

Form **8879-TE****IRS E-file Signature Authorization
for a Tax Exempt Entity**

OMB No. 1545-0047

For calendar year 2024, or fiscal year beginning 10/01/2024 and ending 09/30/2025**2024**Department of the Treasury
Internal Revenue ServiceDo not send to the IRS. Keep for your records.
Go to www.irs.gov/Form8879TE for the latest information.

Name of filer

EIN or SSN

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

Name and title of officer or person subject to tax

KIMBERLY PATNAUDE, CFO

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	☒	b Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	334130468.
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

2024 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 PWC US TAX LLP to enter my PIN 44418 as my signature
ERO firm name Enter five numbers, but do not enter all zeros

on the tax year 2024 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 2024 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

Kimberly Patnaude, FACHE, CFO

Date

08/12/2024**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.

04363892046

Do not enter all zeros

I certify that the above numeric entry is my PIN, which is my signature on the 2024 electronically filed return indicated above. I confirm that I am submitting the 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

Kimberly Patnaude

Date

08/12/2026**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 back of form.

Form **8879-TE** (2024)

JSA

4X3008 3.000

5194IM U493

V24-7.16

Form 990

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2024

Open to Public
Inspection

A For the 2024 calendar year, or tax year beginning 10/01/2024 and ending 09/30/2025	
B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Final return/terminated ☐ Amended return ☐ Application pending	C Name of organization CENTRAL VERMONT MEDICAL CENTER, INC. Doing business as Number and street (or P.O. box if mail is not delivered to street address) Room/suite 130 FISHER ROAD City or town, state or province, country, and ZIP or foreign postal code BERLIN, VT 05602 F Name and address of principal officer: MARC KOSAK 130 FISHER ROAD, BERLIN, VT 05602 H(a) Is this a group return for subordinates? ☐ Yes ☒ No H(b) Are all subordinates included? ☐ Yes ☐ No If "No," attach a list. See instructions. H(c) Group exemption number
D Employer identification number 22-2547186 E Telephone number (802) 371-4100 G Gross receipts \$ 345,605,770.	I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () (insert no.) ☐ 4947(a)(1) or ☐ 527 J Website: WWW.CVMC.ORG K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other L Year of formation: 1963 M State of legal domicile: VT

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: CVMC WORKS COLLABORATIVELY TO MEET THE NEEDS AND IMPROVE THE HEALTH OF THE RESIDENTS OF CENTRAL VERMONT.	
	2 Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.	
	3 Number of voting members of the governing body (Part VI, line 1a) 3 11	
	4 Number of independent voting members of the governing body (Part VI, line 1b) 4 7	
	5 Total number of individuals employed in calendar year 2024 (Part V, line 2a) 5 1,844	
	6 Total number of volunteers (estimate if necessary) 6 129	
	7a Total unrelated business revenue from Part VIII, column (C), line 12 7a NONE	
	b Net unrelated business taxable income from Form 990-T, Part I, line 11 7b NONE	
Revenue	8 Contributions and grants (Part VIII, line 1h) 1,240,649. 1,403,190.	
	9 Program service revenue (Part VIII, line 2g) 315,431,660. 328,360,343.	
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 2,868,784. 3,841,677.	
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 370,305. 525,258.	
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12) 319,911,398. 334,130,468.	
	Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) 63,505. 340,549.
14 Benefits paid to or for members (Part IX, column (A), line 4) NONE NONE		
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) 183,350,803. 181,909,660.		
16a Professional fundraising fees (Part IX, column (A), line 11e) NONE NONE		
b Total fundraising expenses (Part IX, column (D), line 25) 262,418.		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 140,478,054. 149,936,033.		
Net Assets or Fund Balances	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25) 323,892,362. 332,186,242.	
	19 Revenue less expenses. Subtract line 18 from line 12 -3,980,964. 1,944,226.	
	20 Total assets (Part X, line 16) 176,619,849. 189,524,709.	
		21 Total liabilities (Part X, line 26) 87,255,589. 96,663,232.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer KIMBERLY PATNAUDE Type or print name and title	Date 08/12/2026	Check ☐ if self-employed	PTIN P01441612
	Print/Type preparer's name PAUL J TANIS Firm's name PWC US TAX LLP Firm's address 101 SEAPORT BLVD., SUITE 500 BOSTON, MA 02210	Preparer's signature 	Firm's EIN 92-0460586 Phone no. 617-530-5000	

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form 990 (2024)

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☐ Yes ☒ No**1** Briefly describe the organization's mission:

SEE SCHEDULE O

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

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

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

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

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.**4a** (Code:) (Expenses \$ 185,221,044. including grants of \$ 206,900.) (Revenue \$ 251,450,811.)

SEE SCHEDULE O

4b (Code:) (Expenses \$ 83,524,937. including grants of \$ NONE) (Revenue \$ 50,254,000.)

SEE SCHEDULE O

4c (Code:) (Expenses \$ 25,775,789. including grants of \$ 2,000.) (Revenue \$ 26,838,113.)

SEE SCHEDULE O

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

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

4e Total program service expenses 294,521,770.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

	Yes	No
1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable	113	
1b Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable.	NONE	
1c 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)		Yes	No
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a 1,844		
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		X	
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?			X
b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O			
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			X
b If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			X
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			X
c If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			
6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?			X
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			
7 Organizations that may receive deductible contributions under section 170(c).			
a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?			X
b If "Yes," did the organization notify the donor of the value of the goods or services provided?			
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			X
d If "Yes," indicate the number of Forms 8282 filed during the year	7d		
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			X
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			X
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			
8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			
9 Sponsoring organizations maintaining donor advised funds.			
a Did the sponsoring organization make any taxable distributions under section 4966?			
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?			
10 Section 501(c)(7) organizations. Enter:			
a Initiation fees and capital contributions included on Part VIII, line 12	10a		
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b		
11 Section 501(c)(12) organizations. Enter:			
a Gross income from members or shareholders	11a		
b Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b		
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a		
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b		
13 Section 501(c)(29) qualified nonprofit health insurance issuers.			
a Is the organization licensed to issue qualified health plans in more than one state? Note: See the instructions for additional information the organization must report on Schedule O.	13a		
b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b		
c Enter the amount of reserves on hand	13c		
14a Did the organization receive any payments for indoor tanning services during the tax year?	14a		X
b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O	14b		
15 Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.	15		X
16 Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.	16		X
17 Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? If "Yes," complete Form 6069.	17		

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**

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

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain 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.
 KIMBERLY PATNAUDE 130 FISHER RD BERLIN, VT 05602

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII ☒ X**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees****1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (box 5 of Form W-2, 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 dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/ 1099-MISC/ 1099-NEC)	(E) Reportable compensation from related organizations (W-2/ 1099-MISC/ 1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DR. SUNIL EAPPEN TRUSTEE	3.00 47.00	X						NONE	2,009,470.	226,275.
(2) ANNA T. NOONAN PRESIDENT & COO/TRUSTEE	45.00 5.00	X		X				594,284.	NONE	112,264.
(3) RYAN CLOUSER, MD TRUSTEE	45.00 5.00	X						NONE	457,653.	60,109.
(4) DR. BENJAMIN SMITH TRUSTEE (AS OF 3/2025)	1.00 44.00	X						NONE	406,794.	56,828.
(5) KIMBERLY PATNAUDE TREASURER, CFO	50.00 NONE			X				331,379.	NONE	43,401.
(6) JAMES ALVAREZ VP SUPPORT SERVICES	50.00 NONE				X			320,082.	NONE	36,205.
(7) SCOTT (ROBERT) NELSON, MD TRUSTEE (UNTIL 2/2025)	45.00 5.00	X						NONE	284,847.	53,807.
(8) MATTHEW CHOATE VP PATIENT CARE SERVICES	50.00 NONE				X			301,043.	NONE	34,706.
(9) JOSEPH JOHNSTON VP CLINICAL OPERATIONS	50.00 NONE				X			274,970.	NONE	46,191.
(10) ROBERT ROBINSON, MD PHYSICIAN	50.00 NONE					X		260,415.	NONE	26,698.
(11) HELEN HOLLENBACH PHYSICIAN ASST.	50.00 NONE					X		211,480.	NONE	43,370.
(12) SHANNON RIVARD NURSE PRACTITIONER	50.00 NONE					X		186,436.	NONE	45,940.
(13) CHRISTOPHER AUBIN PHYSICIAN ASST.	50.00 NONE					X		190,749.	NONE	33,740.
(14) WILLIAM KOWALEWSKI - ADMIN/VP AGING SVCS WDR (UNTIL 12/2024)	50.00 NONE				X			208,775.	NONE	15,520.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) ANNE LEWIS NURSE MANAGER	50.00 NONE					X		187,912.	NONE	36,342.
(16) LISA MULLER TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(17) JOYCE JUDY TRUSTEE, CHAIR	1.00 NONE	X		X				NONE	NONE	NONE
(18) KRISTIN CARLSON TRUSTEE (AS OF 1/2025)	1.00 NONE	X						NONE	NONE	NONE
(19) SANDY ROUSSE TRUSTEE (UNTIL 12/2024)	1.00 NONE	X						NONE	NONE	NONE
(20) CONSTANCE COLMAN TRUSTEE, SECRETARY	1.00 NONE	X		X				NONE	NONE	NONE
(21) JOAN MARIE MISEK TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
(22) ERICA METZGER HARE TRUSTEE, CHAIR ELECT	1.00 NONE	X		X				NONE	NONE	NONE
(23) MICHAEL DELLIPRISCOLI TRUSTEE	1.00 NONE	X						NONE	NONE	NONE
1b Sub-total								3,067,525.	3,158,764.	871,396.
c Total from continuation sheets to Part VII, Section A								NONE	NONE	NONE
d Total (add lines 1b and 1c)								3,067,525.	3,158,764.	871,396.

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 ► 218

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ► 30

Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII ☐

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants, and Other Similar Amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	40,000.			
	e	Government grants (contributions) . .	1e	955,977.			
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	407,213.			
	g	Noncash contributions included in lines 1a-1f	1g	\$ 10,000.			
	h	Total. Add lines 1a-1f		1,403,190.			
	Program Service Revenue				Business Code		
2a		NET PATIENT SERVICE REVENUE	900099	235,537,525.	235,537,525.		
b		REV FROM MANAGED CARE AND CAPITATED	900099	68,485,556.	68,485,556.		
c		340B CONTRACT PHARMACY REVENUE	900099	15,247,290.	15,247,290.		
d		BLUEPRINT PMPM	900099	854,972.	854,972.		
e		OTHER CONTRACT/CLIENT REVENUE	900099	1,502,814.	1,502,814.		
f		All other program service revenue		6,732,186.	6,732,186.		
g		Total. Add lines 2a-2f		328,360,343.			
Other Revenue		3	Investment income (including dividends, interest, and other similar amounts)		3,581,946.		
	4	Income from investment of tax-exempt bond proceeds . . .		NONE			
	5	Royalties		NONE			
	6a	Gross rents	(i) Real	624,489.			
			(ii) Personal				
	b	Less: rental expenses		99,231.			
	c	Rental income or (loss)		525,258.	NONE		
	d	Net rental income or (loss)		525,258.			525,258.
	7a	Gross amount from sales of assets other than inventory	(i) Securities	11,635,802.			
			(ii) Other				
	b	Less: cost or other basis and sales expenses . .		11,376,071.			
	c	Gain or (loss)		259,731.			
	d	Net gain or (loss)		259,731.			
	8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a	NONE			
	b	Less: direct expenses	8b	NONE			
c	Net income or (loss) from fundraising events		NONE				
9a	Gross income from gaming activities. See Part IV, line 19	9a	NONE				
b	Less: direct expenses	9b	NONE				
c	Net income or (loss) from gaming activities		NONE				
10a	Gross sales of inventory, less returns and allowances	10a	NONE				
b	Less: cost of goods sold	10b	NONE				
c	Net income or (loss) from sales of inventory		NONE				
Miscellaneous Revenue				Business Code			
	11a						
	b						
	c						
	d	All other revenue					
	e	Total. Add lines 11a-11d		NONE			
12	Total revenue. See instructions			334,130,468.	328,360,343.		4,107,204.

