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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
▶ Information about Form 990 and its instructions is at *www IRS gov/form990*

OMB No 1545-0047

2016

Open to Public Inspection

A For the 2016 calendar year, or tax year beginning 10-01-2016 , and ending 09-30-2017

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
% TODD KEATING NETWORK CFO
Doing business as

Number and street (or P O box if mail is not delivered to street address) 130 FISHER ROAD
Room/suite

City or town, state or province, country, and ZIP or foreign postal code
BERLIN, VT 05602

D Employer identification number
22-2547186

E Telephone number
(802) 371-4100

G Gross receipts $ 205,382,172

F Name and address of principal officer
Ms Anna T Noonan
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 ▶

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

1 Briefly describe the organization's mission or most significant activities
WE WORK COLLABORATIVELY TO MEET THE NEEDS AND IMPROVE THE HEALTH 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**	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	10
5	Total number of individuals employed in calendar year 2016 (Part V, line 2a)	**5**	2,005
6	Total number of volunteers (estimate if necessary)	**6**	156
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	0
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	0

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,449,336	714,818
9	Program service revenue (Part VIII, line 2g)	198,325,656	202,889,273
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,278,579	1,273,328
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	252,959	223,710
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	201,306,530	205,101,129
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	184,700	636,491
14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	132,031,942	139,595,585
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶17,435		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	65,277,173	65,207,132
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	197,493,815	205,439,208
19	Revenue less expenses Subtract line 18 from line 12	3,812,715	-338,079

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	166,943,607	180,162,668
21	Total liabilities (Part X, line 26)	92,154,641	89,939,402
22	Net assets or fund balances Subtract line 21 from line 20	74,788,966	90,223,266

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 — 2018-08-13 Date

▶ TODD KEATING NETWORK CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
PAUL TANIS	PAUL TANIS	2018-08-14		P01441612

Firm's name ▶ PricewaterhouseCoopers LLP — Firm's EIN ▶

Firm's address ▶ 101 SEAPORT BLVD SUITE 500
BOSTON, MA 02210

Phone no (617) 530-5000

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

Part III Statement of Program Service Accomplishments

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

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 See Additional Data)	(Expenses $	130,476,898	including grants of $	636,491) (Revenue $	149,827,458)
4b	(Code See Additional Data)	(Expenses $	46,506,921	including grants of $	0) (Revenue $	37,739,496)
4c	(Code See Additional Data)	(Expenses $	17,684,698	including grants of $	0) (Revenue $	15,322,319)
4d	Other program services (Describe in Schedule O)	(Expenses $		including grants of $	) (Revenue $	)
4e	**Total program service expenses ▶**		194,668,517			

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	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
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		No
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	Yes	
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 Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
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		No
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		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
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		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
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	Yes	
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		No
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		No
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		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
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	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
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	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
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		No
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		No
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		No
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		No
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	Yes	
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		No

Part IV **Checklist of Required Schedules** *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	**20a**	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	**20b**	Yes	
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**	Yes	
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? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
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? *If "Yes," complete Schedule J*	**23**	Yes	
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? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
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? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
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? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
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? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V **Statements Regarding Other IRS Filings and Tax Compliance**

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	**1a**	100		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	**1c**		Yes	
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**	2,005		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	**2b**		Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .	**3a**			No
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .	**3b**			
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)? . .	**4a**			No
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? . .	**5a**			No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	**5b**			No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	**5c**			
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? . . .	**6a**			No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	**6b**			
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?	**7a**		Yes	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	**7b**		Yes	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	**7c**			No
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?	**7e**			No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .	**7f**			No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	**7g**			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	**7h**			
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?	**8**			
9a	Did the sponsoring organization make any taxable distributions under section 4966? . . .	**9a**			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .	**9b**			
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**			No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .	**14b**			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	15		
	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 in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	10		
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	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		5		No
6	Did the organization have members or stockholders?		6	Yes	
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	Yes	
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	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?		8a	Yes	
b	Each committee with authority to act on behalf of the governing body?		8b	Yes	
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 in Schedule O*		9		No

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		No
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		No
b	Describe in 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	Yes	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? *If "Yes," describe in Schedule O how this was done*	12c	Yes	
13	Did the organization have a written whistleblower policy?	13		No
14	Did the organization have a written document retention and destruction policy?	14		No
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	Yes	
b	Other officers or key employees of the organization	15b	Yes	
	If "Yes" to line 15a or 15b, describe the process in 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		No
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 Form 1023 (or 1024 if applicable), 990, and 990-T (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 in Schedule O)

19 Describe in 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 ▶TODD KEATING NETWORK CFO 130 FISHER RD Berlin, VT 05602 (802) 847-9975

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid
- List all of the organization's **current** key employees, if any See 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 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations
- List all of the organization's **former** officers, key employees, or 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

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

☐ 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)	(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			
See Additional Data Table										

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			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								5,403,226	2,432,662	701,834

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 ▶ 168

			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*	**3**		No
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*	**4**	Yes	
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*	**5**		No

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
E F WALL ASSOCIATES INC, 131 SOUTH MAIN ST PO BOX 259 BARRE, VT 05641	CONSTRUCTION CNTRCTR	3,909,282
BE SMITH INC, PO BOX 219241 KANSAS CITY, MO 64121	LEADERSHIP STAFFING	646,552
AMN HEALTHCARE INC, 2735 COLLECTION CTR DR CHICAGO, IL 60693	NURSE STAFFING	1,454,289
CONNOR CONTRACTING INC, 1100 US ROUTE 2 BERLIN, VT 05602	CONSTRUCTION CNTRCTR	2,349,053
MEDICAL SOLUTIONS, 1010 NORTH 102ND STREET OMAHA, NE 68114	NURSE STAFFING	654,818

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

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	**1a** Federated campaigns . .	1a			
	b Membership dues . .	1b			
	c Fundraising events . .	1c 18,935			
	d Related organizations	1d			
	e Government grants (contributions)	1e 613,523			
	f All other contributions, gifts, grants, and similar amounts not included above	1f 82,360			
	g Noncash contributions included in lines 1a-1f $ _____				
	h Total. Add lines 1a-1f . . . . . ▶	714,818			

Program Service Revenue	Business Code				
2a NET PATIENT SERVICE REVENUE	900099	183,619,359	183,619,359		
b REV FROM MANAGED CARE AND CAPITATED	900099	10,150,566	10,150,566		
c 340B CONTRACT PHARMACY REVENUE	900099	5,555,873	5,555,873		
d MEANINGFUL USE	900099	240,568	240,568		
e CAFETERIA REVENUE	900099	1,078,721	1,078,721		
f All other program service revenue		2,244,186	2,244,186		
g Total. Add lines 2a–2f . . . . ▶	202,889,273				

Other Revenue					
3 Investment income (including dividends, interest, and other similar amounts) . . . . . ▶		1,273,328			1,273,328
4 Income from investment of tax-exempt bond proceeds ▶		0			
5 Royalties . . . . . ▶		0			
	(i) Real / (ii) Personal				
6a Gross rents	495,828				
b Less rental expenses	269,973				
c Rental income or (loss)	225,855 / 0				
d Net rental income or (loss) . . . . . ▶		225,855			225,855
	(i) Securities / (ii) Other				
7a Gross amount from sales of assets other than inventory					
b Less cost or other basis and sales expenses					
c Gain or (loss)					
d Net gain or (loss) . . . . . ▶		0			
8a Gross income from fundraising events (not including $ 18,935 of contributions reported on line 1c) See Part IV, line 18 . . . . **a**	8,925				
b Less direct expenses . . . **b**	11,070				
c Net income or (loss) from fundraising events . . ▶		-2,145			-2,145
9a Gross income from gaming activities See Part IV, line 19 . . . **a**	0				
b Less direct expenses . . . **b**	0				
c Net income or (loss) from gaming activities . . ▶		0			
10a Gross sales of inventory, less returns and allowances . . **a**	0				
b Less cost of goods sold . . **b**	0				
c Net income or (loss) from sales of inventory . . ▶		0			
Miscellaneous Revenue	Business Code				
11a					
b					
c					
d All other revenue					
e Total. Add lines 11a–11d . . . . . ▶		0			
12 Total revenue. See Instructions . . . . . ▶		205,101,129	202,889,273		1,497,038

