

Form **8879-TE**

# IRS E-file Signature Authorization for a Tax Exempt Entity

OMB No. 1545-0047

For calendar year 2023, or fiscal year beginning OCT 1, 2023, and ending SEP 30, 2024

# 2023

Department of the Treasury  
Internal Revenue Service

Do not send to the IRS. Keep for your records.

Go to [www.irs.gov/Form8879TE](http://www.irs.gov/Form8879TE) for the latest information.

Name of filer

**ELIZABETHTOWN COMMUNITY HOSPITAL**

EIN or SSN

**\*\* - \*\*\*4513**

Name and title of officer or person subject to tax

**ROBERT ORTMYER  
PRESIDENT**

## Part I Type of Return and Return Information

Check the box for the return for which you are using this Form 8879-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 for 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-). But, 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	<b>86,018,876.</b>
2a	Form 990-EZ check here		b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here		b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here		b	Tax based on investment income (Form 990-PF, Part V, line 5)	4b	
5a	Form 8868 check here		b	Balance due (Form 8868, line 3c)	5b	
6a	Form 990-T check here		b	Total tax (Form 990-T, Part III, line 4)	6b	
7a	Form 4720 check here		b	Total tax (Form 4720, Part III, line 1)	7b	
8a	Form 5227 check here		b	FMV of assets at end of tax year (Form 5227, Item D)	8b	
9a	Form 5330 check here		b	Tax due (Form 5330, Part II, line 19)	9b	
10a	Form 8038-CP check here		b	Amount of credit payment requested (Form 8038-CP, Part III, line 22)	10b	

## Part II Declaration and Signature Authorization of Officer or Person Subject to Tax

Under penalties of perjury, I declare that  I am an officer of the above entity or  I am a person subject to tax with respect to (name of entity) \_\_\_\_\_, (EIN) \_\_\_\_\_ and that I have examined a copy of the 2023 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. If applicable, I authorize the U.S. Treasury and its designated Financial Agent to initiate an 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. I have selected a personal identification number (PIN) as my signature for the electronic return and, if applicable, the consent to electronic funds withdrawal.

**PIN: check one box only**

I authorize **FUSTCHARLES LLP** to enter my PIN **12345**  
ERO firm name Enter five numbers, but do not enter all zeros

as my signature on the tax year 2023 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I also authorize the aforementioned ERO to enter my PIN on the return's disclosure consent screen.

As an officer or person subject to tax with respect to the entity, I will enter my PIN as my signature on the tax year 2023 electronically filed return. If I have indicated within this return that a copy of the return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I will enter my PIN on the return's disclosure consent screen.

Signature of officer or person subject to tax

Date

8/12/23

## Part III Certification and Authentication

ERO's EFIN/PIN. Enter your six-digit electronic filing identification number (EFIN) followed by your five-digit self-selected PIN.

**16081698765**

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2023 electronically filed return indicated above. I confirm that I am submitting this return in accordance with the requirements of Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns.

ERO's signature

**THOMAS J. GIUFRE**

Date

08/06/25

**ERO Must Retain This Form - See Instructions**

**Do Not Submit This Form to the IRS Unless Requested To Do So**

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

Form **8879-TE** (2023)

LHA 302521 01-05-24

Return of Organization Exempt From Income Tax

Form 990

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public.
Go to www.irs.gov/Form990 for instructions and the latest information.

2023

Open to Public Inspection

A For the 2023 calendar year, or tax year beginning OCT 1, 2023 and ending SEP 30, 2024

B Check if applicable: C Name of organization: ELIZABETHTOWN COMMUNITY HOSPITAL
D Employer identification number: 14-1364513
E Telephone number: 518-873-6377
G Gross receipts \$: 88,563,068.
H(a) Is this a group return for subordinates?
H(b) Are all subordinates included?
H(c) Group exemption number
I Tax-exempt status:
J Website: ECH.ORG
K Form of organization:
L Year of formation: 1926
M State of legal domicile: NY

Part I Summary

Table with 3 main sections: Activities & Governance (lines 1-7), Revenue (lines 8-12), and Expenses (lines 13-19). Includes sub-sections for Net Assets or Fund Balances (lines 20-22).

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.

Signature of officer: ROBERT ORTMYER, PRESIDENT
Date:
Print/Type preparer's name: THOMAS J. GIUFRE
Preparer's signature: THOMAS J. GIUFRE
Date: 08/06/25
Check if self-employed:
PTIN: P00841958
Firm's name: FUSTCHARLES LLP
Firm's EIN: 16-1226221
Firm's address: 220 S WARREN STREET, SYRACUSE, NY 13202
Phone no.: 315-446-3600

May the IRS discuss this return with the preparer shown above? See instructions [X] 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

If "Yes," describe these new services on Schedule O.

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

If "Yes," describe these changes on Schedule O.

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

Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: ) (Expenses \$ 10,745,814. including grants of \$ ) (Revenue \$ 11,637,837.)

INPATIENT ACUTE UNIT AND SUBACUTE REHABILITATIVE (SWING BED) INPATIENT PROGRAM:

A 25-BED NURSING UNIT PROVIDING ACUTE AND SUB ACUTE (SWING BED) CARE. THE SMALLER ATMOSPHERE CREATES A CLOSER BOND BETWEEN THE PATIENT AND PROFESSIONALS ENCOURAGING OPTIMAL HEALING AND COMPASSIONATE CARE. THE SUB-ACUTE PROGRAM IS VITAL TO AREA RESIDENTS BECAUSE FOLLOWING A HIP-REPLACEMENT, KNEE-SURGERY OR CARDIAC OPERATION, RECUPERATION AND THERAPY CAN BE DONE AT ELIZABETHTOWN COMMUNITY HOSPITAL, SAVING THE FAMILY THE TIME AND EXPENSE OF TRAVEL. THE PROGRAM PROVIDES ONE-ON-ONE THERAPEUTIC CARE.

4b (Code: ) (Expenses \$ 10,480,062. including grants of \$ ) (Revenue \$ 19,979,678.)

CLINIC SERVICES:

ECH OPERATES THE ELIZABETHTOWN COMMUNITY HEALTH CENTER, WESTPORT HEALTH CENTER LOCATED IN WESTPORT, NY, THE HIGH PEAKS HEALTH CENTER LOCATED IN WILMINGTON, NY, THE SMITH HOUSE HEALTH CENTER LOCATED IN WILLSBORO, NY, THE AU SABLE FORKS HEALTH CENTER, LOCATED IN AU SABLE FORKS, NY, AND CROWN POINT HEALTH CENTER, LOCATED IN CROWN POINT, NY. ECH OPERATES AN OUTPATIENT CHEMOTHERAPY PROGRAM, WHICH INCLUDES UPDATED INFUSION EQUIPMENT MAKING IT POSSIBLE TO PROVIDE SAFE AND EFFICIENT METHODS FOR CHEMOTHERAPY AND BLOOD-RELATED INFUSIONS. IN ADDITION, THE NEW SPECIALIZED VENTILATING HOOD ENABLES THE PREPARATION OF CHEMOTHERAPY SOLUTIONS ON-SITE. THIS IS A GREAT CONVENIENCE FOR CANCER PATIENTS, SAVING THEM THE 90-MINUTE ROUND-TRIP DRIVE TO THE CLOSEST CHEMOTHERAPY

4c (Code: ) (Expenses \$ 14,268,388. including grants of \$ ) (Revenue \$ 26,341,123.)

EMERGENCY ROOM SERVICES:

ECH'S PRIOR YEARS EXPANSION OF THE EMERGENCY ROOM ADDED NEW STATE OF THE ART TRAUMA ROOMS, A TELEMETRY SYSTEM FOR PATENT MONITORING, A REGISTRATION AREA DESIGNED FOR PATIENT PRIVACY AND CONFIDENTIALITY AND NEW WAITING AREAS FOR FAMILIES AND THEIR LOVED ONES. THE HOSPITAL OPERATES AN ALL-DIGITAL RADIOLOGY DEPARTMENT, ALLOWING TECHNOLOGISTS TO OBTAIN PATIENT IMAGES ANYWHERE IN THE HOSPITAL. IN THE EVENT OF A SIGNIFICANT EMERGENCY WITH MULTIPLE TRAUMAS, THE UNIT CAN BE USED ANYWHERE IN THE BUILDING. WHEN THE HOSPITAL IS FACED WITH AN UNUSUAL SURGE IN EMERGENCY ROOM TRAUMA CASES, HOSPITAL PROCEDURES ENABLE STAFF TO TRIAGE IN NONTRADITIONAL AREAS OF THE HOSPITAL.

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

(Expenses \$ 17,267,282. including grants of \$ ) (Revenue \$ 27,022,327.)

4e Total program service expenses 52,761,546.