Part IX Statement of Functional Expenses

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

Check if Schedule O contains a response or note to any line in this Part IX ☒ X**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	323,049.	323,049.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	17,500.	17,500.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	NONE			
4 Benefits paid to or for members	NONE			
5 Compensation of current officers, directors, trustees, and key employees	2,079,065.		2,079,065.	
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	NONE			
7 Other salaries and wages	143,090,104.	135,299,719.	7,586,642.	203,743.
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,654,817.	6,202,384.	443,093.	9,340.
9 Other employee benefits	20,359,653.	18,975,485.	1,355,594.	28,574.
10 Payroll taxes	9,726,021.	9,064,790.	647,581.	13,650.
11 Fees for services (nonemployees):				
a Management	NONE			
b Legal	422,295.		422,295.	
c Accounting	NONE			
d Lobbying	26,446.		26,446.	
e Professional fundraising services. See Part IV, line 17	NONE			
f Investment management fees	2,365.		2,365.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Schedule O.)	SEE SCHE O 50,876,745.	28,768,045.	22,105,574.	3,126.
12 Advertising and promotion	13,417.		12,943.	474.
13 Office expenses	3,160,004.	2,568,208.	590,396.	1,400.
14 Information technology	1,336,121.	1,280,953.	55,168.	
15 Royalties	NONE			
16 Occupancy	8,744,994.	8,574,988.	170,006.	
17 Travel	89,230.	74,633.	14,194.	403.
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	NONE			
19 Conferences, conventions, and meetings	997,350.	757,866.	238,730.	754.
20 Interest	66,652.	66,652.		
21 Payments to affiliates	NONE			
22 Depreciation, depletion, and amortization	7,428,178.	7,428,178.		
23 Insurance	1,076,606.	647,620.	428,986.	
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 MEDICAL & SURGICAL SUPPLIES	48,552,195.	48,552,195.		
b STATE TAX ASSESSMENT	17,349,669.	17,349,669.		
c MAINTENANCE & REPAIRS	4,195,191.	4,093,608.	101,583.	
d FOOD EXPENSE	2,273,960.	2,200,663.	72,343.	954.
e All other expenses	3,324,615.	2,275,565.	1,049,050.	
25 Total functional expenses. Add lines 1 through 24e	332,186,242.	294,521,770.	37,402,054.	262,418.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ☐ if following SOP 98-2 (ASC 958-720)				

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	NONE	1	NONE
	2 Savings and temporary cash investments.	15,153,712.	2	18,133,385.
	3 Pledges and grants receivable, net	49,665.	3	596,575.
	4 Accounts receivable, net	26,348,766.	4	23,740,615.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	5	NONE
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B).	NONE	6	NONE
	7 Notes and loans receivable, net	3,148,010.	7	1,762,423.
	8 Inventories for sale or use	4,903,453.	8	5,022,452.
	9 Prepaid expenses and deferred charges	711,727.	9	754,017.
	10 a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 197,409,651.		
	b Less: accumulated depreciation.	10b 137,452,688.		
		54,347,613.	10c	59,956,963.
	11 Investments - publicly traded securities.	NONE	11	NONE
	12 Investments - other securities. See Part IV, line 11.	59,526,176.	12	64,836,329.
	13 Investments - program-related. See Part IV, line 11.	NONE	13	NONE
	14 Intangible assets	NONE	14	NONE
15 Other assets. See Part IV, line 11	12,430,727.	15	14,721,950.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	176,619,849.	16	189,524,709.	
Liabilities	17 Accounts payable and accrued expenses.	63,577,494.	17	61,530,339.
	18 Grants payable	-27,016.	18	42,973.
	19 Deferred revenue	81,235.	19	60,455.
	20 Tax-exempt bond liabilities	NONE	20	NONE
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	NONE	21	NONE
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	NONE	22	NONE
	23 Secured mortgages and notes payable to unrelated third parties	9,055,052.	23	7,456,181.
	24 Unsecured notes and loans payable to unrelated third parties.	NONE	24	NONE
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	14,568,824.	25	27,573,284.
	26 Total liabilities. Add lines 17 through 25.	87,255,589.	26	96,663,232.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here and complete lines 27, 28, 32, and 33. ☒			
	27 Net assets without donor restrictions.	79,459,751.	27	82,269,997.
	28 Net assets with donor restrictions.	9,904,509.	28	10,591,480.
	Organizations that do not follow FASB ASC 958, check here and complete lines 29 through 33. ☐			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	89,364,260.	32	92,861,477.
	33 Total liabilities and net assets/fund balances.	176,619,849.	33	189,524,709.

Form **990** (2024)

Part XI Reconciliation of Net AssetsCheck 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	334,130,468.
2	Total expenses (must equal Part IX, column (A), line 25)	2	332,186,242.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,944,226.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	89,364,260.
5	Net unrealized gains (losses) on investments	5	1,655,149.
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	-102,158.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	92,861,477.

Part XII Financial Statements and ReportingCheck if Schedule O contains a response or note to any line in this Part XII. ☒

- 1 Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis
- b Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis
- c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F?
- b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits . . .

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

Form 990 (2024)

SCHEDULE A
(Form 990)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2024

Open to Public
Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 ☐ A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990).)
- 3 ☒ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
- 10 ☐ An organization that normally receives (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**. Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations
- g Provide the following information about the supported organization(s).

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

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

Schedule A (Form 990) 2024

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) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f).						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2024 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2023 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2024. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization. ☐		
b 33 1/3% support test - 2023. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization ☐		
17a 10%-facts-and-circumstances test - 2024. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here . Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization. ☐		
b 10%-facts-and-circumstances test - 2023. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here . Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization. ☐		
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ☐		

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5.						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in)	(a) 2020	(b) 2021	(c) 2022	(d) 2023	(e) 2024	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						
14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ☐						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2024 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2023 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2024 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2023 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2024. 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 - 2023. 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
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? <i>If "Yes," complete Part I of Schedule L (Form 990).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

	Yes	No
1 Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? 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.		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.		

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

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

Schedule A (Form 990) 2024

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>)	5
6	Other distributions (<i>describe in Part VI</i>). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions.	8
9	Distributable amount for 2024 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2024	(iii) Distributable Amount for 2024
1	Distributable amount for 2024 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2024 (reasonable cause required - <i>explain in Part VI</i>). See instructions.			
3	Excess distributions carryover, if any, to 2024			
a	From 2019			
b	From 2020			
c	From 2021			
d	From 2022			
e	From 2023			
f	Total of lines 3a through 3e			
g	Applied to underdistributions of prior years			
h	Applied to 2024 distributable amount			
i	Carryover from 2019 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4	Distributions for 2024 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2024 distributable amount			
c	Remainder. Subtract lines 4a and 4b from line 4.			
5	Remaining underdistributions for years prior to 2024, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
6	Remaining underdistributions for 2024. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
7	Excess distributions carryover to 2025. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2020			
b	Excess from 2021			
c	Excess from 2022			
d	Excess from 2023			
e	Excess from 2024			

Schedule A (Form 990) 2024

**Schedule B
(Form 990)**

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

Name of the organization

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

☒ 501(c)(3) (enter number) organization

☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

☐ 527 political organization

Form 990-PF

☐ 501(c)(3) exempt private foundation

☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation

☐ 501(c)(3) taxable private foundation

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

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

General Rule

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

Special Rules

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

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

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

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

Name of organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	N/A	\$ 27,210.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
2	N/A	\$ 5,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
3	N/A	\$ 10,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
4	N/A	\$ 20,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
5	N/A	\$ 25,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
6	N/A	\$ 14,531.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)

Name of organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	N/A	\$ 7,063.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
8	N/A	\$ 5,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
9	N/A	\$ 6,540.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
10	N/A	\$ 82,136.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
11	N/A	\$ 5,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
12	N/A	\$ 7,500.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)

Name of organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
13	N/A	\$ 7,200.	Person ☐ Payroll ☐ Noncash ☒ (Complete Part II for noncash contributions.)
14	N/A	\$ 86,700.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
15	N/A	\$ 10,500.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
16	N/A	\$ 50,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
17	N/A	\$ 10,332.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
18	N/A	\$ 10,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)

Name of organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
19	N/A	\$ 5,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
20	N/A	\$ 12,500.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
21	N/A	\$ 40,000.	Person ☒ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
		\$	Person ☐ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
		\$	Person ☐ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)
		\$	Person ☐ Payroll ☐ Noncash ☐ (Complete Part II for noncash contributions.)

22-2547186

[illegible]

Name of organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
(e) Transfer of gift			
Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee	
_____		_____	
_____		_____	
_____		_____	

SCHEDULE C
(Form 990)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

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

Complete if the organization is described below. Attach to Form 990 or Form 990-EZ.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2024

Open to Public
Inspection

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

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

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

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

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

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

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

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."
- 2 Political campaign activity expenditures. See instructions \$
- 3 Volunteer hours for political campaign activities. See instructions

Part I-B Complete if the organization is exempt under section 501(c)(3).

- 1 Enter the amount of any excise tax incurred by the organization under section 4955. \$
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 \$
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
- 4a Was a correction made? ☐ Yes ☐ No
- b If "Yes," describe in Part IV.

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities. \$
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities. \$
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b \$
- 4 Did the filing organization file Form 1120-POL for this year? ☐ Yes ☐ No
- 5 Enter the names, addresses, and EINs of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

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

Schedule C (Form 990) 2024

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

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

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

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

4-Year Averaging Period Under Section 501(h)

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

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2021	(b) 2022	(c) 2023	(d) 2024	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990) 2024

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		26,446.
j Total. Add lines 1c through 1i			26,446.
2a Did the activities in line 1 cause the organization to not be described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

Part IV Supplemental Information

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

SEE PAGE 4

Part IV Supplemental Information *(continued)*

LOBBYING ACTIVITY

SCHEDULE C, PART II-B, LINE 1I

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

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

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

Open to Public
Inspection

Employer identification number

22-2547186

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

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year) . .		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?		☐ Yes ☐ No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?		☐ Yes ☐ No

Part II Conservation Easements

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

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

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

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

	Held at the End of the Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included on line 2a	2c
d Number of conservation easements included on line 2c acquired after July 25, 2006, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

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

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

(i) Revenue included on Form 990, Part VIII, line 1. \$

(ii) Assets included in Form 990, Part X. \$

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

a Revenue included on Form 990, Part VIII, line 1. \$

b Assets included in Form 990, Part X. \$

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 **d** ☐ Loan or exchange program
b ☐ Scholarly research **e** ☐ Other _____
c ☐ Preservation for future generations

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	9,388,705.	7,686,327.	6,959,979.	8,660,412.	7,967,045.
b Contributions			NONE	NONE	NONE
c Net investment earnings, gains, and losses	945,165.	1,778,218.	820,432.	-1,640,633.	779,068.
d Grants or scholarships			NONE	NONE	NONE
e Other expenditures for facilities and programs	30,934.	34,180.	53,432.	NONE	40,000.
f Administrative expenses	45,993.	41,660.	40,651.	59,800.	45,701.
g End of year balance	10,256,943.	9,388,705.	7,686,328.	6,959,979.	8,660,412.

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 37.2600 %
c Term endowment 62.7400 %

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:

- (i)** Unrelated organizations?
(ii) Related organizations?

	Yes	No
3a(i)	X	
3a(ii)	X	
3b	X	

b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		5,510,000.		5,510,000.
b Buildings		124,635,055.	91,270,347.	33,364,708.
c Leasehold improvements		4,503,303.	4,209,369.	293,934.
d Equipment		55,807,677.	41,972,972.	13,834,705.
e Other		6,953,616.		6,953,616.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, line 10c, column (B))				59,956,963.

Part VII Investments - Other Securities

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely held equity interests		
(3) Other		
(A) BENEFICIAL INTEREST IN HEALTH		
(B) NETWORK INVESTMENT POOL	64,836,329.	FMV
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, line 12, col. (B)) . . .	64,836,329.	

Part VIII Investments - Program Related

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

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, 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) OPR LEASE ROU ASSETS, NET	12,602,808.
(2) INVESTMENT 457 PLAN	2,119,142.
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 15, col. (B)).	14,721,950.

Part X Other Liabilities

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) OTHER LIABILITIES	14,975,556.
(3) LEASE LIABILITY - OPERATING	12,597,728.
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, line 25, col. (B)).	27,573,284.

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

SEE SUPPLEMENTAL PAGE

Part XIII Supplemental Information *(continued)*

ENDOWMENT FUNDS

SCHEDULE D, PART V, LINE 4

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

ASC 740 DISCLOSURE

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

CENTRAL VERMONT MEDICAL CENTER, INC. IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK"). PAGE 17 OF THE CONSOLIDATED FINANCIAL STATEMENTS CONTAINS A FOOTNOTE INDICATING THAT NO PROVISION FOR FEDERAL INCOME TAXES HAS BEEN RECORDED.

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2024

Open to Public
Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy (FAP) during the tax year? If "No," skip to question 6a	X	
1b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the FAP to its various hospital facilities during the tax year: ☒ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use federal poverty guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☒ Other 250.0000 %	X	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☒ 400% ☐ Other %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's FAP that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its FAP during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

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

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial assistance at cost (from Worksheet 1)			2,316,445.		2,316,445.	0.70
b Medicaid (from Worksheet 3, column a)			66,346,636.	28,009,918.	38,336,718.	11.54
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial assistance and means-tested government programs			68,663,081.	28,009,918.	40,653,163.	12.24
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			4,914.		4,914.	0.01
f Health professions education (from Worksheet 5)			1,100,482.		1,100,482.	0.33
g Subsidized health services (from Worksheet 6)			12,345,917.	9,289,747.	3,056,170.	0.92
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			365,549.	17,500.	348,049.	0.10
j Total. Other benefits			13,816,862.	9,307,247.	4,509,615.	1.36
k Total. Add lines 7d and 7j			82,479,943.	37,317,165.	45,162,778.	13.60

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

Schedule H (Form 990) 2024

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy	1		2,711.		2,711.	NONE
8 Workforce development	1	100.	1,512.		1,512.	NONE
9 Other						
10 Total	2	100.	4,223.		4,223.	NONE

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	60,845,504.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	162,495,904.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-101,650,400.
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☒ Cost to charge ratio ☐ Other		

Section C. Collection Practices

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

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

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

Part V	Facility Information
---------------	-----------------------------

Section A. Hospital Facilities

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

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

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

[illegible]

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

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

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

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
Community Health Needs Assessment (CHNA)		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	X
3 During the tax year or either of the 2 immediately preceding tax years, did the hospital facility conduct a CHNA? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	X
a ☒ A definition of the community served by the hospital facility		
b ☒ Demographics of the community		
c ☒ Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d ☒ How data was obtained		
e ☒ The significant health needs of the community		
f ☒ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g ☒ The process for identifying and prioritizing community health needs and services to meet the community health needs		
h ☒ The process for consulting with persons representing the community's interests		
i ☒ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA		
j ☐ Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: <u>2024</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	5	X
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	X
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	X
a ☒ Hospital facility's website (list url): <u>SEE SECTION C</u>		
b ☒ Other website (list url): <u>SEE SECTION C</u>		
c ☒ Made a paper copy available for public inspection without charge at the hospital facility		
d ☐ Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: <u>2025</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X
a If "Yes," list url: <u>SEE SECTION C</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

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

	Yes	No
Did the hospital facility have in place during the tax year a written FAP that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13 X	
a ☒ FPG, with FPG family income limit for eligibility for free care of and FPG family income limit <u>250.0000</u> % for eligibility for discounted care of <u>400.0000</u> %		
b ☐ Income level other than FPG (describe in Section C)		
c ☒ Asset level		
d ☒ Medical indigency		
e ☒ Insurance status		
f ☒ Underinsurance status		
g ☒ Residency		
h ☐ Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14 X	
15 Explained the method for applying for financial assistance?	15 X	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a ☒ Described the information the hospital facility may require an individual to provide as part of their application		
b ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of their application		
c ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e ☒ Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	16 X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a ☒ The FAP was widely available on a website (list url): <u>SEE SECTION C</u>		
b ☒ The FAP application form was widely available on a website (list url): <u>SEE SECTION C</u>		
c ☒ A plain language summary of the FAP was widely available on a website (list url): <u>SEE SECTION C</u>		
d ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f ☒ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g ☒ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i ☒ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by limited-English proficiency (LEP) populations		
j ☒ Other (describe in Section C)		

Schedule H (Form 990) 2024

Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group: CENTRAL VERMONT MEDICAL CENTER

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information (continued)**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group: CENTRAL VERMONT MEDICAL CENTER

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care:		
a	☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	☐ The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.	23	X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.	24	X

Schedule H (Form 990) 2024

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 3E

IN ACCORDANCE WITH THE REQUIREMENTS OF THE AFFORDABLE CARE ACT AND IN SUPPORT OF ITS COMMUNITY MISSION, CENTRAL VERMONT MEDICAL CENTER (CVMC) COMPLETED A FY2025/TY2024 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND A CORRESPONDING THREE-YEAR COMMUNITY HEALTH IMPROVEMENT PLAN. THIS ASSESSMENT REPRESENTS A CONTINUATION OF CVMC'S LONGSTANDING CHNA PROCESS, WITH PRIOR ASSESSMENTS CONDUCTED EVERY THREE YEARS SINCE 2013. THE FY2025 CHNA BUILDS ON EARLIER FINDINGS TO FURTHER STRENGTHEN COMMUNITY AND POPULATION HEALTH STRATEGIES, WITH A SUSTAINED EMPHASIS ON SOCIAL DRIVERS OF HEALTH AND ADVANCING HEALTH EQUITY ACROSS CENTRAL VERMONT.