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	636,491	636,491		
2 Grants and other assistance to domestic individuals See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	3,084,115	632,364	2,451,751	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	40,797	40,797		
7 Other salaries and wages	107,944,056	104,261,023	3,669,158	13,875
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	7,017,065	6,629,485	386,704	876
9 Other employee benefits	14,445,284	13,647,415	796,067	1,802
10 Payroll taxes	7,064,268	6,674,081	389,305	882
11 Fees for services (non-employees)				
a Management	27,409		27,409	
b Legal	113,756		113,756	
c Accounting	69,691		69,691	
d Lobbying	0			
e Professional fundraising services See Part IV, line 17	0			
f Investment management fees	188,150		188,150	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	8,152,790	7,475,281	677,509	
12 Advertising and promotion	795,589	136,298	659,291	
13 Office expenses	28,113,843	27,905,088	208,755	
14 Information technology	2,704,982	2,330,616	374,366	
15 Royalties . .	0			
16 Occupancy	5,743,595	5,616,939	126,656	
17 Travel	131,476	94,405	37,071	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials .	0			
19 Conferences, conventions, and meetings	469,706	443,466	26,240	
20 Interest	598,940	598,940		
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization . .	9,792,873	9,792,873		
23 Insurance . . .	787,754	638,216	149,538	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a BAD DEBT EXPENSE	5,837,575	5,837,575		
b STATE NURSING BED TAX ASMNT	752,688	752,688		
c DUES & FEES	659,183	380,759	278,424	
d SUNDRY EXPENSE	100,142	66,105	34,037	
e All other expenses	166,990	77,612	89,378	
25 **Total functional expenses.** Add lines 1 through 24e	205,439,208	194,668,517	10,753,256	17,435
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 Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing	0	1	0
	2	Savings and temporary cash investments	18,338,172	2	25,366,122
	3	Pledges and grants receivable, net	0	3	0
	4	Accounts receivable, net	22,586,553	4	25,238,575
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L	0	6	0
	7	Notes and loans receivable, net	1,184,660	7	1,852,885
	8	Inventories for sale or use	4,065,469	8	4,172,245
	9	Prepaid expenses and deferred charges	1,476,111	9	1,834,543
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D — 10a: 171,574,632			
	b	Less accumulated depreciation — 10b: 100,178,048	74,623,675	10c	71,396,584
	11	Investments—publicly traded securities	42,768,290	11	47,606,209
	12	Investments—other securities See Part IV, line 11	0	12	0
	13	Investments—program-related See Part IV, line 11	0	13	0
	14	Intangible assets	0	14	0
	15	Other assets See Part IV, line 11	1,900,677	15	2,695,505
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	166,943,607	16	180,162,668
Liabilities	17	Accounts payable and accrued expenses	29,733,965	17	37,941,501
	18	Grants payable	0	18	0
	19	Deferred revenue	0	19	0
	20	Tax-exempt bond liabilities	1,662,941	20	682,081
	21	Escrow or custodial account liability Complete Part IV of Schedule D	0	21	0
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L	0	22	0
	23	Secured mortgages and notes payable to unrelated third parties	16,437,800	23	18,899,157
	24	Unsecured notes and loans payable to unrelated third parties	0	24	0
	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	44,319,935	25	32,416,663
	26	**Total liabilities.** Add lines 17 through 25	92,154,641	26	89,939,402
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	65,547,044	27	80,671,395
	28	Temporarily restricted net assets	5,805,106	28	6,290,378
	29	Permanently restricted net assets	3,436,816	29	3,261,493
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	74,788,966	33	90,223,266
	34	Total liabilities and net assets/fund balances	166,943,607	34	180,162,668

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	205,101,129
2	Total expenses (must equal Part IX, column (A), line 25)	2	205,439,208
3	Revenue less expenses Subtract line 2 from line 1	3	-338,079
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	74,788,966
5	Net unrealized gains (losses) on investments	5	5,050,341
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 in Schedule O)	9	10,722,038
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	90,223,266

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990 ☐ Cash ☑ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O			
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
	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?	2b	Yes	
	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?	2c	Yes	
	If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	Yes	
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 in Schedule O and describe any steps taken to undergo such audits	3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 22-2547186

Name: CENTRAL VERMONT MEDICAL CENTER INC

Form 990 (2016)

Form 990, Part III, Line 4a:

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 18,736 INPATIENT DAYS, MORE THAN 245,000 OUTPATIENT PROCEDURES, AND 24,675 EMERGENCY ROOM VISITS WERE RECORDED DURING FISCAL YEAR 2017 OUTPATIENT ANCILLARY SERVICE UNITS MAKE UP THE MAJORITY OF SERVICE VOLUME, INCLUDING 37,917 RADIOLOGY PROCEDURES, 471,983 LAB TESTS, 16,388 CARDIOLOGY TESTS, AND 142,328 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 17 WAS 24,675 THE CANCER TREATMENT CENTER PROVIDED 4,206 ONCOLOGY AND RADIATION TREATMENTS THE HOSPITAL ALSO HAS BEEN ACTIVE IN ITS OUTREACH TO CENTRAL VERMONT'S UNINSURED AND UNDER INSURED RESIDENTS

Form 990, Part III, Line 4b:

MEDICAL GROUP PRACTICES AT THE END OF THE FISCAL YEAR WE HAD 26 PRIMARY CARE, INFIRMARY, AND SPECIALTY PRACTICES THIS INCLUDED 7 PRIMARY AND FAMILY CARE CLINICS, 2 PEDIATRIC CLINICS, AS WELL AS SPECIALTY CLINICS FOR UROLOGY, PODIATRY, RHEUMATOLOGY, ENDOCRINOLOGY, ORTHOPAEDICS, PSYCHOLOGY, AND OBSTETRICS/ GYNECOLOGY THERE WERE A TOTAL OF 221,921 PRACTICE VISITS DURING FISCAL YEAR 2017

Form 990, Part III, Line 4c:

WOODRIDGE SKILLED NURSING FACILITY CVMC ALSO OPERATES A 153 LICENSED BED SKILLED NURSING FACILITY THE FACILITY CONCENTRATES ITS SERVICES TO PALLIATIVE CARE, REHABILITATION, PAIN MANAGEMENT, AND ADVANCED WOUND CARE 44,635 PATIENT DAYS WERE RECORDED IN FISCAL YEAR 2017

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
CHRISTOPHER BARBIERI TRUSTEE	1 0 0 0	X						0	0	0
JOHN BRUMSTED MD TRUSTEE	6 0 44 0	X						0	1,887,039	213,152
JEREMIAH ECKHAUS MD TRUSTEE, PRES-ELECT MED STAFF	50 0 0 0	X						219,947	0	38,401
MICHAEL DELLIPRISCOLI TRUSTEE, IMMEDIATE PAST CHAIR	1 0 2 0	X						0	0	0
MARK DEPMAN MD TRUSTEE, REGNAL PHYS LEADER	43 0 2 0	X						355,232	0	21,255
SARAH FIELD TRUSTEE	1 0 0 0	X						0	0	0
THOMAS GALONKA TRUSTEE, CHAIR-ELECT	1 0 2 0	X						0	0	0
JOYCE JUDY TRUSTEE	1 0 0 0	X						0	0	0
MARY MOULTON TRUSTEE, AS OF 12/2016	1 0 0 0	X						0	0	0
MARTA MURPHY MARBLE TRUSTEE, CHAIR	1 0 2 0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
ANNA T NOONAN TRUSTEE, PRESIDENT/COO 7/2017	45 0 5 0	X		X				0	309,597	60,279
CATHY PALMER MD TRUSTEE	3 0 42 0	X						15,000	236,026	0
LAURA PLUDE TRUSTEE, UNTIL 12/7/2016	1 0 0 0	X						0	0	0
SANDY ROUSSE TRUSTEE	1 0 0 0	X						0	0	0
STEVEN SHEA TRUSTEE, UNTIL 12/7/16	1 0 0 0	X						0	0	0
JUDITH TARR TARTAGLIA TRUSTEE, PRES/CEO UNTIL 3/2017	45 0 5 0	X		X				648,492	0	20,620
PAULETTE THABAULT TRUSTEE, AS OF 02/2017	1 0 0 0	X						0	0	0
GREG VOORHEIS TRUSTEE, UNTIL 12/7/16	1 0 0 0	X						0	0	0
MARILYN WHITE TRUSTEE	1 0 0 0	X						0	0	0
KATHERINE BORNE SEC, EXEC ASST UNTIL 4/10/17	50 0 0 0			X				76,766	0	19,400

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
ELEANOR KACZMAREK SEC, EXEC ASST AS OF 03/2017	50 0 0 0			X				46,711	0	21,916
CHEYENNE HOLLAND TREASURER, CFO/VP FISCAL SRVS	50 0 0 0			X				287,389	0	44,852
NANCY LOTHIAN CHIEF OPERATING OFFICER,9/2017	50 0 0 0			X				351,659	0	19,495
PHILIP BROWN DO CHIEF MEDICAL OFFICER	50 0 0 0				X			336,261	0	29,463
RICHARD MORLEY VP SUPPORT SERVICES	50 0 0 0				X			217,900	0	27,960
MATTHEW CHOATE CNO, AS OF 12/2016	50 0 0 0				X			127,132	0	26,668
KARIN MORROW CNO, UNTIL 12/2016	50 0 0 0				X			230,771	0	8,632
DAVID TURNER VP PHYSICIAN SERVICES	50 0 0 0				X			178,168	0	12,988
MAHLON BRADLEY MD PHYSICIAN	50 0 0 0					X		503,423	0	47,197
CHRISTIAN BEAN MD PHYSICIAN	50 0 0 0					X		412,734	0	21,511

Form 990, Part VII - Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(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			
JOHN BRAUN MD PHYSICIAN	50 0 0 0					X		507,237	0	16,350
CHRISTOPHER MERIAM MD PHYSICIAN	50 0 0 0					X		410,463	0	21,965
SARA GRAVES MD PHYSICIAN	50 0 0 0					X		477,941	0	29,730

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SCHEDULE A (Form 990 or 990EZ)

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.**

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

OMB No 1545-0047

2016

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 or 990-EZ))

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 **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 in 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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**
(Complete only if you checked the box on line 5, 7, 8, or 9 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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")						
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)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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 five 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 2016 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2015 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2016.** 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—2015.** 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—2016.** 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—2015.** 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) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(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) ▶	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
13 **Total support.** (Add lines 9, 10c, 11, and 12)						