**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? .....		
<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? .....		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? .....		
<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 noncash 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 returns, gross income, foreign accounts, prohibited transactions, and charitable contributions.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members... 13; 1b Enter the number of voting members included on line 1a... 12; 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
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
SCOTT COMEAU, CFO - 518-873-3136
75 PARK STREET PO BOX 277, ELIZABETHTOWN, NY 12932

**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, box 6 of 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. DAVID CLAUSS MEDICAL DIRECTOR - FORMER	1.00 49.00						X	0.	586,260.	122,456.
(2) IL CHON CHIEF MEDICAL OFFICER	40.00				X			0.	573,006.	55,390.
(3) DR. JASON SANDERS UVMMG PRESIDENT & CEO	1.00 49.00				X			0.	508,675.	95,550.
(4) BOB ORTMYER PRESIDENT & CEO	25.00 25.00	X		X				362,761.	0.	62,284.
(5) AMY PUTNAM VP MEDICAL GROUP NETWORK DEPARTMENTS	1.00 49.00				X			0.	284,720.	55,360.
(6) SCOTT COMEAU CFO	10.00 40.00	X		X				0.	269,533.	41,728.
(7) MATTHEW NOLAN CHIEF OPERATING OFFICER	40.00				X			255,842.	0.	13,978.
(8) JULIE TROMBLEE CHIEF NURSING OFFICER	40.00				X			215,751.	0.	12,669.
(9) GRANT MARTIN INFORMATION TECHNOLOGY	40.00					X		188,688.	0.	38,728.
(10) JOHN REMILLARD PRESIDENT - FORMER	0.00 35.00						X	0.	227,250.	0.
(11) NANCY CAFFREY PHYSICIAN ASSISTANT	40.00					X		178,681.	0.	37,675.
(12) JAMES L'EPISCOPO PHYSICIAN ASSISTANT	40.00					X		190,569.	0.	19,439.
(13) REBECCA SIMARD REGISTERED NURSE	40.00					X		169,759.	0.	19,713.
(14) FRANK COOLIDGE REGISTERED NURSE	40.00					X		179,516.	0.	8,200.
(15) SUSAN ALLOTT BOARD MEMBER	1.00	X						0.	0.	0.
(16) STEVEN CACCHIO VICE CHAIR	1.00	X		X				0.	0.	0.
(17) EVAN GEORGE SECRETARY	1.00	X		X				0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) JOSEPH BOGARDUS, PHD TREASURER	1.00	X		X				0.	0.	0.
(19) ALAN JONES BOARD MEMBER	1.00	X						0.	0.	0.
(20) CHARLES WALTER LENDER BOARD MEMBER	1.00	X						0.	0.	0.
(21) TERRI MORSE BOARD MEMBER	1.00	X						0.	0.	0.
(22) MEGAN MURPHY BOARD MEMBER	1.00	X						0.	0.	0.
(23) LYNNE REALE BOARD MEMBER	1.00	X						0.	0.	0.
(24) WILLIAM TANSEY BOARD MEMBER	1.00	X						0.	0.	0.
(25) DAVID SHELMEDEINE CHAIR	1.00	X		X				0.	0.	0.
(26) ROLAND ALLEN BOARD MEMBER	1.00	X						0.	0.	0.
<b>1b Subtotal</b>								1,741,567.	2,449,444.	583,170.
<b>c Total from continuation sheets to Part VII, Section A</b>								0.	0.	0.
<b>d Total (add lines 1b and 1c)</b>								1,741,567.	2,449,444.	583,170.

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 59

	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
MAZARS USA LLP, 300 UNIVERSITY AVE SUITE 100, SACRAMENTO, CA 95825	ACCOUNTING/CONSULTING SERVICES	280,265.
COMPHEALTH MEDICAL STAFFING PO BOX 972625, DALLAS, TX 75397-2625	MEDICAL STAFFING	189,910.
E4H-ENVIRONMENTS FOR HEALTH ARCHITECTURE 185 TALCOTT ROAD, WILLISTON, VT 05495	ARCHITECTURAL SERVICES	137,815.
ASSOCIATES IN RADIOLOGY PO BOX 2007, EAST SYRACUSE, NY 13507	RADIOLOGY SERVICES	108,333.

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 4

**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>	213.				
	<b>d</b>	Related organizations	<b>1d</b>					
	<b>e</b>	Government grants (contributions)	<b>1e</b>	284,406.				
	<b>f</b>	All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	253,796.				
	<b>g</b>	Noncash contributions included in lines 1a-1f	<b>1g</b>	\$				
	<b>h</b>	<b>Total.</b> Add lines 1a-1f			538,415.			
Program Service Revenue	<b>2 a</b>	CRITICAL ACCESS HOSPITAL	<b>Business Code</b>	900099	79,665,410.	79665410.		
	<b>b</b>	340B REVENUE		900099	2,320,037.	2,320,037.		
	<b>c</b>	MEANINGFUL USE INCOME		900099	49,784.	49,784.		
	<b>d</b>							
	<b>e</b>							
	<b>f</b>	All other program service revenue						
	<b>g</b>	<b>Total.</b> Add lines 2a-2f			82,035,231.			
Other Revenue	<b>3</b>	Investment income (including dividends, interest, and other similar amounts)			812,994.		812,994.	
	<b>4</b>	Income from investment of tax-exempt bond proceeds						
	<b>5</b>	Royalties						
	<b>6 a</b>	Gross rents	(i) Real	159,915.				
			(ii) Personal					
	<b>b</b>	Less: rental expenses	<b>6b</b>	351,687.				
	<b>c</b>	Rental income or (loss)	<b>6c</b>	-191,772.				
	<b>d</b>	Net rental income or (loss)			-191,772.	-219,951.	28,179.	
	<b>7 a</b>	Gross amount from sales of assets other than inventory	(i) Securities	2,050,762.				
			(ii) Other					
	<b>b</b>	Less: cost or other basis and sales expenses	<b>7b</b>	2,184,689.				
<b>c</b>	Gain or (loss)	<b>7c</b>	-133,927.					
<b>d</b>	Net gain or (loss)			-133,927.		-133,927.		
<b>8 a</b>	Gross income from fundraising events (not including \$ 213. of contributions reported on line 1c). See Part IV, line 18		20,017.					
		<b>8a</b>						
<b>b</b>	Less: direct expenses	<b>8b</b>	7,816.					
<b>c</b>	Net income or (loss) from fundraising events			12,201.		12,201.		
<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		900099	2,945,734.	2,945,734.		
	<b>e</b>	<b>Total.</b> Add lines 11a-11d			2,945,734.			
<b>12</b>	<b>Total revenue.</b> See instructions			86,018,876.	84980965.	-219,951.	719,447.	

**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 Grants and other assistance to domestic individuals. See Part IV, line 22 .....				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 .....				
4 Benefits paid to or for members .....				
5 Compensation of current officers, directors, trustees, and key employees .....	923,285.		923,285.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) .....				
7 Other salaries and wages .....	28,282,929.	24,898,072.	3,384,857.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,151,996.	1,008,952.	143,044.	
9 Other employee benefits .....	3,756,137.	2,970,929.	785,208.	
10 Payroll taxes .....	1,970,577.	1,699,444.	271,133.	
11 Fees for services (nonemployees):				
a Management .....				
b Legal .....	137,862.		137,862.	
c Accounting .....	160,462.		160,462.	
d Lobbying .....				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees .....	25,043.		25,043.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	6,545,574.	5,076,550.	1,469,024.	
12 Advertising and promotion .....				
13 Office expenses .....	8,939,831.	8,433,901.	505,930.	
14 Information technology .....	13,490.		13,490.	
15 Royalties .....				
16 Occupancy .....	832,976.	244,054.	588,922.	
17 Travel .....	296,860.	221,921.	74,939.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
19 Conferences, conventions, and meetings .....	58,985.	58,115.	870.	
20 Interest .....	370,776.	370,776.		
21 Payments to affiliates .....				
22 Depreciation, depletion, and amortization .....	3,306,742.	2,794,209.	512,533.	
23 Insurance .....	634,667.	580,002.	54,665.	
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>SHARED SERVICE</b>	3,926,343.		3,926,343.	
b <b>BAD DEBT EXPENSE</b>	3,686,669.	3,686,669.		
c <b>PROVIDER TAX</b>	282,151.	282,151.		
d _____				
e All other expenses _____	1,163,380.	435,801.	727,579.	
<b>25 Total functional expenses.</b> Add lines 1 through 24e	<b>66,466,735.</b>	<b>52,761,546.</b>	<b>13,705,189.</b>	<b>0.</b>
<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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	5,759,122.	<b>1</b>	4,551,099.
	<b>2</b> Savings and temporary cash investments .....	7,233,096.	<b>2</b>	8,557,788.
	<b>3</b> Pledges and grants receivable, net .....		<b>3</b>	
	<b>4</b> Accounts receivable, net .....	10,958,047.	<b>4</b>	9,897,747.
	<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 .....		<b>7</b>	
	<b>8</b> Inventories for sale or use .....	952,295.	<b>8</b>	957,434.
	<b>9</b> Prepaid expenses and deferred charges .....	925,010.	<b>9</b>	1,934,848.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 62,438,085.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 32,079,453.	30,295,945.	<b>10c</b> 30,358,632.
	<b>11</b> Investments - publicly traded securities .....	25,436,001.	<b>11</b>	51,647,450.
	<b>12</b> Investments - other securities. See Part IV, line 11 .....		<b>12</b>	
	<b>13</b> Investments - program-related. See Part IV, line 11 .....		<b>13</b>	
	<b>14</b> Intangible assets .....		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 .....	1,312,176.	<b>15</b>	537,997.
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	82,871,692.	<b>16</b>	108,442,995.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	5,394,247.	<b>17</b>	6,563,051.
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....	31,343.	<b>19</b>	30,941.
	<b>20</b> Tax-exempt bond liabilities .....		<b>20</b>	
	<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 .....	12,412,204.	<b>23</b>	11,555,440.
	<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 .....	9,490,110.	<b>25</b>	8,416,841.
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	27,327,904.	<b>26</b>	26,566,273.
<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 .....	54,363,351.	<b>27</b>	80,702,775.
	<b>28</b> Net assets with donor restrictions .....	1,180,437.	<b>28</b>	1,173,947.
	<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 .....	55,543,788.	<b>32</b>	81,876,722.
	<b>33</b> Total liabilities and net assets/fund balances .....	82,871,692.	<b>33</b>	108,442,995.