THE FY2025 CHNA FOCUSES ON CVMC'S PRIMARY SERVICE AREA OF WASHINGTON COUNTY AND WAS CONDUCTED BETWEEN NOVEMBER 2024 AND JUNE 2025. CVMC PARTNERED WITH THRIVE, CENTRAL VERMONT'S ACCOUNTABLE COMMUNITY FOR HEALTH, AND CONVENED A MULTI-SECTOR STEERING COMMITTEE OF HOSPITAL LEADERS AND COMMUNITY PARTNERS TO GUIDE THE PROCESS. CVMC CONTRACTED WITH BUILD COMMUNITY, A WOMAN-OWNED RESEARCH FIRM SPECIALIZING IN EQUITY-CENTERED COMMUNITY RESEARCH, TO CONDUCT THE ASSESSMENT, ANALYZE FINDINGS, AND SUPPORT REPORTING. THE CHNA INCORPORATED ROBUST PRIMARY AND SECONDARY DATA COLLECTION, INCLUDING SURVEYS OF 1,312 COMMUNITY RESIDENTS, 186 KEY STAKEHOLDERS, AND MULTIPLE COMMUNITY CONVERSATIONS AND LISTENING SESSIONS.

REPRESENTATIVES FROM CVMC, THRIVE, AND THE COLLABORATIVE ACTION NETWORK (CAN) REVIEWED CHNA FINDINGS IN ALIGNMENT WITH STATEWIDE HEALTH DATA AND PRIORITIES, INCLUDING THE VERMONT DEPARTMENT OF HEALTH'S STATE HEALTH IMPROVEMENT PLAN. TO DETERMINE PRIORITY FOCUS AREAS, PARTNERS APPLIED STANDARDIZED CRITERIA ASSESSING THE SCOPE OF NEED, SEVERITY OF IMPACT, EXISTING DISPARITIES, FEASIBILITY OF ACTION, AVAILABILITY OF COMMUNITY RESOURCES, AND READINESS FOR COLLECTIVE IMPACT.

THROUGH THIS PRIORITIZATION PROCESS, CVMC IDENTIFIED FOUR PRIMARY COMMUNITY HEALTH PRIORITIES FOR THE 2025-2028 CYCLE:

- ACCESS TO CARE
- COST OF LIVING
- HOUSING
- MENTAL HEALTH AND SUBSTANCE USE DISORDERS

WHILE NOT DESIGNATED AS A STANDALONE PRIORITY, CVMC ALSO RECOGNIZES THE GROWING AND COMPLEX NEEDS OF OLDER ADULTS AND IS COMMITTED TO ADDRESSING AGING-RELATED HEALTH AND SOCIAL CONCERNS THROUGH INTEGRATED STRATEGIES ACROSS ALL PRIORITY AREAS.

OVERALL, THE 2025 CHNA CONFIRMS THAT WASHINGTON COUNTY CONTINUES TO EXPERIENCE BETTER OVERALL HEALTH OUTCOMES AND HIGHER LIFE EXPECTANCY THAN STATE AND NATIONAL AVERAGES, SUPPORTED BY STRONG COMMUNITY CONDITIONS, ACCESS TO HEALTHCARE SERVICES, AND A COLLABORATIVE NETWORK OF HEALTH AND

Part V Facility Information (continued)

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

HUMAN SERVICE PROVIDERS. HOWEVER, THE ASSESSMENT ALSO HIGHLIGHTS PERSISTENT AND WIDENING DISPARITIES WITHIN THE COUNTY, WITH SIGNIFICANT VARIATION IN LIFE EXPECTANCY, ECONOMIC STABILITY, HOUSING SECURITY, AND ACCESS TO CARE ACROSS ZIP CODES AND POPULATION GROUPS. MANY OF THESE CHALLENGES WERE EXACERBATED BY THE COVID-19 PANDEMIC, REPEATED FLOODING EVENTS, AND RISING COSTS OF LIVING, PLACING INCREASED STRAIN ON INDIVIDUALS, FAMILIES, AND SERVICE SYSTEMS.

THE FY2025 CHNA ALIGNS CLOSELY WITH VERMONT DEPARTMENT OF HEALTH PRIORITIES AND REINFORCES THE IMPORTANCE OF COORDINATED ACTION AMONG HOSPITALS, PUBLIC HEALTH AGENCIES, AND COMMUNITY-BASED ORGANIZATIONS. AS A RESULT OF THE CHNA PROCESS, CVMC AND ITS PARTNERS HAVE CONTINUED TO MAKE TARGETED INVESTMENTS IN COMMUNITY BENEFIT PROGRAMS, PARTNERSHIPS, AND INITIATIVES TO ADDRESS IDENTIFIED NEEDS. WHILE LONG-TERM OUTCOMES WILL BE EVALUATED OVER TIME, CVMC REMAINS COMMITTED TO ADVANCING EQUITABLE ACCESS TO CARE, STRENGTHENING COMMUNITY RESILIENCE, AND IMPROVING HEALTH AND WELLBEING FOR ALL CENTRAL VERMONTERS.

PART V, SECTION B, LINE 5

CENTRAL VERMONT MEDICAL CENTER (CVMC) TOOK INTO ACCOUNT INPUT FROM PERSONS REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY THROUGH A COMPREHENSIVE, MULTI-METHOD COMMUNITY ENGAGEMENT PROCESS CONDUCTED BETWEEN NOVEMBER 2024 AND JUNE 2025. THE FY2025/TY2024 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) INCORPORATED BOTH PRIMARY AND SECONDARY DATA AND WAS CONDUCTED IN COLLABORATION WITH COMMUNITY PARTNERS TO ENSURE THAT IDENTIFIED HEALTH NEEDS REFLECTED DATA-DRIVEN FINDINGS AS WELL AS LIVED EXPERIENCE.

PRIMARY DATA COLLECTION INCLUDED DIRECT ENGAGEMENT WITH COMMUNITY RESIDENTS, HEALTH AND HUMAN SERVICE PROVIDERS, PUBLIC HEALTH PROFESSIONALS, AND COMMUNITY LEADERS. CVMC RECEIVED INPUT FROM MORE THAN 1,500 INDIVIDUALS THROUGH MULTIPLE MECHANISMS, INCLUDING A COMMUNITY SURVEY COMPLETED BY 1,312 RESIDENTS OF WASHINGTON COUNTY AND AN ELECTRONIC KEY STAKEHOLDER SURVEY COMPLETED BY 186 REPRESENTATIVES FROM HEALTHCARE, PUBLIC HEALTH, SOCIAL SERVICE, EDUCATION, HOUSING, AND COMMUNITY-BASED ORGANIZATIONS. ADDITIONAL QUALITATIVE INPUT WAS GATHERED THROUGH COMMUNITY CONVERSATIONS, LISTENING SESSIONS, AND SMALL-GROUP DISCUSSIONS WITH SERVICE PROVIDERS AND COMMUNITY LEADERS.

SPECIAL EFFORTS WERE MADE TO SOLICIT INPUT FROM AND INCORPORATE THE PERSPECTIVES OF UNDERSERVED AND HISTORICALLY MARGINALIZED POPULATIONS, INCLUDING INDIVIDUALS WITH LOW INCOME, OLDER ADULTS, PEOPLE EXPERIENCING HOUSING INSTABILITY, PEOPLE WITH DISABILITIES, LGBTQIA+ COMMUNITY MEMBERS, AND PEOPLE OF COLOR. INPUT FOCUSED ON HEALTH CONCERNS, BARRIERS TO CARE, SERVICE GAPS, AND COMMUNITY-IDENTIFIED PRIORITIES AND SOLUTIONS.

Part V Facility Information (continued)

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

CVMC CONVENED A CHNA STEERING COMMITTEE COMPOSED OF HOSPITAL LEADERSHIP AND REGIONAL PARTNERS TO PROVIDE OVERSIGHT AND GUIDANCE THROUGHOUT THE ASSESSMENT PROCESS. THE STEERING COMMITTEE INCLUDED REPRESENTATIVES FROM CVMC, THE VERMONT DEPARTMENT OF HEALTH, WASHINGTON COUNTY MENTAL HEALTH SERVICES, GREEN MOUNTAIN UNITED WAY, AND THE UNIVERSITY OF VERMONT HEALTH NETWORK. A SUBCOMMITTEE OF THRIVE-THE REGION'S ACCOUNTABLE COMMUNITY FOR HEALTH-MET REGULARLY WITH CVMC TO REVIEW FINDINGS AND GUIDE THE CHNA PROCESS, HELPING TO ENSURE REGIONAL ALIGNMENT AND COLLECTIVE IMPACT.

IN ADDITION TO STEERING COMMITTEE MEMBERS, CVMC CONSULTED WITH A BROAD RANGE OF ORGANIZATIONS AND INDIVIDUALS REPRESENTING THE COMMUNITY, AS DOCUMENTED IN THE CHNA'S KEY STAKEHOLDER SURVEY PARTICIPANT LIST. THESE CONSULTEES INCLUDED REPRESENTATIVES FROM PUBLIC HEALTH AGENCIES, HOSPITALS AND CLINICS, BEHAVIORAL HEALTH PROVIDERS, HOUSING AND HOMELESSNESS ORGANIZATIONS, FOOD ACCESS PROGRAMS, SOCIAL SERVICE AGENCIES, SCHOOLS AND SCHOOL DISTRICTS, EMERGENCY MEDICAL SERVICES, FAITH-BASED ORGANIZATIONS, MUNICIPAL LEADERSHIP, ADVOCACY ORGANIZATIONS, AND PRIVATE CITIZENS. TOGETHER, THESE INDIVIDUALS REPRESENTED THE BROAD INTERESTS OF THE COMMUNITY SERVED BY CVMC.

OVERALL, CVMC SYSTEMATICALLY INTEGRATED QUANTITATIVE DATA AND EXTENSIVE COMMUNITY INPUT INTO THE IDENTIFICATION AND PRIORITIZATION OF SIGNIFICANT HEALTH NEEDS FOR THE FY2025/TY2024 CHNA, ENSURING THAT COMMUNITY VOICES MEANINGFULLY INFORMED COMMUNITY HEALTH PLANNING AND FUTURE IMPLEMENTATION STRATEGIES.

PART V, SECTION B, LINE 6B

THE FY2025/TY2024 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) FOR CENTRAL VERMONT MEDICAL CENTER (CVMC) WAS CONDUCTED IN COLLABORATION WITH MULTIPLE ORGANIZATIONS OTHER THAN HOSPITAL FACILITIES. CONSISTENT WITH PRIOR CHNA CYCLES (INCLUDING THE 2022-2025 CHNA), CVMC PARTNERED WITH THRIVE, THE REGIONAL ACCOUNTABLE COMMUNITY FOR HEALTH SERVING CENTRAL VERMONT. THRIVE IS A MULTI AGENCY COALITION COMPOSED OF HEALTH PROVIDERS, SOCIAL SERVICE AGENCIES, GOVERNMENT ENTITIES, CIVIC ORGANIZATIONS, FAITH BASED ORGANIZATIONS, AND OTHER COMMUNITY PARTNERS FOCUSED ON IMPROVING HEALTH FOR RESIDENTS OF WASHINGTON COUNTY AND SURROUNDING AREAS.

THROUGH THRIVE'S GOVERNANCE AND ADVISORY STRUCTURE, REPRESENTATIVES FROM A BROAD RANGE OF NON HOSPITAL ORGANIZATIONS PARTICIPATED IN CHNA LEADERSHIP, OVERSIGHT, DATA REVIEW, AND PRIORITY SETTING. ORGANIZATIONS REPRESENTED DURING THE FY2025 CHNA PROCESS INCLUDED, BUT WERE NOT LIMITED TO:

- . GREEN MOUNTAIN UNITED WAY
- . VERMONT DEPARTMENT OF HEALTH (INCLUDING THE BARRE LOCAL HEALTH OFFICE)

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.

. WASHINGTON COUNTY MENTAL HEALTH SERVICES
. CENTRAL VERMONT PREVENTION COALITION
. FAMILY CENTER OF WASHINGTON COUNTY
. PEOPLE'S HEALTH & WELLNESS CLINIC
. CAPSTONE COMMUNITY ACTION
. DOWNSTREET HOUSING & COMMUNITY DEVELOPMENT
. TURNING POINT CENTER OF CENTRAL VERMONT
. MONTPELIER AND BARRE COMMUNITY JUSTICE CENTERS
. GOOD BEGINNINGS OF CENTRAL VERMONT
. VERMONT FOODBANK
. MOSAIC VERMONT
. COMMUNITY FAITH BASED AND CIVIC ORGANIZATIONS, MUNICIPAL PARTNERS, AND
EDUCATION PARTNERS

THESE ORGANIZATIONS CONTRIBUTED SUBJECT MATTER EXPERTISE, COMMUNITY
PERSPECTIVES, AND GUIDANCE ON IDENTIFYING AND PRIORITIZING COMMUNITY
HEALTH NEEDS.

