDINARY COLLECTION ACTIONS.**

**PART V, SECTION B, LINES 7A AND 10A: HOSPITAL FACILITY'S WEBSITE  
HTTPS://WWW.UVMHEALTH.ORG/MEDCENTER/ABOUT-UVM-MEDICAL-CENTER/THE-COMMUNITY/NEEDS-ASSESSMENT**

**PART V, SECTION B, LINE 15E**

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

**PART V, LINES 16A-16C: FINANCIAL ASSISTANCE POLICY RESOURCES**

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

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

THE FINANCIAL ASSISTANCE POLICY ("FAP"), THE FAP APPLICATION FORM, AND

A PLAIN LANGUAGE SUMMARY OF THE FAP WAS WIDELY AVAILABLE AT THE UVMHC

FINANCIAL ASSISTANCE WEBPAGE LOCATED AT:

HTTPS://WWW.UVMHEALTH.ORG/MEDCENTER/PATIENTS-AND-VISITORS/BILLING-INSURA

NCE-AND-REGISTRATION/FINANCIAL-ASSISTANCE

Multiple horizontal lines for supplemental information.

**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? 6

Name and address	Type of Facility (describe)
1 UVM MEDICAL CENTER DIALYSIS S BURLINGT 35 JOY DRIVE SOUTH BURLINGTON, VT 05403	DIALYSIS
2 UVM MEDICAL CENTER DIALYSIS RUTLAND 160 ALLEN STREET RUTLAND, VT 05701	DIALYSIS
3 UVM MEDICAL CENTER DIALYSIS BERLIN 130 FISHER ROAD BERLIN, VT 05602	DIALYSIS
4 UVM MEDICAL CENTER DIALYSIS ST ALBANS 7-8 CREST ROAD ST ALBANS, VT 05478	DIALYSIS
5 UVM MEDICAL CENTER DIALYSIS BURLINGTON 111 COLCHESTER AVE BURLINGTON, VT 05401	DIALYSIS
6 UVM MEDICAL CENTER DIALYSIS NEWPORT 189 PROUTY DRIVE NEWPORT, VT 05855	DIALYSIS

**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:

ELIGIBILITY FOR FINANCIAL ASSISTANCE WILL BE CONSIDERED FOR THOSE INDIVIDUALS WHO ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR ANY GOVERNMENT HEALTH CARE BENEFIT PROGRAM. TO QUALIFY FOR FINANCIAL ASSISTANCE, AN ELIGIBLE PATIENT MUST PASS BOTH AN INCOME AND ASSETS TEST. INCOME IS SET AT A MAXIMUM OF 400% OF FEDERAL POVERTY LEVEL GUIDELINES ("FPLG") AND THE ASSETS TEST IS SET AT \$50,000 LIQUID ASSETS, AS FURTHER DEFINED AND DESCRIBED IN THE POLICY. ASSISTANCE IS GRANTED BASED UPON THE PATIENT'S INCOME FPLG. PATIENTS MUST RESIDE WITHIN THE UNIVERSITY OF VERMONT MEDICAL SERVICE AREA, UNLESS MEDICAL SERVICES WERE URGENT OR EMERGENT IN NATURE. FINANCIAL ASSISTANCE FOR RESIDENTS OUTSIDE OF THE UVMC SERVICE AREA WILL BE GRANTED ONLY IN UNIQUE CIRCUMSTANCES AND WITH APPROPRIATE APPROVAL.

PART I, LN 7 COL(F):

THE PROVISION FOR BAD DEBT INCLUDED ON FORM 990, PART IX, LINE 25 BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE AMOUNT REPORTED ON LINE 7(F) IS \$0. ALL PATIENT RELATED BAD DEBT IS SHOWN AS A DEDUCTION FROM PATIENT

**Part VI** Supplemental Information (Continuation)

REVENUE. A VERY SMALL PORTION OF BAD DEBT ATTRIBUTABLE TO NON-PATIENTS IS INCLUDED IN LINE 24E OF THE STATEMENT OF FUNCTIONAL EXPENSES.

## PART I, LINE 7

UVM MEDICAL CENTER UTILIZED ITS COST ACCOUNTING SYSTEM TO CALCULATE THE AMOUNTS REPORTED IN THE TABLE ON LINE 7, AS WELL AS LYON SOFTWARE'S COMMUNITY BENEFIT INVENTORY FOR SOCIAL ACCOUNTABILITY. THE COST ACCOUNTING SYSTEM ADDRESSES ALL PATIENT SEGMENTS, INCLUDING, BUT NOT LIMITED TO, INPATIENT, OUTPATIENT, EMERGENCY ROOM, PRIVATE INSURANCE, MEDICAID, MEDICARE, UNINSURED AND SELF PAY. THE COST-TO-CHARGE RATIO DERIVED FROM WORKSHEET 2 WAS ALSO UTILIZED FOR SOME OF THE FIGURES REPORTED IN THE TABLE ON LINE 7.

THE UNIVERSITY OF VERMONT MEDICAL CENTER'S ANNUAL MEDICAID PROVIDER TAX IS ASSESSED ON VERMONT ACUTE CARE HOSPITALS BY THE STATE OF VERMONT. THE TAX ASSESSMENT IS CALCULATED AS 6% OF A HOSPITAL'S BASE YEAR NET PATIENT CARE REVENUE.

## PART III, LINE 2:

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

## PART III, LINE 3:

**Part VI** Supplemental Information (Continuation)

DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE NETTED AGAINST THE TOTAL GROSS CHARGES WHEN DETERMINING BAD DEBT EXPENSE. THE \$363,307 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. UVM MEDICAL CENTER HAS A DATABASE WHICH TRACKS ALL APPLICATIONS AND THEIR STATUS; A QUERY EXTRACTED 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.

UVM MEDICAL CENTER ATTEMPTS TO ENSURE THAT CONSPICUOUS DISPLAY OF OUR FINANCIAL ASSISTANCE POLICY APPEARS THROUGHOUT OUR FACILITY.

PART III, LINE 4:

THE ORGANIZATION'S BAD DEBT EXPENSE IS ADDRESSED ON PAGE 26 IN FOOTNOTE 4 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 UVM MEDICAL CENTER'S FYE 9/30/22 MEDICARE COST REPORT, WORKSHEET D-1, COMPUTATION OF INPATIENT OPERATING COSTS, WORKSHEET E PART B, CALCULATION OF OUTPATIENT SETTLEMENT, AND WORKSHEET I-4, COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS. WHILE UVM MEDICAL CENTER HAS HISTORICALLY FOLLOWED THE CATHOLIC HOSPITAL ASSOCIATION'S GUIDANCE AND HAS NOT CONSIDERED ANY MEDICARE SHORTFALL (REPORTED IN PART III, LINE 7) AS A COMMUNITY BENEFIT, IT IS LIKELY THAT SOME PORTION OF MEDICARE PATIENTS WOULD HAVE QUALIFIED FOR CHARITY CARE

Schedule H (Form 990)

**Part VI** Supplemental Information (Continuation)

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 UVM MEDICAL CENTER CREDIT AND COLLECTIONS POLICY IS DETACHED IN TERMS  
OF WHETHER PATIENTS QUALIFY FOR ASSISTANCE. INVOICES OF PATIENTS WHO DO  
QUALIFY OR ARE KNOWN TO QUALIFY WILL NOT AGE TO COLLECTIONS AND ARE NOT  
PURSUED. BALANCES THAT REMAIN UNPAID AFTER THE APPROPRIATE DISCOUNT HAS  
BEEN ADJUSTED WILL AGE TO COLLECTIONS.

AN EXTENSION OF UP TO 120 DAYS CAN BE GRANTED IN THE COLLECTION AGENCY  
WINDOW WHEN PATIENTS APPLY AND ARE APPROVED FOR ASSISTANCE WITHIN THE  
APPLICATION WINDOW.

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

SCHEDULE H PART V:

IN ADDITION TO THE FACILITIES OPERATED BY THE UNIVERSITY OF VERMONT  
MEDICAL CENTER, INC. (UVM MEDICAL CENTER) LISTED IN SECTION A AND

Schedule H (Form 990)

**Part VI** Supplemental Information (Continuation)

SECTION D, UVM MEDICAL CENTER OPERATES 30 ADDITIONAL CLINIC SITES

AROUND ITS SERVICE AREA. EACH OF THESE SITES IS COVERED UNDER THE UVM MEDICAL CENTER HOSPITAL LICENSE. ALL LISTED OR NON-LISTED FACILITIES OPERATED BY UVM MEDICAL CENTER OR ITS SUBSIDIARIES FOLLOW ALL OF THE SAME POLICIES AND PROCEDURES AS THE UVM MEDICAL CENTER.

PART VI, LINE 2:

UVM MEDICAL CENTER OFFERS FREE TO THE COMMUNITY A WIDE RANGE OF HEALTH, PREVENTION AND WELLNESS PROGRAMS, ALL OF WHICH ADDRESS THE HEALTH CARE NEEDS OF THE COMMUNITY AND LIMIT THE NEED FOR MORE EXPENSIVE ACUTE CARE. IN CONJUNCTION WITH THE UNIVERSITY OF VERMONT, THE ORGANIZATION OPERATES THE FRYMOYER COMMUNITY HEALTH RESOURCE CENTER, WHICH OFFERS FREE, PERSONALIZED ASSISTANCE TO HELP COMMUNITY MEMBERS FIND INFORMATION ABOUT MEDICAL CONDITIONS, HEALTHIER LIFESTYLE HABITS, AND MAKE INFORMED HEALTHCARE DECISIONS. ADDITIONALLY, THE UVM MEDICAL CENTER PARTNERS WITH A NUMBER OF COMMUNITY HEALTH RESOURCE GROUPS, INCLUDING THE UNITED WAY, THE VISITING NURSE ASSOCIATION, THE HOWARD CENTER AND THE COMMUNITY HEALTH CENTER TO ADDRESS THE NEEDS OF VERMONT AND NORTHERN NEW YORK RESIDENTS. A MORE COMPREHENSIVE LIST OF HEALTH, WELLNESS AND SAFETY PROGRAMS CONDUCTED BY OR IN CONJUNCTION WITH UVM MEDICAL CENTER IS AVAILABLE AT [HTTPS://WWW.UVMHEALTH.ORG/MEDCENTER/DEPARTMENTS-AND-PROGRAMS/COMMUNITY-HEALTH-IMPROVEMENT](https://www.uvmhealth.org/medcenter/departments-and-programs/community-health-improvement).

PART VI, LINE 3:

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



**Part VI** Supplemental Information (Continuation)

**INFORM & EDUCATE:**

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

- PRE-ARRIVAL SCREENING/REGISTRATION TO POINT OF SALE EDUCATION AT REGISTRATION
- AT THE BEDSIDE OF AN INPATIENT OR OBSERVATION PATIENT
- AFTER DISCHARGE WITH CONTINUED FOLLOW-UP BY FINANCIAL ADVOCATES AND
- DURING THE SELF-PAY BILLING FOLLOW-UP PROCESS.