**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	86,018,876.
2	Total expenses (must equal Part IX, column (A), line 25)	2	66,466,735.
3	Revenue less expenses. Subtract line 2 from line 1	3	19,552,141.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	55,543,788.
5	Net unrealized gains (losses) on investments	5	6,635,865.
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	144,928.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	81,876,722.

**Part XII Financial Statements and Reporting**

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

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> 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: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
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: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
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.	X	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F? _____	X	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits _____	X	

Form 990 (2023)



**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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(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 2023 (line 6, column (f), divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2022 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2023.</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 - 2022.</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 - 2023.</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 - 2022.</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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(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) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(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 2023 (line 8, column (f), divided by line 13, column (f)) .....	<b>15</b>	%
<b>16</b> Public support percentage from 2022 Schedule A, Part III, line 15 .....	<b>16</b>	%

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

<b>17</b> Investment income percentage for 2023 (line 10c, column (f), divided by line 13, column (f)) .....	<b>17</b>	%
<b>18</b> Investment income percentage from 2022 Schedule A, Part III, line 17 .....	<b>18</b>	%

**19a 33 1/3% support tests - 2023.** 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 - 2022.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization

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

**Part IV Supporting Organizations**

(Complete only if you checked a box on line 12 of Part I. If you checked 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>	Yes	No
<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 2023 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-2023</b>	<b>(iii) Distributable Amount for 2023</b>
<b>1</b> Distributable amount for 2023 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2023 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2023			
<b>a</b> From 2018			
<b>b</b> From 2019			
<b>c</b> From 2020			
<b>d</b> From 2021			
<b>e</b> From 2022			
<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 2023 distributable amount			
<b>i</b> Carryover from 2018 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b> Distributions for 2023 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2023 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b> Remaining underdistributions for years prior to 2023, 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 2023. 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 2024.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2019			
<b>b</b> Excess from 2020			
<b>c</b> Excess from 2021			
<b>d</b> Excess from 2022			
<b>e</b> Excess from 2023			

**Part VI**

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

Horizontal lines for supplemental information input.

SCHEDULE 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

2023

Open to Public Inspection

Name of the organization ELIZABETHTOWN COMMUNITY HOSPITAL Employer identification number 14-1364513

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two yes/no questions about donor property and grant fund usage.

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

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

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

Table with 3 columns: Question, (a) Donor advised funds, (b) Funds and other accounts. Rows include questions about reporting requirements for art and historical treasures, including revenue and asset amounts.

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule D (Form 990) 2023

**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 in Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	1,180,437.	1,031,571.	1,230,200.	1,658,795.	1,644,993.
b Contributions	137,598.	280,840.	600,318.	3,105,896.	8,433,494.
c Net investment earnings, gains, and losses	158,313.	70,093.	-145,736.	115,670.	49,870.
d Grants or scholarships					
e Other expenditures for facilities and programs	288,060.	202,067.	653,211.	3,650,161.	8,469,562.
f Administrative expenses	14,341.				
g End of year balance	1,173,947.	1,180,437.	1,031,571.	1,230,200.	1,658,795.

- 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 29.8800%
  - c Term endowment 70.1200%
- 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		1,279,731.		1,279,731.
b Buildings		41,670,729.	18,089,037.	23,581,692.
c Leasehold improvements				
d Equipment		14,907,726.	12,317,099.	2,590,627.
e Other		4,579,899.	1,673,317.	2,906,582.
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B))				30,358,632.

**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)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, line 12, col. (B))		

**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, line 13, col. (B))		

**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, line 15, col. (B))	

**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) <b>DUE TO AFFILIATES</b>	1,597,706.
(3) <b>THIRD PARTY PAYOR SETTLEMENTS</b>	6,281,138.
(4) <b>OPERATING LEASE LIABILITY</b>	537,997.
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, line 25, col. (B))	8,416,841.

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:**

CERTAIN BOARD-DESIGNATED FUNDS HAVE BEEN ESTABLISHED TO MEET SPECIFIC CURRENT AND FUTURE NEEDS OF THE HOSPITAL OR TO ADEQUATELY DISCHARGE FUTURE LIABILITES. THESE FUNDS INCLUDE THE PLANT AND CAPITAL IMPROVEMENT FUNDS, WHICH ARE DESIGNATED FOR SPECIFIC PROJECTS SUCH AS THE SURGICAL CENTER CONSTRUCTION, AND DESIGNATED FUNDS FOR BOTH SELF-INSURANCE AND FOR CVPH'S VARIOUS EMPLOYEE BENEFIT PLANS. TEMPORARILY RESTRICTED NET ASSETS ARE INTENDED FOR THE PURCHASE OF PROPERTY AND EQUIPMENT. PERMANENTLY RESTRICTED NET ASSETS ARE TO BE HELD IN PERPETUITY, THE INCOME FROM WHICH IS EXPENDABLE TO SUPPORT HEALTH CARE SERVICES, INCLUDING MEDICAL SERVICES PROVIDED TO CHILDREN, AND PROVIDING FOR CHARITY CARE.

**Part XIII** Supplemental Information (continued)

PART X, LINE 2:

ELIZABETHTOWN COMMUNITY HOSPITAL IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE UNIVERSITY OF VERMONT HEALTH NETWORK. PAGE 18 OF THE CONSOLIDATED FINANCIAL STATEMENTS CONTAIN A FOOTNOTE INDICATING THAT NO PROVISION FOR FEDERAL INCOME TAXES HAS BEEN RECORDED, AND THAT NO UNCERTAIN TAX POSITIONS WERE TAKEN.



**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 (event type)	(event type)	NONE (total number)	
Revenue	1	20,230.			20,230.
	2	213.			213.
	3	20,017.			20,017.
Direct Expenses	4	860.			860.
	5	998.			998.
	6	3,670.			3,670.
	7	2,288.			2,288.
	8				
	9				
	10	Direct expense summary. Add lines 4 through 9 in column (d)			7,816.
	11	Net income summary. Subtract line 10 from line 3, column (d)			12,201.

**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				
	2				
Direct Expenses	3				
	4				
	5				
	6	<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: \_\_\_\_\_





**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Hospitals**

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

**2023**

Open to Public  
Inspection

<b>Name of the organization</b> <b>ELIZABETHTOWN COMMUNITY HOSPITAL</b>	<b>Employer identification number</b> <b>14-1364513</b>
--	--

**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 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 type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>250</u> %		
<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? .....		<input checked="" type="checkbox"/>
<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) .....			604,064.		604,064.	.96%
<b>b</b> Medicaid (from Worksheet 3, column a) .....			11531764.	7184312.	4347452.	6.92%
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) .....			330,880.		330,880.	.53%
<b>d Total.</b> Financial Assistance and Means-Tested Government Programs .....			12466708.	7184312.	5282396.	8.41%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .....	4	226	52,664.		52,664.	.08%
<b>f</b> Health professions education (from Worksheet 5) .....	2	54	150,532.		150,532.	.24%
<b>g</b> Subsidized health services (from Worksheet 6) .....			1270678.	1256786.	13,892.	.02%
<b>h</b> Research (from Worksheet 7) .....						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....	4	1,375	57,282.		57,282.	.09%
<b>j Total.</b> Other Benefits .....	10	1,655	1531156.	1256786.	274,370.	.43%
<b>k Total.</b> Add lines 7d and 7j .....	10	1,655	13997864.	8441098.	5556766.	8.84%



Part V Facility Information

Section A. Hospital Facilities

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

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

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

1 ELIZABETHTOWN COMMUNITY HOSPITAL
75 PARK STREET, PO BOX 277
ELIZABETHTOWN, NY 12932

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: X, X, X, X, 25 BEDS (ACUTE & SWING), 6 HEALTHCENTERS, CT,

**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: ELIZABETHTOWN COMMUNITY HOSPITAL

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 type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>22</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 checked="" type="checkbox"/> Other website (list url): <u>SEE PART V, SECTION C</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>23</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: ELIZABETHTOWN COMMUNITY HOSPITAL

	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>250</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
<b>b</b> <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input type="checkbox"/> Asset level		
<b>d</b> <input type="checkbox"/> Medical indigency		
<b>e</b> <input type="checkbox"/> Insurance status		
<b>f</b> <input type="checkbox"/> Underinsurance status		
<b>g</b> <input 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 their application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of their 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 checked="" 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 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 type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input 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 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: ELIZABETHTOWN COMMUNITY HOSPITAL

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

**Policy Relating to Emergency Medical Care**

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

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

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

Name of hospital facility or letter of facility reporting group: ELIZABETHTOWN COMMUNITY HOSPITAL

	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 checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
<b>c</b> <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
<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? .....	23	X
If "Yes," explain in Section C.		
<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? .....	24	X
If "Yes," explain in Section C.		

Schedule H (Form 990) 2023

**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.

ELIZABETHTOWN COMMUNITY HOSPITAL:

PART V, SECTION B, LINE 5: EXECUTIVES FROM THE FOLLOWING INSTITUTIONS:

ADIRONDACK HEALTH, ADIRONDACK MEDICAL CENTER, ADIRONDACK RURAL HEALTH NETWORK AND ESSEX COUNTY PUBLIC HEALTH.