IN ADDITION, CVMC ENGAGED BUILD COMMUNITY, A NON HOSPITAL, WOMAN OWNED
RESEARCH AND PLANNING FIRM, TO SERVE AS THE EXTERNAL RESEARCH PARTNER FOR
THE FY2025 CHNA. BUILD COMMUNITY WAS RESPONSIBLE FOR PRIMARY AND
SECONDARY DATA COLLECTION, COMMUNITY ENGAGEMENT ACTIVITIES, ANALYSIS, AND
PREPARATION OF THE CHNA REPORT.

THIS COLLABORATIVE, MULTI SECTOR APPROACH REFLECTS CONTINUITY WITH PRIOR
CHNA CYCLES, DURING WHICH CVMC SIMILARLY PARTNERED WITH THRIVE, COMMUNITY
BASED ORGANIZATIONS, PUBLIC AGENCIES, AND COMMUNITY RESIDENTS TO ASSESS
NEEDS AND INFORM COMMUNITY HEALTH IMPROVEMENT PLANNING.

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

COMMUNITY HEALTH NEEDS ASSESSMENT
[HTTPS://WWW.UVMHEALTH.ORG/ABOUT-US/COMMUNITY-BENEFIT](https://www.uvmhealth.org/about-us/community-benefit)

IMPLEMENTATION STRATEGY
[HTTPS://WWW.UVMHEALTH.ORG/ABOUT-US/COMMUNITY-BENEFIT](https://www.uvmhealth.org/about-us/community-benefit)

HOSPITAL FACILITY WEBSITE:
[HTTPS://WWW.UVMHEALTH.ORG/PATIENTS-VISITORS/BILLING-INSURANCE/FINANCIAL-
ASSISTANCE](https://www.uvmhealth.org/patients-visitors/billing-insurance/financial-assistance)

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 11

CENTRAL VERMONT MEDICAL CENTER (CVMC) ADDRESSES THE SIGNIFICANT HEALTH NEEDS IDENTIFIED IN ITS MOST RECENTLY ADOPTED COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) THROUGH IMPLEMENTATION OF ITS COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP), DEVELOPED IN PARTNERSHIP WITH THRIVE, THE REGION'S ACCOUNTABLE COMMUNITY FOR HEALTH. THE ACTIVITIES DESCRIBED BELOW ARE BASED ON THE PRIORITIES AND IMPLEMENTATION STRATEGIES IDENTIFIED IN THE 2022-2025 CHNA CYCLE, WHICH REMAINED IN EFFECT FOR THE MAJORITY OF THE REPORTING PERIOD. ALTHOUGH CVMC COMPLETED A NEW CHNA IN 2025, THE UPDATED CHNA WAS NOT FORMALLY ADOPTED BY THE BOARD OF TRUSTEES OF THE UNIVERSITY OF VERMONT HEALTH NETWORK - CENTRAL VERMONT MEDICAL CENTER UNTIL SEPTEMBER 10, 2025. THEREFORE, THE PROGRAMS, INITIATIVES, AND OUTCOMES REPORTED BELOW PRIMARILY REFLECT EFFORTS UNDERTAKEN TO ADDRESS THE SIGNIFICANT COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA AND CORRESPONDING 2022-2025 COMMUNITY HEALTH IMPROVEMENT PLAN. THESE PRIORITY AREAS INCLUDED DIVERSITY, EQUITY AND INCLUSION; CHRONIC DISEASE PREVENTION; MENTAL HEALTH; SOCIAL DRIVERS OF HEALTH; AND SUBSTANCE USE DISORDERS. CVMC ADDRESSES THESE NEEDS THROUGH HOSPITAL-BASED PROGRAMS, COMMUNITY PARTNERSHIPS, REGIONAL COALITIONS, AND POPULATION HEALTH INITIATIVES DESIGNED TO IMPROVE HEALTH OUTCOMES AND ADVANCE HEALTH EQUITY THROUGHOUT CENTRAL VERMONT.

DIVERSITY, EQUITY AND INCLUSION

CVMC CONTINUED EFFORTS TO CREATE AN INCLUSIVE CARE ENVIRONMENT THAT HONORS THE DIVERSITY OF THE COMMUNITY, INCREASES CULTURAL AWARENESS AND HUMILITY, AND ADVANCES HEALTH EQUITY. DURING 2025, MORE THAN 90% OF CVMC LEADERS COMPLETED FACILITATOR-LED TRAINING ON UNCONSCIOUS BIAS AND MICROAGGRESSIONS, AND NEARLY 25% OF THE WORKFORCE COMPLETED AT LEAST ONE CULTURE, EXPERIENCE AND COMMUNITY HEALTH (CECH) EDUCATIONAL OFFERING. DIVERSITY, EQUITY, AND INCLUSION PRINCIPLES WERE INCORPORATED INTO TEAM HUDDLES AND HEART CHATS, REINFORCING EVERYDAY INCLUSION PRACTICES.

CVMC ALSO IMPLEMENTED A MULTI-MONTH MICROAGGRESSIONS EDUCATION SERIES, FACILITATED CASE-BASED LEARNING OPPORTUNITIES, EXPANDED LANGUAGE ACCESS AWARENESS, AND PARTICIPATED IN SYSTEM-WIDE HEALTH EQUITY INITIATIVES. THESE EFFORTS SUPPORT THE CHNA GOAL OF REDUCING DISPARITIES IN CARE AND IMPROVING EQUITABLE ACCESS AND PATIENT EXPERIENCE.

CHRONIC DISEASE PREVENTION

TO ADDRESS CHRONIC DISEASE PREVENTION AND IMPROVE CARE COORDINATION, CVMC PARTICIPATES IN THE VERMONT TEAM-BASED CARE INITIATIVE AND SUPPORTS INTEGRATED, TEAM-BASED MODELS OF CARE. THROUGH COLLABORATION WITH COMMUNITY PARTNERS, CVMC HELPED DEVELOP A REGIONAL ECOSYSTEM MAP OF CASE MANAGEMENT SERVICES, ESTABLISHED A LEAD CASE MANAGER FRAMEWORK, AND

Part V Facility Information (continued)

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

ADVANCED SHARED CARE PLANNING EFFORTS DESIGNED TO IMPROVE COORDINATION FOR INDIVIDUALS WITH COMPLEX HEALTH NEEDS.

CVMC'S INTEGRATED CARE MANAGEMENT TEAM, IN PARTNERSHIP WITH BLUEPRINT FOR HEALTH, PROVIDES COORDINATED CARE FOR PATIENTS WITH CHRONIC CONDITIONS INCLUDING DIABETES, HYPERTENSION, AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD). THE PROGRAM CONNECTS PATIENTS TO CLINICAL, BEHAVIORAL HEALTH, AND COMMUNITY-BASED SUPPORTS WHILE ADDRESSING BARRIERS TO CARE AND SOCIAL NEEDS THAT IMPACT HEALTH OUTCOMES.

CVMC ALSO SUPPORTS DISEASE PREVENTION AND SELF-MANAGEMENT THROUGH MYHEALTHYVT, WHICH PROVIDES OUTREACH, EDUCATION, AND EVIDENCE-BASED HEALTH PROMOTION PROGRAMS THROUGHOUT THE SERVICE AREA.

MENTAL HEALTH

IMPROVING ACCESS TO MENTAL HEALTH SERVICES REMAINS A KEY PRIORITY IDENTIFIED IN THE CHNA. CVMC HAS IMPLEMENTED PRIMARY CARE MENTAL HEALTH INTEGRATION (PCMHI) IN ALL PRIMARY CARE PRACTICES, EMBEDDING BEHAVIORAL HEALTH SERVICES WITHIN PRIMARY CARE SETTINGS AND IMPROVING ACCESS TO MENTAL HEALTH EVALUATION, TREATMENT, AND CARE COORDINATION. IN 2025, 954 UNIQUE PATIENTS RECEIVED PCMHI SERVICES, REPRESENTING A 74% INCREASE COMPARED TO 2024. THIS INTEGRATED MODEL SUPPORTS EARLY INTERVENTION, REDUCES BARRIERS TO TREATMENT, AND STRENGTHENS COORDINATION BETWEEN PRIMARY CARE AND BEHAVIORAL HEALTH PROVIDERS.

SOCIAL DRIVERS OF HEALTH

CVMC ADDRESSES SOCIAL DRIVERS OF HEALTH THROUGH PARTNERSHIPS THAT IMPROVE ACCESS TO FOOD, TRANSPORTATION, COMMUNITY RESOURCES, AND SUPPORTIVE SERVICES.

AS FISCAL SPONSOR AND CONVENER OF THRIVE, CVMC COLLABORATES WITH HEALTHCARE, PUBLIC HEALTH, SOCIAL SERVICE, EDUCATION, AND COMMUNITY PARTNERS TO ADDRESS SOCIAL CONDITIONS THAT INFLUENCE HEALTH AND WELL-BEING. THRIVE ALSO PARTNERED WITH CVMC IN CONDUCTING THE CHNA AND DEVELOPING THE CHIP.

FOOD INSECURITY INITIATIVES INCLUDE THE HEALTH CARE SHARES PROGRAM, OPERATED IN PARTNERSHIP WITH THE VERMONT YOUTH CONSERVATION CORPS, AND SPONSORSHIP OF THE VERMONT FOODBANK VEGGIE VAN GO PROGRAM. DURING FY2025, VEGGIE VAN GO SERVED 6,378 HOUSEHOLDS ACROSS CENTRAL VERMONT, A 13% INCREASE FROM THE PRIOR YEAR.

TRANSPORTATION BARRIERS ARE ADDRESSED THROUGH PARTNERSHIPS WITH VERMONT RIDE NETWORK AND COMMUNITY RIDES VERMONT. THESE PROGRAMS PROVIDE TRANSPORTATION TO MEDICAL APPOINTMENTS AND OTHER HEALTHCARE SERVICES, INCLUDING WHEELCHAIR-ACCESSIBLE TRANSPORTATION AND ZERO-EMISSION VEHICLE TRANSPORTATION OPTIONS FOR COMMUNITY MEMBERS WITH LIMITED ACCESS TO CARE.

Part V Facility Information (continued)

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

SUBSTANCE USE DISORDERS

THE CHNA IDENTIFIED SUBSTANCE USE DISORDERS AS A SIGNIFICANT COMMUNITY HEALTH NEED. CVMC ADDRESSES THIS PRIORITY THROUGH PREVENTION, TREATMENT, RECOVERY SUPPORT, HARM REDUCTION, AND COMMUNITY COLLABORATION. THROUGH THE BLUEPRINT FOR HEALTH SPOKE PROGRAM, CVMC PROVIDES INTEGRATED SERVICES FOR INDIVIDUALS RECEIVING MEDICATION FOR OPIOID USE DISORDER, INCLUDING COUNSELING, CARE COORDINATION, AND CONNECTIONS TO RECOVERY RESOURCES.

CVMC ALSO SUPPORTS THE CENTRAL VERMONT PREVENTION COALITION (CVPC), A REGIONAL COALITION REPRESENTING MORE THAN 115 PARTNER ORGANIZATIONS WORKING TO PREVENT SUBSTANCE MISUSE AND STRENGTHEN RECOVERY SYSTEMS. DURING 2025, CVPC IMPLEMENTED THE FIRST YEAR OF THE FUTURE VERMONT GRANT, WHICH FOCUSES ON YOUTH PREVENTION, FAMILY ENGAGEMENT, RECOVERY SUPPORT, AND COORDINATED COMMUNITY INTERVENTION STRATEGIES.

ADDITIONAL INITIATIVES INCLUDE PROJECT BEACON, WHICH SUPPORTS OVERDOSE SURVIVORS THROUGH NALOXONE DISTRIBUTION, HARM REDUCTION EDUCATION, AND CONNECTIONS TO TREATMENT AND RECOVERY SERVICES, AND THE RESOURCES AND OPTIONS FOR ALCOHOL DRINKING (ROAD) PROGRAM, WHICH EXPANDS EVIDENCE-BASED TREATMENT AND SUPPORT FOR INDIVIDUALS WITH ALCOHOL USE DISORDER. THROUGH ROAD, 17% OF PATIENTS SCREENING POSITIVE FOR ALCOHOL USE DISORDER IN CVMC PRIMARY CARE PRACTICES RECEIVED EVIDENCE-BASED MEDICATION TREATMENT, COMPARED WITH A NATIONAL RATE OF APPROXIMATELY 2%.

NEEDS NOT BEING ADDRESSED

CVMC IS ACTIVELY ADDRESSING ALL SIGNIFICANT HEALTH NEEDS IDENTIFIED IN ITS MOST RECENT CHNA THROUGH DIRECT PROGRAMS, COLLABORATIVE INITIATIVES, AND COMMUNITY PARTNERSHIPS. BECAUSE MANY HEALTH ISSUES-PARTICULARLY THOSE RELATED TO HEALTH EQUITY, CHRONIC DISEASE, BEHAVIORAL HEALTH, SUBSTANCE USE, AND SOCIAL DRIVERS OF HEALTH-ARE COMPLEX AND INFLUENCED BY MULTIPLE FACTORS, PROGRESS REQUIRES LONG-TERM COLLABORATION ACROSS HEALTHCARE, PUBLIC HEALTH, SOCIAL SERVICE, EDUCATION, GOVERNMENT, AND COMMUNITY ORGANIZATIONS. ACCORDINGLY, CVMC CONTINUES TO WORK WITH THRIVE AND NUMEROUS COMMUNITY PARTNERS TO ADVANCE SUSTAINABLE, COMMUNITY-WIDE SOLUTIONS. AT THIS TIME, NO SIGNIFICANT CHNA HEALTH NEED HAS BEEN IDENTIFIED AS WHOLLY UNADDRESSED.