PATIENTS ARE INFORMED OF THE PROGRAM, APPLICATIONS AND ASSISTANCE WITH COMPLETION ARE PROVIDED WITH FINANCIAL ADVOCATES ALSO PROVIDING EDUCATION AND ASSISTANCE FOR MEDICAID AND HEALTH INFORMATION EXCHANGE PROGRAMS, ALONG WITH ASSISTANCE IN APPLYING FOR THE UVM MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM. PATIENTS ARE ROUTINELY REFERRED TO ADVOCATES AND ADVISORS IN ADVANCE OF SERVICE WITH ADVOCATES ACTIVELY ASSISTING PATIENTS WHO ARE ADMITTED TO THE ORGANIZATION URGENTLY OR EMERGENTLY. POLICIES, SUMMARIES AND APPLICATIONS ARE AVAILABLE AT ALL REGISTRATION LOCATIONS, THEY ARE REFERENCED IN ALL INTERVIEW PROCESSES AND FURTHER AVAILABLE IN THE WAITING AREAS. OUR ORGANIZATIONAL WEBSITES PROVIDE EDUCATION, APPLICATIONS, POLICIES, SUMMARIES, FAQ DOCUMENTS ALONG WITH CONTACT INFORMATION AS A PASSIVE MEANS OF COMMUNICATION IN ADDITION TO THE ACTIVE EDUCATION REFERENCED PREVIOUSLY. OUR BILLING STATEMENTS REFLECT FINANCIAL ASSISTANCE HELP AND OUR COMMUNITY BENEFIT TEAM EDUCATE WITHIN THE COMMUNITY ON OUR PROGRAMS. APPLICATIONS AND INFORMATION ARE ADDITIONALLY AVAILABLE IN THE LOCAL COMMUNITY HEALTH CENTERS.

**ASSIST:**

- ALL INPATIENT AND OUTPATIENT PROCEDURES ARE FINANCIALLY SCREENED TO

**Part VI** Supplemental Information (Continuation)

IDENTIFY THE UNDERINSURED OR UNINSURED PATIENT POPULATION. PRIOR TO SERVICE, CONCURRENT WITH SERVICE AND POST SERVICE, OUR PATIENT FINANCIAL COUNSELORS WILL CALL AND/OR MEET WITH PATIENTS AND FAMILIES TO EDUCATE THEM ON THE AVAILABLE PROGRAMS AND WHERE APPLICABLE, ASSIST IN THE APPLICATION PROCESS. THIS INCLUDES STATE AND FEDERAL AID APPLICATIONS AND THE UVM MEDICAL CENTER CHARITY APPLICATION PROCESS.

- OUR FINANCIAL COUNSELORS/ADVOCATES HAVE BEEN CERTIFIED AS ASSISTERS IN THE STATE OF VT AND WILL ADDITIONALLY AID PATIENTS IN THE APPLICATION PROCESS FOR HEALTH EXCHANGE INSURANCE, MEDICAID AND THE FINANCIAL ASSISTANCE PROGRAMS. COUNSELORS WILL ADDITIONALLY MEET WITH PATIENTS AT THE BEDSIDE TO HELP COMPLETE THE APPLICATIONS, PROVIDE DETAILS ON SUPPORTING DOCUMENTATION NEEDS AND FACILITATE AND EXPEDITE THE REVIEW PROCESS UNTIL A NOTICE OF DECISION HAS BEEN RECEIVED.

- OUR COMMUNITY HEALTH IMPROVEMENT OFFICE PROVIDES EDUCATION AND APPLICATION ASSISTANCE FOR A VARIETY OF PROGRAMS, INCLUDING THE STATE AND FEDERAL MEDICAID APPLICATION PROCESS, THE PATIENT ASSISTANCE PROGRAM APPLICATION (CHARITY) AS WELL AS ASSIST WITH FINANCIAL ASSISTANCE TO PATIENTS FOR PHARMACEUTICALS. PROCESSES HAVE BEEN ESTABLISHED TO REFER URGENT CARE AND EMERGENCY DEPARTMENT PATIENTS TO THE PROGRAM, WHERE CASE MANAGERS ASSIST IN BOTH THE APPLICATION PROCESS AND COMMUNITY RESOURCE NEEDS IDENTIFICATION. ADDITIONALLY, THE CASE MANAGERS RECEIVE AND REVIEW REPORTS FOR THE UNINSURED EMERGENCY PATIENTS WHO HAVE FREQUENTED THE EMERGENCY DEPARTMENT MORE THAN 1 TIME PER MONTH. THE MANAGERS WILL THEN REACH OUT TO THE PATIENTS, SEEKING TO ASSIST PATIENTS IN IDENTIFYING FINANCIAL SPONSORSHIP.

PART VI, LINE 4:

COMMUNITY INFORMATION: UVM MEDICAL CENTER IS BOTH A COMMUNITY HOSPITAL

**Part VI** Supplemental Information (Continuation)

AND, IN PARTNERSHIP WITH THE UNIVERSITY OF VERMONT, THE STATE'S ONLY ACADEMIC MEDICAL CENTER. IN ITS COMMUNITY HOSPITAL ROLE, UVM MEDICAL CENTER SERVES 175,616 RESIDENTS IN CHITTENDEN AND GRAND ISLE COUNTIES. THESE COUNTIES REPRESENT THE FASTEST AND THE THIRD FASTEST GROWING POPULATIONS IN THE STATE. CHITTENDEN COUNTY CONTINUES TO BE THE MOST RACIALLY AND ETHNICALLY DIVERSE COUNTY IN VERMONT.

1 IN 8 RESIDENTS IN CHITTENDEN AND GRAND ISLE COUNTIES ARE BELOW THE FEDERAL POVERTY LEVEL. MEDIAN HOUSEHOLD INCOMES HAVE INCREASED ACROSS THE HEALTH SERVICE AREA, YET DISPARITIES REMAIN BY RACE AND ETHNICITY AND SEX. THE OVERALL HIGH SCHOOL GRADUATION RATE IS 94% YET DISPARITIES ARE EVIDENT BY RACE AND ETHNICITY.

PART VI, LINE 5:

PROMOTION OF COMMUNITY HEALTH: UVM MEDICAL CENTER IS GOVERNED BY A BOARD OF COMMUNITY VOLUNTEERS FROM ITS SERVICE AREA, INCLUDING ITS PRIMARY, SECONDARY AND TERTIARY REFERRAL REGION. THE MAJORITY OF BOARD MEMBERS ARE INDEPENDENT AND NOT DIRECTLY AFFILIATED WITH THE ORGANIZATION. UVM MEDICAL CENTER'S MEDICAL STAFF IS AN "OPEN STAFF" MODEL WITH MEMBERSHIP GOVERNED BY THE MEDICAL STAFF'S BY-LAWS, AND INCLUDES APPROXIMATELY 720 EMPLOYED PHYSICIANS AND 170 COMMUNITY-BASED PHYSICIANS. AS A NON-PROFIT, ANY SURPLUS FUNDS GENERATED BY UVM MEDICAL CENTER ARE RE-INVESTED IN THE ORGANIZATION TO SUPPORT ITS MISSION. PLEASE SEE SCHEDULE O FOR A MORE DETAILED DESCRIPTION OF UVM MEDICAL CENTER'S ROLE IN ITS REGIONAL HEALTH CARE SYSTEM AND COMMUNITY BENEFIT ACTIVITIES.

PART VI, LINE 6:

AFFILIATED HEALTH CARE SYSTEM:

**Part VI** Supplemental Information (Continuation)

AS OF OCTOBER 1, 2011, THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. (UVM MEDICAL CENTER) AND THE UNIVERSITY OF VERMONT HEALTH NETWORK-CENTRAL VERMONT MEDICAL CENTER, INC. (UVM HEALTH NETWORK-CENTRAL VERMONT MEDICAL CENTER), BECAME MEMBERS OF THE UNIVERSITY OF VERMONT HEALTH NETWORK, (UVM HEALTH NETWORK), AN INTEGRATED SYSTEM OF CARE SERVING THE COMMUNITIES OF VERMONT AND NORTHERN NEW YORK. ON JANUARY 1, 2013 UVM HEALTH NETWORK BECAME THE SOLE MEMBER OF COMMUNITY PROVIDERS, INC. (CPI), THE SOLE MEMBER OF CHAMPLAIN VALLEY PHYSICIANS HOSPITAL (CVPH), ELIZABETHTOWN COMMUNITY HOSPITAL (ECH) AND ALICE HYDE MEDICAL CENTER (AHMC).

ON APRIL 1, 2017, UVM HEALTH NETWORK BECAME THE SOLE MEMBER OF PORTER MEDICAL CENTER, INC. ON JANUARY 1, 2018 UVM HEALTH NETWORK ALSO BECAME THE SOLE MEMBER OF UVM HEALTH NETWORK HOME HEALTH & HOSPICE. UVM HEALTH NETWORK IS CARRYING 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. UVM MEDICAL CENTER 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, OTHER VERMONT HOSPITALS, AND PHYSICIAN PRACTICES), AS WELL AS COMMUNITY-BASED ORGANIZATIONS WHOSE MISSIONS ARE SIMILAR TO OURS. FOR EXAMPLE, UVM MEDICAL CENTER COLLABORATES WITH COMMUNITY PARTNERS TO REGULARLY ASSESS COMMUNITY AND HEALTH CARE NEEDS, WHICH HELPS GUIDE OUR ORGANIZATION'S PRIORITIES. PLEASE READ FORM 990 PART III NARRATIVE IN SCHEDULE O FOR ADDITIONAL INFORMATION ON THE UVM MEDICAL CENTER'S INTERACTIONS IN AND WITH ITS COMMUNITY.

**Part VI** Supplemental Information (Continuation)

PART VI, LINE 7

THE UNIVERSITY OF VERMONT MEDICAL, INC. FILES A COMMUNITY BENEFIT  
REPORT WITH THE STATE OF VERMONT.