14 **First five 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 2016 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2015 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2016** (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from **2015** Schedule A, Part III, line 17	18	

19a **33 1/3% support tests—2016.** 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—2015.** 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 12a of Part I, complete Sections A and B If you checked 12b of Part I, complete Sections A and C If you checked 12c of Part I, complete Sections A, D, and E If you checked 12d of 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? *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*	1		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509 (a)(1) or (2)? *If "Yes," explain in* ***Part VI*** *how the organization determined that the supported organization was described in section 509(a)(1) or (2)*	2		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? *If "Yes," answer (b) and (c) below*	3a		
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)? *If "Yes," describe in* ***Part VI*** *when and how the organization made the determination*	3b		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? *If "Yes," explain in* ***Part VI*** *what controls the organization put in place to ensure such use*	3c		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? *If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below*	4a		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? *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*	4b		
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)? *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*	4c		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? *If "Yes," answer (b) and (c) 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)*	5a		
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?	5b		
c	**Substitutions only.** Was the substitution the result of an event beyond the organization's control?	5c		
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? *If "Yes," provide detail in* ***Part VI.***	6		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (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? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ)*	7		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? *If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ)*	8		
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))? *If "Yes," provide detail in* ***Part VI.***	9a		
b	Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? *If "Yes," provide detail in* ***Part VI.***	9b		
c	Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? *If "Yes," provide detail in* ***Part VI.***	9c		
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)? *If "Yes," answer line 10b below*	10a		
b	Did the organization have any excess business holdings in the tax year? *(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings)*	10b		

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 in (b) and (c) below, the governing body of a supported organization?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI*	11c		

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's 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 directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year*	1		
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*	2		

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)*	1		

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?	1		
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)*	2		
3	By reason of the relationship described in (2), 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*	3		

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 government entity (see instructions)

			Yes	No
2	Activities Test **Answer (a) and (b) 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*	2a		
b	Did the activities described in (a) 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*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) 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? *Provide details in* ***Part VI.***	3a		
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*	3b		

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 **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)	1		
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 (explain in detail in Part VI)			
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 1-1/2% 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 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 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)

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	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 **Total annual distributions.** Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	**(i) Excess Distributions**	**(ii) Underdistributions Pre-2016**	**(iii) Distributable Amount for 2016**
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013.			
d From 2014.			
e From 2015.			
f **Total** of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 $			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 **Excess distributions carryover to 2017.** Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013.			
c Excess from 2014.			
d Excess from 2015.			
e Excess from 2016.			

Part VI **Supplemental Information.**

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

Facts And Circumstances Test

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SCHEDULE C (Form 990 or 990-EZ)

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

OMB No 1545-0047

2016

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

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization	Employer identification number
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
2 Political expenditures ▶ $
3 Volunteer hours

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

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

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

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

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

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 (grass roots 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		
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-		

If the amount on line 1e, column (a) or (b) is:	**The lobbying nontaxable amount is:**
Not over $500,000	20% of the amount on line 1e
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000
Over $17,000,000	$1,000,000

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)** 2013	**(b)** 2014	**(c)** 2015	**(d)** 2016	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) Yes	(a) No	(b) 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?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		24,724
j	Total Add lines 1c through 1i			24,724
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
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 expenditures from the prior year?	3		

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

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

Part IV **Supplemental Information**

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

Return Reference	Explanation
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, THE VERMONT HEALTH CARE ASSOCIATION, AND THE MEDICAL GROUP MANAGEMENT ASSOCIATION A PORTION OF THE DUES IS USED FOR LOBBYING PURPOSES

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

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 (e g , recreation or education) ☐ Preservation of an 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 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 in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06, 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 2(d) 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 SFAS 116 (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 SFAS 116 (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 SFAS 116 (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 are a significant use of its collection items (check all that apply)

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . . . ☐

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

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	7,988,798	7,726,226	8,130,234	7,489,540	7,318,467
b Contributions					
c Net investment earnings, gains, and losses	358,742	306,265	-366,990	676,127	810,401
d Grants or scholarships					
e Other expenditures for facilities and programs	350,000	43,693	37,018	35,433	639,328
f Administrative expenses					
g End of year balance	7,997,540	7,988,798	7,726,226	8,130,234	7,489,540

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 ▶ 41 000 %
- c Temporarily restricted endowment ▶ 59 000 %

The percentages on lines 2a, 2b, and 2c should equal 100%

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

	Yes	No
(i) unrelated organizations . . . . . 3a(i)	Yes	
(ii) related organizations . . . . . 3a(ii)		No
b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? 3b		

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c)Accumulated depreciation	(d)Book value
1a Land		5,510,000		5,510,000
b Buildings		55,888,420	32,177,059	23,711,361
c Leasehold improvements		31,562,433	13,286,649	18,275,784
d Equipment		72,165,484	51,149,676	21,015,808
e Other		6,448,295	3,564,664	2,883,631
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* ▶				71,396,584

Part VII **Investments—Other Securities.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 12)* ▶		

Part VIII **Investments—Program Related.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. *(Column (b) must equal Form 990, Part X, col (B) line 13)* ▶		

Part IX **Other Assets.** Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d See Form 990, Part X, line 15

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

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	0
ACCRUED PENSION LIABILITY	30,188,465
OTHER LIABILITIES	2,228,198
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	32,416,663

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 FIN 48 (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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 22-2547186
Name: CENTRAL VERMONT MEDICAL CENTER INC

Supplemental Information

Return Reference	Explanation
ENDOWMENT FUNDS	SCHEDULE D, PART V, LINE 4 CVMC HAS ENDOWMENT INVESTMENTS AND SPENDING POLICIES THAT ATTEMPT TO PROVIDE A PREDICTABLE STREAM OF FUNDING FOR CAPITAL AND OPERATIONAL PROGRAMS PERTAINING TO THE DELIVERY OF HOSPITAL AND SKILLED NURSING CARE SERVICES AS WELL AS INTERNAL MEDICINE, FAMILY AND SPECIALTY PHYSICIAN SERVICES IN ORDER TO MEET THE HEALTH CARE NEEDS OF THE CENTRAL VERMONT COMMUNITY

Supplemental Information

Return Reference	Explanation
ASC 740 DISCLOSURE	SCHEDULE D, PART X, LINE 2, FIN 48 (ASC 740) CENTRAL VERMONT MEDICAL CENTER, INC IS INCLU DED IN THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE UNIVERSITY OF VERMONT HEALTH NETWORK ("UVM HEALTH NETWORK") THE FOOTNOTE STATES UVM HEALTH NETWORK ACCOUNTS FOR RECOGNITION A ND MEASUREMENT OF UNCERTAIN TAX POSITIONS IN ACCORDANCE WITH ACCOUNTING STANDARDS CODIFICA TION (ASC) 740 INCOME TAXES, WHICH ADDRESSES HOW TO ACCOUNT FOR AND REPORT THE EFFECTS OF TAXES BASED ON INCOME NO PROVISION FOR UNCERTAIN TAX POSITIONS IS RECORDED IN THE ACCOMPA NYING CONSOLIDATED FINANCIAL STATEMENTS

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a

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

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

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

Employer identification number
22-2547186

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

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

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

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

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

	(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? **Yes**	**No**	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col **(i)**	**(vi)** Amount paid to (or retained by) organization
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Total		▶					

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

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

Revenue		(a) Event #1 GOLF TOURNAMENT (event type)	(b) Event #2 (event type)	(c) Other events 0 (total number)	(d) Total events (add col (a) through col (c))
	1 Gross receipts	27,860			27,860
	2 Less Contributions	18,935			18,935
	3 Gross income (line 1 minus line 2)	8,925			8,925
Direct Expenses	4 Cash prizes				
	5 Noncash prizes				
	6 Rent/facility costs	7,912			7,912
	7 Food and beverages	1,852			1,852
	8 Entertainment				
	9 Other direct expenses	1,306			1,306
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				11,070
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				-2,145

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

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

9 Enter the state(s) in which the organization conducts gaming activities _____

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

b If "No," explain _____

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

b If "Yes," explain _____

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

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

13 Indicate the percentage of gaming activity conducted in

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

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

Name ▶ ----------

Address ▶ ----------

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

b If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____

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

Name ▶ ----------

Address ▶

----

16 Gaming manager information

Name ▶ ----------

Gaming manager compensation ▶ $----------

Description of services provided ▶ ----------

☐ Director/officer ☐ Employee ☐ Independent contractor

17 Mandatory distributions

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

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

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

Return Reference	Explanation

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

OMB No 1545-0047

2016

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 during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
	☑ 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	3a	Yes	
	☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %			
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	3b	Yes	
	☐ 200% ☐ 250% ☐ 300% ☐ 350% ☑ 400% ☐ Other _____ %			
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
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 eligibile for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	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)			2,766,828		2,766,828	1 390 %
b Medicaid (from Worksheet 3, column a)			47,364,647	28,286,973	19,077,674	9 560 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			50,131,475	28,286,973	21,844,502	10 950 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			56,401		56,401	0 030 %
f Health professions education (from Worksheet 5)			396,663		396,663	0 200 %
g Subsidized health services (from Worksheet 6)			49,289,485	38,082,782	11,206,703	5 610 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			555,350		555,350	0 280 %
j **Total.** Other Benefits			50,297,899	38,082,782	12,215,117	6 120 %
k **Total.** Add lines 7d and 7j			100,429,374	66,369,755	34,059,619	17 070 %