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 15E

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

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

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

FINANCIAL ASSISTANCE POLICY (FAP) RESOURCES
THE FAP, THE FAP APPLICATION FORM, AND A PLAIN LANGUAGE SUMMARY OF THE FAP IS AVAILABLE AND PUBLISHED ON THE UNIVERSITY OF VERMONT HEALTH NETWORK FINANCIAL ASSISTANCE WEBPAGE LOCATED AT:
[HTTPS://WWW.UVMHEALTH.ORG/PATIENTS-VISITORS/BILLING-INSURANCE/FINANCIAL-ASSISTANCE](https://www.uvmhealth.org/patients-visitors/billing-insurance/financial-assistance)

PART V, SECTION B, LINE 16J

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

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.

GOVERNMENT AND EXCHANGE PROGRAMS AS WELL AS ASSISTANCE IN THE CENTRAL VERMONT MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM.

PART V, SECTION B, LINE 18F

CVMC DID NOT INITIATE ANY OF THE ACTIONS DESCRIBED IN SCHEDULE H, PART V, SECTION B, LINE 18. HOWEVER, IF THE HOSPITAL HAD UNDERTAKEN ANY OF THE LISTED ACTIONS, THE FACILITY WOULD HAVE FIRST NOTIFIED PATIENTS OF ITS FINANCIAL ASSISTANCE POLICY ON ADMISSION, PRIOR TO DISCHARGE, AND IN COMMUNICATIONS WITH THE PATIENTS REGARDING THEIR BILLS. ADDITIONALLY, CVMC WOULD HAVE DOCUMENTED DETERMINATION OF WHETHER PATIENTS WERE ELIGIBLE FOR FINANCIAL ASSISTANCE UNDER THE HOSPITAL FACILITY'S FINANCIAL ASSISTANCE POLICY.

PART V, SECTION B, LINE 20A

THE CENTRAL VERMONT MEDICAL CENTER'S BAD DEBT POLICY PROVIDES THAT CVMC SHALL NOT TAKE ANY EXTRAORDINARY COLLECTION ACTIONS.

Part V Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? 1

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

Schedule H (Form 990) 2024

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SCHEDULE H, PART VI, LINE 1

THE ORGANIZATION'S REQUIRED SCHEDULE H SPECIFIC LINE ITEM DESCRIPTIONS

ARE AS FOLLOWS:

PART I, LINES 3A-C:

ELIGIBILITY FOR FINANCIAL ASSISTANCE WILL BE CONSIDERED FOR THOSE WHO ARE UNINSURED, UNDERINSURED, AND INELIGIBLE FOR ANY GOVERNMENT HEALTH CARE BENEFIT PROGRAM. TO QUALIFY FOR FINANCIAL ASSISTANCE, AN ELIGIBLE PATIENT MUST PASS BOTH AN INCOME AND ASSETS TEST. THE INCOME TEST IS SET AT A MAXIMUM OF 400% FEDERAL POVERTY LEVEL GUIDELINES (FPLG) AND THE ASSET TEST ALLOWS LIQUID ASSETS EQUAL TO INCOME LEVELS OF 400% OF THE FEDERAL POVERTY LEVEL, ADJUSTED TO HOUSEHOLD SIZE. IF ASSETS ARE BELOW THE GUIDELINE, THE PATIENT PASSES THE ASSET TEST. ADDITIONALLY AND INDEPENDENTLY, FINANCIAL ASSISTANCE IS AVAILABLE TO MEDICALLY INDIGENT INDIVIDUALS WHOSE HOSPITAL BILLS EXCEED 20% OF ANNUAL HOUSHOLD INCOME.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PATIENTS MUST RESIDE WITHIN CENTRAL VERMONT MEDICAL CENTER'S SERVICE AREA, WHICH INCLUDES ALL OF VERMONT AND SELECT COUNTIES IN NEW YORK AND NEW HAMPSHIRE, UNLESS MEDICAL SERVICES WERE URGENT OR EMERGENT IN NATURE. FINANCIAL ASSISTANCE FOR RESIDENTS OUTSIDE OF CVMC'S SERVICE AREA WILL BE GRANTED IN UNIQUE CIRCUMSTANCES AND WITH APPROPRIATE APPROVAL.

PART I, LINE 7:

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7, COLUMN (F):

THE AMOUNT OF BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25,
BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE AMOUNT REPORTED ON LINE
7(F) IS \$0. PATIENT-RELATED BAD DEBT IN THE AMOUNT OF \$9,458,977 IS
NETTED FROM PATIENT REVENUE IN PART VIII, LINE 2.

PART III, LINE 2:

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 3:

DISCOUNTS AND PAYMENTS ON PATIENT ACCOUNTS ARE NETTED AGAINST THE TOTAL GROSS CHARGES WHEN DETERMINING BAD DEBT EXPENSE. THE \$189,180 REFLECTS THE ADJUSTED BAD DEBT EXPENSE FOR ALL PATIENTS WHO SUBMITTED AN INITIAL APPLICATION, BUT UPON FOLLOW-UP, DID NOT RESPOND TO REQUESTS FOR ADDITIONAL INFORMATION OR SUPPORTING DOCUMENTATION.

PART III, LINE 4:

PLEASE REFERENCE FOOTNOTE NUMBER 4 ON PAGE 17 IN THE FISCAL YEAR 2025 AUDITED CONSOLIDATED FINANCIAL STATEMENTS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 8:

THE AMOUNT REPORTED IN PART III, LINE 6, MEDICARE ALLOWABLE COSTS OF CARE, IS DERIVED FROM CENTRAL VERMONT MEDICAL CENTER'S FYE 9/30/25 MEDICARE COST REPORT, WORKSHEET D-1, COMPUTATION OF INPATIENT OPERATING COSTS, AND WORKSHEET E PART B, CALCULATION OF OUTPATIENT SETTLEMENT. WHILE CVMC HAS HISTORICALLY FOLLOWED THE CATHOLIC HOSPITAL ASSOCIATION'S GUIDANCE AND HAS NOT CONSIDERED ANY MEDICARE SHORTFALL (REPORTED IN PART III, LINE 7) AS A COMMUNITY BENEFIT, IT IS LIKELY THAT SOME PORTION OF MEDICARE PATIENTS WOULD HAVE QUALIFIED FOR CHARITY CARE UNDER OUR POLICIES IN THE ABSENCE OF MEDICARE COVERAGE, SUCH THAT SHORTFALLS ASSOCIATED WITH THOSE PATIENTS WOULD OTHERWISE HAVE BEEN INCLUDED IN OUR COMMUNITY BENEFITS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, LINE 9B:

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

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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

NEEDS ASSESSMENT

PART VI, LINE 2

CENTRAL VERMONT MEDICAL CENTER (CVMC) REGULARLY ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITIES IT SERVES THROUGH ONGOING DATA ANALYSIS, COMMUNITY ENGAGEMENT, AND CROSS-SECTOR COLLABORATION. THE 2025 CHNA WAS CONDUCTED IN PARTNERSHIP WITH THRIVE, THE REGIONAL ACCOUNTABLE COMMUNITY FOR HEALTH, AND AN INDEPENDENT RESEARCH FIRM, BUILD COMMUNITY. THE ASSESSMENT INCLUDED AN EXTENSIVE REVIEW OF PRIMARY AND SECONDARY DATA,

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

HEALTH TRENDS, DEMOGRAPHIC AND SOCIOECONOMIC INDICATORS, AND THE SOCIAL
DRIVERS OF HEALTH AFFECTING RESIDENTS IN CVMC'S SERVICE AREA.

PRIMARY DATA COLLECTION METHODS INCLUDED BROAD COMMUNITY ENGAGEMENT, SUCH
AS AN ONLINE COMMUNITY SURVEY WITH MORE THAN 1,300 RESIDENTS, A KEY
STAKEHOLDER SURVEY WITH 186 INDIVIDUALS REPRESENTING HEALTH CARE
PROVIDERS, SOCIAL SERVICE ORGANIZATIONS, GOVERNMENT AGENCIES, AND
COMMUNITY GROUPS, AS WELL AS COMMUNITY CONVERSATIONS AND LISTENING
SESSIONS WITH PROFESSIONALS SERVING PRIORITY POPULATIONS, INCLUDING OLDER
ADULTS. THESE METHODS WERE USED TO GATHER INPUT ON UNMET HEALTH AND
SOCIAL NEEDS, BARRIERS TO ACCESSING SERVICES, SERVICE DELIVERY GAPS, AND
OPPORTUNITIES FOR IMPROVEMENT.

SECONDARY DATA SOURCES INCLUDED LOCAL, STATE, AND NATIONAL PUBLIC HEALTH
AND DEMOGRAPHIC DATA, INCLUDING INFORMATION FROM THE U.S. CENSUS BUREAU,
CENTERS FOR DISEASE CONTROL AND PREVENTION, VERMONT DEPARTMENT OF HEALTH,
HEALTH RESOURCES AND SERVICES ADMINISTRATION, AND OTHER RECOGNIZED DATA
SETS. DATA WERE ANALYZED AT THE COUNTY, ZIP CODE, AND CENSUS TRACT LEVELS

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

TO IDENTIFY DISPARITIES, EMERGING TRENDS, AND AREAS OF HIGHER UNMET NEED.

THE ASSESSMENT INCORPORATED FRAMEWORKS SUCH AS SOCIAL DRIVERS OF HEALTH,

THE UNMET NEED SCORE, AND THE SOCIAL VULNERABILITY INDEX TO BETTER

UNDERSTAND DIFFERENCES IN HEALTH OUTCOMES AND ACCESS ACROSS COMMUNITIES.

CVMC AND THRIVE ALIGNED CHNA FINDINGS WITH THE VERMONT DEPARTMENT OF HEALTH STATE HEALTH IMPROVEMENT PLAN (SHIP) TO SUPPORT COORDINATED COMMUNITY HEALTH PLANNING AND PRIORITIZATION. THE RESULTS OF THE CHNA ARE USED TO INFORM CVMC'S COMMUNITY HEALTH IMPROVEMENT PLAN AND TO GUIDE COMMUNITY BENEFIT INVESTMENTS AND PARTNERSHIPS.

BEYOND THE FORMAL CHNA PROCESS, CVMC CONTINUOUSLY MONITORS COMMUNITY HEALTH NEEDS THROUGH ITS ROLE AS A PARTNER AND FISCAL SPONSOR OF THRIVE. THRIVE CONVENES A MULTI-SECTOR LEADERSHIP PARTNERSHIP THAT INCLUDES HEALTH CARE PROVIDERS, MENTAL HEALTH AND SUBSTANCE USE TREATMENT ORGANIZATIONS, SOCIAL SERVICE AGENCIES, GOVERNMENT ENTITIES, INSURERS, HOUSING ORGANIZATIONS, AND COMMUNITY-BASED NONPROFITS. THESE PARTNERS MEET REGULARLY TO SHARE DATA, IDENTIFY EMERGING ISSUES, COORDINATE

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SERVICES, AND SUPPORT SYSTEM-LEVEL SOLUTIONS TO IMPROVE ACCESS TO CARE,
REDUCE DISPARITIES, AND ADDRESS UPSTREAM SOCIAL AND ECONOMIC FACTORS
AFFECTING HEALTH.

THROUGH THIS COMBINATION OF PERIODIC COMPREHENSIVE ASSESSMENT AND ONGOING
COLLABORATIVE ENGAGEMENT, CVMC MAINTAINS A DYNAMIC UNDERSTANDING OF THE
HEALTH CARE AND HEALTH-RELATED NEEDS OF CENTRAL VERMONT RESIDENTS AND
ADAPTS STRATEGIES TO RESPOND TO EVOLVING COMMUNITY CONDITIONS.

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

[HTTPS://WWW.UVMHEALTH.ORG/SITES/DEFAULT/FILES/2025-09/CVMC-COMMUNITY-HEALTH-NEEDS-ASSESSMENT-2025.PDF](https://www.uvmhealth.org/sites/default/files/2025-09/CVMC-COMMUNITY-HEALTH-NEEDS-ASSESSMENT-2025.PDF)

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

PART VI, LINE 3

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

INFORM & EDUCATE:

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

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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

ASSIST:

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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

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

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

COMMUNITY INFORMATION

PART VI, LINE 4

COMMUNITY INFORMATION

CENTRAL VERMONT MEDICAL CENTER (CVMC) PRIMARILY SERVES RESIDENTS OF WASHINGTON COUNTY, WITH A SECONDARY SERVICE AREA INCLUDING NEIGHBORING COMMUNITIES IN CALEDONIA, CHITTENDEN, LAMOILLE, AND ORANGE COUNTIES.

DEMOGRAPHICS

. POPULATION GROWTH HAS REMAINED LIMITED. WASHINGTON COUNTY HAD AN ESTIMATED POPULATION OF 59,958 RESIDENTS IN 2023, REFLECTING APPROXIMATELY 1% TOTAL GROWTH FROM 2010 TO 2023, COMPARED TO FASTER GROWTH NATIONALLY. VERMONT AND WASHINGTON COUNTY CONTINUE TO GROW MORE SLOWLY THAN THE NATION OVERALL.

. THE POPULATION IS AGING RAPIDLY. FROM 2010 TO 2023, THE NUMBER OF ADULTS AGED 65 OR OLDER INCREASED BY MORE THAN 50% IN BOTH WASHINGTON COUNTY (52.1%) AND VERMONT OVERALL (53.8%). NEARLY 1 IN 5 RESIDENTS (ABOUT 21%) IN WASHINGTON COUNTY ARE NOW AGE 65 OR OLDER, COMPARED TO 16.8% NATIONALLY. THE MEDIAN AGE IN WASHINGTON COUNTY IS 43.7, SEVERAL

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

YEARS OLDER THAN THE NATIONAL MEDIAN.

. THE YOUTH POPULATION IS PROPORTIONALLY SMALLER. CHILDREN UNDER AGE 18

REPRESENT 18.3% OF WASHINGTON COUNTY RESIDENTS, COMPARED TO 22.2%

NATIONALLY, REFLECTING BOTH LOW BIRTH RATES AND OUT-MIGRATION OF YOUNGER

ADULTS.