**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](http://www.irs.gov/Form990) for the latest information.**

OMB No. 1545-0047

**2021**

**Open to Public  
Inspection**

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

**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.

<b>1 (a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section (if applicable)	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of noncash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of noncash assistance	<b>(h)</b> Purpose of grant or assistance
AMERICAN CANCER SOCIETY 30 SPEEN STREET FRAMINGHAM, MA 01701	13-1788491	501(C)(3)	75,000.	0.			COMMUNITY HEALTH IMPROVEMENT
ANEW PLACE PO BOX 1481 BURLINGTON, VT 05401	03-0287599	501(C)(3)	50,000.	0.			COMMUNITY HEALTH IMPROVEMENT
AREA HEALTH EDUCATION CENTER 1 SO. PROSPECT ST BURLINGTON, VT 05401	03-0179440	501(C)(3)	260,000.	0.			COMMUNITY HEALTH IMPROVEMENT
BURLINGTON HOUSING AUTHORITY 65 MAIN STREET BURLINGTON, VT 05401	03-0216305	OTHER GOV'T	50,000.	0.			COMMUNITY HEALTH IMPROVEMENT
COMMUNITY HEALTH CENTERS OF BURLINGTON - 617 RIVERSIDE AVENUE - BURLINGTON, VT 05401	23-7182584	501(C)(3)	100,000.	0.			COMMUNITY HEALTH IMPROVEMENT
GREEN UP VERMONT 14 BALDWIN STREET #16 MONTPELIER, VT 05602	03-0274312	501(C)(3)	6,000.	0.			COMMUNITY HEALTH IMPROVEMENT

**2** Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 22.

**3** Enter total number of other organizations listed in the line 1 table ▶ 0.

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

Schedule I (Form 990) 2021

**Part II** Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(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 non-cash assistance	(h) Purpose of grant or assistance
HUDSON HEADWATERS HEALTH NETWORK 9 CAREY ROAD QUEENSBURY, NY 12804	14-1628237	501(C)(3)	350,000.	0.			COMMUNITY HEALTH IMPROVEMENT
JANET S MUNT FAMILY ROOM INC 20 ALLEN STREET BURLINGTON, VT 05401	81-5449524	501(C)(3)	50,000.	0.			COMMUNITY HEALTH IMPROVEMENT
LUND FAMILY CENTER 76 GLEN ROAD BURLINGTON, VT 05401	03-0179434	501(C)(3)	54,000.	0.			COMMUNITY HEALTH IMPROVEMENT
MERCY CONNECTIONS INC 255 SOUTH CAMPLAIN ST SUITE 8 BURLINGTON, VT 05401	03-0369962	501(C)(3)	35,000.	0.			COMMUNITY HEALTH IMPROVEMENT
PATHWAYS VERMONT INC 125 COLLEGE ST STE 2 BURLINGTON, VT 05401	30-0604758	501(C)(3)	50,000.	0.			COMMUNITY HEALTH IMPROVEMENT
SPECTRUM YOUTH AND FAMILY SERVICES 131 ELMWOOD AVE BURLINGTON, VT 05401	03-0253232	501(C)(3)	35,000.	0.			COMMUNITY HEALTH IMPROVEMENT
THE DREAM PROGRAM INC PO BOX 361 WINOOSKI, VT 05404	26-0030908	501(C)(3)	25,000.	0.			COMMUNITY HEALTH IMPROVEMENT
TURNING POINT CENTER OF CHITTENDEN COUNTY INC - 191 BANK ST STE 200 - BURLINGTON, VT 05401	04-3682092	501(C)(3)	55,000.	0.			COMMUNITY HEALTH IMPROVEMENT
UNITED WAY OF CHITTENDEN COUNTY 412 FARRELL STREET SO. BURL., VT 05403	03-0217229	501(C)(3)	310,000.	0.			COMMUNITY HEALTH IMPROVEMENT

Schedule I (Form 990)

**Part II** Continuation of Grants and Other Assistance to Domestic Organizations and Domestic Governments (Schedule I (Form 990), Part II.)

(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 non-cash assistance	(h) Purpose of grant or assistance
UVM FOUNDATION 411 MAIN STREET BURLINGTON, VT 05401	45-1556038	501(C)(3)	127,367.	0.			COMMUNITY HEALTH IMPROVEMENT
VERMONT CHAMBER FOUNDATION PO BOX 37 MONTPELIER, VT 05601	03-0335635	501(C)(3)	10,000.	0.			COMMUNITY HEALTH IMPROVEMENT
VERMONT FOUNDATION OF RECOVERY INC PO BOX 5490 ESSEX JUNCTION, VT 05453	46-4554970	501(C)(3)	100,000.	0.			COMMUNITY HEALTH IMPROVEMENT
VERMONT PROFESSIONALS OF COLOR NETWORK - 76 SAINT PAUL ST FL 7 - BURLINGTON, VT 05401	86-2667055	501(C)(3)	40,000.	0.			COMMUNITY HEALTH IMPROVEMENT
VERMONTERS FOR CRIMINAL JUSTICE REFORM - PO BOX 8753 - BURLINGTON, VT 05402	80-0906305	501(C)(3)	45,350.	0.			COMMUNITY HEALTH IMPROVEMENT
VT BUSINESS ROUNDTABLE 30 KIMBALL AVENUE, SUITE 300 SO. BURL., VT 05403	22-2867726	501(C)(3)	50,000.	0.			COMMUNITY HEALTH IMPROVEMENT
VT ETHICS NETWORK INC 61 ELM STREET MONTPELIER, VT 05601	03-0336174	501(C)(3)	20,000.	0.			COMMUNITY HEALTH IMPROVEMENT



**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
NURSING SCHOLARSHIPS	12	43,500.	0.		
ENDOWMENT SCHOLARSHIPS	7	8,000.	0.		
SOCIAL WORK INDIGENT NON-CASH	183	0.	268,218.	FMV	PHARMACEUTICALS, CREMATION SVCS, MEDICAL SUPPLIES, ETC.
ALLIED HEALTH SCHOLARSHIPS	10	68,300.	0.		

**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:

UNIVERSITY OF VERMONT MEDICAL CENTER, INC. (UVM MEDICAL CENTER) REQUIRES ITS GRANTEES TO PROVIDE SEMI-ANNUAL AND FINAL REPORTS WITH PERCENTAGES OF AWARD GOALS COMPLETED AS OF THE REPORT DATE.

SCHOLARSHIP MONITORING

THE ORGANIZATION REQUIRES STRICT APPLICATION AND APPROVAL CRITERIA FOR SCHOLARSHIP RECIPIENTS TO MAINTAIN THE INTEGRITY OF EACH RESPECTIVE AWARD.

**Part IV** Supplemental Information

NURSING SCHOLARSHIPS:

NURSING SCHOOL ASSISTANCE IS AWARDED TO APPLICANTS IN ORDER FOR THEM TO OBTAIN A DEGREE IN NURSING. FOR THE APPLICANT TO QUALIFY FOR THE SCHOLARSHIP, HE/SHE MUST AGREE TO USE IT TO HELP FURTHER UVM MEDICAL CENTER'S CHARITABLE STATUS. THIS IS DONE BY HAVING THE APPLICANT COMMIT TO TWO YEARS OF SERVICE AT THE ORGANIZATION AFTER SUCCESSFUL COMPLETION OF THE DEGREE PROGRAM. IN ADDITION, A WRITTEN PROPOSAL STATING HOW ATTAINMENT OF THE DEGREE WILL BENEFIT NURSING AT THE ORGANIZATION IS REQUIRED.

ALLIED HEALTH SCHOLARSHIPS:

ALLIED HEALTH SCHOLARSHIPS ARE AWARDED TO SUPPORT THE CAREER DEVELOPMENT OF UVM MEDICAL CENTER'S EMPLOYEES IN POSITION CATEGORIES WHERE CURRENT AND PROJECTED SHORTAGES EXIST. FOR THE APPLICANT TO QUALIFY FOR THE SCHOLARSHIP, THEY MUST BE AN EMPLOYEE OF UVM MEDICAL CENTER FOR ONE YEAR OR MORE, COMPLETE AN APPLICATION AND WRITTEN ESSAY, HAVE A HISTORY OF SOLID JOB PERFORMANCE, BE ACCEPTED INTO AN APPROVED ACADEMIC PROGRAM, AND PROVIDE TWO LETTERS OF RECOMMENDATION. ONCE THE SCHOLARSHIP IS AWARDED, RECIPIENTS MUST SIGN AN AGREEMENT TO WORK FOR UVM MEDICAL CENTER FOR A MINIMUM OF THREE YEARS UPON GRADUATION, TAKE A MINIMUM OF SIX CREDIT HOURS EACH SEMESTER, MAINTAIN HIGH GRADES, AND WORK A MINIMUM OF 20 HOURS PER WEEK.

SCHOLARSHIPS FROM THE NURSING EDUCATION ENDOWMENT FUND AND THE MARY FLETCHER HOSPITAL SCHOOL OF NURSING ALUMNI FUND:

ASSISTANCE FROM THE NURSING EDUCATION ENDOWMENT FUND IS AWARDED TO ELIGIBLE APPLICANTS GOING INTO THE NURSING FIELD. APPLICANTS MUST BE

**Part IV Supplemental Information**

EMPLOYED AT LEAST TWO YEARS AT UVM MEDICAL CENTER, WORK AT LEAST 40 HOURS PER PAY PERIOD, BE ENROLLED IN A NURSING CERTIFICATE, DEGREE OR DOCTORATE PROGRAM, AND HAVE NO CURRENT DISCIPLINARY ACTION IN THEIR FILE. DECISION TO APPROVE FUNDING IS BASED ON THE APPLICANT'S COMPLETED APPLICATION FORM, TWO LETTERS OF RECOMMENDATION, AND COMMITMENT TO TWO YEARS OF SERVICE AT UVM MEDICAL CENTER AFTER SUCCESSFUL COMPLETION OF THE DEGREE PROGRAM.

ASSISTANCE FROM THE MARY FLETCHER HOSPITAL SCHOOL OF NURSING ALUMNI FUND IS ALSO AWARDED TO ELIGIBLE APPLICANTS GOING INTO THE NURSING FIELD. APPLICANTS MUST BE ENROLLED IN EITHER A FORMAL OR CONTINUING EDUCATION PROGRAM RELATED TO SOME ASPECT OF HEALTH CARE (FOR EXAMPLE, HOLISTIC NURSING, CHILD-BIRTH EDUCATION, CHEMICAL DEPENDENCY, NURSE PRACTITIONER).

IN ADDITION, APPLICANTS MUST MEET THE FOLLOWING REQUIREMENTS: BE EMPLOYED BY UVM MEDICAL CENTER FOR AT LEAST ONE YEAR, AND PROVIDE A COMPLETED APPLICATION FORM, RESUME, WRITTEN ESSAY AND TWO LETTERS OF RECOMMENDATION.