ELIZABETHTOWN COMMUNITY HOSPITAL:

PART V, SECTION B, LINE 6B: COUNTY HEALTH DEPARTMENT

ELIZABETHTOWN COMMUNITY HOSPITAL:

PART V, SECTION B, LINE 7D: ESSEX COUNTY PUBLIC HEALTH

ELIZABETHTOWN COMMUNITY HOSPITAL:

PART V, SECTION B, LINE 11: COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY:

COMMUNITY SERVED - ELIZABETHTOWN COMMUNITY HOSPITAL'S PRIMARY SERVICE AREA IS COMPOSED OF TWENTY-TWO ZIP CODES IN NORTHEASTERN ESSEX COUNTY. THE HOSPITAL IS LOCATED 45-60 MINUTES AWAY FROM ANY OTHER HOSPITAL, THROUGH A MOUNTAINOUS REGION AND MOSTLY ALONG A SERIES OF SECONDARY ROADS. THE REGION BOASTS A ROBUST SEASONAL POPULATION, SWELLING SIGNIFICANTLY THROUGHOUT THE SUMMER AND WINTER MONTHS, DUE TO THE CONSIDERABLE NUMBER OF SECOND HOMEOWNERS IN THE REGION, ALONG WITH INCREASED TOURISM.

**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.

**DEMOGRAPHICS OF ESSEX COUNTY:**

- 37,381 RESIDENTS
- 25% ARE 65 YEARS OF AGE OR OLDER
- 91.7% OF THE POPULATION IS WHITE, 1.3% IS HISPANIC, AND 2.95% IS

**BLACK/AFRICAN AMERICAN**

- 94.4% ADULTS HAVE HEALTH INSURANCE

**SIGNIFICANT HEALTH NEEDS IDENTIFIED IN 2023 CHNA:**

- CHRONIC DISEASE
- OBESITY
- ACCESS TO HEALTHY FOOD
- ACCESS TO CARE
- SUBSTANCE ABUSE
- BEHAVIORAL HEALTH

**NEEDS SELECTED FOR 2023 IMPLEMENTATION STRATEGY:**

- PREVENT CHRONIC DISEASE
- PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE ABUSE DISORDERS
- PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

**NEEDS NOT SELECTED:**

- PROMOTE A HEALTHY AND SAFE ENVIRONMENT
- PREVENT COMMUNICABLE DISEASE

**RATIONALE:**

- WHILE NOT SELECTED FOR THE COMMUNITY SERVICE PLAN, THE TWO INTERVENTIONS ARE INCORPORATED INTO THE SELECTED PRIORITIES

**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.

**HIGHLIGHTS FROM 2023 IMPLEMENTATION STRATEGY:**

- PREVENT CHRONIC DISEASE

- FOOD PANTRY IN CPHC OPENED IN 10/2019 AND FOOD PANTRY IN APHC OPENED IN 11/2019. JOINED THE REGIONAL FOOD BANK IN 9/2020

- EVENTS HELD IN 2024

- HEART HEALTH

- WOMEN'S HEALTH

- HUNTER'S SCREENING

- MENTAL HEALTH AWARENESS

- BLOOD DRIVES

- DIABETES AWARENESS

- STROKE READINESS

- TELEHEALTH INCREASE - OUTPATIENT VISITS FOR PRIMARY CARE

ADDED IN 2020.

- CHRONIC DISEASE WELLNESS COACH - CERTIFIED AND TO BEGIN DIABETES

PREVENTION PROGRAM

- PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDER

- SBIRT IMPLEMENTED IN BOTH HOSPITAL CAMPUSES AND ALL 6 PRIMARY CARE

SITES

- CREATION OF MEDICAL VILLAGE IN PRIMARY CARE. (ADDITION OF PRIMARY

CARE 2021)

- NARCAN KITS IN BOTH ED'S

- 2 PROVIDERS TRAINED IN MAT AND ABLE TO PRESCRIBE

- OPIOID STEWARDSHIP CREATED. PROVIDERS WILL BE MONITORED FOR

PRESCRIBING PATTERNS.

**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.

**ESTIMATED COMPLETION DATE FOR NEXT CHNA AND IMPLEMENTATION STRATEGY:**

- CHNA: DECEMBER 2024
- IMPLEMENTATION STRATEGY: JANUARY 2025

**METHODS PLANNED FOR QUALITATIVE RESEARCH FOR NEXT CHNA:**

- TO BE DONE AS JOINT DOCUMENT WITH ESSEX COUNTY PUBLIC HEALTH

**DEPARTMENT BASED ON RESULTS OF COMMUNITY STAKEHOLDER SURVEY**

**METHODS PLANNED FOR QUANTITATIVE RESEARCH FOR NEXT CHNA:**

- ADIRONDACK RURAL HEATH NETWORK (AHRN) TO ASSIST WITH DATA COLLECTION

**AND INTERPRETATION AS WELL AS COMMUNITY STAKEHOLDER SURVEY**

**ELIZABETHTOWN COMMUNITY HOSPITAL:**

PART V, SECTION B, LINE 13B: TO BE ELIGIBLE FOR FINANCIAL ASSISTANCE FROM ELIZABETHTOWN COMMUNITY HOSPITAL, YOUR INCOME SHOULD BE AT OR BELOW THE YEARLY GUIDELINES BELOW. IF YOUR INCOME EXCEEDS THE GUIDELINES (400%) BUT YOU HAVE EXTENUATING CIRCUMSTANCES, AN APPLICATION MAY BE CONSIDERED WHEN SUBMITTED WITH A LETTER EXPLAINING YOUR EXTENUATING CIRCUMSTANCES.

**PART V, LINE 7A, HOSPITAL FACILITY'S WEBSITE:**

[HTTPS://WWW.ECH.ORG/ABOUT-US/COMMITMENT-TO-QUALITY](https://www.ech.org/about-us/commitment-to-quality)

**PART V, LINE 7B, OTHER WEBSITES FOR CHNA REPORT:**

[HTTPS://ESSEXCOUNTYNY.GOV/HEALTH/WP-CONTENT/UPLOADS/ESSEX-COUNTY-NY-CHA-2022\\_CHIP-2022-2024.PDF](https://essexcountyny.gov/health/wp-content/uploads/essex-county-ny-cha-2022_chip-2022-2024.pdf)

**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.

HTTPS://WWW.ADIRONDACKHEALTH.ORG/ABOUT/ABOUT-US

PART V, LINE 10A, MOST RECENTLY ADOPTED IMPLEMENTATION STARTEGY'S WEBSITE:

HTTPS://WWW.ECH.ORG/ABOUT-US/COMMITMENT-TO-QUALITY

PART V, LINE 16A, FAP WEBSITE

HTTPS://WWW.ECH.ORG/ABOUT-US/FINANCIAL-ASSISTANCE

PART V, LINE 16B, FAP APPLICATION WEBSITE:

HTTPS://WWW.ECH.ORG/ABOUT-US/FINANCIAL-ASSISTANCE

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

HTTPS://WWW.ECH.ORG/ABOUT-US/FINANCIAL-ASSISTANCE

**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? 7

Name and address	Type of facility (describe)
1 ELIZABETHTOWN COMMUNITY HEALTH CENTER 66 PARK STREET ELIZABETHTOWN, NY 12932	PRIMARY CARE HEALTH CENTER
2 HIGH PEAKS HEALTH CENTER 18 COMMUNITY CIRCLE WILMINGTON, NY 12997	PRIMARY CARE HEALTH CENTER
3 SMITH HOUSE HEALTH CENTER 39 FARRELL ROAD WILLSBORO, NY 12996	PRIMARY CARE HEALTH CENTER
4 WESTPORT HEALTH CENTER 6097 NYS ROUTE 9N WESTPORT, NY 12993	PRIMARY CARE HEALTH CENTER
5 AU SABLE FORKS HEALTH CENTER 15 PLEASANT STREET AU SABLE FORKS, NY 12912	PRIMARY CARE HEALTH CENTER
6 CROWN POINT HEALTH CENTER 2679 MAIN STREET CROWN POINT, NY 12928	PRIMARY CARE HEALTH CENTER
7 ECH TICONDEROGA OUTPATIENT CAMPUS 101 ADIRONDACK DRIVE, SUITE 1 TICONDEROGA, NY 12883	MEDICAL FACILITY OP CAMPUS

**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 (for example, open medical staff, community board, use of surplus funds, etc.).
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7, COLUMN (F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A),  
BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN  
THIS COLUMN IS \$ 3,686,669.

PART II, COMMUNITY BUILDING ACTIVITIES:

THE HOSPITAL STAFF PARTICIPATES IN MANY LOCAL EVENTS THAT PROVIDE  
COMMUNITY MEMBERS THE OPPORTUNITY TO LEARN ABOUT THE HOSPITAL AND ABOUT  
IMPORTANT HEALTH SCREENINGS. IN ADDITION, THE HOSPITAL HOSTS EVENTS AND  
OFFERS TRAINING AND SUPPORT SERVICES TO OTHER HEALTH-ORIENTED  
ORGANIZATIONS. ECH PARTICIPATES IN THE FOLLOWING:

- (1) PROVIDES ADVANCED LIFE SUPPORT TRAINING FOR REGIONAL EMERGENCY MEDICAL  
TECHNICIANS. (2) PROVIDES MEDICAL DIRECTORSHIP TO SEVERAL LOCAL EMS  
AGENCIES, PROVIDES MONTHLY COURSES AND EDUCATION FOR CME CREDITS. (3)  
OFFERS FREE DIABETES HEALTH SCREENINGS AT COMMUNITY HEALTH EVENTS. (4)  
LEND SPACE TO THE NORTH COUNTRY REGIONAL BLOOD DONOR CENTER FOR BLOOD  
DRIVES. (5) MEETING SPACE IS DONATED ON A MONTHLY BASIS TO EMS SQUADS.