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

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2 5,837,575			
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 116,751			
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	73,005,847
6	Enter Medicare allowable costs of care relating to payments on line 5	6	88,673,264
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-15,667,417
8	Describe in Part VI the extent to which any shortfall reported in 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	Yes	
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	Yes	

Part IV Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

Part V Facility Information

Section A. Hospital Facilities

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

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

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

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

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
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		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
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(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 15			
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	Yes	
6 a 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		No
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		No
7 Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) HTTP //WWW CVMC ORG/ABOUT-CVMC/COMMUNITY			
b ☑ Other website (list url) HTTP //WWW GMCBOARD VERMONT GOV			
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	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
If "Yes" (list url) SEE SECTION C			
a			
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		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" on 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)

CENTRAL VERMONT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 400 %			
b ☐ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☑ Insurance status			
f ☑ Underinsurance discount			
g ☑ Residency			
h ☐ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
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 his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her 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**	Yes	
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) SEE SECTION C			
b ☑ The FAP application form was widely available on a website (list url) SEE SECTION C			
c ☑ A plain language summary of the FAP was widely available on a website (list url) SEE SECTION C			
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 LEP populations			
j ☑ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

CENTRAL VERMONT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	**17**	Yes	
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**		No
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 ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs			
b ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
c ☑ Processed incomplete and complete FAP applications			
d ☑ Made presumptive eligibility determinations			
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 financial assistance policy?	**21**	Yes	
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)

CENTRAL VERMONT MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

		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? **23**		No
	If "Yes," explain in Section C		
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? **24**		No
	If "Yes," explain in Section C		

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, 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.

Form and Line Reference	Explanation
See Add'l Data	

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? **27**

Name and address	Type of Facility (describe)
1 See Additional Data Table	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 1	THE ORGANIZATION'S REQUIRED SCHEDULE H SPECIFIC LINE ITEM DESCRIPTIONS ARE AS FOLLOWS

Form and Line Reference	Explanation
PART I, LINES 3A-C	PATIENT ELIGIBILITY ELIGIBILITY FOR FINANCIAL ASSISTANCE WILL BE CONSIDERED FOR THOSE IND IVIDUALS WHO ARE UNINSURED, UNDERINSURED, INELIGIBLE FOR ANY GOVERNMENT HEALTH CARE BENEFI T PROGRAM, AND WHO ARE UNABLE TO PAY FOR THEIR CARE, BASED UPON A DETERMINATION OF FINANCI AL NEED IN ACCORDANCE WITH THIS POLICY THE GRANTING OF CHARITY SHALL BE BASED ON AN INDIV IDUALIZED DETERMINATION OF FINANCIAL NEED, AND SHALL NOT TAKE INTO ACCOUNT AGE, GENDER, RA CE, SOCIAL OR IMMIGRANT STATUS, SEXUAL ORIENTATION, GENDER IDENTITY OR EXPRESSION, OR RELI GIOUS AFFILIATION ELIGIBILITY FOR FINANCIAL ASSISTANCE IS BASED ON BOTH AN INCOME TEST AN D A REVIEW OF LIQUID ASSETS -INCOME TEST THIS PROGRAM IS LIMITED TO PATIENTS WITH DEMONS TRATED FINANCIAL NEED EITHER DUE TO LIMITED INCOME OR IF THEIR MEDICAL BILLS ARE AN EXCESS IVE PORTION OF THEIR INCOME THE MOST RECENTLY PUBLISHED FEDERAL PROVIDER GUIDELINES WILL BE USED AS THE PRIMARY DETERMINANT PATIENTS WHOSE HOUSEHOLD INCOME IS AT OR BELOW 400% OF THE FEDERAL POVERTY LEVEL GUIDELINES (FPLG), AS ADJUSTED FOR HOUSEHOLD SIZE, MAY PASS THE INCOME TEST AND ARE CONSIDERED FOR CHARITY CARE ASSISTANCE -NON-CUSTODIAL PARENTS MAY HA VE THEIR INCOME ADJUSTED FOR CHILD SUPPORT WHEN SUPPORTING DOCUMENTATION OF PAYMENT IS PRO VIDED -PATIENTS MAY HAVE THEIR INCOME ADJUSTED FOR ALIMONY WHEN SUPPORTING DOCUMENTATION OF PAYMENT IS PROVIDED -DEPENDENTS MAY BE INCLUDED WITHIN THE HOUSEHOLD WHEN MORE THAN 50 % OF THE SUPPORT IS PROVIDED BY THE GUARANTOR TO QUALIFY FOR THIS HOUSEHOLD EXTENSION, TH E DEPENDENT MUST BE LISTED AS A DEPENDENT ON THE FEDERAL INCOME TAX RETURN EXCLUSIONS -P RIMARY RESIDENCE, ASSETS HELD IN A TAX DEFERRED COMPARABLE RETIREMENT SAVINGS ACCOUNT AND COLLEGE SAVINGS ACCOUNTS HELD BY THE PATIENT FOR THE PATIENT ARE EXCLUDED FROM THE ASSETS REVIEW -ACCOUNTS ALREADY REFERRED TO A COLLECTION AGENCY GREATER THAN 120 DAYS FROM PLACE MENT TO AGENCY, UNLESS REFERRED IN ERROR, -SERVICES REIMBURSED DIRECTLY TO THE PATIENT(S) BY AN INSURANCE CARRIER OR ALREADY COVERED BY ANOTHER THIRD PARTY RESIDENCY CRITERIA PAT IENTS MUST RESIDE WITHIN THE CENTRAL VERMONT MEDICAL CENTER SERVICE AREA, UNLESS MEDICAL S ERVICES WERE URGENT OR EMERGENT IN NATURE SCHEDULED SERVICES FOR PATIENTS RESIDING OUTSID E OF THE CVMC SERVICE AREA ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE FINANCIAL ASSISTANCE FOR RESIDENTS OUTSIDE OF THE CVMC SERVICE AREA WILL BE GRANTED ONLY IN UNIQUE CIRCUMSTANC ES AND WITH APPROPRIATE APPROVAL INTERNATIONAL PATIENTS WHO ARE NOT LEGAL, PERMANENT RESI DENTS DO NOT QUALIFY FOR FINANCIAL ASSISTANCE THESE PATIENTS SHOULD BE COVERED BY TRAVELE R COVERAGE VERMONT RESIDENTS AND COLLEGE STUDENTS WHO RESIDE IN VERMONT PART-TIME MUST LI VE IN OUR SERVICE AREA GREATER THAN 6 MONTHS PER ANNUM TO MEET THE RESIDENCY REQUIREMENT PROOF OF RESIDENCY MAY BE ESTABLISHED BY ONE OF IS REQUIRED BY ONE OF THE FOLLOWING -VERM ONT SERVICE AREA DRIVERS LICENSE, TAX BILL WITH VERMONT SERVICE AREA ADDRESS, LEASE FOR VE RMONT SERVICE AREA PROPERTY OR A VERMONT SERVICE AREA UTILITY BILL, -POTENTIAL EXCEPTIONS MAY BE CONSIDERED ON AN INDIVIDUAL CASE-BY-CASE PUBLIC HEALTH CARE PROGRAM/HEALTHCARE EXC HANGE CRITERION PATIENTS APPLYING FOR CENTRAL VERMONT MEDICAL CENTER FINANCIAL ASSISTANCE ARE REVIEWED FOR THEIR POTENTIAL ELIGIBILITY FOR STATE OR FEDERAL HEALTHCARE PROGRAM BENE FITS AND/OR BENEFITS OFFERED THROUGH THE VERMONT HEALTHCARE EXCHANGE PROGRAMS ANY PATIENT IDENTIFIED WITH POTENTIAL TO BE GRANTED SUCH ASSISTANCE WILL BE INSTRUCTED TO APPLY FOR THOSE PATIENTS IDENTIFIED AS CANDIDATES FOR ELIGIBILITY FOR THE VERMONT HEALTHCARE EXCHANG E PROGRAM, APPLICATION FOR AND COMPLIANCE WITH THOSE PROGRAM GUIDELINES IS A PRE-REQUISITE FOR CENTRAL VERMONT MEDICAL CENTER PATIENT FINANCIAL ASSISTANCE DETERMINATION OF FINANCI AL NEED FINANCIAL NEED WILL BE DETERMINED IN ACCORDANCE WITH PROCEDURES THAT INVOLVE AN I NDIVIDUAL ASSESSMENT OF FINANCIAL NEED WHICH WILL INCLUDE THE FOLLOWING NOTE, IN THE CASE OF PRESUMPTIVE CHARITY, THE APPLICATION PROCESS MAY BE EXCLUDED -INCLUDE AN APPLICATION PROCESS, IN WHICH THE PATIENT OR THE PATIENTS GUARANTOR ARE REQUIRED TO COOPERATE AND SUPP LY PERSONAL, FINANCIAL AND OTHER INFORMATION AND DOCUMENTATION RELEVANT TO MAKING A DETERM INATION OF FINANCIAL NEED, -INCLUDE THE USE OF EXTERNAL PUBLICLY-AVAILABLE DATA SOURCES TH AT PROVIDE INFORMATION ON A PATIENTS OR A PATIENTS GUARANTORS ABILITY TO PAY CENTRAL VERM ONT MEDICAL CENTER RESERVES THE RIGHT TO OBTAIN A CREDIT REPORT, WHEN APPROVAL FROM THE PA TIENT IS GRANTED, BEFORE FINANCIAL ASSISTANCE IS AUTHORIZED -INCLUDE REASONABLE EFFORTS B Y CENTRAL VERMONT MEDICAL CENTER TO EXPLORE APPROPRIATE ALTERNATIVE SOURCES OF PAYMENT AND COVERAGE FROM PUBLIC AND PRIVATE PAYMENT PROGRAMS, AND TO ASSIST PATIENTS TO APPLY FOR SU CH PROGRAMS, -TAKE INTO ACCOUNT THE PATIENTS AVAILABLE ASSETS, AND ALL OTHER FINANCIAL RES OURCES AVAILABLE TO THE PATIENT, AND -INCLUDE A REVIEW OF THE PATIENTS CENTRAL VERMONT MED ICAL CENTER OUTSTANDING ACCOUNTS RECEIVABLE FOR PR