. RACIAL AND ETHNIC DIVERSITY IS INCREASING, THOUGH THE POPULATION

REMAINS PREDOMINANTLY WHITE. BETWEEN 2010 AND 2023, THE SHARE OF

RESIDENTS IDENTIFYING AS MULTIRACIAL AND LATINX INCREASED, WHILE THE

PROPORTION IDENTIFYING AS WHITE DECLINED. DESPITE THESE SHIFTS,

WASHINGTON COUNTY RESIDENTS IDENTIFYING AS WHITE STILL REPRESENT OVER 90%

OF THE POPULATION, ALTHOUGH THIS SHARE CONTINUES TO TREND DOWNWARD.

. APPROXIMATELY 14.2% OF WASHINGTON COUNTY RESIDENTS LIVE WITH A

DISABILITY, WHICH IS SLIGHTLY HIGHER THAN THE NATIONAL AVERAGE (13.0%)

AND REFLECTS THE COUNTY'S OLDER AGE PROFILE. DISABILITY PREVALENCE IS

SUBSTANTIALLY HIGHER AMONG OLDER ADULTS (30.1% OF RESIDENTS AGE 65+).

. POVERTY LEVELS ARE BELOW NATIONAL AVERAGES BUT VARY SIGNIFICANTLY BY

LOCATION AND POPULATION.

- 9.4% OF WASHINGTON COUNTY RESIDENTS LIVE IN POVERTY, COMPARED TO

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

10.3% STATEWIDE AND 12.4% NATIONALLY.

- 10.7% OF CHILDREN AND 9.2% OF ADULTS AGE 65+ IN WASHINGTON COUNTY

LIVE IN POVERTY.

- SUBSTANTIAL VARIATION EXISTS BY ZIP CODE, WITH HIGHER POVERTY AND CHILD POVERTY RATES IN COMMUNITIES SUCH AS BARRE, ROXBURY, NORTHFIELD, AND MARSHFIELD, ILLUSTRATING LOCALIZED SOCIOECONOMIC DISPARITIES.

. HOUSING COST BURDEN REMAINS A SIGNIFICANT CHALLENGE.

- APPROXIMATELY 26% OF HOMEOWNERS IN WASHINGTON COUNTY ARE HOUSING COST BURDENED (SPENDING 30% OR MORE OF INCOME ON HOUSING).

- 42.9% OF RENTERS ARE COST BURDENED, MEANING NEARLY 1 IN 2 RENTER HOUSEHOLDS EXPERIENCES HOUSING-RELATED FINANCIAL STRAIN. ALTHOUGH THIS REPRESENTS A SLIGHT IMPROVEMENT SINCE THE PRIOR CHNA, HOUSING AFFORDABILITY REMAINS A KEY DRIVER OF INSTABILITY.

ACCESS TO HEALTH CARE

. INSURANCE COVERAGE IS HIGH. IN 2023, 97.1% OF WASHINGTON COUNTY RESIDENTS HAD HEALTH INSURANCE, EXCEEDING STATE AND NATIONAL BENCHMARKS AND SURPASSING THE HEALTHY PEOPLE 2030 GOAL. EMPLOYER-SPONSORED INSURANCE REMAINS THE MOST COMMON SOURCE OF COVERAGE, WHILE MEDICARE ENROLLMENT

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

INCREASED TO 23.3%, REFLECTING THE COUNTY'S AGING POPULATION.

. PRIMARY CARE AVAILABILITY EXCEEDS NATIONAL LEVELS BUT ACCESS CHALLENGES

PERSIST. WASHINGTON COUNTY HAS MORE PRIMARY CARE PHYSICIANS PER 100,000

RESIDENTS THAN THE NATIONAL AVERAGE, THOUGH THE RATE HAS DECLINED

SLIGHTLY SINCE 2018. DESPITE THIS RELATIVE AVAILABILITY, ONLY

APPROXIMATELY 70% OF ADULTS ACCESSED ROUTINE PRIMARY CARE IN 2022, WHICH

IS BELOW BOTH STATE AND NATIONAL AVERAGES.

. DENTAL CARE ACCESS IS BETTER THAN STATE AND NATIONAL NORMS BUT REMAINS

UNMET FOR MANY. ABOUT 69.1% OF ADULTS RECEIVED DENTAL CARE IN 2022,

HIGHER THAN VERMONT AND U.S. AVERAGES, YET ROUGHLY 3 IN 10 ADULTS DID NOT

OBTAIN NEEDED DENTAL SERVICES.

. BARRIERS TO CARE INCLUDE PROVIDER SHORTAGES, COST, TRANSPORTATION, AND

WAIT TIMES. COMMUNITY MEMBERS AND STAKEHOLDERS CONSISTENTLY IDENTIFIED

LONG WAIT TIMES, LIMITED PROVIDERS ACCEPTING MEDICAID OR MEDICARE, RISING

OUT-OF-POCKET COSTS, AND TRANSPORTATION CHALLENGES-PARTICULARLY FOLLOWING

CLINIC CLOSURES AND IN RURAL AREAS-AS KEY BARRIERS TO ACCESSING TIMELY

AND PREVENTIVE CARE.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PROMOTION OF COMMUNITY HEALTH

PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH

AS A PARTNER IN THE UNIVERSITY OF VERMONT HEALTH NETWORK, CENTRAL VERMONT MEDICAL CENTER (CVMC) ADVANCES ITS EXEMPT PURPOSE BY PROMOTING THE HEALTH OF THE COMMUNITY THROUGH REGION-WIDE COLLABORATION, OPEN ACCESS TO CARE, STRONG COMMUNITY GOVERNANCE, AND TARGETED INVESTMENTS ALIGNED WITH IDENTIFIED COMMUNITY HEALTH NEEDS. CVMC SERVES AS THE PRIMARY HEALTHCARE PROVIDER FOR APPROXIMATELY 66,000 RESIDENTS ACROSS 26 CENTRAL VERMONT COMMUNITIES AND IS COMMITTED TO IMPROVING POPULATION HEALTH, ADVANCING HEALTH EQUITY, AND ADDRESSING BOTH CLINICAL AND SOCIAL DRIVERS OF HEALTH.

CVMC CONDUCTS A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) EVERY THREE YEARS IN COLLABORATION WITH COMMUNITY PARTNERS AND RESIDENTS TO IDENTIFY PRIORITY HEALTH NEEDS AND GUIDE COMMUNITY BENEFIT INVESTMENTS. FINDINGS FROM THE 2022-2025 CHNA CYCLE AND THE FINALIZED 2025 CHNA IDENTIFIED PRIORITY AREAS INCLUDING ACCESS TO CARE AND SERVICES, MENTAL HEALTH AND

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SUBSTANCE USE DISORDERS, HOUSING AND COST OF LIVING, CHRONIC DISEASE PREVENTION, AND SOCIAL DRIVERS OF HEALTH. THESE FINDINGS DIRECTLY INFORM CVMC'S COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) AND ASSOCIATED STRATEGIES.

CVMC IS A FISCAL SPONSOR AND LEAD CONVENER FOR THRIVE, THE ACCOUNTABLE COMMUNITY FOR HEALTH IN CENTRAL VERMONT. THROUGH THRIVE, CVMC COLLABORATES WITH HEALTH CARE PROVIDERS, SOCIAL SERVICE AGENCIES, GOVERNMENT ENTITIES, AND COMMUNITY-BASED ORGANIZATIONS TO ADVANCE COLLECTIVE IMPACT AND IMPROVE COMMUNITY WELLBEING. NO SINGLE ORGANIZATION CAN ADDRESS POPULATION HEALTH NEEDS ALONE; CVMC'S LEADERSHIP ROLE SUPPORTS COORDINATED, REGIONAL SOLUTIONS.

IN ADDITION, CVMC SERVES AS THE ADMINISTRATIVE ENTITY FOR THE VERMONT BLUEPRINT FOR HEALTH FOR THE BARRE HEALTH SERVICE AREA, SUPPORTING PATIENT-CENTERED MEDICAL HOMES AND COMMUNITY HEALTH TEAMS FOCUSED ON CHRONIC DISEASE MANAGEMENT, MENTAL HEALTH INTEGRATION, AND CARE COORDINATION. COMMUNITY HEALTH TEAMS PROVIDE MULTIDISCIPLINARY

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SUPPORT-INCLUDING NURSING, DIETETICS, CARE MANAGEMENT, WELLNESS COACHING,
AND SOCIAL WORK-AT NO COST TO PATIENTS WITHIN PRIMARY CARE PRACTICES AND
WOMEN'S HEALTH SETTINGS.

THE MAJORITY OF CVMC'S GOVERNING BODY IS COMPOSED OF INDIVIDUALS WHO
RESIDE WITHIN THE HOSPITAL'S PRIMARY SERVICE AREA AND WHO ARE NOT
EMPLOYEES, CONTRACTORS, OR FAMILY MEMBERS, ENSURING STRONG COMMUNITY
OVERSIGHT AND ACCOUNTABILITY.

CVMC PARTICIPATES IN THE UNIVERSITY OF VERMONT HEALTH UNIFIED MEDICAL
STAFF. MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES ARE AVAILABLE TO
QUALIFIED PHYSICIANS AND OTHER ELIGIBLE PRACTITIONERS WHO MEET THE
QUALIFICATIONS, STANDARDS, AND REQUIREMENTS ESTABLISHED IN THE MEDICAL
STAFF BYLAWS AND CREDENTIALING POLICIES. APPLICATIONS FOR MEMBERSHIP AND
PRIVILEGES ARE EVALUATED THROUGH A CREDENTIALING AND PEER REVIEW PROCESS
AND ARE CONSIDERED WITHOUT DISCRIMINATION ON ANY BASIS PROHIBITED BY LAW.
CLINICAL PRIVILEGES MAY BE GRANTED IN DEPARTMENTS AND SPECIALTIES FOR
WHICH CVMC HAS ESTABLISHED PRIVILEGING CRITERIA AND HAS THE FACILITIES,

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

RESOURCES, AND SUPPORT SERVICES NECESSARY TO PROVIDE CARE SAFELY AND EFFECTIVELY.

CVMC ACTIVELY COLLABORATES WITH A BROAD NETWORK OF COMMUNITY PARTNERS TO FURTHER ITS CHARITABLE MISSION, INCLUDING BUT NOT LIMITED TO CENTRAL VERMONT HOME HEALTH AND HOSPICE, GREEN MOUNTAIN UNITED WAY, PEOPLE'S HEALTH AND WELLNESS CLINIC, VERMONT DEPARTMENT OF HEALTH, WASHINGTON COUNTY MENTAL HEALTH SERVICES, CENTRAL VERMONT PREVENTION COALITION, VERMONT FOODBANK, FAMILY CENTER OF WASHINGTON COUNTY, DOWNSTREET HOUSING AND COMMUNITY DEVELOPMENT, TURNING POINT CENTER OF CENTRAL VERMONT, AND LOCAL EMERGENCY MEDICAL SERVICES AND FOOD PANTRIES.

COMMUNITY BENEFIT ACTIVITIES AND INVESTMENTS IN 2023 AND 2024 SUPPORTED SUBSTANCE USE PREVENTION AND RECOVERY, FOOD SECURITY, TRANSPORTATION ACCESS, HOUSING STABILITY, WORKFORCE DEVELOPMENT, AND EMERGENCY RESPONSE. THESE EFFORTS INCLUDED CONVENING THE CENTRAL VERMONT PREVENTION COALITION, SUPPORTING HARM REDUCTION AND OVERDOSE PREVENTION INITIATIVES, EXPANDING FOOD ACCESS PROGRAMS SUCH AS HEALTH CARE SHARES AND VEGGIE VAN

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

GO, AND PARTNERING TO ADDRESS BARRIERS RELATED TO TRANSPORTATION,
HOUSING, AND ECONOMIC INSTABILITY.

CVMC ALSO APPLIES SURPLUS FUNDS TO IMPROVE COMMUNITY HEALTH BY
REINVESTING IN FACILITY UPGRADES, EQUIPMENT PURCHASES, STAFF EDUCATION,
AND PROGRAM ENHANCEMENTS THAT STRENGTHEN PATIENT- AND FAMILY-CENTERED
CARE AND ENSURE ACCESS TO HIGH-QUALITY SERVICES FOR THE COMMUNITY.

FINALLY, CVMC ADVANCES COMMUNITY HEALTH THROUGH WORKFORCE DEVELOPMENT AND
EDUCATION. IN RECENT YEARS, THE ORGANIZATION EXPANDED HEALTHCARE CAREER
PATHWAY PROGRAMS IN PARTNERSHIP WITH VERMONT EDUCATIONAL INSTITUTIONS,
FOCUSING ON LICENSED PRACTICAL NURSING, REGISTERED NURSING, SURGICAL
TECHNOLOGY, AND OTHER CRITICAL ROLES. THESE PROGRAMS SUPPORT ECONOMIC
STABILITY, WORKFORCE CAPACITY, AND LONG-TERM ACCESS TO CARE IN CENTRAL
VERMONT.

THROUGH COLLABORATIVE GOVERNANCE, STRATEGIC REINVESTMENT OF RESOURCES,
AND PARTNERSHIPS ADDRESSING BOTH HEALTHCARE AND SOCIAL NEEDS, CENTRAL

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

VERMONT MEDICAL CENTER CONTINUES TO FURTHER ITS EXEMPT PURPOSE BY
PROMOTING THE HEALTH AND WELLBEING OF THE COMMUNITIES IT SERVES.

AFFILIATED HEALTH CARE SYSTEM

PART VI, LINE 6

AFFILIATED HEALTH CARE SYSTEM:

AS OF OCTOBER 1, 2011, CENTRAL VERMONT MEDICAL CENTER, INC. (CVMC) AND
THE UNIVERSITY OF VERMONT MEDICAL CENTER (UVMC) BECAME MEMBERS OF THE
UNIVERSITY OF VERMONT HEALTH NETWORK (UVMHN), AN INTEGRATED SYSTEM OF
CARE SERVING THE COMMUNITIES OF VERMONT AND NORTHERN NEW YORK. THE
UNIVERSITY OF VERMONT HEALTH NETWORK IS CARRYING OUT CENTRALIZED
ACTIVITIES FOR THE BENEFIT OF PATIENTS OF PARTNER ORGANIZATIONS,
INCLUDING IMPROVING ACCESS TO LOCAL CARE, COST SAVINGS THROUGH GREATER
JOINT PURCHASING POWER, ENHANCING INFORMATION TECHNOLOGY, INCREASING
ACADEMIC OPPORTUNITIES FOR PHYSICIANS, ENGAGING IN REGIONAL STRATEGIC
PLANNING, AND PARTICIPATING IN JOINT QUALITY AND CLINICAL INITIATIVES.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

SINCE THE HEALTH NETWORK'S INCEPTION, CHAMPLAIN VALLEY PHYSICIANS
HOSPITAL MEDICAL CENTER, ELIZABETH COMMUNITY HOSPITAL, ALICE HYDE MEDICAL
CENTER, PORTER MEDICAL CENTER, AND UVM HEALTH NETWORK HOME HEALTH &
HOSPICE HAVE ALSO JOINED.