SOCIAL WORK INDIGENT NON-CASH MONITORING COST ARE CATALOGUED AND TRACKED THROUGH A COORDINATED PROCESS THAT INCLUDES CASE MANAGEMENT AND FINANCIAL SPECIALISTS IN ORDER TO CONFIRM ELIGIBILITY OF RECIPIENTS AND COMPLIANCE WITH POLICY.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Employer identification number

03-0219309

**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
<b>1b</b>		X
<b>2</b>		X
<b>4a</b>	X	
<b>4b</b>	X	
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>	X	
<b>8</b>		X
<b>9</b>		

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) DR. JOHN BRUMSTED PRES/CEO OF UVMHN	(i)	1,089,798.	357,989.	650,567.	34,800.	31,914.	2,165,068.	330,450.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(2) ALFRED GOBEILLE EXEC VP NETWORK HOSP OPS	(i)	636,290.	162,500.	14,967.	88,738.	31,586.	934,081.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) DR. STEPHEN M. LEFFLER PRES & COO	(i)	604,319.	167,049.	91,977.	34,800.	29,244.	927,389.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) RICHARD VINCENT SVP/CFO (TIL 10/21); NTWK CFO	(i)	524,254.	127,181.	101,337.	26,100.	31,703.	810,575.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) DR. DOUGLAS GENTILE SVP, NETWORK IT	(i)	421,740.	114,312.	41,424.	64,196.	24,540.	666,212.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) JERALD NOVAK NETWORK CHIEF PEOPLE OFFICER	(i)	406,993.	107,555.	62,442.	20,300.	30,343.	627,633.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) ERIC MILLER, ESQ SVP, NETWORK GEN COUNSEL	(i)	395,098.	106,116.	30,275.	55,020.	24,434.	610,943.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) DR. ISABELLE DESJARDINS CHIEF MEDICAL OFFICER	(i)	416,256.	67,463.	64,747.	26,100.	31,493.	606,059.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(9) DIANA SCALISE SVP, HIGH VALUE CARE (TIL 6/22)	(i)	387,390.	99,484.	62,382.	26,100.	14,757.	590,113.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(10) DR. CLAUDE DESCHAMPS PRES/CEO OF UVMHN MG (TIL 9/21)	(i)	296,394.	146,877.	74,744.	26,100.	4,210.	548,325.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(11) CHARLES M. MICELI NETWORK CHIEF SUPPLY CHAIN	(i)	310,908.	146,952.	13,266.	26,100.	23,835.	521,061.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(12) DR. HOWARD M. SCHAPIRO SVP CHIEF POP HEAL & QUAL (TIL 6/21)	(i)	439,181.	0.	36,990.	24,314.	12,589.	513,074.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(13) LISA L. GOODRICH VP MEDICAL GROUP OPS	(i)	363,140.	54,946.	8,254.	34,800.	31,248.	492,388.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(14) REBECCA FREEMAN NETWORK VP HEALTH INFORMATICS	(i)	317,942.	88,000.	5,270.	20,300.	23,919.	455,431.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(15) RAY KELLER NETWORK CHIEF MEDICAL INFO	(i)	348,910.	51,057.	9,866.	34,800.	4,569.	449,202.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(16) MARY BROADWORTH VP, HUMAN RESOURCES	(i)	340,698.	52,500.	5,370.	5,226.	31,560.	435,354.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC 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				
(17) MARC STANISLAS NETWORK VP TREASURY & FIN	(i)	281,494.	45,050.	25,769.	26,100.	32,758.	411,171.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(18) MARGARET GAGNE CHIEF NURSING OFFICER	(i)	264,581.	37,001.	32,116.	33,269.	26,368.	393,335.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(19) CHRISTINA OLIVER VP CLINICAL SERVICES	(i)	266,825.	43,223.	27,734.	32,501.	22,713.	392,996.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(20) THERESA ALBERGHINI DIPALMA NETWORK SVP EXTERN RELAT (TIL 6/21)	(i)	164,601.	0.	146,830.	14,814.	11,698.	337,943.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(21) ADAM P. BUCKLEY FMR NETWORK CIO	(i)	0.	0.	271,134.	0.	0.	271,134.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(22) TODD KEATING FMR NETWORK CFO	(i)	167,192.	0.	28,942.	15,047.	1,236.	212,417.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(23) LAURIE A. GUNN FMR VP EMPL PAT & FAM EXP	(i)	0.	0.	192,004.	0.	0.	192,004.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(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.

## SCHEDULE J, PART I, QUESTION 1A

## PERSONAL SERVICE COMPENSATION

CERTAIN UVM MEDICAL CENTER OFFICERS, TRUSTEES, KEY EMPLOYEES, AND  
HIGHLY COMPENSATED EMPLOYEES RECIEVED COMPENSATION OF \$1,400 TO COVER  
TAX PREPARATION AND FINANCIAL ADVISORY SERVICES. WHILE THERE IS NO  
ORGANIZATION-WIDE WRITTEN POLICY REGARDING SUCH PAYMENTS, THE AMOUNT IS  
INCLUDED IN EACH INDIVIDUAL'S EMPLOYMENT CONTRACT, WHICH IS SUBJECT TO  
ANNUAL REVIEW (AS DISCUSSED IN SCHEDULE O). PERSONAL SERVICE  
COMPENSATION IS INCLUDED IN EACH INDIVIDUAL'S 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.

## COMPENSATION DETERMINATION

## SCHEDULE J, PART I, QUESTION 3

THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. ("UVM MEDICAL CENTER")  
RELIED ON UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK"),  
THE PARENT ORGANIZATION OF UVM MEDICAL CENTER, TO ESTABLISH SENIOR  
EXECUTIVE 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.

UVM HEALTH NETWORK UTILIZED THE FOLLOWING METHODS TO ESTABLISH

COMPENSATION:

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

PART I, LINE 4A

FORMER NETWORK CIO ADAM BUCKLEY ENTERED INTO A SEPARATION AGREEMENT  
 EFFECTIVE 7/2020 UNDER WHICH HE RECEIVED A LUMP SUM PAYMENT REFLECTED  
 IN THE AMOUNT REPORTED IN PART II, COL(B)(III), 12 MONTHS CONTINUATION  
 OF BASE SALARY, AND CONTINUATION OF CERTAIN HEALTH BENEFITS. PAYMENTS  
 MADE UNDER THIS AGREEMENT ARE INCLUDED IN THE AMOUNTS REPORTED HEREIN.

FORMER VP AND CHIEF EXPERIENCE OFFICER LAURIE GUNN ENTERED INTO A  
 SEPARATION AGREEMENT EFFECTIVE 7/2020 UNDER WHICH SHE RECEIVED 12  
 MONTHS CONTINUATION OF BASE SALARY AND CONTINUATION OF CERTAIN HEALTH  
 BENEFITS. PAYMENTS MADE UNDER THIS AGREEMENT ARE INCLUDED IN THE



**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.

**AMOUNTS REPORTED HEREIN.**

FORMER NETWORK SVP, EXTERNAL RELATIONS THERESA ALBERGHINI DIPALMA ENTERED INTO AN AGREEMENT EFFECTIVE 6/2021 UNDER WHICH SHE RECEIVED CONTINUATION OF BASE SALARY THROUGH 9/30/2021 AND CONTINUATION OF CERTAIN HEALTH BENEFITS. PAYMENTS MADE UNDER THIS AGREEMENT ARE INCLUDED IN THE AMOUNTS REPORTED HEREIN.

NETWORK SVP, HIGH VALUE CARE DIANA SCALISE ENTERED INTO A SEVERANCE AGREEMENT EFFECTIVE 6/2022 UNDER WHICH SHE RECEIVED 12 MONTHS CONTINUATION OF BASE SALARY PLUS CONTINUATION OF CERTAIN HEALTH BENEFITS. PAYMENTS MADE UNDER THIS AGREEMENT WERE MADE IN THE 2022 CALENDAR YEAR AND ARE THEREFORE NOT INCLUDED IN THE AMOUNTS REPORTED HEREIN.

**SCHEDULE J, PART I, QUESTION 4B**

THE UNIVERSITY OF VERMONT HEALTH NETWORK, BY AND THROUGH ITS AFFILIATED SUBSIDIARIES, MAINTAINS A SUPPLEMENTAL RETIREMENT BENEFIT PLAN (SRP) UNDER CONTRACTUAL ARRANGEMENTS WITH SEVERAL PERSONS LISTED

**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.

ON FORM 990, PART VII, SECTION A, LINE 1A. PURSUANT TO THE TERMS OF THE SRP, ANNUAL CREDITS WERE MADE EQUAL TO A FIXED PERCENTAGE OF BASE SALARY. THE FOLLOWING PERSONS PARTICIPATED IN THE SRP IN CALENDAR YEAR 2021, AND THEIR RESPECTIVE FIXED PERCENTAGE IS DESIGNATED IN PARENTHESES; ALFRED GOBEILLE (10.95%); ERIC MILLER (8.68%); AND DOUGLAS GENTILE (8.68%). DEFERRED AMOUNTS VEST ON THE EARLIER OF: (I) JANUARY 1 OF THE THIRD PLAN YEAR AFTER THE PLAN YEAR FOR WHICH THE ACCOUNT WAS CREATED; OR (II) THE PARTICIPANT'S 65TH BIRTHDAY.

UNTIL 9/31/2021, THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. MAINTAINED A SEPARATE SRP PURSUANT TO A CONTRACTUAL ARRANGMENT WITH NETWORK PRESIDENT AND CEO JOHN BRUMSTED, UNDER WHICH UVM MEDICAL CENTER MADE ANNUAL CREDITS EQUAL TO 15% OF THE CEO'S BASE SALARY. UPON TERMINATION OF THE SRP, DR. BRUMSTED RECEIVED A DISTRIBUTION INCLUDED IN SCH J, PART II, COLUMN B(III).

FOR THE PLANS NOTED ABOVE, 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 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.

**NON-FIXED PAYMENTS**

**SCHEDULE J, PART I, QUESTION 7**

**UVM MEDICAL CENTER PAID AWARDS TO CERTAIN MEMBERS OF UPPER MANAGEMENT**

**(DIRECTORS, VICE PRESIDENTS, PHYSICIAN CHAIRS AND SENIOR EXECUTIVES)**

**THROUGH ITS ANNUAL VARIABLE PAY PLAN AS THE PLAN'S PERFORMANCE MEASURES**

**WERE MET. 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.**

**Supplemental Information on Tax-Exempt Bonds**

ENTITY 1

OMB No. 1545-0047

▶ **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](http://www.irs.gov/Form990) for instructions and the latest information.**

**2021**  
**Open to Public Inspection**

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

<b>Part I Bond Issues</b>											
<b>SEE PART VI FOR COLUMN (F) CONTINUATIONS</b>											
(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
<b>A</b> VEBFA SERIES 2008A & SERIES 2004B	23-7154467	924166CJ8	05/21/08	215386067.	REFUND BONDS ISSUED 4/15/2004		X		X		X
<b>B</b> VEBFA SERIES 2016A	23-7154467	924166HJ3	02/03/16	203831137.	REFUND BONDS ISSUED 4/15/04, 1/		X		X		X
<b>C</b> VEBFA SERIES 2015A	23-7154467	000000000	01/08/15	23840000.	REFUND BONDS ISSUED 4/15/2004		X		X		X
<b>D</b> VEBFA SERIES 2013A	23-7154467	000000000	03/05/13	29500000.	REFUND BONDS ISSUED 2000		X		X		X

<b>Part II Proceeds</b>										
	A		B		C		D			
<b>1</b> Amount of bonds retired	22,981,067.		21,615,000.		14,910,000.		3,087,500.			
<b>2</b> Amount of bonds legally defeased	137,700,000.									
<b>3</b> Total proceeds of issue	215,386,067.		203,852,365.		23,840,000.		29,500,000.			
<b>4</b> Gross proceeds in reserve funds										
<b>5</b> Capitalized interest from proceeds										
<b>6</b> Proceeds in refunding escrows										
<b>7</b> Issuance costs from proceeds	8,880,529.		1,915,049.		183,840.		263,962.			
<b>8</b> Credit enhancement from proceeds	24,978.									
<b>9</b> Working capital expenditures from proceeds										
<b>10</b> Capital expenditures from proceeds			5,893,332.							
<b>11</b> Other spent proceeds	213,225,000.		250,340,345.		23,656,160.		29,236,038.			
<b>12</b> Other unspent proceeds										
<b>13</b> Year of substantial completion	2005		2005		1985		2005			
	Yes	No	Yes	No	Yes	No	Yes	No		
<b>14</b> 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		X		X		X			
<b>15</b> Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X	X			X			X	
<b>16</b> Has the final allocation of proceeds been made?	X		X		X		X			
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X			