Form and Line Reference	Explanation
PART I, LINES 3A-C	IOR SERVICES RENDERED AND THE PATIENTS PAYMENT HISTORY IT IS PREFERRED BUT NOT REQUIRED T HAT A REQUEST FOR FINANCIAL ASSISTANCE AND A DETERMINATION OF FINANCIAL NEED OCCUR PRIOR T O RENDERING OF SERVICES A PATIENT MUST HAVE A CURRENT PATIENT BALANCE THAT IS DUE TO CENT RAL VERMONT MEDICAL CENTER, AN EXPECTATION THAT AN ACCOUNT CURRENTLY PENDING INSURANCE WIL L LEAVE A BALANCE THAT IS DUE TO CENTRAL VERMONT MEDICAL CENTER, OR A FUTURE SCHEDULED SER VICE AT CENTRAL VERMONT MEDICAL CENTER THAT IS EXPECTED TO LEAVE A PATIENT BALANCE HOWEVE R, THE DETERMINATION MAY BE DONE AT ANY POINT IN THE BILLING CYCLE THE NEED FOR CHARITY A SSISTANCE SHALL BE RE-EVALUATED AT EACH SUBSEQUENT TIME OF SERVICE IF THE LAST FINANCIAL E VALUATION WAS COMPLETED MORE THAN SIX MONTHS PRIOR, OR AT ANY TIME ADDITIONAL INFORMATION RELEVANT TO THE ELIGIBILITY OF THE PATIENT FOR CHARITY BECOMES KNOWN RE-EVALUATION OF PAT IENTS WHOSE AGE EXCEEDS 65 AND WHOSE INCOME IS FIXED BELOW 400% FPLG SHALL OCCUR ANNUALLY NOTE IT IS PERMISSIBLE FOR PATIENTS TO SUBMIT NEW SUPPORTING FINANCIAL DOCUMENTATION PRO VIDED THE APPLICATION ON FILE IS LESS THAN ONE YEAR OLD CENTRAL VERMONT MEDICAL CENTERS V ALUE OF HUMAN DIGNITY AND STEWARDSHIP SHALL BE REFLECTED IN THE APPLICATION PROCESS, FINAN CIAL NEED DETERMINATION AND GRANTING OF FINANCIAL ASSISTANCE REQUESTS FOR CHARITY SHALL B E PROCESSED PROMPTLY AND CVMC SHALL NOTIFY THE PATIENT/APPLICANT OF DECISION IN WRITING WI THIN 30 DAYS OF RECEIPT OF A COMPLETED APPLICATION

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G	FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2017 CENTRAL VERMONT MEDICAL CENTER INCLUDED PHYSICIAN CLINIC EXPENSES IN SUBSIDIZED HEALTH SERVICES CENTRAL VERMONT MEDICAL CENTER PHYSICIANS INCURRED $49,289,485 OF COSTS ASSOCIATED WITH PROVIDING OUTPATIENT CLINIC SERVICES NEARLY ALL OF THE EXPENSES INCLUDED AS SUBSIDIZED HEALTH SERVICES ARE ATTRIBUTABLE TO PHYSICIAN CLINICS AS A RESULT OF THE UNIQUE GEOGRAPHY AND POPULATION DENSITY OF THE COMMUNITY THAT CVMC SERVES, WE CONSIDER ALL OF THE PRIMARY AND SPECIALTY OUTPATIENT CARE PROVIDED BY OUR EMPLOYED GROUP OF PHYSICIANS TO BE SUBSIDIZED IT HAS BEEN APPARENT OVER THE LAST 16 YEARS THAT THERE ARE NO NEW, UNAFFILIATED PROVIDERS COMING INTO THE CVMC SERVICE AREA AND STARTING PRACTICES ADDITIONALLY THE MAJORITY OF THE INDEPENDENT PRACTICES THAT WERE ESTABLISHED IN THE CVMC SERVICE AREA HAVE JOINED CVMC DUE TO MANY REASONS INCLUDING ECONOMIC VIABILITY AND SUCCESSION PLANNING AS A RESULT OF THIS SHIFT, WHICH IS COMMON NOT ONLY IN THE NORTHEAST BUT ACROSS THE UNITED STATES, CVMC'S EMPLOYED PHYSICIANS MAKE UP THE MAJORITY AND IN SOME CASES THE ENTIRETY OF THE OUTPATIENT CARE SERVICES IN OUR COMMUNITY WERE CVMC TO CEASE THE PROVISION OF THESE SERVICES, THERE IS NO WAY THAT THE COMMUNITY AS IT EXISTS TODAY WOULD HAVE THE CAPACITY TO ABSORB THE PATIENTS AND PROVIDE THE NECESSARY CARE GIVEN THE HISTORIC LACK OF PROVIDERS ESTABLISHING NEW PRACTICES IN THE AREA, THE PATIENTS CURRENTLY SERVED BY THESE SUBSIDIZED HEALTH SERVICES WOULD END UP RECEIVING CARE FROM THE FEDERALLY QUALIFIED HEALTH CENTER WITHIN OUR SERVICE AREA, THE CVMC EMERGENCY DEPARTMENT, OR RECEIVING CARE FROM PROVIDERS OF NEIGHBORING HOSPITALS AND HEALTH SERVICE AREAS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN F	THE PROVISION FOR BAD DEBT INCLUDED ON FORM 990, PART IX, LINE 25 BUT SUBTRACTED FOR PURPOSE OF CALCULATING THE AMOUNT REPORTED ON LINE 7(F) IS $5,837,575

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	CVMC FOLLOWS THE IRS GUIDELINE FOR THE COMPLETION OF SCHEDULE H, PART I, LINES 7A-K, COLUMNS A-F CVMC'S COST-TO-CHARGE RATIO IS USED FOR EACH OF THESE CALCULATIONS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	BAD DEBT EXPENSE WAS CALCULATED BY TAKING THE CHARGES THAT WERE WRITTEN OFF TO ALLOWANCE TO BAD DEBT RESERVE AND REDUCING BY ANY RECOVERIES THE BAD DEBT RESERVE IS BASED ON AN EVALUATION OF THE COLLECTABILITY OF ACCOUNTS RECEIVABLE CVMC ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR CATEGORIES OF REVENUE TO ESTIMATE THE APPROPRIATE BAD DEBT RESERVE MANAGEMENT REGULARLY REVIEWS ACCOUNTS RECEIVABLE DATA AND THE BAD DEBT RESERVE FOR REASONABLENESS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	THE AMOUNT ATTRIBUTABLE TO PATIENTS ELIGIBLE FOR CHARITY CARE WAS CALCULATED USING A PERCENTAGE OF COLLECTION CASES WHEREBY THE COLLECTION AGENCY HAS, UPON FURTHER COLLECTION ACTIVITY BEEN INFORMED THAT THE PATIENT REQUESTED FINANCIAL ASSISTANCE WITH HIS/HER BILL THIS PERCENTAGE IS APPROXIMATELY 2% OF ALL COLLECTION CALL ACTIVITY THIS PERCENTAGE WAS CALCULATED FROM THE NUMBER OF CALLS WITH A REQUEST FOR FINANCIAL ASSISTANCE LISTED ON THE COLLECTION AGENCY'S LOG AS A PERCENTAGE OF THE TOTAL NUMBER OF CALLS THE COLLECTION AGENCY MADE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	PLEASE REFERENCE FOOTNOTE NUMBER 18 ON PAGE 43-44 IN THE FISCAL YEAR 2017 AUDITED CONSOLIDATED FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	SERVING PATIENTS WITH GOVERNMENT HEALTH BENEFITS SUCH AS MEDICARE IS A COMPONENT OF THE COMMUNITY BENEFIT STANDARD TO WHICH TAX-EXEMPT HOSPITALS ARE HELD THIS IMPLIES THAT SERVING MEDICARE PATIENTS IS A COMMUNITY BENEFIT AND THAT THE HOSPITAL OPERATES TO PROMOTE THE HEALTH OF THE COMMUNITY CVMC DETERMINES THE ALLOWABLE MEDICARE COSTS BY USING A COST TO CHARGE RATIO CALCULATION