**Part VI** Supplemental Information (Continuation)

TECHNOLOGICAL CAPABILITIES ALLOW FOR DISTANCE TRAINING / EDUCATION. (6) WORKS WITH THE CANCER SCREENING PROGRAM TO PROVIDE INFORMATION ABOUT MAMMOGRAMS AND BONE DENSITY SCREENING AT THE ANNUAL BREAST CANCER AWARENESS EVENT. (7) HOSTS THE ESSEX COUNTY DIABETES SUPPORT GROUP MEETINGS IN THE HOSPITAL BOARDROOM. (8) EMPLOYEES FROM THROUGHOUT THE HOSPITAL USE HOSPITAL PAID TIME TO LEND THEIR EXPERTISE AND INCREASE THEIR INTERESTS IN SUCH AREAS AS THE ESSEX CO. HEALTHY LIVING PARTNERSHIP, BEHAVIOR HEALTH SERVICES NORTH, RETIRED SENIOR VOLUNTEER PROGRAM, TASK FORCE AGAINST DOMESTIC VIOLENCE, KIWANIS AND NORTH COUNTRY LIFE FLIGHT. (9) ECH'S CLINICAL STAFF COMPLETES ADDITIONAL TRAINING EACH YEAR (ACLS, PALS, BLS, VARIOUS RN / NURSING TRAINING PROGRAMS, CHEMOTHERAPY EDUCATION, PHYSICIAN EDUCATION, INFECTION CONTROL TRAINING, RADIOLOGY DEPARTMENT CONTINUING EDUCATION, LAB STAFF EDUCATION, ETC.) (10) MEETING SPACE FOR AA AND NA. (11) EACH YEAR, THE HOSPITAL ALSO HOSTS EVENTS THAT OFFER FREE HEALTH SCREENINGS TO LOCAL RESIDENTS. THE COMMUNITY HEALTH SCREENINGS ARE COORDINATED BY PUBLIC RELATIONS STAFF BUT ARE DEPENDENT UPON CLINICAL STAFF TO PERFORM EXAMS AND INTERPRET THE RESULTS. EACH EVENT IS STAFFED BY 5-8 CLINICAL STAFF MEMBERS FOR APPROXIMATELY 3-4 HOURS PER EVENT.

(1) FALL HEALTH SCREENING (SEPTEMBER) IS A FREE, ANNUAL EVENT SPONSORED BY THE HOSPITAL. PARTICIPANTS RECEIVE A BASIC PHYSICAL / HEALTH SCREENING (EKG, BLOOD WORK, BLOOD PRESSURE, LAB TESTING, PHYSICIAN REVIEW AND REPORTING) AT NO COST. EVENT IS ARRANGED, COORDINATED AND PROMOTED BY ECH PUBLIC RELATIONS STAFF. IN 2024, THERE WERE 56 PARTICIPANTS AS THE EVENT REQUIRED APPOINTMENTS. (2) IN OCTOBER THE HOSPITAL HOSTS AN EVENT CO-SPONSORED BY THE CANCER SERVICES SCREENING PROGRAM OF ESSEX AND FRANKLIN COUNTIES. WOMEN WHO QUALIFIED (UN- OR UNDER-INSURED) WERE ABLE TO RECEIVE A CLINICAL BREAST EXAM AND MAMMOGRAM AT NO COST TO THEM, THROUGH THE CANCER SERVICES SCREENING PROGRAM OF ESSEX AND FRANKLIN COUNTIES. IN

**Part VI** Supplemental Information (Continuation)

2024, 10 FREE MAMMOGRAMS WERE COMPLETED DUE TO REQUIRED APPOINTMENTS.

PART III, LINE 4:

THE BAD DEBT INCLUDED ON LINE 2 IS DETERMINED AT COST. FINANCIAL STATEMENT FOOTNOTE FOR BAD DEBT EXPENSE:

PATIENT ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. IN EVALUATING THE COLLECTIBILITY OF PATIENT ACCOUNTS RECEIVABLE, THE HOSPITAL ANALYZES PAST PAYMENT HISTORY AND IDENTIFIES TRENDS FOR EACH MAJOR PAYOR SOURCE OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS AND PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE HOSPITAL ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS AND FOR PAYORS WHO ARE KNOWN TO BE HAVING FINANCIAL DIFFICULTIES THAT MAKE THE REALIZATION OF AMOUNTS DUE UNLIKELY). FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, THE HOSPITAL ALSO ANALYZES AMOUNTS DUE AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND A PROVISION FOR BAD DEBTS IN THE PERIOD OF SERVICE BASED ON PAST EXPERIENCE, INCLUDING CONSIDERATION OF CURRENT BUSINESS AND ECONOMIC CONDITIONS. WHEN THE HOSPITAL ESTABLISHES THE ALLOWANCE FOR DOUBTFUL ACCOUNTS THE HOSPITAL TAKES INTO CONSIDERATION THE FACT THAT MANY SELF-PAY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. THE DIFFERENCE BETWEEN THE STANDARD RATES AND THE AMOUNTS ACTUALLY COLLECTED AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.

THE HOSPITAL'S ALLOWANCE FOR DOUBTFUL ACCOUNTS WAS 28.9% AND 26.2% OF THE

**Part VI** Supplemental Information (Continuation)

RELATED PATIENT ACCOUNTS RECEIVABLE, NET OF CONTRACTUAL ALLOWANCES AT SEPTEMBER 30, 2024 AND 2023, RESPECTIVELY.

PART III, LINE 8:

USED MEDICARE ONLY TOTAL CHARGES FROM REVENUE REPORT FOR 2024 AND APPLIED THE RATIO OF COST TO CHARGES FROM THE 2023 COST REPORT DATA.

PART III, LINE 9B:

THE ELIZABETHTOWN COMMUNITY HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM OFFERS FREE OR REDUCED CARE TO OUR PATIENTS WHO ARE UNINSURED OR UNDERINSURED AND MEET THE INCOME ELIGIBILITY CRITERIA SET BY THE FOLLOWING GUIDELINES. THE FREE OR REDUCED CARE APPLIES ONLY TO THE SERVICES PROVIDED BY THE ELIZABETHTOWN COMMUNITY HOSPITAL, WESTPORT HEALTH CENTER, ELIZABETHTOWN COMMUNITY HEALTH CENTER, HIGH PEAKS HEALTH CENTER, AU SABLE FORKS HEALTH CENTER, SMITH HOUSE HEALTH CENTER, AND CROWN POINT HEALTH CENTER.

PART VI, LINE 2:

A NUMBER OF COMMUNITY PARTNERS ARE INVOLVED IN ASSESSING COMMUNITY HEALTH NEEDS WITHIN THE HOSPITAL'S SERVICE AREA. MEETINGS CONTINUED VIRTUALLY EACH QUARTER IN 2023-2024.

IN ADDITION TO ITS ESTABLISHED RELATIONSHIPS WITH OTHER HOSPITALS, COMMUNITY ORGANIZATIONS AND HEALTHCARE-BASED ORGANIZATIONS (EMS, PUBLIC HEALTH, MENTAL HEALTH, ETC.), ELIZABETHTOWN COMMUNITY HOSPITAL HAS PARTNERED WITH TWO REGIONAL GROUPS TO ASSESS THE REGION'S COMMUNITY HEALTH NEEDS - THE MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS COMMITTEE, AND THE ADIRONDACK RURAL HEALTH NETWORK.

**Part VI** Supplemental Information (Continuation)

MOBILIZING FOR ACTION THROUGH PLANNING & PARTNERSHIP (MAPP): AGENCY REPRESENTATIVES FROM CLINTON, ESSEX, AND FRANKLIN COUNTIES MEET TO APPLY COMMUNITY BASED APPROACHES TO LOCAL HEALTH ISSUES. THE MAPP GROUP HAS WORKED TO CULL INFORMATION THROUGH ASSESSMENTS OF THE LOCAL PUBLIC HEALTH SYSTEMS, A CDC LOCAL PUBLIC HEALTH INDICATOR SURVEY, A QUALITY OF LIFE SURVEY OF SENIORS AND PARENTS WITH CHILDREN, AND FOCUS GROUPS. THE MAPP GROUP SHARES UPDATED INFORMATION ON A CONTINUAL BASIS TO REASSESS PRIORITIES AND GAUGE PROGRAM SUCCESS.

ADIRONDACK RURAL HEALTH NETWORK (ARHN): THE ADIRONDACK RURAL HEALTH NETWORK IS A PARTNERSHIP OF PUBLIC, PRIVATE AND NON-PROFIT ORGANIZATIONS IN UPSTATE NEW YORK. ARHN MEMBERS COLLABORATE TO DEVELOP STRATEGIES ALONG WITH IMPLEMENTING, MONITORING AND EVALUATING VARIOUS INITIATIVES.

THIS GROUP CONTINUES TO MEET ON A (ROUGHLY) QUARTERLY BASIS IN ORDER TO SHARE INFORMATION, STATISTICS, SUCCESSES, CHALLENGES AND OUTCOMES.