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

Schedule K (Form 990) 2021

**Supplemental Information on Tax-Exempt Bonds**

ENTITY 2

OMB No. 1545-0047

▶ **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](http://www.irs.gov/Form990) for instructions and the latest information.**

**2021**  
**Open to Public Inspection**

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

Part I	Bond Issues	SEE PART VI FOR COLUMN (F) 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	VEHBFA SERIES 2016B	23-7154467	924166JA0	07/28/16	101572833.	CONSTRUCTION INPATIENT BED TOW		X		X		X	
B													
C													
D													

Part II	Proceeds	A		B		C		D	
1	Amount of bonds retired								
2	Amount of bonds legally defeased								
3	Total proceeds of issue	101,844,192.							
4	Gross proceeds in reserve funds								
5	Capitalized interest from proceeds	7,305,877.							
6	Proceeds in refunding escrows								
7	Issuance costs from proceeds	366,636.							
8	Credit enhancement from proceeds								
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	94,136,912.							
11	Other spent proceeds								
12	Other unspent proceeds								
13	Year of substantial completion	2019							
		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							

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

Schedule K (Form 990) 2021

**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		X				
2 Are there any lease arrangements that may result in private business use of bond-financed property? .....		X		X				
3a Are there any management or service contracts that may result in private business use of bond-financed property? .....	X		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?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property? .....		X		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		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		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		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			X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet? .....				X		X		X
b Exception to rebate? .....				X	X		X	
c No rebate due? .....			X			X		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			X		X		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						

Part IV Arbitrage (continued)

Table with 4 main columns (A, B, C, D) and 2 sub-columns (Yes, No). Rows include questions about qualified hedge with respect to the bond issue, name of provider (CITIBANK), term of hedge (14.1000000), superintegrated status, terminated status, gross proceeds invested in a GIC, regulatory safe harbor, and written procedures to monitor requirements of section 148.

Part V Procedures To Undertake Corrective Action

Table with 4 main columns (A, B, C, D) and 2 sub-columns (Yes, No). Row includes question about written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program.

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

Multiple horizontal lines for providing supplemental information.



**Part IV Arbitrage** (continued)

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

**Part V Procedures To Undertake Corrective Action**

	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: VEHBFA SERIES 2016A  
 (F) DESCRIPTION OF PURPOSE: REFUND BONDS ISSUED 4/15/04,1/25/07

(A) ISSUER NAME: VEHBFA SERIES 2016B  
 (F) DESCRIPTION OF PURPOSE: CONSTRUCTION INPATIENT BED TOWER

**SCHEDULE K, PART IV, ARBITRAGE, LINE 2C:**

(A) ISSUER NAME: VEHBFA SERIES 2016A  
 DATE THE REBATE COMPUTATION WAS PERFORMED: 02/03/2021

(A) ISSUER NAME: VEHBFA SERIES 2016B  
 DATE THE REBATE COMPUTATION WAS PERFORMED: 07/28/2021

**PARTS I & II DIFFERENCE IN ISSUE PRICE AND PROCEEDS**  
 BOND SERIES 2016A ISSUE PRICE \$203,831,137 DIFFERS FROM PART II TOTAL PROCEEDS \$203,852,365 AS A RESULT OF INVESTMENT EARNINGS.

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

BOND SERIES 2016B ISSUE PRICE \$101,572,833 DIFFERS FROM PART II TOTAL PROCEEDS \$101,844,192 AS A RESULT OF INVESTMENT EARNINGS.

PART III, LINES 4-6

2016A ISSUANCE: THE 2016A BONDS WERE OBTAINED TO REFUND BOTH THE 2004B AND 2007A BOND ISSUANCES. REFUNDING ESCROWS WERE SET UP INDIVIDUALLY. THE 2007A SERIES BONDS WERE COMPLETELY PAID OFF IN FY17. THE 2004B SERIES WERE COMPLETELY PAID OFF IN FY18.

2016B ISSUANCE: EQUITY IS PRESENT IN THE PROJECT AND IS FIRST DIRECTED TO PRIVATE BUSINESS USE.

**SCHEDULE L**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Transactions With Interested Persons**

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

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

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

OMB No. 1545-0047

**2021**

**Open To Public Inspection**

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

**Part I Excess Benefit Transactions** (section 501(c)(3), section 501(c)(4), and section 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

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

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

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

**Part II Loans to and/or From Interested Persons.**

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
<b>Total</b> .....						▶ \$ _____						

**Part III Grants or Assistance Benefiting Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

**Part IV Business Transactions Involving Interested Persons.**

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
MARIA MCCLELLAN	FAMILY MEMBER OF OF	179,142.	COMPENSATIO		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	1,156,642.	LEGAL SERVI		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	997,081.	LEGAL SERVI		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	9,135,349.	CONSULTING		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	112,152.	CONSTRUCTIO		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	610,850.	CONSTRUCTIO		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	770,515.	REAL PROPER		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	231,588.	CONSTRUCTIO		X
SUBSTANTIAL CONTRIBUTOR	SUBSTANTIAL CONTRIB	345,303.	CONSTRUCTIO		X

**Part V Supplemental Information.**

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: MARIA MCCLELLAN

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF OFFICER AND TRUSTEE

(D) DESCRIPTION OF TRANSACTION: COMPENSATION FOR EMPLOYMENT

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: LEGAL SERVICES

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: LEGAL SERVICES

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

**Part V** Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions).

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: CONSTRUCTION

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: CONSTRUCTION

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: REAL PROPERTY LEASING

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: CONSTRUCTION

(A) NAME OF PERSON: SUBSTANTIAL CONTRIBUTOR

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

SUBSTANTIAL CONTRIBUTOR

(D) DESCRIPTION OF TRANSACTION: CONSTRUCTION

**SCHEDULE M  
(Form 990)**

**Noncash Contributions**

OMB No. 1545-0047

**2021**

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

- ▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
- ▶ Attach to Form 990.
- ▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

**Part I Types of Property**

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications	X		46 . COST	
5 Clothing and household goods	X		6,378 . COST	
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded	X	12	77,811 . MARKET VALUE	
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ( GIFT CERTIFIC )	X	34	13,259 . COST	
26 Other ( )				
27 Other ( )				
28 Other ( )				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part V, Donee Acknowledgement **29** **0**

	Yes	No
30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?		X
b If "Yes," describe the arrangement in Part II.		
31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	X	
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		X
b If "Yes," describe in Part II.		
33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.		

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule M (Form 990) 2021

**Part II** **Supplemental Information.** Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

SCHEDULE M, LINE 33:

SCHEDULE M, PART I, COLUMN B

UNIVERSITY OF VERMONT MEDICAL CENTER, INC. (UVM MEDICAL CENTER) IS REPORTING THE TOTAL NUMBER OF CONTRIBUTIONS.

**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](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2021**

Open to Public  
Inspection

Name of the organization

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

EDUCATION, AND RESEARCH IN A CARING ENVIRONMENT.

NUMBER OF VOLUNTEERS

FORM 990, PART I, LINE 6

THE TOTAL NUMBER OF VOLUNTEERS INCLUDES NON-COMPENSATED MEMBERS OF THE BOARD OF TRUSTEES. IN ADDITION, VOLUNTEERS WORK IN OVER 50 DEPARTMENTS TO SUPPORT THE WORK OF EMPLOYEES TO MEET PATIENT NEEDS AND ENHANCE THE PATIENT EXPERIENCE AT THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. (UVM MEDICAL CENTER).

COMMUNITY BENEFIT REPORT

FORM 990, PART III

UVM MEDICAL CENTER IS BOTH A COMMUNITY HOSPITAL AND, IN PARTNERSHIP WITH THE UNIVERSITY OF VERMONT, THE STATE'S ONLY ACADEMIC MEDICAL CENTER. IT IS OUR MISSION TO IMPROVE THE HEALTH OF THE PEOPLE IN THE COMMUNITIES WE SERVE BY INTEGRATING PATIENT CARE, EDUCATION AND RESEARCH IN A CARING ENVIRONMENT.

IN ITS COMMUNITY HOSPITAL ROLE, UVM MEDICAL CENTER SERVES APPROXIMATELY 168,000 RESIDENTS IN CHITTENDEN AND GRAND ISLE COUNTIES AND PROVIDES PRIMARY CARE SERVICES AT ELEVEN VERMONT SITES. THE ORGANIZATION ALSO OFFERS FREE TO THE COMMUNITY A WIDE RANGE OF HEALTH, PREVENTION AND WELLNESS PROGRAMS, ALL OF WHICH HELP TO LIMIT THE NEED FOR MORE EXPENSIVE ACUTE CARE.



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THROUGH A VITAL PARTNERSHIP, UVM MEDICAL CENTER, THE UNIVERSITY OF VERMONT COLLEGE OF MEDICINE AND THE UNIVERSITY OF VERMONT COLLEGE OF NURSING AND HEALTH SCIENCES FORM VERMONT'S ACADEMIC MEDICAL CENTER - ONE OF ONLY APPROXIMATELY 130 SUCH CENTERS IN THE COUNTRY. TOGETHER, THESE INSTITUTIONS ARE COMMITTED TO HELPING IMPROVE OUR REGION'S QUALITY OF LIFE WITH INNOVATIONS IN MEDICINE AND HEALTH CARE THAT ARISE FROM NEW KNOWLEDGE AND DISCOVERY. THROUGH ITS ALLIANCE WITH THE UNIVERSITY OF VERMONT, UVM MEDICAL CENTER IS ABLE TO PROVIDE THE BEST PATIENT CARE POSSIBLE BY BRINGING MEDICAL EDUCATION AND RESEARCH TO THE BEDSIDE, THE DOCTOR'S OFFICE AND INTO THE COMMUNITY.

AS A REGIONAL REFERRAL CENTER, UVM MEDICAL CENTER PROVIDES ADVANCED-LEVEL CARE TO A POPULATION OF APPROXIMATELY ONE MILLION PEOPLE THROUGHOUT VERMONT AND NORTHERN NEW YORK. THE MEDICAL CENTER EXTENDS BEYOND ITS THREE MAIN CAMPUSES IN THE BURLINGTON AREA TO INCLUDE MORE THAN 30 PATIENT CARE SITES AND 68 OUTREACH CLINICS, PROGRAMS AND SERVICES THROUGHOUT THE REGION. THE UVM MEDICAL CENTER'S MILLER BUILDING OPENED ON JUNE 1, 2019, AND IS PLAYING A BIG ROLE IN ACHIEVING THE GOAL OF ENHANCING CARE FOR THE COMMUNITY BY PROVIDING 128 SINGLE-BED ROOMS AND FACILITATING THE CREATION OF MANY MORE PRIVATE ROOMS THROUGHOUT THE HOSPITAL. EVIDENCE-BASED STUDIES SHOW THAT PRIVATE ROOMS WITH AMPLE ROOM FOR FAMILIES CAN PROMOTE BETTER HEALING, REDUCE MEDICAL ERRORS, IMPROVE SLEEP QUALITY AND FACILITATE GREATER INVOLVEMENT OF FAMILIES AND CARE TEAMS.