Form and Line Reference	Explanation
PART III, LINE 9B	PAYMENT FOR SERVICES PROVIDED BY CENTRAL VERMONT MEDICAL CENTER IS DUE IN FULL AT THE TIME OF SERVICE THE ORGANIZATION MAY DEFER PAYMENT TO SUBMIT CLAIMS TO INSURERS, AND WILL WOR K WITH THEM TO FACILITATE TIMELY PROCESSING THE ORGANIZATION WILL SUBMIT CLAIMS TO INSURE RS AND FACILITATE TIMELY PAYMENT FOR ITS SERVICES WHEREVER POSSIBLE PAYMENT PENALTIES ASS ESSED BY THE PATIENTS INSURER APPLIED AS THEIR OBLIGATION TO THE HOSPITAL, PRACTICES OR NU RSING HOME IS THE GUARANTORS RESPONSIBILITY THE GUARANTOR IS RESPONSIBLE FOR COMPLYING WI TH ALL PRE-AUTHORIZATION, PRE-CERTIFICATION, PHYSICIAN REFERRAL, AND OTHER POLICY REQUIREM ENTS THE PATIENTS INSURANCE POLICY IS AN AGREEMENT BETWEEN THE PATIENT/GUARANTOR AND THE INSURANCE CARRIER, IT IS NOT AN AGREEMENT BETWEEN THE ORGANIZATION AND THE INSURANCE CARRI ER CVMC (MARCAM) BILLING STAFF WILL ADHERE TO ALL LOCAL, STATE AND FEDERAL COLLECTION LAW S AND REGULATIONS REGARDING CREDIT AND COLLECTIONS THE FAIR DEBT COLLECTION PRACTICES ACT AND THE 501R REGULATIONS ARE THE CURRENT STANDARD THE ORGANIZATION UTILIZES A GUARANTOR BILLING SYSTEM ADULT PATIENTS WILL BE RESPONSIBLE FOR THEMSELVES, AS WELL AS THEIR MINOR CHILDREN TO COMPLY WITH HIPAA PRIVACY STANDARDS, MARRIED COUPLES WILL MAINTAIN SEPARATE G UARANTOR STATUS STATEMENTS WILL BE SENT AFTER INSURANCES HAVE ACTED ON THE CLAIMS, OR IF THERE IS NO RESPONSE FROM THE INSURANCE COMPANY AFTER A REASONABLE TIME IF THERE IS NO IN SURANCE, STATEMENTS ARE SENT AS SOON AS THE CHARGES HAVE BEEN ENTERED AND THE ACCOUNT HAS BEEN FINALIZED EACH GUARANTOR WILL BE SENT AN ITEMIZED FIRST STATEMENT AND A COMBINED STA TEMENT GOING FORWARD UNLESS WE RECEIVE RETURNED MAIL WITH NO FORWARDING ADDRESS WE WILL A LSO ATTEMPT TO CONTACT THE GUARANTOR BY TELEPHONE IF THE BILL IS NOT PAID WITHIN 30 DAYS O F THE FIRST STATEMENT MAILING ALL STATEMENTS INDICATE THAT FINANCIAL ASSISTANCE IS AVAILA BLE, AND THE PHONE NUMBER TO CONTACT A FINANCIAL COUNSELOR IS INCLUDED AFTER 120 DAYS FRO M THE DATE OF THE FIRST STATEMENT BILLING THE ACCOUNT WILL COME UP FOR REVIEW FOR PLACEMEN T WITH OUR COLLECTION AGENCY IF THE PATIENT DOES NOT PAY THE ACCOUNT IN FULL, SET UP A MO NTHLY PAYMENT PLAN, OR APPLY FOR FINANCIAL AID OR OTHER STATE PROGRAM, THE BALANCE MAY THE N BE SENT TO OUR COLLECTION AGENCY OR ATTORNEY WE MAY FILE A PROPERTY LIEN AGAINST ATTACH ABLE ASSETS IN ORDER TO SECURE OUR INTEREST GUARANTORS WHO ARE IDENTIFIED BY THE ORGANIZA TION AS POTENTIALLY ELIGIBLE FOR OUR FINANCIAL ASSISTANCE PROGRAM WILL BE ENCOURAGED TO AP PLY GUARANTORS MAY ALSO INITIATE AND REQUEST CONSIDERATION FOR THE FINANCIAL AID PROGRAM BY REQUESTING AN APPLICATION FROM THE ORGANIZATION THE PROGRAM IS ADMINISTERED BY THE PAT IENT FINANCIAL SERVICES DEPARTMENT IN ACCORD WITH THE ORGANIZATIONS FINANCIAL AID POLICY (A-119) PROCEDURE 1 GUARANTORS SHALL BE BILLED FOR BALANCES WHICH ARE DETERMINED TO BE TH EIR RESPONSIBILITY THIS DETERMINATION WILL BE MADE ACCORDING TO THE FOLLOWING STANDARDS A THERE WAS NO INSURANCE COVERAGE FOR SERVICES RENDERED B INSURANCE WAS BILLED AND THE ENTIRE BALANCE WAS NOT SATISFIED BY THE INSURER BECAUSE THE PATIENT HAD OUT-OF-POCKET EXPE NSES (CO-PAYMENT, CO-INSURANCE, DEDUCTIBLE, AND COST-SHARE) TO BE SATISFIED IN ACCORDANCE WITH THEIR INSURANCE POLICY PROVISIONS C INSURANCE WAS BILLED AND THE ENTIRE BALANCE WAS NOT SATISFIED BY THE INSURER BECAUSE THE PATIENT DID NOT COMPLY WITH THE INSURANCE POLICY REQUIREMENTS D INSURANCE WAS BILLED AND THE ENTIRE BALANCE WAS NOT SATISFIED BY THE INS URER BECAUSE THE SERVICES PROVIDED WERE NOT COVERED UNDER THE PATIENTS POLICY E INSURANC E WAS BILLED, BUT THE INSURANCE CARRIER DOES NOT RESPOND IN A TIMELY MANNER F THE GUARAN TOR REFUSES TO ACCEPT A REASONABLE SETTLEMENT OFFER WHICH INCLUDES PAYMENT FOR OUR SERVICE S (EX THIRD PARTY LIABILITY CLAIMS) ONCE THE SELF-PAY BALANCE HAS BEEN DETERMINED, MONTH LY STATEMENTS WILL BE GENERATED TO INFORM THE GUARANTOR OF THEIR OBLIGATIONS TO THE ORGANI ZATION AND TO REQUEST PAYMENT 2 UNLESS STATEMENTS ARE RETURNED DUE TO AN INCORRECT ADDRE SS, A MINIMUM OF FOUR STATEMENTS WILL BE SENT TO THE GUARANTOR FOR EACH ACCOUNT BEFORE THE ACCOUNT IS ELIGIBLE FOR BAD DEBT WRITE-OFF AND ASSIGNED TO A THIRD PARTY COLLECTION VENDO R ACCOUNTS IN EXCESS OF $500 WITH INCORRECT ADDRESSES WILL BE RESEARCHED TO OBTAIN A CORR ECT ADDRESS, AND ATTEMPTS WILL BE MADE TO CONTACT THE GUARANTOR BY TELEPHONE PRIOR TO REFE RRING THEM TO COLLECTIONS BILLING OF DECEASED PATIENTS WILL CONTINUE AS WITH OTHER PATIEN TS UNLESS IT IS ESTABLISHED THAT THE PATIENT LEFT NO ESTATE OR THAT AVAILABLE ESTATE FUNDS HAVE BEEN EXHAUSTED 3 GUARANTORS WHO WISH TO ESTABLISH A MONTHLY PAYMENT ARRANGEMENT MU ST CONTACT THE ORGANIZATION TO REQUEST ONE BOTH THE ORGANIZATION AND THE GUARANTOR MUST A GREE ON THE TERMS OF PAYMENT FAILURE TO ABIDE BY THE TERMS OF PAYMENT WILL RESULT IN REFE RRAL TO A THIRD PARTY COLLECTION VENDOR (SEE ATTACHMENT I PAYMENT ARRANGEMENT PROCESSES AND PROCEDURES) 4 THIRD PARTY LIABILITY AND LITIG