ELIZABETHTOWN COMMUNITY HOSPITAL (ECH): IN ADDITION TO PARTNERSHIPS WITH THE ARHN AND THE MAPP PROCESSES, ECH INDEPENDENTLY SEEKS THE VIEWS OF COMMUNITY MEMBERS TO GAIN THEIR THOUGHTS REGARDING HEALTH CARE IN THEIR COMMUNITY AND GAIN FEEDBACK REGARDING ECH SERVICES. THROUGHOUT 2023-2024 MANY DIFFERENT METHODS WERE USED TO COMMUNICATE WITH AREA RESIDENTS. EACH YEAR THE HOSPITAL ADMINISTRATOR ATTENDS TOWN BOARD MEETINGS THROUGHOUT ESSEX COUNTY IN AN EFFORT TO UPDATE TOWN LEADERS AND COMMUNITY MEMBERS ABOUT THE HOSPITAL, ITS PLANS FOR THE FUTURE; AND TO ADDRESS ANY QUESTIONS. ANNUALLY, THE ADMINISTRATOR MEETS WITH EMS AND FIRE DEPARTMENTS WITHIN THE HOSPITAL SERVICE AREA TO ENCOURAGE OPEN COMMUNICATION AND FOSTER A GOOD WORKING RELATIONSHIP. THE ECH BOARD OF DIRECTORS IS COMPOSED

**Part VI** Supplemental Information (Continuation)

OF 14 REPRESENTATIVES OF EITHER A SPECIFIC COMMUNITY AND/OR ORGANIZATION, INCLUDING THE ESSEX COUNTY OFFICE FOR THE AGING, TOWN OF ELIZABETHTOWN SUPERVISORS OFFICE, AND ESSEX COUNTY MENTAL HEALTH. A PLANNING COMMITTEE, COMPRISED OF BOARD MEMBERS, IDENTIFIES GAPS IN SERVICE AND DEVELOPS GOALS TO FILL THESE NEEDS. PATIENT SATISFACTION SURVEYS ARE CONDUCTED FOR EACH DEPARTMENT ON A CONTINUAL BASIS.

PART VI, LINE 4:

ELIZABETHTOWN COMMUNITY HOSPITAL'S PRIMARY SERVICE AREA HAS REMAINED UNCHANGED FOR 2024 PLANNING PURPOSES. IT IS COMPOSED OF TWENTY-TWO ZIP CODES IN NORTHEASTERN ESSEX COUNTY. THE HOSPITAL IS LOCATED 45-60 MINUTES AWAY FROM ANY OTHER HOSPITAL; THROUGH A MOUNTAINOUS REGION AND MOSTLY ALONG A SERIES OF SECONDARY ROADS.

BASED ON U.S. CENSUS FOR 2020, 37,381 PEOPLE LIVE WITHIN ESSEX COUNTY OF WHICH 51.8% ARE MALE AND 48.2% ARE FEMALE. PEOPLE OVER THE AGE OF 65 CONSTITUTE 25% OF THE POPULATION AND INDIVIDUALS UNDER THE AGE OF 25 MAKE UP 21% OF THE POPULATION.

ETHNICALLY, 92.0% OF THE POPULATION IS WHITE, NON-HISPANIC.

PART VI, LINE 5:

THE HOSPITAL STAFF PARTICIPATES IN MANY LOCAL EVENTS THAT PROVIDE COMMUNITY MEMBERS THE OPPORTUNITY TO LEARN ABOUT THE HOSPITAL AND ABOUT IMPORTANT HEALTH SCREENINGS. IN ADDITION, THE HOSPITAL HOSTS EVENTS AND OFFERS TRAINING AND SUPPORT SERVICES TO OTHER HEALTH-ORIENTED ORGANIZATIONS. ECH PARTICIPATES IN THE FOLLOWING:

- (1) PROVIDES ADVANCED LIFE SUPPORT TRAINING FOR REGIONAL EMERGENCY MEDICAL

**Part VI** Supplemental Information (Continuation)

TECHNICIANS. (2) PROVIDES MEDICAL DIRECTORSHIP TO SEVERAL LOCAL EMS AGENCIES, PROVIDES MONTHLY COURSES AND EDUCATION FOR CME CREDITS. (3) OFFERS FREE DIABETES HEALTH SCREENINGS AT COMMUNITY HEALTH EVENTS. (4) LENDS SPACE TO THE NORTH COUNTRY REGIONAL BLOOD DONOR CENTER FOR BLOOD DRIVES. (5) MEETING SPACE IS DONATED ON A MONTHLY BASIS TO EMS SQUADS. TECHNOLOGICAL CAPABILITIES ALLOW FOR DISTANCE TRAINING / EDUCATION. (6) WORKS WITH THE CANCER SCREENING PROGRAM TO PROVIDE INFORMATION ABOUT MAMMOGRAMS AND BONE DENSITY SCREENING AT THE ANNUAL BREAST CANCER AWARENESS EVENT. (7) HOSTS THE ESSEX COUNTY DIABETES SUPPORT GROUP MEETINGS IN THE HOSPITAL BOARDROOM. (8) EMPLOYEES FROM THROUGHOUT THE HOSPITAL USE HOSPITAL PAID TIME TO LEND THEIR EXPERTISE AND INCREASE THEIR INTERESTS IN SUCH AREAS AS THE ESSEX CO. HEALTHY LIVING PARTNERSHIP, BEHAVIOR HEALTH SERVICES NORTH, RETIRED SENIOR VOLUNTEER PROGRAM, TASK FORCE AGAINST DOMESTIC VIOLENCE, KIWANIS AND NORTH COUNTRY LIFE FLIGHT. (9) ECH'S CLINICAL STAFF COMPLETES ADDITIONAL TRAINING EACH YEAR (ACLS, PALS, BLS, VARIOUS RN / NURSING TRAINING PROGRAMS, CHEMOTHERAPY EDUCATION, PHYSICIAN EDUCATION, INFECTION CONTROL TRAINING, RADIOLOGY DEPARTMENT CONTINUING EDUCATION, LAB STAFF EDUCATION, ETC.) (10) MEETING SPACE FOR AA AND NA. (11) THE COMMUNITY HEALTH FAIR HELD ALLOWED FOR COMMUNITY MEMBERS TO LEARN ABOUT AVAILABLE RESOURCES PERTAINING TO HEALTH AND WELLNESS. ELIZABETHTOWN COMMUNITY HOSPITAL WAS ABLE TO EDUCATE 125 PARTICIPANTS ABOUT THE SERVICES OFFERED AT THE HOSPITAL AND SIX PRIMARY CARE SITES. THE 2024 COMMUNITY HEALTH FAIR WAS CO-SPONSORED BY ADIRONDACK HEALTH INSTITUTE, FIDELIS, AND THE HOSPITAL'S AUXILIARY. CLINICAL STAFF WAS ON SITE CONDUCTING BLOOD PRESSURE SCREENS, ISS TEAM MEMBERS WERE AVAILABLE FOR PEOPLE WANTING TO ENROLL IN THE PATIENT PORTAL. HEALTHY REFRESHMENTS WERE PROVIDED AND NUTRITION EDUCATION WAS AVAILABLE WITH A DIABETIC EDUCATOR. EACH YEAR, THE HOSPITAL ALSO HOSTS EVENTS THAT OFFER FREE HEALTH

**Part VI** Supplemental Information (Continuation)

SCREENINGS TO LOCAL RESIDENTS. THE COMMUNITY HEALTH SCREENINGS ARE COORDINATED BY PUBLIC RELATIONS STAFF BUT ARE DEPENDENT UPON CLINICAL STAFF TO PERFORM EXAMS AND INTERPRET THE RESULTS. EACH EVENT IS STAFFED BY 5-8 CLINICAL STAFF MEMBERS FOR APPROXIMATELY 3-4 HOURS PER EVENT. (1) FALL HEALTH SCREENING (SEPTEMBER) IS A FREE, ANNUAL EVENT SPONSORED BY THE HOSPITAL. PARTICIPANTS RECEIVE A BASIC PHYSICAL / HEALTH SCREENING (EKG, BLOOD WORK, BLOOD PRESSURE, LAB TESTING, PHYSICIAN REVIEW AND REPORTING) AT NO COST. EVENT IS ARRANGED, COORDINATED AND PROMOTED BY ECH PUBLIC RELATIONS STAFF. IN 2024, THERE WERE 56 PARTICIPANTS. (2) IN OCTOBER THE HOSPITAL HOSTS AN EVENT CO-SPONSORED BY THE CANCER SERVICES SCREENING PROGRAM OF ESSEX AND FRANKLIN COUNTIES AND THE HOSPITAL'S AUXILIARY. THE EVENING FEATURES A SPEAKER, ALONG WITH THE OPPORTUNITY TO TAKE PART IN A FREE HEALTH SCREENING. WOMEN WHO QUALIFIED (UN- OR UNDER-INSURED) WERE ABLE TO RECEIVE A CLINICAL BREAST EXAM AND MAMMOGRAM AT NO COST TO THEM, THROUGH THE CANCER SERVICES SCREENING PROGRAM OF ESSEX AND FRANKLIN COUNTIES. IN 2024 THERE WERE 10 PARTICIPANTS.

PART VI, LINE 6:

THE UNIVERSITY OF VERMONT HEALTH NETWORK, A NOT-FOR-PROFIT CORPORATION, IS THE SOLE MEMBER OF THE HOSPITAL, ELIZABETHTOWN COMMUNITY HOSPITAL, LOCATED IN ELIZABETHTOWN, NEW YORK. ADDITIONAL AFFILIATES INCLUDE CHAMPLAIN VALLEY PHYSICIANS HOSPITAL, ALICE HYDE MEDICAL CENTER, CENTRAL VERMONT MEDICAL CENTER, PORTER MEDICAL CENTER AND HOME HEALTH AND HOSPICE.