STATE FILING OF COMMUNITY BENEFIT REPORT

PART VI, LINE 7

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

SCHEDULE I
(Form 990)

Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Name of the organization

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

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

Attach to Form 990.

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

OMB No. 1545-0047

Open to Public
Inspection

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? ☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of noncash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) PEOPLES HEALTH AND WELLNESS CENTER 51 CHURCH ST BARRE, VT 05641	03-0343290	501(C)(3)	35,000.		FMV		HEALTH CARE FOR THE SVCS TO UNINSURED
(2) ONE ARTS COMMUNITY SCHOOLS PO BOX 532, BURLINGTON, VT 05401	86-3243278	501(C)(3)	150,000.		FMV		COMMUNITY SUPPORT
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 2
- 3 Enter total number of other organizations listed in the line 1 table NONE

Part III

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

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
1 ENDOWMENT SCHOLARSHIPS	7	17,500.		FMV	SCHOLARSHIPS
2					
3					
4					
5					
6					
7					

Part IV

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

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

SCHEDULE I, PART I, LINE 2

CENTRAL VERMONT MEDICAL CENTER OCCASIONALLY PROVIDES GRANT FUNDING TO ORGANIZATIONS WHOSE ACTIVITIES FURTHER THE HOSPITAL'S CHARITABLE PURPOSE OF SERVING THE HEALTH CARE NEEDS OF RESIDENTS OF CENTRAL VERMONT. GRANT FUNDS ARE AWARDED TO ORGANIZATIONS WITH PROGRAMS THAT ADDRESS COMMUNITY HEALTH NEEDS IDENTIFIED THROUGH THE HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), INCLUDING, BUT NOT LIMITED TO, INITIATIVES THAT IMPROVE ACCESS TO CARE, ADVANCE HEALTH EQUITY, SUPPORT POPULATION HEALTH,

Part III

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

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

Part IV

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

OR ADDRESS SOCIAL DETERMINANTS OF HEALTH. ALL GRANT AWARDS ARE SUBJECT TO

REVIEW, APPROVAL, AND OVERSIGHT BY THE HOSPITAL'S BOARD.

SCHEDULE J
(Form 990)

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

OMB No. 1545-0047

Open to Public
Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

Part I Questions Regarding Compensation

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

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

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

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.

- | | |
|--|--|
| ☐ Compensation committee | ☐ Written employment contract |
| ☐ Independent compensation consultant | ☐ Compensation survey or study |
| ☐ Form 990 of other organizations | ☐ Approval by the board or compensation committee |

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

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

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

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

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

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

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

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

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

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

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

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

Schedule J (Form 990) (Rev. 12-2024)

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 RYAN CLOUSER, MD TRUSTEE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	365,525.	66,386.	25,742.	24,150.	35,959.	517,762.	NONE
2 DR. BENJAMIN SMITH TRUSTEE (AS OF 3/2025)	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	392,058.	NONE	14,736.	20,700.	36,128.	463,622.	NONE
3 ANNA T. NOONAN PRESIDENT & COO/TRUSTEE	(i)	379,392.	128,425.	86,467.	76,788.	35,476.	706,548.	48,724.
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
4 MATTHEW CHOATE VP PATIENT CARE SERVICES	(i)	242,639.	46,243.	12,161.	18,297.	16,409.	335,749.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
5 JAMES ALVAREZ VP SUPPORT SERVICES	(i)	248,457.	46,166.	25,459.	12,729.	23,476.	356,287.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
6 DR. SUNIL EAPPEN TRUSTEE	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	1,366,935.	596,073.	46,462.	189,967.	36,308.	2,235,745.	NONE
7 KIMBERLY PATNAUDE TREASURER, CFO	(i)	287,891.	40,707.	2,781.	17,108.	26,293.	374,780.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
8 ROBERT ROBINSON, MD PHYSICIAN	(i)	247,445.	NONE	12,970.	13,563.	13,135.	287,113.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
9 ANNE LEWIS NURSE MANAGER	(i)	183,337.	NONE	4,575.	11,004.	25,338.	224,254.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
10 HELEN HOLLENBACH PHYSICIAN ASST.	(i)	144,736.	NONE	66,744.	12,510.	30,860.	254,850.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
11 CHRISTOPHER AUBIN PHYSICIAN ASST.	(i)	155,213.	10,000.	25,536.	1,878.	31,862.	224,489.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
12 SCOTT (ROBERT) NELSON, TRUSTEE (UNTIL 2/2025)	(i)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
	(ii)	246,379.	NONE	38,468.	17,031.	36,776.	338,654.	NONE
13 WILLIAM KOWALEWSKI - A AGING SVCS WDR (UNTIL 12/2024)	(i)	172,868.	31,445.	4,462.	12,441.	3,079.	224,295.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
14 JOSEPH JOHNSTON VP CLINICAL OPERATIONS	(i)	230,490.	43,198.	1,282.	7,739.	38,452.	321,161.	NONE
	(ii)	NONE	NONE	NONE	NONE	NONE	NONE	NONE
15 SHANNON RIVARD NURSE PRACTITIONER	(i)	142,559.		43,877.	11,491.	34,449.	232,376.	
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

SCHEDULE J, PART I, LINES 1A AND 1B

CERTAIN CENTRAL VERMONT MEDICAL CENTER OFFICERS, TRUSTEES, KEY EMPLOYEES, AND HIGHLY COMPENSATED EMPLOYEES RECEIVED COMPENSATION OF \$1,400 TO COVER TAX PREPARATION AND FINANCIAL ADVISORY SERVICES. ONE OFFICER RECEIVED THIS BENEFIT IN CALENDAR YEAR 2024. 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.

SCHEDULE J, PART I, LINE 3

CVMC RECEIVES GUIDANCE REGARDING ITS PRESIDENT'S COMPENSATION FROM THE UVM HEALTH NETWORK COMPENSATION COMMITTEE OF THE BOARD OF TRUSTEES, WHICH IS THE SOLE MEMBER OF THE HOSPITAL, THAT NETWORK COMPENSATION COMMITTEE

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.

UTILIZES THE FOLLOWING METHODS TO ESTABLISH THE GUIDANCE:

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

SCHEDULE J, PART I, LINE 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 2024, AND THEIR RESPECTIVE FIXED PERCENTAGE IS DESIGNATED IN PARENTHESES: ANNA T. NOONAN (8.68%) AND SUNIL EAPPEN (12.24%). 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.

ANNA T. NOONAN RECEIVED SRP DISTRIBUTIONS REFLECTED IN SCH J, PART II,
COL (B)(III) AND (F).

FOR THE PLANS NOTED ABOVE, THE AMOUNT DEFERRED FOR CALENDAR YEAR 2024 IS
INCLUDED ON SCHEDULE J, PART II, COLUMN C. AMOUNTS DEFERRED REMAIN
SUBJECT TO FORFEITURE IF CERTAIN CONDITIONS ARE NOT MET.

SCHEDULE J, PART I, LINE 7

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

SCHEDULE L

(Form 990)

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

**Open To Public
Inspection**

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

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

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

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

Part II Loans to and/or From Interested Persons

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

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

Part III Grants or Assistance Benefiting Interested Persons

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

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

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

Schedule L (Form 990) (Rev. 12-2024)

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) SUBSTANTIAL DONOR	SUBSTANTIAL CONTRIBUTOR	2,202,865.	CONSTRUCTION SERVICES		X
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

DESCRIPTION OF THE ORGANIZATION'S MISSION

FORM 990, PART III, LINE 1

CENTRAL VERMONT MEDICAL CENTER IS THE PRIMARY HEALTH CARE PROVIDER FOR
66,000 PEOPLE WHO LIVE AND WORK IN THE 26 COMMUNITIES OF CENTRAL VERMONT.
WE PROVIDE A COMPREHENSIVE RANGE OF SERVICES THROUGH OUR HOSPITAL, 25
COMMUNITY-BASED MEDICAL PRACTICES, AND 153-BED SKILLED NURSING FACILITY.

CENTRAL VERMONT MEDICAL CENTER HOSPITAL PROVIDES 24-HOUR EMERGENCY CARE,
WITH A FULL SPECTRUM OF INPATIENT (LICENSED FOR 122 BEDS) AND OUTPATIENT
SERVICES, CLOSE TO HOME. CENTRAL VERMONT MEDICAL CENTER NAMED ONE OF THE
NATION'S TOP 100 RURAL & COMMUNITY HOSPITALS BY THE NATIONAL RURAL HEALTH
ASSOCIATION (NRHA). TOP 100 RURAL COMMUNITY HOSPITALS ARE THOSE ACHIEVING
SUCCESS IN OVERALL PERFORMANCE BASED ON A COMPOSITE RATING FROM EIGHT
INDICATORS OF STRENGTH - INPATIENT MARKET SHARE, OUTPATIENT MARKET SHARE,
QUALITY, OUTCOMES, PATIENT PERSPECTIVES, COSTS, CHARGES AND FINANCIAL
STABILITY. IN ADDITION, CENTRAL VERMONT MEDICAL CENTER RECEIVED THE
AMERICAN HEART ASSOCIATION'S GET WITH THE GUIDELINES-RESUSCITATION SILVER
QUALITY ACHIEVEMENT AWARD. THIS AWARD ACKNOWLEDGES CVMC'S DEDICATION TO
IMPROVING SURVIVAL RATES FOR IN-HOSPITAL CARDIAC ARREST PATIENTS BY
CONSISTENTLY FOLLOWING THE LATEST RESEARCH-BASED TREATMENT GUIDELINES.
THESE GUIDELINES FOCUS ON PATIENT SAFETY, TIMELY MEDICAL EMERGENCY TEAM
RESPONSE, EFFECTIVE CPR, AND COMPREHENSIVE POST-RESUSCITATION CARE.

THE CENTRAL VERMONT MEDICAL CENTER PROFESSIONAL STAFF INCLUDES OVER 175
PHYSICIANS AND 90 ADVANCED PRACTICE PROVIDERS REPRESENTING 25 MEDICAL

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

SPECIALTIES.

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

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

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

GOVERNING BODY AND MANAGEMENT

FORM 990, PART VI, LINE 2

THERE IS A BUSINESS RELATIONSHIP BETWEEN DR. SUNIL EAPPEN, OFFICER OF THE
UNIVERSITY OF VERMONT MEDICAL CENTER (UVMCMC), DR. RYAN CLOUSER, AN
OFFICER OF CVMC, DR. BENJAMIN SMITH, A TRUSTEE OF CVMC, AND DR. SCOTT
(ROBERT) NELSON, AN OFFICER OF CVMC.

CHANGES TO GOVERNING DOCUMENTS

FORM 990, PART VI, LINE 4

EFFECTIVE DURING FISCAL YEAR 2025, THE BYLAWS FOR CVMC WERE AMENDED TO
REVISE THE MINIMUM NUMBER OF VOTING TRUSTEES SERVING ON THE BOARD OF
TRUSTEES. THE AMENDEMENT CHANGED THE GOVERNING PROVISIONS RELATED TO THE
COMPOSITION OF THE ORGANIZATION'S VOTING GOVERNING BODY BY ESTABLISHING A

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

MINIMUM OF EIGHT (8) VOTING TRUSTEES. NO OTHER SUBSTANTIVE CHANGES TO THE
GOVERNANCE STRUCTURE WERE MADE.

DESCRIPTION OF CLASSES OF MEMBERS OR STOCKHOLDERS

FORM 990, PART VI, LINE 6

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

ELECTION OF GOVERNING BODY & GOVERNANCE DECISIONS

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

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

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

FORM 990, PART VI, LINE 11B

THE FORM 990 IS PREPARED BY THE ACCOUNTING MANAGER AND REVIEWED IN DETAIL
BY CVMC'S OUTSIDE TAX ADVISORS BEFORE BEING REVIEWED BY THE OFFICERS OF
THE CORPORATION AND BY THE OTHER MEMBERS OF THE SENIOR MANAGEMENT TEAM.
THE ACCOUNTING MANAGER PROVIDES REGULATORY UPDATES REGARDING THE FORM 990
TO THE EXECUTIVE COMMITTEE AND MAKES AVAILABLE TO THE EXECUTIVE COMMITTEE
THE FORM 990 ALONG WITH HIGHLIGHTS OF ALL SIGNIFICANT PARTS OF THE FORM
990. THE COMPLETED FORM 990 IS PROVIDED TO ALL MEMBERS OF THE BOARD OF

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

TRUSTEES PRIOR TO THE FORM BEING FILED WITH THE IRS.

DESCRIPTION OF PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST

FORM 990, PART VI, LINE 12C

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

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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

BE PERFORMED.

WHISTLEBLOWER & DOCUMENT RETENTION - DESTRUCTION POLICIES

FORM 990, PART VI, LINES 13 & 14

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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

INDIVIDUAL REQUEST A SECONDARY REVIEW BE PERFORMED.

OFFICES & POSITIONS FOR WHICH PROCESS WAS USED, & YEAR PROCESS WAS BEGUN

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

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

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

THE COMPENSATION OF OTHER KEY EMPLOYEES OF THE ORGANIZATION IS DETERMINED
THROUGH MARKET STUDY ANALYSIS PERFORMED BY THE UVMHN COMPENSATION
COMMITTEE.

AVAIL OF GOV DOCS, CONFLICT OF INTEREST POLICY, & FIN STMTS TO GEN PUBLIC

FORM 990, PART VI, LINE 19

THE ORGANIZATION MAKES AVAILABLE GOVERNING DOCUMENTS, CONFLICT OF
INTEREST POLICIES AND FINANCIAL STATEMENTS TO THE GENERAL PUBLIC UPON

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

**Open to Public
Inspection**

Employer identification number

CENTRAL VERMONT MEDICAL CENTER, INC.