Form and Line Reference	Explanation
PART III, LINE 9B	ATION ACCOUNTS ARE TO BE CONSIDERED AS THE GUARANTORS RESPONSIBILITY GUARANTORS WILL BE B ILLED AND THE ACCOUNTS MOVED TO BAD DEBT IF NO WRITTEN GUARANTEE IS RECEIVED FROM THE GUAR ANTOR OR THIRD PARTY, NO ARRANGEMENTS ARE MADE, NO LETTER OF PROTECTION IS RECEIVED FROM T HE GUARANTORS ATTORNEY, OR PAYMENT IN FULL IS NOT RECEIVED THE ORGANIZATION RESERVES ITS RIGHT AND RESPONSIBILITY TO REPORT THIRD PARTY LIABILITY TO PRIMARY MEDICAL INSURANCE CARR IERS THE ORGANIZATION MAY UTILIZE ITS COLLECTION ATTORNEY TO SECURE ITS INTERESTS IN ANY SETTLEMENT THE ORGANIZATION SHALL FILE LIENS AS ALLOWED BY LAW 5 ACCOUNTS WILL BE REFER RED TO BAD DEBT IF THE GUARANTOR IS UNCOOPERATIVE, THE ORGANIZATIONS INTERESTS ARE UNSECUR ED AND IN DANGER OF BEING LOST, ACCEPTABLE ARRANGEMENTS HAVE NOT BEEN MADE, ARRANGEMENTS A RE IN DEFAULT, OR IF THE DEBTOR CANNOT BE REACHED BY MAIL OR TELEPHONE THE CATEGORIES OF WRITE OFF ARE AS FOLLOWS A MEDICARE BAD DEBT B NON-MEDICARE BAD DEBT C UNCOLLECTIBLE B ANKRUPT, DECEASED WITH NO ESTATE, NOT BILLABLE 6 SETTLEMENT ON OBLIGATIONS WILL BE CONSI DERED ON AN INDIVIDUAL BASIS THE GUARANTORS CIRCUMSTANCES, THE ORGANIZATIONS DEBT, THE LI KELINESS OF RECEIVING PAYMENT IN FULL AND OTHER CONCERNS WILL BE CONSIDERED THE FINANCIAL COUNSELING TEAM LEAD IS RESPONSIBLE FOR NEGOTIATING AND APPROVING ALL OFFERS UP TO $5,000 IN LOSS THE DIRECTOR OF PATIENT ACCESS WILL NEGOTIATE AND APPROVE ALL OFFERS UP TO $10,0 00 IN LOSS THE CHIEF FINANCIAL OFFICER WILL APPROVE ALL LOSSES IN EXCESS OF $10,000 CVMC WILL OFFER A 30% PROMPT PAY DISCOUNT FOR CHARGES FOR WHICH NO INSURANCE COVERAGE IS AVAIL ABLE AND A 10% DISCOUNT FOR PATIENT BALANCES AFTER INSURANCE PAYMENTS AND ADJUSTMENTS PRO MPT PAYMENT MEANS PAYMENT OF THE AGREED-UPON AMOUNT WITHIN 10 WORKING DAYS FROM THE TIME W E OFFER A DISCOUNT TO THE GUARANTOR 7 RESPONSIBILITY FOR DETERMINING THE GUARANTOR FOR A N ACCOUNT WILL BE BASED ON THE GUARANTOR ASSIGNMENT POLICY THE ORGANIZATIONS POSITION ON DIVORCE DECREES IS THAT THE GUARANTOR IS THE PERSON WHO RECEIVED THE SERVICE OR THE PARENT WHO BRINGS THE CHILD IN FOR SERVICES AND SIGNS THE CONSENT (NOT THE SUBSCRIBER OF INSURAN CE) THE ORGANIZATION CANNOT ENFORCE DIVORCE DECREES SINCE THEY ARE AN AGREEMENT BETWEEN T HE DIVORCING PARTIES AND THE COURT SYSTEM 8 PAYMENT FOR COSMETIC SERVICES OR SERVICES WH ICH ARE NOT MEDICALLY NECESSARY IS DUE ON OR BEFORE THE DAY SERVICES ARE PROVIDED EXCEPTI ONS MUST BE APPROVED BY THE DIRECTOR OF ACCESS OR ADMINISTRATION 9 ALL COLLECTION ACTIVI TY PRIOR TO REFERRAL TO AN OUTSIDE COLLECTION AGENCY OR ATTORNEY WILL BE DOCUMENTED IN THE ACCOUNT NOTES

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Form and Line Reference	Explanation
NEEDS ASSESSMENT	PART VI, LINE 2 THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS COMPLETED USING BOTH QUALITATIVE AND QUANTITATIVE RESEARCH TECHNIQUES INITIALLY, MEMBERS OF THE CVMC STEERING COMMITTEE GAVE VERBAL REPORTS ON THE ISSUES THEY BELIEVED TO BE THE MOST PRESSING IN THEIR ORGANIZATIONS OR IN THE GENERAL CENTRAL VERMONT COMMUNITY FROM THERE, THE STEERING COMMITTEE REVIEWED THE RECOMMENDED LIST OF HEALTH AND SOCIOECONOMIC INDICATORS PROVIDED BY THE VERMONT DEPARTMENT OF HEALTH, AND GATHERED DATA PERTAINING TO POPULATION DEMOGRAPHICS, ACCESS TO HEALTH SERVICES, MATERNAL AND CHILD HEALTH, HEALTH STATUS AND PREVENTION, AND SOCIAL ENVIRONMENTAL MEASURES TO EVALUATE THESE CONCERNS THIS SECONDARY RESEARCH COUPLED WITH THE STEERING COMMITTEE'S CONCERNS ALLOWED SIGNIFICANT CONCLUSIONS TO BE DRAWN AND CVMC'S PRIORITY HEALTH NEEDS TO BE SELECTED IN ADDITION TO THE TRIENNIAL COMMUNITY HEALTH NEEDS ASSESSMENT, CVMC REGULARY MONITORS THE HEALTH NEEDS OF THE CENTRAL VERMONT COMMUNITY, THROUGHT THE COMMUNITY ALLIANCE FOR HEALTH EXCELLENCE COMMITTE (CAHE) WICH MEETS MONTHLY AND BRINGS LEADERS AND COMMUNITY PROVIDERS OF 17 DIFFERENT HEALTH CARE ORGANIZATIONS TOGETHER TO DIALOGUE AND MAKE DECIDIONS AT THE COMMUNITY LEVEL TO IMPROVE THE HEALTH CARE AND EXPERIENCE OF CARE FOR THOSE IN OUR COMMUNITY CURRENT CAHE PROJECTS INCLUDE CARE NAVIGATION, CHRONIC HEART FAILURE, HOSPICE AND PALLIATIVE CARE AND ACES PILOT PROJECT THE COMMUNITY HEALTH NEEDS ASSESSMENT IS AVAILABLE AT THE FOLLOWING WEB ADDRESS HTTP //WWW CVMC ORG/SITE/DEFAULT/FILES/DOCUMENTS/COMMUNITY-HEALTH-NEEDS-AS SESSMENT-2016 PDF

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Form and Line Reference	Explanation
PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE	PART VI, LINE 3 CVMC'S FINANCIAL ASSISTANCE SUMMARIES ARE POSTED IN ALL PATIENT ADMISSION PACKETS AND ON THE CVMC WEBSITE CVMC ALSO PROVIDES CONSPICUOUS DISPLAYS REGARDING THE AVAILABILITY OF FINANCIAL ASSISTANCE IN THE FACILITY ALL PATIENT INVOICES LIST THE PHONE NUMBER FOR CONTACTING CVMC PATIENT FINANCIAL SERVICES FOR FINANCIAL ASSISTANCE IF PATIENTS ARE UNABLE TO PAY THEIR BILL PATIENT FINANCIAL SERVICES HAS APPLICATIONS FOR ALL STATE FINANCIAL AID PROGRAMS ON FILE AND EMPLOYS THREE FINANCIAL COUNSELORS WHO WILL SIT DOWN WITH PATIENTS TO HELP THEM DETERMINE WHICH PROGRAMS THEY QUALIFY FOR, AS WELL AS HELP THEM FILL OUT THESE FORMS PATIENT FINANCIAL SERVICES PROACTIVELY SCREENS PATIENT BILLING INFORMATION TO IDENTIFY INDIVIDUALS WHO MAY BE ELIGIBLE FOR STATE OR CVMC ASSISTANCE, AND WILL EITHER VISIT THAT PATIENT IN THE HOSPITAL, CALL THEM AT HOME, OR MAIL THEM THE INFORMATION

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Form and Line Reference	Explanation
COMMUNITY INFORMATION	PART VI, LINE 4 CENTRAL VERMONT MEDICAL CENTER IS THE ONLY HOSPITAL LOCATED IN OUR IMMEDIATE SERVICE AREA OF WASHINGTON COUNTY AND PARTS OF ORANGE COUNTY THIS SERVICE AREA CONSISTS OF 23 TOWNS WITH A TOTAL POPULATION OF APPROXIMATELY 66,280 INCLUDED IN THIS SERVICE AREA IS THE FEDERALLY DESIGNATED ORWELL TOWN MEDICALLY UNDERSERVED AREA VITAL STATISTICS 96% WHITE 24% UNDER THE AGE OF 18 58% AGED 18 TO 64 18% OVER THE AGE OF 65 MEDIAN HOUSEHOLD INCOME OF $58,171 11% LIVE BELOW THE POVERTY LEVEL 3 9% NON ENGLISH SPEAKING HOUSEHOLDS ACCESS TO HEALTHCARE 2 5% UNINSURED 18 4% MEDICAID (OR OTHER STATE PROGRAMS) RECIPIENTS 43 1% MEDICARE 36% PRIVATE INSURANCE