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

NY

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

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

OMB No. 1545-0047

**2023**

Open to Public  
Inspection

Name of the organization

**ELIZABETHTOWN COMMUNITY HOSPITAL**

Employer identification number

**14-1364513**

**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 checked="" type="checkbox"/> Compensation committee   | <input checked="" type="checkbox"/> Written employment contract                     |
| <input type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study                    |
| <input type="checkbox"/> Form 990 of other organizations     | <input checked="" 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>	X	

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

Schedule J (Form 990) 2023

**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. DAVID CLAUS MEDICAL DIRECTOR - FORMER	(i) 0.	0.	0.	0.	0.	0.	0.
(ii) 498,926.	70,619.	16,715.	87,792.	34,664.	708,716.	0.	
(2) IL CHON CHIEF MEDICAL OFFICER	(i) 0.	0.	0.	0.	0.	0.	0.
(ii) 374,487.	28,088.	170,431.	19,800.	35,590.	628,396.	0.	
(3) DR. JASON SANDERS UVMG PRESIDENT & CEO	(i) 0.	0.	0.	0.	0.	0.	0.
(ii) 407,420.	89,269.	11,986.	58,037.	37,513.	604,225.	0.	
(4) BOB ORTMYER PRESIDENT & CEO	(i) 298,981.	28,139.	35,641.	51,084.	11,200.	425,045.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(5) AMY PUTNAM VP MEDICAL GROUP NETWORK DEPARTMENTS	(i) 0.	0.	0.	0.	0.	0.	0.
(ii) 245,473.	19,891.	19,356.	18,807.	36,553.	340,080.	0.	
(6) SCOTT COMEAU CFO	(i) 0.	0.	0.	0.	0.	0.	0.
(ii) 246,766.	17,387.	5,380.	11,017.	30,711.	311,261.	0.	
(7) MATTHEW NOLAN CHIEF OPERATING OFFICER	(i) 213,594.	15,797.	26,451.	11,516.	2,462.	269,820.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(8) JULIE TROMBLEE CHIEF NURSING OFFICER	(i) 195,856.	14,517.	5,378.	9,713.	2,956.	228,420.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(9) GRANT MARTIN INFORMATION TECHNOLOGY	(i) 160,023.	1,235.	27,430.	8,882.	29,846.	227,416.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(10) JOHN REMILLARD PRESIDENT - FORMER	(i) 0.	0.	0.	0.	0.	0.	0.
(ii) 227,250.	0.	0.	0.	0.	227,250.	0.	
(11) NANCY CAFFREY PHYSICIAN ASSISTANT	(i) 176,304.	1,306.	1,071.	8,372.	29,303.	216,356.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(12) JAMES L'EPISCOPO PHYSICIAN ASSISTANT	(i) 183,461.	1,195.	5,913.	8,396.	11,043.	210,008.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(13) REBECCA STWARD REGISTERED NURSE	(i) 159,144.	1,321.	9,294.	7,551.	12,162.	189,472.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(14) FRANK COOLIDGE REGISTERED NURSE	(i) 166,221.	1,366.	11,929.	8,046.	154.	187,716.	0.
(ii) 0.	0.	0.	0.	0.	0.	0.	
(i) 0.	0.	0.	0.	0.	0.	0.	
(ii) 0.	0.	0.	0.	0.	0.	0.	
(i) 0.	0.	0.	0.	0.	0.	0.	
(ii) 0.	0.	0.	0.	0.	0.	0.	

Part III Supplemental Information

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

PART I, LINE 1B:

(1A) PERSONAL SERVICE COMPENSATION

CERTAIN ELIZABETHTOWN COMMUNITY HOSPITAL OFFICERS, TRUSTEES, KEY EMPLOYEES, AND HIGHLY COMPENSATED EMPLOYEES RECEIVED 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.

PART I, LINE 3:

ELIZABETHTOWN COMMUNITY HOSPITAL RELIED ON THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK"), THE PARENT ORGANIZATION, 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 4B:

THE UNIVERSITY OF VERMONT HEALTH NETWORK, BY AND THROUGH ITS AFFILIATED SUBSIDIARIES, MAINTAINS A SUPPLEMENTAL RETIREMENT BENEFIT PLAN (SRP) UNDER CONTRACTUAL ARRANGEMENTS WITH SEVERAL PERSONS LISTED ON FORM 990, PART VII, SECTION A, LINE 1A. PURSUANT TO THE TERMS OF THE SRP, ANNUAL CREDITS WERE MADE EQUAL TO A FIXED PERCENTAGE OF BASE SALARY. THE FOLLOWING PERSONS PARTICIPATED IN THE SRP IN CALENDAR YEAR 2023, AND THEIR RESPECTIVE FIXED PERCENTAGE IS DESIGNATED IN PARENTHESES: BOB ORTMYER (6.42%)

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.

**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.

FOR THE PLANS NOTED ABOVE, AMOUNTS DEFERRED DURING CALENDAR YEAR 2023 ARE INCLUDED ON SCHEDULE J, PART II, COLUMN C. AMOUNTS DEFERRED REMAIN SUBJECT TO FOREFITURE IF CERTAIN CONDITIONS ARE NOT MET.

PART I, LINE 7:

ELIZABETHTOWN COMMUNITY HOSPITAL 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 REVISED AND APPROVED BY THE COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES. THESE MEASURES INCLUDED FINANCIAL, POPULATION HEALTH & QUALITY, AND OPERATIONAL RELATED METRICS.

PART I, LINE 8:

SALARIES AND OTHER FIXED AMOUNTS PAYABLE TO EXECUTIVES SUCH AS OFFICERS AND CERTAIN KEY EMPLOYEES ARE SET BY CONTRACTS THAT ARE NEGOTIATED AND ENTERED INTO PRIOR TO THE COMMENCEMENT OF EACH EXECUTIVES' EMPLOYMENT. THE TERMS OF SUCH CONTRACTS ARE APPROVED IN ADVANCE BY THE APPROPRIATE COMPENSATION COMMITTEE OR OTHER BOARD-AUTHORIZED BODY, WHICH OBTAINS AND RELIES ON

**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.

**APPROPRIATE DATA AS TO COMPARABILITY PRIOR TO MAKING SUCH OFFER, AND  
CONCURRENTLY DOCUMENTS ITS BASIS FOR DETERMINATION.**

Multiple horizontal lines for providing supplemental information.

**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

**2023**

Open to Public  
Inspection

Name of the organization

ELIZABETHTOWN COMMUNITY HOSPITAL

Employer identification number

14-1364513

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

TO PROMOTE WELLNESS IN THE COMMUNITIES WE SERVE BY PROVIDING QUALITY  
HEALTHCARE WITH SKILL, COMPASSION AND DIGNITY.

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

THE MISSION OF ECH IS TO PROMOTE HEALTH AND WELLNESS IN THE COMMUNITY  
AND TO PROVIDE QUALITY HEALTHCARE WITH SKILL, COMPASSION AND DIGNITY.  
IN CREATING OUR COMMUNITY BENEFITS PLAN WE KEEP THIS MISSION IN MIND,  
CONTINUALLY LOOKING FOR WAYS TO MEET COMMUNITY HEALTH NEEDS AND TO BE A  
GOOD NEIGHBOR. ECH IS DRIVEN BY PEOPLE WHO LIVE IN THE SERVICE AREA  
AND WHO WANT TO SEE THEIR FRIENDS AND NEIGHBORS GET THE CARE AND  
SERVICES THEY NEED.

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

FACILITY.

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

SCOTT COMEAU WAS EMPLOYED BY PORTER MEDICAL CENTER, INC., A RELATED  
ORGANIZATION AT WHICH HE AND ROBERT ORTMYER SERVED AS OFFICERS.

FORM 990, PART VI, SECTION A, LINE 4:

EFFECTIVE JANUARY 1, 2024, THE BYLAWS FOR ELIZABETHTOWN COMMUNITY HOSPITAL  
WERE AMENDED IN CONNECTION WITH A NETWORK-WIDE EFFORT TO PROMOTE EFFICIENCY  
AND STANDARDIZATION IN THE DELIVERY OF MEDICAL SERVICES THROUGH THE  
CREATION OF A SINGLE, UNIFIED MEDICAL STAFF (THE "MEDICAL STAFF"). THE  
AMENDMENTS REMOVE PROVISIONS IN THE BYLAWS RELATING TO THE ADMINISTRATION

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

Schedule O (Form 990) 2023

LHA 332211 11-14-23

Name of the organization <b>ELIZABETHTOWN COMMUNITY HOSPITAL</b>	Employer identification number <b>14-1364513</b>
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OF A SEPARATE MEDICAL STAFF, INCLUDING PROVISIONS GRANTING THE BOARD OF TRUSTEES AUTHORITY TO APPROVE MEDICAL STAFF AND CREDENTIALS. IN THE PLACE OF THESE PROVISIONS, ADDITIONAL PROVISIONS WERE ADDED RELATING TO THE ADMINISTRATION OF A CAMPUS ADVISORY COMMITTEE OF THE MEDICAL STAFF. THE CHAIR OF THE CAMPUS ADVISORY COMMITTEE SHALL SERVE EX OFFICIO, WITHOUT VOTE, ON THE BOARD OF TRUSTEES.