22-2547186

REQUEST. THE FINANCIAL STATEMENTS OF THE ORGANIZATION FOR FY2025 CAN ALSO
BE FOUND ON THE WEBSITE,
[HTTPS://WWW.UVMHEALTH.ORG/ABOUT-US/FINANCIALS](https://www.uvmhealth.org/about-us/financials)

COMPENSATION

FORM 990, PART VII

THREE PHYSICIANS SERVING AS BOARD MEMBERS, DR. CLOUSER, DR. SMITH, AND
DR. NELSON, RECEIVE COMPENSATION FROM A RELATED ORGANIZATION (UVMMG) FOR
THEIR SERVICES AS PHYSICIANS. THIS COMPENSATION IS NOT RELATED TO THEIR
PARTICIPATION AS MEMBERS OF THE BOARD OF TRUSTEES.

OTHER CHANGES IN NET ASSETS

FORM 990, PART XI, LINE 9

OTHER CHANGES IN NET ASSETS OR FUND BALANCES:

CHANGE IN MINIMUM PENSION LIABILITY	\$ (61,089)
TRANSFER OF NET ASSETS	(1,215,598)
ASSETS RELEASED FROM CAPITAL	487,558
OTHER CHANGES OF NET ASSETS WITH	
DONOR RESTRICTIONS	686,971

TOTAL: \$ (102,158)

CIRCULAR A-133 AUDIT

FORM 990, PART XII, LINE 3B:

DURING FY25, CVMC DID NOT REACH THE LEVEL REQUIRED TO WARRANT AN AUDIT
UNDER OMB CIRCULAR A-133. HOWEVER, BECAUSE OF CVMC'S AFFILIATION WITH THE
UNIVERSITY OF VERMONT HEALTH NETWORK, CVMC WAS INCLUDED IN THE A-133

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2024

Open to Public
Inspection

Employer identification number

22-2547186

WHICH WAS PERFORMED FOR THE UNIVERSITY OF VERMONT MEDICAL CENTER.

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186**FORM 990, PART III - PROGRAM SERVICE**
=====**LINE 4A, PROGRAM SERVICE**

HOSPITAL SERVICES: INPATIENT, OUTPATIENT, AND 24/7 EMERGENCY DEPARTMENT SERVICES: CVMC HAS 122 LICENSED BEDS TO PROVIDE FOR A FULL SPECTRUM OF INPATIENT, OUTPATIENT, AND EMERGENCY CARE SERVICES. 16,458 INPATIENT DAYS, MORE THAN 250,000 OUTPATIENT PROCEDURES, AND 28,163 EMERGENCY ROOM VISITS WERE RECORDED DURING FISCAL YEAR 2025. OUTPATIENT ANCILLARY SERVICE UNITS MAKE UP THE MAJORITY OF SERVICE VOLUME, INCLUDING 42,184 RADIOLOGY PROCEDURES, 555,601 LAB TESTS, 20,524 CARDIOLOGY TESTS, AND 153,143 UNITS OF PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY. EMERGENCY DEPARTMENT: THE ER IS OPEN 24 HOURS A DAY 365 DAYS A YEAR. THE NUMBER OF PATIENTS SEEN IN THE ER IN FISCAL YEAR 2025 WAS 28,029. THE CANCER TREATMENT CENTER PROVIDED 2,471 ONCOLOGY AND RADIATION TREATMENTS. THE HOSPITAL ALSO HAS BEEN ACTIVE IN ITS OUTREACH TO CENTRAL VERMONT'S UNINSURED AND UNDER INSURED RESIDENTS.

LINE 4B, PROGRAM SERVICE

MEDICAL GROUP PRACTICES: AT THE END OF THE FISCAL YEAR WE HAD 25 PRIMARY CARE, INFIRMARY, AND SPECIALTY PRACTICES. THIS INCLUDED 10 PRIMARY AND FAMILY CARE CLINICS, 1 PEDIATRIC CLINIC, AS WELL AS SPECIALTY CLINICS FOR UROLOGY, CARDIOLOGY, PODIATRY, RHEUMATOLOGY, ENT, ENDOCRINOLOGY, ORTHOPAEDICS, PSYCHOLOGY, AND OBSTETRICS/GYNECOLOGY. THERE WERE A TOTAL OF 613,433 PRACTICE VISITS DURING FISCAL YEAR 2025.

LINE 4C, PROGRAM SERVICE

WOODRIDGE REHAB & NURSING IS A MEDICARE-CERTIFIED 153-LICENSED BED SKILLED NURSING FACILITY LOCATED ON THE CAMPUS OF CENTRAL VERMONT MEDICAL CENTER. APPROXIMATELY TWO-THIRDS OF THE FACILITIES BEDS ARE DEDICATED TO LONG TERM CARE, INCLUDING PALLIATIVE CARE/END OF LIFE CARE AND THE OTHER ONE-THIRD PROVIDE SHORT TERM REHABILITATION THERAPY AND POST-ACUTE CARE FOR A GREAT VARIETY OF MEDICAL CARE CATEGORIES, INCLUDING PAIN MANAGEMENT AND WOUND CARE. THE FACILITY PROVIDES "PERSON-CENTERED", ROUND THE CLOCK NURSING CARE AND SOCIAL SERVICES SUPPORT COMPLEMENTING DAILY, ROBUST ACTIVITIES PROGRAMS, FINE DINING AND HAS A FULL COMPLIMENT OF SUPPORT SERVICES INCLUDING HOUSEKEEPING/LAUNDRY, MAINTENANCE AND

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186**FORM 990, PART III - PROGRAM SERVICE**
=====

TRANSPORTATION. MANY OTHER AMENITIES ARE AVAILABLE TO FACILITY
RESIDENTS.

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

NAME AND ADDRESS -----	DESCRIPTION OF SERVICES -----	COMPENSATION -----
CROSS COUNTRY STAFFING, INC. PO BOX 404674 ATLANTA, GA 30384-4678	CLINICAL STAFFING	17,253,871.
ENGELBERTH CONSTRUCTION, INC. 150 WATER TOWER CIRCLE COLCHESTER, VT 05446	CONSTRUCTION	949,828.
HEALTHCARE WORKFORCE LOGISTICS LLC 2655 NORTHWINDS PARKWAY ALPHARETTA, GA 30009	CLINICAL STAFFING	940,013.
MORRISON MANAGEMENT SPECIALISTS PO BOX 102289 ATLANTA, GA 30368-2289	KITCHEN MGMT	931,385.
HAYES LOCUMS PO BOX 844543 DALLAS, TX 75284-4543	PHYSICIAN STAFFING	805,564.

FORM 990, PART IX - OTHER FEES

=====

DESCRIPTION	(A) TOTAL FEES	(B) PROGRAM SERVICE EXP.	(C) MANAGEMENT AND GENERAL	(D) FUNDRAISING EXPENSES
-----	-----	-----	-----	-----
OTHER PURCHASED SERVICES	50,876,745.	28,768,045.	22,105,574.	3,126.
TOTALS	-----	-----	-----	-----
	50,876,745.	28,768,045.	22,105,574.	3,126.
	=====	=====	=====	=====

SCHEDULE R
(Form 990)

(Rev. December 2024)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

Attach to Form 990.

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

OMB No. 1545-0047

Open to Public
Inspection

Name of the organization

CENTRAL VERMONT MEDICAL CENTER, INC.

Employer identification number

22-2547186

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
SEE SUPPLEMENTAL PAGE							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

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

Schedule R (Form 990) (Rev. 12-2024)

PART II - IDENTIFICATION OF RELATED TAX-EXEMPT ORGANIZATIONS

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512 YES	512 NO

UNIVERSITY OF VERMONT MEDICAL CENTER, INC 111 COLCHESTER AVE	03-0219309 BURLINGTON, VT 05401 HOSPITAL	VT	501(C)(3)	3	UVMHN	X	
UNIV OF VERMONT HEALTH NETWORK, INC. 111 COLCHESTER AVE	45-2880726 BURLINGTON, VT 05401 HOLDING CO	VT	501(C)(3)	12A-I	N/A		X
UNIVERSITY OF VERMONT MEDICAL GROUP 111 COLCHESTER AVE	03-0225105 BURLINGTON, VT 05401 PHYS SVCS	VT	501(C)(3)	12A-I	UVMHN	X	
UNIV OF VERMONT MEDICAL CTR. FDN, INC. 111 COLCHESTER AVE	26-3159849 BURLINGTON, VT 05401 FUNDRAISING	VT	501(C)(3)	12A-I	UVMHC	X	
CENTRAL VERMONT HOSPITAL AUXILIARY 130 FISHER RD	03-0264240 BERLIN, VT 05602 SERVICE	VT	501(C)(3)	12D-III-0	N/A		X
COMMUNITY PROVIDERS, INC. 75 BEEKMAN ST.	22-2544844 PLATTSBURGH, NY 12901 HLTH SVC COOR	NY	501(C)(3)	12A-I	UVMHN	X	
CHAMPLAIN VALLEY PHYSICIANS HOSPITAL 75 BEEKMAN STREET	14-1338471 PLATTSBURGH, NY 12901 HOSPITAL	NY	501(C)(3)	3	CPI	X	
ELIZABETHTOWN COMMUNITY HOSPITAL 75 PARK STREET	14-1364513 ELIZABETHTOWN, NY 12932 HOSPITAL	NY	501(C)(3)	3	CPI	X	
EMERGENCY MEDICAL TRANSPORT OF CVPH, INC 75 BEEKMAN ST	06-1718419 PLATTSBURGH, NY 12901 AMBULANCE SVC	NY	501(C)(3)	12B-II	CPI	X	
CVPH MEDICAL CENTER FOUNDATION 75 BEEKMAN ST	14-1727048 PLATTSBURGH, NY 12901 HLTH SVC SUPP	NY	501(C)(3)	12B-II	CVPH	X	

(A) NAME\ADDRESS\EIN	(B) ACTIVITY	(C) LEGAL DOMICILE	(D) EXEMPT CODE	(E) CHARITY STATUS	(F) DIRECT CONTROLLING	(G) SEC 512 YES NO

UNIVERSITY MEDICAL EDUCATION ASSOCIATES 89 BEAUMONT AVE	23-7107832 BURLINGTON, VT 05405 EDUCATIONAL	VT	501(C)(3)	11	UVMMG	X
UNIVERSITY HEALTH CENTER 111 COOLCHESTER AVE	03-0229931 BURLINGTON, VT 05401 HOSPITAL	VT	501(C)(3)	12C-III-FI	UVMMG	X
ALICE HYDE MEDICAL CENTER 133 PARK STREET	15-0346515 MALONE, NY 12953 HOSPITAL	NY	501(C)(3)	3	CPI	X
PORTER MEDICAL CENTER INC 115 PORTER DRIVE	03-0310862 MIDDLEBURY, VT 05753 SUPPTG ORG	VT	501(C)(3)	12-BII	UVMHN	X
HELEN PORTER NURSING HOME 37 PORTER DRIVE	03-0306549 MIDDLEBURY, VT 05753 NURSING HOME	VT	501(C)(3)	3	PMC	X
AUXILIARY OF PORTER MEDICAL CENTER 37 PORTER DRIVE	23-7363227 MIDDLEBURY, VT 05753 SUPPORTG ORG	VT	501(C)(3)	12-B, II	PMC	X
PORTER HOSPITAL INC 37 PORTER DRIVE	03-0181058 MIDDLEBURY, VT 05753 HOSPITAL	VT	501(C)(3)	3	PMC	X
VMC INDEMNITY COMPANY, INC. 95 ST. PAUL ST.	83-1102018 BURLINGTON, VT 05401 INSURANCE	VT	501(C)(3)	12A-I	UVMHN	X
LAKE CHAMPLAIN PHYSICIANS SERVICES, P.C. 75 BEEKMAN STREET	27-3785445 PLATTSBURGH, NY 12901 PHYSICIAN SVC	NY	501(C)(3)	12A-I	CVPH	X
UVMHN HOME HEALTHCARE & HOSPICE 1110 PRIM ROAD	03-0179603 COLCHESTER, VT 05446 HOME HEALTH	VT	501(C)(3)	10	UVMHN	X

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) CHARITABLE IRREVOCABLE TRUST (8)									
	SUPPORT	VT	UVMC/CVMC	TRUST					
(2) UNIV OF VT MED CTR HEALTH VENT INC 04-3380045									
111 COLCHESTER AVE BURLINGTON, VT 05401	COMPANY	VT	UVMC	C CORP					
(3) CHARITABLE REMAINDER TRUST (6)									
	SUPPORT	VT	UVMC/CVMC	TRUST					
(4) PERPETUAL TRUST (10)									
	SUPPORT	VT	UVMC	TRUST					
(5) CHAMPLAIN VALLEY HEALTH NETWORK 16-1586102									
75 BEEKMAN STREET PLATTSBURGH, NY 12901	ADMIN SERVICE	NY	N/A	C CORP					
(6) MEDQUEST INC 14-1663061									
PO BOX 1656 PLATTSBURGH, NY 12901	LEASE	NY	N/A	C CORP					
(7) UVMHN CREDENTIALING & ENROLLMENT 03-0333056									
111 COLCHESTER AVE BURLINGTON, VT 05401	ADMIN SVC	VT	UVMHN VENTURES	C CORP					

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note:** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

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

(a) Name of related organization	(b) Transaction type (a - s)	(c) Amount involved	(d) Method of determining amount involved
(1) UNIVERSITY OF VERMONT MEDICAL CENTER	I	429,161.	FMV
(2) UNIVERSITY OF VERMONT MEDICAL CENTER	A	151,468.	FMV
(3) UNIVERSITY OF VERMONT MEDICAL CENTER	P	43,810,675.	FMV
(4) VMC INDEMNITY COMPANY	M	614,847.	FMV
(5)			
(6)			

Part VI

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

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

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

Part VII **Supplemental Information**Provide additional information for responses to questions on Schedule R. See instructions.

SCHEDULE R, PART IV, LINE 1

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