THE NEW SPACE WAS DESIGNED WITH INPUT FROM FORMER PATIENTS AND FAMILIES. IT BRINGS CAREGIVERS CLOSER TO THEIR PATIENTS, AND SUPPORTS THE COLLABORATIVE MODEL OF PATIENT-AND FAMILY-CENTERED CARE.

Name of the organization THE UNIVERSITY OF VERMONT MEDICAL CENTER	Employer identification number 03-0219309
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EACH OF THESE RESPONSIBILITIES IS EQUALLY IMPORTANT IN FULFILLING UVM MEDICAL CENTER'S MISSION.

1. PATIENT CARE - SERVING A POPULATION OF APPROXIMATELY ONE MILLION THROUGHOUT VERMONT AND NORTHERN NEW YORK, UVM MEDICAL CENTER PROVIDES A FULL RANGE OF SERVICES COVERING EVERY MAJOR AREA OF MEDICINE. THE MEDICAL CENTER AVERAGES MORE THAN A MILLION PATIENT VISITS EACH YEAR, INCLUDING INPATIENT, OUTPATIENT, EMERGENCY DEPARTMENT AND PHYSICIAN OFFICE VISITS. UVM MEDICAL CENTER IS AT THE LEADING EDGE OF HEALTH CARE INNOVATIONS, INCLUDING HAVING IMPLEMENTED A SYSTEM-WIDE ELECTRONIC HEALTH RECORD THAT SUPPORTS IMPROVED HEALTH CARE FOR OUR COMMUNITIES AND SERVING AS ONE OF THE FIRST TWO PILOT SITES FOR THE VERMONT BLUEPRINT FOR HEALTH, A STATEWIDE PUBLIC/PRIVATE PARTNERSHIP FOCUSED ON ENSURING THAT ALL VERMONTERS HAVE ACCESS TO PRIMARY CARE SERVICES USING THE "PATIENT-CENTERED MEDICAL HOME" CARE DELIVERY MODEL. IN LINE WITH THE BLUEPRINT, UVM MEDICAL CENTER HAS IMPLEMENTED A COMMUNITY HEALTH TEAM TO SERVE ALL OF OUR PRIMARY CARE PRACTICES, ALL OF WHICH HAVE BEEN RECOGNIZED BY THE NATIONAL COMMITTEE ON QUALITY ASSURANCE AS PATIENT-CENTERED MEDICAL HOMES.

2. EDUCATION - AS AN ACADEMIC MEDICAL CENTER, WE HAVE THE SPECIAL RESPONSIBILITY OF EDUCATING THE NEXT GENERATION OF DOCTORS, NURSES AND ALLIED HEALTH PROFESSIONALS. THE VAST MAJORITY OF UVM MEDICAL CENTER DOCTORS NOT ONLY TAKE CARE OF PATIENTS, THEY ALSO TEACH MEDICAL STUDENTS THROUGH THEIR POSITIONS AS MEMBERS OF THE UNIVERSITY OF VERMONT COLLEGE OF MEDICINE FACULTY. A NUMBER OF UVM MEDICAL CENTER NURSES AND ALLIED HEALTH PROFESSIONALS ALSO TEACH AT THE UNIVERSITY OF

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VERMONT COLLEGE OF NURSING AND HEALTH SCIENCES.

UVM MEDICAL CENTER SERVES AS THE CLINICAL TRAINING SITE FOR THE MEDICAL STUDENTS AND NURSING AND ALLIED HEALTH STUDENTS WHO ATTEND THE UNIVERSITY OF VERMONT. ADDITIONALLY, UVM MEDICAL CENTER IS THE TRAINING SITE FOR RESIDENTS AND FELLOWS. PATIENTS BENEFIT FROM HAVING RESIDENTS, MEDICAL STUDENTS AND NURSING AND ALLIED HEALTH STUDENTS AS PART OF THEIR CARE TEAM.

IN COLLABORATION WITH THE UNIVERSITY OF VERMONT, UVM MEDICAL CENTER CONTINUES TO USE THE DEVELOPMENT OF A SIMULATION CENTER THAT INCLUDES 9,000 SQUARE FEET OF TEACHING SPACE WITH FULLY-FUNCTIONING HOSPITAL ROOMS AND HIGH-TECH MANNEQUINS THAT SIMULATE ALL KINDS OF DISEASES AND INJURIES. THE SIMULATION CENTER ALSO HAS HANDS-ON LABS FOR SKILL-BUILDING AS WELL AS A VIRTUAL REALITY TRAINER THAT IMPROVES ON OLD TEACHING METHODS. IN ADDITION TO BEING USED TO TRAIN FUTURE DOCTORS AND NURSES, THE NEW FACILITY IS OPEN TO ALL VERMONT MEDICAL PROFESSIONALS, INCLUDING EMERGENCY MEDICAL TECHNICIANS AND VERMONT NATIONAL GUARD MEDICS.

3. RESEARCH - A CORE MISSION OF THE ACADEMIC MEDICAL CENTER IS TO ADVANCE MEDICAL KNOWLEDGE THROUGH RESEARCH, SO IN ADDITION TO TEACHING AND TRAINING, MANY OF OUR PHYSICIANS, NURSES AND OTHER PROVIDERS ENGAGE IN BIOMEDICAL RESEARCH, SEEKING NEW CURES AND MORE EFFECTIVE TREATMENTS. THERE ARE OVER 1,000 ACTIVE CLINICAL TRIALS AT THE UNIVERSITY OF VERMONT AND UVM MEDICAL CENTER. CLINICAL TRIALS ARE RESEARCH STUDIES CONDUCTED USING VOLUNTEERS. EACH STUDY ANSWERS SCIENTIFIC QUESTIONS AND TRIES TO FIND BETTER WAYS TO PREVENT, SCREEN

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FOR, DIAGNOSE, OR TREAT A DISEASE. THIS ACTIVE RESEARCH PROGRAM HAS A DIRECT BENEFIT TO PATIENTS AT UVM MEDICAL CENTER, WHO HAVE ACCESS TO THE LATEST TREATMENTS AND TECHNOLOGY AND WHO ARE CARED FOR BY SOME OF THE LEADING EXPERTS IN THEIR FIELD. THE ACADEMIC MEDICAL CENTER IS ALSO ACTIVELY ENGAGED IN POPULATION-BASED HEALTH RESEARCH, INCLUDING EVALUATING VERMONT BLUEPRINT FOR HEALTH PILOT PROJECTS INVOLVING THE DEVELOPMENT AND IMPACT OF PATIENT-CENTERED MEDICAL HOMES WITHIN THE STATE.

4. COMMUNITY BENEFIT - IN ADDITION TO DELIVERING HEALTH CARE, EDUCATING HEALTH CARE PROFESSIONALS, AND RESEARCHING NEW KNOWLEDGE, UVM MEDICAL CENTER ALSO LIVES ITS MISSION - TO IMPROVE THE HEALTH OF THE PEOPLE IN THE COMMUNITIES IT SERVES - BY REACHING OUT TO HELP PEOPLE TAKE CARE OF THEIR HEALTH. THESE EFFORTS INCLUDE, BUT ARE NOT LIMITED TO:

COMMUNITY WELLNESS AND EDUCATION - UVM MEDICAL CENTER OFFERS NUMEROUS FREE HEALTH EDUCATION CLASSES, IN WHICH HEALTH PROFESSIONALS PROVIDE INFORMATION ON A VARIETY OF TOPICS. MANY OTHER HEALTH AND WELLNESS PROGRAMS OFFERED THROUGHOUT THE YEAR SERVE AS A VALUABLE RESOURCE TO OUR COMMUNITY, RANGING FROM CHILD PASSENGER CAR SEAT SAFETY CHECKS TO FREE BLOOD PRESSURE SCREENINGS, TOBACCO CESSATION CLASSES, AND WORKSHOPS FOR SENIORS.

FRYMOYER COMMUNITY HEALTH RESOURCE CENTER - PATIENTS, FAMILIES AND THE PUBLIC ARE MORE INTERESTED THAN EVER IN GAINING ACCESS TO THE LATEST HEALTH INFORMATION AVAILABLE. THE FRYMOYER COMMUNITY HEALTH RESOURCE CENTER AT UVM MEDICAL CENTER OFFERS THE COMMUNITY EASY, FREE, GUIDED ACCESS TO THE BEST INFORMATION ABOUT HEALTH AND MEDICINE.

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COLLABORATIVE EFFORTS - UVM MEDICAL CENTER REGULARLY PARTNERS WITH OTHER ORGANIZATIONS AND PROVIDERS TO HELP MEET THE NEEDS OF OUR COMMUNITY. THIS INCLUDES WORKING WITH OTHER ORGANIZED SYSTEMS OF CARE (SUCH AS HOME HEALTH AGENCIES, OTHER VERMONT HOSPITALS, AND PHYSICIAN PRACTICES), AS WELL AS COMMUNITY-BASED ORGANIZATIONS WHOSE MISSIONS ARE SIMILAR TO OURS. FOR EXAMPLE, UVM MEDICAL CENTER COLLABORATES WITH COMMUNITY PARTNERS TO REGULARLY ASSESS COMMUNITY AND HEALTH CARE NEEDS, WHICH HELPS GUIDE OUR ORGANIZATION'S PRIORITIES.

OUR COMMUNITY BENEFITS FALL INTO FOUR GENERAL CATEGORIES:

\*DIRECT FINANCIAL ASSISTANCE TO PATIENTS. THIS REPRESENTS FREE CARE GIVEN TO PATIENTS WHO QUALIFY UNDER UVM MEDICAL CENTER'S "PATIENT ASSISTANCE PROGRAM" POLICY. THAT POLICY OFFERS FREE CARE TO PATIENTS UNDER 200% OF THE FEDERAL POVERTY LEVEL (FPL), WITH PATIENTS BETWEEN 200% AND 400% FPL PAYING A SLIDING-SCALE DEDUCTIBLE ONLY. FOR THE PRESENT YEAR, THIS AMOUNT WAS CALCULATED AT APPROXIMATELY \$13.2 MILLION IN ACTUAL COSTS (NOT CHARGES) (SEE SCHEDULE H, LINE 7A, COLUMN E).

\*SUBSIDIZED PROGRAMS. THESE INCLUDE RESEARCH ACTIVITIES AND EDUCATION AND TRAINING PROGRAMS FOR HEALTH PROFESSIONALS THAT ARE NOT FULLY REIMBURSED THROUGH OTHER MEANS, AS WELL AS SUBSIDIES TO SUPPORT HEALTH SERVICES THAT BENEFIT OUR COMMUNITY, INCLUDING THE UNINSURED AND LOW-INCOME INDIVIDUALS. THOSE SERVICES INCLUDE MENTAL HEALTH SERVICES, EMERGENCY SERVICES AND CRITICAL CARE TRANSPORTATION SERVICES. FOR THE PRESENT YEAR, THESE SUBSIDIES WERE CALCULATED AT APPROXIMATELY \$57.4 MILLION IN COMMUNITY BENEFIT (SEE SCHEDULE H, LINE 7G, COLUMN E).