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

THE UNIVERSITY OF VERMONT HEALTH NETWORK (UVMHN) IS THE SOLE MEMBER OF ELIZABETHTOWN COMMUNITY HOSPITAL.

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

UVM HEALTH NETWORK HAS POWERS TO ELECT ELIZABETHTOWN COMMUNITY HOSPITAL'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, AMENDMENTS TO ELIZABETHTOWN COMMUNITY HOSPITAL'S BYLAWS AND ARTICLES OF THE ORGANIZATION, AND APPROVAL OF MAJOR FINANCIAL DECISIONS INCLUDING MERGERS, BANKRUPTCIES, AND THE DEVELOPMENT OR TERMINATION OF PROGRAM SERVICES. UVM HEALTH NETWORK IS A NON-PROFIT CORPORATION WHICH HAS BEEN RECOGNIZED BY THE IRS AS A 501(C)(3) ORGANIZATION THAT IS NOT A PRIVATE FOUNDATION.

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

THE 990 WILL BE PROVIDED TO THE BOARD PRIOR TO FILING.

Name of the organization ELIZABETHTOWN COMMUNITY HOSPITAL	Employer identification number 14-1364513
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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 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:

ELIZABETHTOWN COMMUNITY HOSPITAL DELEGATES THE SETTING OF EXECUTIVE COMPENSATION TO THE UVM HEALTH NETWORK COMPENSATION COMMITTEE, AN

Name of the organization

ELIZABETHTOWN COMMUNITY HOSPITAL

Employer identification number

14-1364513

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.

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

THESE DOCUMENTS ARE AVAILABLE TO THE PUBLIC UPON WRITTEN REQUEST.

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

CHG IN FAIR VALUE OF INTEREST RATE SWAP	357,028.
TRANSFER OF NET ASSETS	-212,100.
TOTAL TO FORM 990, PART XI, LINE 9	144,928.

FORM 990, PART XII, LINE 2C

THE FINANCE COMMITTEE (BOARD OF DIRECTORS) ASSUMES RESPONSIBILITY FOR





**Part II** Continuation of Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization?	
						Yes	No
CENTRAL VT MEDICAL CENTER - 22-2547186 111 COLCHESTER AVE BURLINGTON, VT 05401	HOSPITAL	VERMONT	501(C)(3)	LINE 3	JVMHN		X
UNIVERSITY HEALTH CENTER - 03-0229931 111 COLCHESTER AVE BURLINGTON, VT 05401	HOSPITAL	VERMONT	501(C)(3)	LINE 12D, III-O	JVMHNMG		X
COMMUNITY PROVIDERS INC - 22-2544844 75 BEEKMAN STREET PLATTSBURGH, NY 12901	HLTH SVC COORD	NEW YORK	501(C)(3)	LINE 12B, II	JVMHN		X
CHAMPLAIN VALLEY PHYSICIANS HOSPITAL - 14-1338471, 75 BEEKMAN STREET, PLATTSBURGH, NY 12901	HOSPITAL	NEW YORK	501(C)(3)	LINE 3	JVMHN		X
EMERGENCY MEDICAL TRANSPORT OF CVPH, INC - 06-1718419, 75 BEEKMAN STREET, PLATTSBURGH, NY 12901	AMBULANCE SVC	NEW YORK	501(C)(3)	LINE 12C, III-FI	CPI		X
CVPH MEDICAL CENTER FOUNDATION - 14-1727048 75 BEEKMAN STREET PLATTSBURGH, NY 12901	HLTH SVC COORD	NEW YORK	501(C)(3)	LINE 12C, III-FI	CVPH		X
UNIVERSITY MEDICAL EDUCATION ASSOCIATES - 23-7107832, 89 BEAUMONT AVENUE, BURLINGTON, VT 05401	EDUCATIONAL	VERMONT	501(C)(3)	LINE 11	JVMHNMG		X
ALICE HYDE MEDICAL CENTER - 15-0346515 133 PARK STREET MALONE, NY 12953	HOSPITAL	NEW YORK	501(C)(3)	LINE 3	JVMHN		X
PORTER MEDICAL CENTER INC - 03-0310862 115 PORTER DRIVE MIDDLEBURY, VT 05753	SUPPTG ORG	VERMONT	501(C)(3)	LINE 12C, III-FI	JVMHN		X
HELEN PORTER NURSING HOME - 03-0306549 37 PORTER DRIVE MIDDLEBURY, VT 05753	NURSING HOME	VERMONT	501(C)(3)	LINE 3	PMC		X
AUXILIARY OF PORTER MEDICAL CENTER - 23-7363227, 37 PORTER DRIVE, MIDDLEBURY, VT 05753	SUPPTG ORG	VERMONT	501(C)(3)	LINE 12C, III-FI	PMC		X
PORTER HOSPITAL INC - 03-0181058 37 PORTER DRIVE MIDDLEBURY, VT 05753	HOSPITAL	VERMONT	501(C)(3)	LINE 3	PMC		X







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

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

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

	Yes	No
<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
<b>(1)</b>	THE UNIVERSITY OF VERMONT HEALTH NETWORK	P	3,396,687.FMV	
<b>(2)</b>	VMCIC, INC.	M	401,275.FMV	
<b>(3)</b>	THE UNIVERSITY OF VERMONT MEDICAL CENTER	P	11,922,955.FMV	
<b>(4)</b>				
<b>(5)</b>				
<b>(6)</b>				





**Application for Extension of Time To File an Exempt Organization  
Return or Excise Taxes Related to Employee Benefit Plans**

Department of the Treasury  
Internal Revenue Service

File a separate application for each return.  
Go to [www.irs.gov/Form8868](http://www.irs.gov/Form8868) for the latest information.

**Electronic filing (e-file).** You can electronically file Form 8868 to request up to a 6-month extension of time to file any of the forms listed below except for Form 8870, Information Return for Transfers Associated With Certain Personal Benefit Contracts. An extension request for Form 8870 must be sent to the IRS in a paper format (see instructions). For more details on the electronic filing of Form 8868, visit [www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits](http://www.irs.gov/e-file-providers/e-file-for-charities-and-non-profits).

Caution: If you are going to make an electronic funds withdrawal (direct debit) with this Form 8868, see Form 8453-TE and Form 8879-TE for payment instructions.

All corporations required to file an income tax return other than Form 990-T (including 1120-C filers), partnerships, REMICs, and trusts must use Form 7004 to request an extension of time to file income tax returns.

**Part I - Identification**

<b>Type or Print</b>	Name of exempt organization, employer, or other filer, see instructions. <b>ELIZABETHTOWN COMMUNITY HOSPITAL</b>	Taxpayer identification number (TIN) <b>14-1364513</b>
File by the due date for filing your return. See instructions.	Number, street, and room or suite no. If a P.O. box, see instructions. <b>75 PARK STREET, P.O. BOX 277</b>	
	City, town or post office, state, and ZIP code. For a foreign address, see instructions. <b>ELIZABETHTOWN, NY 12932</b>	

Enter the Return Code for the return that this application is for (file a separate application for each return) 01

Application Is For	Return Code	Application Is For	Return Code
Form 990 or Form 990-EZ	01	Form 4720 (other than individual)	09
Form 4720 (individual)	03	Form 5227	10
Form 990-PF	04	Form 6069	11
Form 990-T (sec. 401(a) or 408(a) trust)	05	Form 8870	12
Form 990-T (trust other than above)	06	Form 5330 (individual)	13
Form 990-T (corporation)	07	Form 5330 (other than individual)	14
Form 1041-A	08		

• After you enter your Return Code, complete either Part II or Part III. Part III, including signature, is applicable only for an extension of time to file Form 5330.

• If this application is for an extension of time to file Form 5330, you must enter the following information.

Plan Name \_\_\_\_\_  
 Plan Number \_\_\_\_\_  
 Plan Year Ending (MM/DD/YYYY) \_\_\_\_\_

**Part II - Automatic Extension of Time To File for Exempt Organizations (see instructions)**

The books are in the care of **SCOTT COMEAU, CFO**  
**75 PARK STREET PO BOX 277 - ELIZABETHTOWN, NY 12932**

Telephone No. **518-873-3136** Fax No. \_\_\_\_\_

- If the organization does not have an office or place of business in the United States, check this box
- If this is for a Group Return, enter the organization's four-digit Group Exemption Number (GEN) \_\_\_\_\_. If this is for the whole group, check this box . If it is for part of the group, check this box  and attach a list with the names and TINs of all members the extension is for.

**1** I request an automatic 6-month extension of time until **AUGUST 15**, 20 **25**, to file the exempt organization return for the organization named above. The extension is for the organization's return for:  
 calendar year 20 \_\_\_\_ or  
 tax year beginning **OCT 1**, 20 **23**, and ending **SEP 30**, 20 **24**

**2** If the tax year entered in line 1 is for less than 12 months, check reason:  Initial return  Final return  
 Change in accounting period

<b>3a</b> If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter the tentative tax, less any nonrefundable credits. See instructions.	<b>3a</b>	\$	0.
<b>b</b> If this application is for Forms 990-PF, 990-T, 4720, or 6069, enter any refundable credits and estimated tax payments made. Include any prior year overpayment allowed as a credit.	<b>3b</b>	\$	0.
<b>c Balance due.</b> Subtract line 3b from line 3a. Include your payment with this form, if required, by using EFTPS (Electronic Federal Tax Payment System). See instructions.	<b>3c</b>	\$	0.

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