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\*COMMUNITY PROGRAMS AND DIRECT GRANTS. THESE INCLUDE, FOR EXAMPLE, COMMUNITY HEALTH SERVICES (HEALTH EDUCATION CLASSES, SUPPORT GROUPS, SCREENING SERVICES, FREE CLINICS, ETC.), FINANCIAL CONTRIBUTIONS AND IN-KIND DONATIONS (CASH DONATIONS, GRANTS, IN-KIND SUPPORT SUCH AS MEETING ROOMS, PARKING VOUCHERS, ETC.), COMMUNITY-BUILDING AND LEADERSHIP ACTIVITIES (INCLUDING ADVOCACY FOR COMMUNITY HEALTH IMPROVEMENT, ECONOMIC DEVELOPMENT, AND ENVIRONMENTAL IMPROVEMENTS), AND COMMUNITY BENEFIT OPERATIONS (INCLUDING COSTS ASSOCIATED WITH THE OFFICE OF COMMUNITY HEALTH IMPROVEMENT, COMMUNITY NEEDS ASSESSMENTS, ETC.). THE PRESENT YEAR, THE VALUE OF THESE COMMUNITY PROGRAMS AND GRANTS WERE CALCULATED AT \$6.4 MILLION (SEE SCHEDULE H, LINE 7E AND 7I, COLUMN E).

\*MEDICAID AND OTHER PUBLIC PROGRAM UNDERPAYMENTS. THESE INCLUDE UNDERPAYMENTS FROM VERMONT'S MEDICAID PROGRAM AS WELL AS SEVERAL SMALLER PUBLIC PROGRAMS (FOR EXAMPLE, LADIES FIRST). THESE DO NOT INCLUDE ANY UNDERPAYMENTS BY MEDICARE. FOR THE PRESENT YEAR, THIS AMOUNT WAS CALCULATED AT \$175.7 MILLION (SEE SCHEDULE H, LINE 7B, COLUMN E).

TOTAL NET COMMUNITY BENEFIT SPENDING IN FY 2022 WAS \$279.1 MILLION. THIS REPRESENTS APPROXIMATELY 14.6% OF UVM MEDICAL CENTER'S TOTAL PROGRAM SERVICE EXPENSE AS REPORTED ON THIS RETURN (SEE SCHEDULE H, LINE 7K, COLUMN F).

ORGANIZATION'S MISSION

FORM 990, PART III, LINE 1

ACADEMIC MEDICAL CENTER AND COMMUNITY HOSPITAL. MISSION: TO IMPROVE THE HEALTH OF THE PEOPLE IN THE COMMUNITIES WE SERVE BY INTEGRATING PATIENT

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CARE, EDUCATION, AND RESEARCH IN A CARING ENVIRONMENT.

VISION: WORKING TOGETHER, WE IMPROVE PEOPLE'S LIVES.

STATEMENT OF VALUES:

\*WE RESPECT THE DIGNITY OF ALL INDIVIDUALS AND ARE RESPONSIVE TO THEIR PHYSICAL, EMOTIONAL, SPIRITUAL AND SOCIAL NEEDS AND CULTURAL DIVERSITY.

\*WE ARE JUST AND PRUDENT STEWARDS OF LIMITED NATURAL AND FINANCIAL RESOURCES.

\*WE FOSTER A CLIMATE WHICH ENCOURAGES BOTH THOSE RECEIVING AND PROVIDING CARE TO MAKE RESPONSIBLE CHOICES.

\*WE STRIVE FOR EXCELLENCE IN QUALITY AND CARE AND SEEK TO CONTINUOUSLY LEARN AND IMPROVE.

\*WE ACKNOWLEDGE A PARTNERSHIP WITH THE COMMUNITY TO ENSURE THE BEST POSSIBLE CARE AT THE RIGHT TIME, IN THE RIGHT PLACE, AND BY THE RIGHT PROVIDER.

\*WE ARE CARING AND COMPASSIONATE TO EACH OTHER AND TO THOSE WE SERVE.

\*WE COMMUNICATE OPENLY AND HONESTLY WITH THE COMMUNITY WE SERVE.

PROGRAM SERVICE ACCOMPLISHMENTS

FORM 990, PART III, LINE 4A-4C

THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC. (UVM MEDICAL CENTER) IS A TERTIARY CARE TEACHING HOSPITAL THAT, IN AFFILIATION WITH THE UNIVERSITY OF VERMONT, SERVES AS VERMONT'S ONLY ACADEMIC MEDICAL CENTER. AS ARTICULATED IN OUR MISSION STATEMENT, OUR FOCUS IS ON IMPROVING THE HEALTH OF THE PEOPLE IN THE COMMUNITIES WE SERVE BY INTEGRATING PATIENT CARE, EDUCATION, AND RESEARCH IN A CARING ENVIRONMENT. THESE EFFORTS ARE RECOGNIZED IN OUR 501(C)(3) STATUS AS A

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CHARITABLE AND EDUCATIONAL ORGANIZATION.

AS A CHARITABLE ORGANIZATION, THE PROMOTION OF HEALTH THROUGH OUR ACADEMIC MISSION - HEALTH CARE DELIVERY, RESEARCH AND EDUCATION - IS OUR PRIMARY WORK. IN ADDITION TO THE COMMUNITY BENEFITS WE PROVIDE, UVM MEDICAL CENTER OFFERS THE BROAD RANGE AND SCOPE OF SERVICES NECESSARY TO ACHIEVE THAT GOAL. THIS INCLUDES A FULL-TIME EMERGENCY DEPARTMENT THAT IS CERTIFIED AS A LEVEL 1 TRAUMA CENTER BY THE AMERICAN COLLEGE OF SURGEONS, AS WELL AS NON-EMERGENCY SERVICES, ALL OF WHICH ARE AVAILABLE TO ALL PATIENTS REGARDLESS OF INSURANCE STATUS OR ABILITY TO PAY; AN OPEN MEDICAL STAFF THAT INCLUDES PHYSICIANS EMPLOYED BY UVM MEDICAL CENTER'S FACULTY PRACTICE (THE UNIVERSITY OF VERMONT MEDICAL GROUP), AS WELL AS COMMUNITY PHYSICIANS; AND AN INDEPENDENT BOARD OF TRUSTEES THAT REPRESENTS OUR COMMUNITY AS A WHOLE.

IN TERMS OF PROGRAM SERVICES, UVM MEDICAL CENTER'S THREE LARGEST PROGRAMS (BY EXPENSES AND REVENUES) ARE OUR ACTUAL HEALTH CARE DELIVERY SERVICES, AS FOLLOWS:

INPATIENT SERVICES: SERVICES PROVIDED TO THOSE PATIENTS WHO REQUIRE ACUTE-CARE SERVICES IN A HOSPITAL SETTING. THESE SERVICES INCLUDE, FOR EXAMPLE, OUR LABOR AND DELIVERY UNIT, NURSING UNITS FOR GENERAL MEDICAL AND SURGICAL ISSUES, AND OUR INTENSIVE CARE UNITS (INCLUDING A PEDIATRIC ICU, A NEONATAL ICU, A SURGICAL ICU AND A MEDICAL ICU).

OUTPATIENT SERVICES: SERVICES PROVIDED TO THOSE PATIENTS WHO REQUIRE CARE, ON A WALK-IN BASIS, EITHER IN THE HOSPITAL OR IN ONE OF OUR MANY CLINIC SETTINGS. THESE INCLUDE ROUTINE PHYSICIAN VISITS, LABORATORY



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TESTS, CLINIC VISITS, EMERGENCY ROOM VISITS, AND MEDICAL EQUIPMENT AND SUPPLIES.

PROFESSIONAL SERVICES: SERVICES DELIVERED BY MEMBERS OF THE UVM MEDICAL GROUP, OUR EMPLOYED GROUP OF PHYSICIANS.

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

THE FOLLOWING INDIVIDUALS SERVED AS DIRECTORS AND OFFICERS AT THE UNIVERSITY OF VERMONT HEALTH VENTURES, INC., A RELATED ORGANIZATION: DR. JOHN BRUMSTED, DR. HOWARD SCHAPIRO, AND RICHARD VINCENT.

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

THE UNIVERSITY OF VERMONT HEALTH NETWORK INC. (UVM HEALTH NETWORK) IS THE SOLE MEMBER OF THE ORGANIZATION.

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

UVM HEALTH NETWORK HAS POWERS TO ELECT UVM MEDICAL CENTER'S BOARD OF TRUSTEES.

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 UVM MEDICAL CENTER'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.

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

THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC.'S (UVM MEDICAL CENTER'S) FORM 990 IS PREPARED BY UVM MEDICAL CENTER STAFF AND REVIEWED BY PRICEWATERHOUSECOOPERS (PWC). FOLLOWING PWC'S REVIEW, THE RETURN IS REVIEWED BY UVM MEDICAL CENTER'S SENIOR LEADERSHIP. FINALLY, UVM MEDICAL CENTER'S MANAGEMENT PRESENTS THE FORM 990 TO THE AUDIT COMMITTEE FOR REVIEW AND COMMENT. THE COMPLETED FORM 990 IS PROVIDED TO ALL MEMBERS OF THE BOARD OF TRUSTEES OF THE UVM MEDICAL CENTER BOARD OF TRUSTEES PRIOR TO THE FORM BEING FILED WITH THE IRS.

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

THE ORGANIZATION REGULARLY MONITORS AND ENFORCES COMPLIANCE WITH THE UVM HEALTH NETWORK'S CONFLICT OF INTEREST POLICY, WHICH IT HAS ADOPTED. IN ACCORDANCE WITH THE POLICY, TRUSTEES, OFFICERS, KEY EMPLOYEES AND PHYSICIANS ARE REQUIRED TO COMPLETE A CONFLICT OF INTEREST DISCLOSURE AND CERTIFICATION UPON HIRING, AT LEAST ANNUALLY, PRIOR TO PARTICIPATING IN ANY DECISION THAT MAY BE AFFECTED BY A PERSONAL INTEREST, AND WHENEVER A POTENTIALLY CONFLICTING INTEREST FIRST ARISES.

CONFLICT OF INTEREST DISCLOSURES AND CERTIFICATIONS MAY BE MADE ONLINE OR IN WRITING AND ARE REGULARLY REVIEWED BY THE GENERAL COUNSEL. THE CONFLICT OF INTEREST POLICY IS ENFORCED BY THE OFFICE OF GENERAL COUNSEL AND OVERSEEN BY A FIVE-PERSON CONFLICT OF INTEREST COMMITTEE. THE GENERAL COUNSEL REPORTS AT LEAST QUARTERLY ON CONFLICT OF INTEREST ISSUES TO THE AUDIT COMMITTEE OF THE BOARD OF TRUSTEES. CONFLICTS OF INTEREST ARE MANAGED IN ACCORDANCE WITH THE POLICY, WHICH PROVIDES FOR A VARIETY OF REMEDIES TO ADDRESS CONFLICTS OF INTEREST. IN ADDITION, "DISQUALIFIED PERSONS", CONSISTING OF TRUSTEES, OFFICERS AND KEY EMPLOYEES ARE SUBJECT TO SPECIAL

Name of the organization

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Employer identification number

03-0219309

PROCEDURES TO COMPLY WITH THE INTERMEDIATE SANCTION RULES, AS OUTLINED IN THE CONFLICT OF INTEREST POLICY. REMEDIES TO ADDRESS CONFLICTS OF INTEREST MAY INCLUDE THE FOLLOWING: RECUSAL FROM DECISION MAKING, DISCLOSURE TO APPROPRIATE PARTIES, COMMITTEE PARTICIPATION LIMITS AND REQUESTED DIVESTITURE. AN APPEALS PROCESS EXISTS SHOULD THE INDIVIDUAL REQUEST A SECONDARY REVIEW BE PERFORMED.

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

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

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 AFFILIATE HOSPITAL CEOS. CALCULATIONS ARE PERFORMED USING THE SAME PHILOSOPHY FOR THE THIRD TIER OF LEADERSHIP. ALL ACTIONS TAKEN REGARDING EXECUTIVE COMPENSATION ARE CONTEMPORANEOUSLY DOCUMENTED BY THE APPROPRIATE ORGANIZATION. THIS REVIEW IS PERFORMED ANNUALLY.

Name of the organization THE UNIVERSITY OF VERMONT MEDICAL CENTER	Employer identification number 03-0219309
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FORM 990, PART VI, SECTION C, LINE 19:

GOVERNANCE DOCUMENTS CONSIST OF THE ORGANIZATION'S ARTICLES OF INCORPORATION AND BYLAWS. THE ARTICLES OF INCORPORATION ARE FILED WITH THE VERMONT SECRETARY OF STATE AND ARE PUBLICLY AVAILABLE THROUGH THAT OFFICE. THE BYLAWS ARE NOT PUBLICLY POSTED, BUT A COPY WOULD BE FURNISHED TO ANY MEMBER OF THE PUBLIC WHO REQUESTED ONE.

THE CONFLICT OF INTEREST POLICY IS NOT PUBLICLY POSTED, BUT A COPY WOULD BE FURNISHED TO ANY MEMBER OF THE PUBLIC WHO REQUESTED ONE.

WITH THE ENACTMENT OF VERMONT'S ACT 48 IN MAY 2011, THE GREEN MOUNTAIN CARE BOARD (GMCB) BECAME THE REGULATORY BODY OVERSEEING HOSPITALS IN THE STATE OF VERMONT. AS A RESULT, THE BUDGET FOR UVM MEDICAL CENTER IS SUBJECT TO REVIEW BY THE GMCB ON AN ANNUAL BASIS. ONGOING DISCLOSURE OF OPERATING RESULTS IS ALSO REQUIRED AND UVM MEDICAL CENTER SUBMITS ITS FINANCIAL STATEMENTS REGULARLY THROUGHOUT THE YEAR. UVM MEDICAL CENTER ALSO REGULARLY DISCLOSES ITS FINANCIAL RESULTS ON ITS WEBSITE AND SUBMITS PRESS RELEASES RELATING TO PERFORMANCE ON A REGULAR BASIS TO LOCAL NEWS ORGANIZATIONS. THE ANNUAL EXTERNAL AUDIT OF THE UVM HEALTH NETWORK IS ALSO POSTED ON THE WEB SITE AND IS ATTACHED TO THE CURRENT YEAR'S FORM 990.

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

TRANSFER OF NET ASSETS	-31,115,617.
PENSION ADJUSTMENT	670,248.
ASSETS RELEASED FROM RESTRICTIONS	293,317.
OTHER COMPONENTS OF CURRENT PERIOD PENSION EXPENSE	165,712.
ELIMINATIONS AND OTHER	-5,667,583.
TOTAL TO FORM 990, PART XI, LINE 9	-35,653,923.

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Related Organizations and Unrelated Partnerships**

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

**2021**

Open to Public Inspection

Name of the organization **THE UNIVERSITY OF VERMONT MEDICAL CENTER** Employer identification number **03-0219309**

**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
UVM MEDICAL CTR SKILLED NURSING - 03-0219309 111 COLCHESTER AVENUE BURLINGTON, VT 05401	HOLDING COMPANY	VERMONT	0.	0.	UVMCMC
UVMHN SPECIALTY CARE TRNSPT - 03-0219309 111 COLCHESTER AVENUE BURLINGTON, VT 05401	AMBULANCE SVC	VERMONT	-10,491,966.	1,925,131.	UVMCMC
UVM MEDICAL CTR EXEC SERVICES - 03-0219309 111 COLCHESTER AVENUE BURLINGTON, VT 05401	EXEC STAFFING	VERMONT	0.	0.	UVMCMC

**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
UVM HEALTH NETWORK MEDICAL GROUP, INC. - 03-0225105, 111 COLCHESTER AVENUE, BURLINGTON, VT 05401	PHYSICIAN SVC	VERMONT	501(C)(3)	12A-I	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 AVENUE, BURLINGTON, VT 05401	FUNDRAISING	VERMONT	501(C)(3)	12A-I	UVMCMC	X	
UVMCMC AUXILLARY, INC - 20-8022004 111 COLCHESTER AVENUE BURLINGTON, VT 05401	SERVICE	VERMONT	501(C)(3)	12C-III-FI	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
UNIVERSITY OF VERMONT HEALTH NETWORK INC - 45-2880726, 111 COLCHESTER AVENUE, BURLINGTON, VT 05401	HOLDING COMPANY	VERMONT	501(C)(3)	12A-I	N/A		X
CENTRAL VERMONT MEDICAL CENTER - 22-2547186 130 FISHER ROAD BERLIN, VT 05602	HOSPITAL	VERMONT	501(C)(3)	3	UVMHN	X	
UNIVERSITY HEALTH CENTER - 03-0229931 111 COLCHESTER AVENUE BURLINGTON, VT 05401	HOSPITAL	VERMONT	501(C)(3)	12C-III-FI	UVMHNMG	X	
COMMUNITY PROVIDERS INC - 22-2544844 75 BEEKMAN STREET PLATTSBURGH, NY 12901	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 COOR	NEW YORK	501(C)(3)	12B-II	CVPH	X	
UNIVERSITY MEDICAL EDUCATION ASSOCIATES - 23-7107832, 89 BEUMONT 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)	12-BII	UVMHN	X	
HELEN PORTER NURSING HOME - 03-0306549 37 PORTER DRIVE MIDDLEBURY, VT 05753	NURSING HOME	VERMONT	501(C)(3)	3	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
AUXILIARY OF PORTER MEDICAL CENTER - 23-7363227, 37 PORTER DRIVE, MIDDLEBURY, VT 05753	SUPPORTING ORG	VERMONT	501(C)(3)	12-B, II	PMC	X	
PORTER HOSPITAL INC - 03-0181058 37 PORTER DRIVE MIDDLEBURY, VT 05753	HOSPITAL	VERMONT	501(C)(3)	3	PMC	X	
UVMHN HOME HEALTHCARE & HOSPICE - 03-0179603 1110 PRIM ROAD COLCHESTER, VT 05446	HOME HEALTHCARE	VERMONT	501(C)(3)	10	UVMHN	X	
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	
VMC INDEMNITY COMPANY, INC. - 83-1102018 95 ST. PAUL ST. BURLINGTON, VT 05401	INSURANCE	VERMONT	501(C)(3)	12A-I	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 CREDENTIALING & ENROLLMENT - 03-0333056, 111 COLCHESTER AVENUE, BURLINGTON, VT 05401	ADMIN SERVICE	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	
CHAMPLAIN VALLEY HEALTH NETWORK - 16-1586102 75 BEEKMAN STREET PLATTSBURGH, NY 12901	ADMIN SERVICE	NY	N/A	C CORP	N/A	N/A	N/A	X	



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

Table with columns: (a) Name, address, and EIN of related organization; (b) Primary activity; (c) Legal domicile; (d) Direct controlling entity; (e) Type of entity; (f) Share of total income; (g) Share of end-of-year assets; (h) Percentage ownership; (i) Section 512(b)(13) controlled entity? (Yes/No). Rows include MEDQUEST INC, UVMHN VENTURES INC, and YANKEE MEDICAL INC.

**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
<b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity .....	X	
<b>b</b> Gift, grant, or capital contribution to related organization(s) .....		X
<b>c</b> Gift, grant, or capital contribution from related organization(s) .....	X	
<b>d</b> Loans or loan guarantees to or for related organization(s) .....		X
<b>e</b> Loans or loan guarantees by related organization(s) .....		X
<b>f</b> Dividends from related organization(s) .....		X
<b>g</b> Sale of assets to related organization(s) .....		X
<b>h</b> Purchase of assets from related organization(s) .....		X
<b>i</b> Exchange of assets with related organization(s) .....	X	
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) .....		X
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) .....		X
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) .....		X
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) .....	X	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) .....		X
<b>o</b> Sharing of paid employees with related organization(s) .....		X
<b>p</b> Reimbursement paid to related organization(s) for expenses .....	X	
<b>q</b> Reimbursement paid by related organization(s) for expenses .....	X	
<b>r</b> Other transfer of cash or property to related organization(s) .....		X
<b>s</b> Other transfer of cash or property from related organization(s) .....		X

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) UNIVERSITY OF VERMONT MEDICAL GROUP	P	335,867,677.	FMV
(2) VMCIC, INC. UNIVERSITY OF VERMONT HEALTH NETWORK HOME	M	6,998,402.	FMV
(3) HEALTH AND HOSPICE UNIVERSITY OF VERMONT HEALTH NETWORK HOME	I	125,108.	FMV
(4) HEALTH AND HOSPICE	Q	616,137.	FMV
(5) PORTER MEDICAL CENTER INC	I	217,788.	FMV
(6) PORTER MEDICAL CENTER INC	Q	18,911,596.	FMV

**Part V** Continuation of Transactions With Related Organizations (Schedule R (Form 990), Part V, line 2)

(a) Name of other organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(7) ADIRONDACK ACO LLC	Q	198,963.	FMV
(8) ALICE HYDE MEDICAL CENTER	Q	17,014,596.	FMV
(9) CENTRAL VERMONT MEDICAL CENTER	A	293,078.	FMV
(10) CENTRAL VERMONT MEDICAL CENTER	I	730,973.	FMV
(11) CENTRAL VERMONT MEDICAL CENTER	Q	37,466,283.	FMV
(12) ELIZABETHTOWN COMMUNITY HOSPITAL	Q	6,799,565.	FMV
(13) CHAMPLAIN VALLEY PHYSICIAN'S HOSPITAL	I	1,475,197.	FMV
(14) CHAMPLAIN VALLEY PHYSICIAN'S HOSPITAL	Q	60,242,710.	FMV
(15) UNIVERSITY OF VERMONT HEALTH NETWORK VENTURES, INC.	A	51,821.	FMV
(16) YANKEE MEDICAL	A	1,565.	FMV
(17) UNIVERSITY OF VERMONT HEALTH NETWORK	P	123,832,602.	FMV
(18)			
(19)			
(20)			
(21)			
(22)			
(23)			
(24)			