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Form and Line Reference	Explanation
PROMOTION OF COMMUNITY HEALTH	PART VI, LINE 5 CENTRAL VERMONT MEDICAL CENTER IS THE ONLY HOSPITAL AND EMERGENCY CARE FACILITY LOCATED IN OUR IMMEDIATE SERVICE AREA ALL OF ITS SERVICES, INCLUDING EMERGENCY CARE, ARE PROVIDED TO ALL PERSONS REGARDLESS OF ABILITY TO PAY CENTRAL VERMONT MEDICAL CENTER (CVMC) IS THE ADMINISTRATIVE ENTITY FOR THE VERMONT BLUEPRINT FOR HEALTH, PATIENT CENTERED MEDICAL HOMES FOR THE BARRE HEALTH SERVICE AREA (HSA) THE GOAL OF THE VERMONT BLUEPRINT FOR HEALTH, PASSED BY THE VERMONT LEGISLATURE IN 2010, IS TO SUPPORT VERMONT'S EFFORTS TO DEVELOP A COMPREHENSIVE, PROACTIVE SYSTEM OF CARE THAT IMPROVES THE QUALITY OF LIFE FOR PEOPLE WITH, OR AT RISK FOR CHRONIC CONDITIONS IN A PATIENT CENTERED MEDICAL HOME, PATIENTS HAVE ACCESS TO A COMMUNITY HEALTH TEAM, WHICH CONSISTS OF A NURSE, OR DIETITIAN OR CLINICAL SOCIAL WORKER OR WELLNESS COACH THIS TEAM WORKS WITH THE PATIENT TO HELP SET REALISTIC GOALS AND TIMELINES AND PROVIDES ONE-ON-ONE SUPPORT THEY ALSO WORK WITH A BROAD BASE OF COMMUNITY SERVICES TO PROVIDE EACH PATIENT WITH INDIVIDUAL SUPPORT AND CARE AT THE END OF 2017, OVER 50 PRIMARY CARE PROVIDERS WERE ALL PART OF A RECOGNIZED NATIONAL COMMITTEE FOR QUALITY ASSURANCE, PATIENT CENTERED MEDICAL HOME IN THE BARRE HSA CARING FOR OVER 33,000 PATIENTS THERE ARE 17 COMMUNITY HEALTH TEAM STAFF MEMBERS IN THE CVMC PRACTICES CVMC IS PROUD TO BE A PARTICIPANT IN THE VERMONT BLUEPRINT FOR HEALTH IN ADDITION TO FINANCIAL ASSISTANCE AND SLIDING SCALE DISCOUNTS (SEE SCHEDULE H, PART I, LINES 3A & B), CVMC OFFERS NO INTEREST MONTHLY PAYMENT PLANS FOR PATIENTS WHO CANNOT PAY THEIR OUTSTANDING BALANCE IN FULL BUT ARE ABLE TO PAY OVER TIME CVMC EXTENDS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITY CVMC APPLIES SURPLUS FUNDS TO IMPROVEMENTS IN PATIENT CARE, SUCH AS NEW TECHNOLOGIES (MRI), FACILITIES AND SERVICES THE MAJORITY OF THE CVMC'S GOVERNING BODY (BOARD OF TRUSTEES) IS COMPRISED OF INDIVIDUALS WHO RESIDE IN CVMCS PRIMARY SERVICE AREA WHO ARE NEITHER EMPLOYEES, FAMILY MEMBERS, NOR CONTRACTORS OF THE ORGANIZATION CVMC ACTIVELY PARTNERS WITH MANY COMMUNITY ORGANIZATIONS, SUCH AS WASHINGTON COUNTY MENTAL HEALTH SERVICES, THE PEOPLE'S HEALTH AND WELLNESS CLINIC, CENTRAL VERMONT HOME HEALTH & HOSPICE, AND GREEN MOUNTAIN UNITED WAY, TO IMPROVE THE HEALTH AND WELLBEING OF OUR COMMUNITY ONE EXAMPLE IS OUR FREE WOMEN'S HEALTH CLINICS WITH FINANCIAL SUPPORT FROM THE SUSAN G KOMEN FOR THE CURE THAT CVMC SPONSORS ALONG WITH THE PEOPLE'S HEALTH AND WELLNESS CLINIC CVMC APPLIES SURPLUS FUNDS TO REVITALIZE FACILITIES, PURCHASE EQUIPMENT, AND TO ENHANCE PROGRAMS TO BETTER SERVE OUR PATIENTS

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Form and Line Reference	Explanation
AFFILIATED HEALTH CARE SYSTEM	PART VI, LINE 6 AS OF OCTOBER 1, 2011, CENTRAL VERMONT MEDICAL CENTER, INC (CVMC) AND THE UNIVERSITY OF VERMONT MEDICAL CENTER BECAME MEMBERS OF THE UNIVERSITY OF VERMONT HEALTH NETWORK, 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 SINCE THE HEALTH NETWORK'S INCEPTION, CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER, ELIZABETH COMMUNITY HOSPITAL, ALICE HYDE MEDICAL CENTER, AND PORTER MEDICAL CENTER HAVE ALSO JOINED

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Form and Line Reference	Explanation
STATE FILING OF COMMUNITY BENEFIT REPORT	PART VI, LINE 7 VT

Additional Data

Software ID:

Software Version:

EIN: 22-2547186

Name: CENTRAL VERMONT MEDICAL CENTER INC

Form 990 Schedule H, Part V Section A. Hospital Facilities

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		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	CENTRAL VERMONT MEDICAL CENTER 130 FISHER ROAD BERLIN, VT 05602 WWW CVMC ORG 470001	X	X					X			

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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, 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.

Form and Line Reference	Explanation
PART V, LINE 5	CVMC INVITED A WIDE VARIETY OF PUBLIC HEALTH PROFESSIONALS, COMMUNITY LEADERS, HUMAN SERVICE PROVIDERS, AND CVMC STAFF MEMBERS TO SERVE AS A STEERING COMMITTEE THROUGHOUT THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS MEETINGS WERE HELD THROUGHOUT 2016 FOR THE COMMITTEE MEMBERS TO DELIBERATE OVER ALL COMMUNITY HEALTH CONCERNS AND REVIEW PERTINENT DATA AND INFORMATION INPUT WAS PROVIDED BY A WASHINGTON COUNTY MENTAL HEALTH SERVICES B CENTRAL VERMONT HOME HEALTH & HOSPICE C PEOPLES HEALTH AND WELLNESS CLINIC D U32 HIGH SCHOOL E CENTRAL VERMONT COUNCIL ON AGING F GREEN MOUNTAIN UNITED WAY G VERMONT DEPARTMENT OF HEALTH H CENTRAL VERMONT MEDICAL CENTER - LEADERSHIP, MEDICAL STAFF & COMMUNITY HEALTH TEAM I FAMILY CENTER OF WASHINGTON COUNTY J CENTRAL VERMONT NEW DIRECTIONS COALITION K CENTRAL VERMONT REGIONAL PLANNING COMMISSION CENTER

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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, 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.

Form and Line Reference	Explanation
PART V, LINE 10A	COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGY WEBSITE HTTPS //WWW CVMC ORG/SITES/DEFAULT/FILES/DOCUMENTS/COMMUNITY-NEEDS-ASSESSM ENT-2016 PDF

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, 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.

Form and Line Reference	Explanation
PART V, LINE 11	AT CENTRAL VERMONT MEDICAL CENTER, WE COLLABORATE WITH OTHER NON-PROFITS, BUSINESSES, COMM UNITY LEADERS, AND GOVERNMENTAL AGENCIES TO PROVIDE A VARIETY OF PROGRAMS AND EDUCATIONAL OFFERINGS INTENDED TO IMPROVE THE HEALTH OF THE COMMUNITIES WE SERVE OUR AFFILIATION, BEG INNING IN 2011 WITH THE UNIVERSITY OF VERMONT MEDICAL CENTER, CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER, ELIZABETHTOWN COMMUNITY HOSPITAL, AND ALICE HYDE MEDICAL CENTER, UNDER THE UNIVERSITY OF VERMONT HEALTH NETWORK, HAS INCREASED OUR REACH AND CAPABILITIES A S THE PRIMARY MEDICAL CENTER IN CENTRAL VERMONT THIS CONNECTION WITH THE UNIVERSITY OF VE RMONT HEALTH NETWORK HAS BEEN A SIGNIFICANT STEP IN PROMOTING REGIONAL STRATEGIC PLANNING, IMPROVING ACCESS TO LOCAL CARE, ENHANCING INFORMATION TECHNOLOGY, AND ENCOURAGING JOINT Q UALITY AND CLINICAL INITIATIVES TOGETHER, OUR ORGANIZATIONS HAVE WORKED TO ALIGN WITH THE STATE AND FEDERAL HEALTH CARE REFORM AGENDAS THAT PROMOTE ENHANCED INTEGRATION AND BUILD UPON OUR EXISTING CLINICAL PARTNERSHIPS A NUMBER OF CVMC STAFF MEMBERS SERVE ON BOARDS OF OTHER MISSION-RELATED COMMUNITY ORGANIZATIONS AND PLANNING GROUPS SUCH AS THE VERMONT BLU EPRINT FOR HEALTH, ONECARE VERMONT, CENTRAL VERMONT HEALTH CARE COALITION, CENTRAL VERMONT SUBSTANCE ABUSE SERVICES, GREEN MOUNTAIN UNITED WAY, PEOPLES HEALTH & WELLNESS CLINIC, VE RMONT DIETETIC ASSOCIATION, VERMONT ETHICS NETWORK, VERMONT MEDICAL SOCIETY BOARD, AND MAN Y MORE THIS IMPLEMENTATION PLAN POINTS TO AND ACKNOWLEDGES THE VALUABLE WORK OF MANY EFFO RTS ALREADY UNDERWAY THROUGHOUT THE COUNTY TO ADDRESS COMMUNITY HEALTH OUR COMMUNITY HEAL TH TEAM HAS DISCUSSED REGIONAL STRATEGIES THAT ARE WORKING, GAPS THAT REMAIN, AND OPPORTUN ITIES FOR IMPROVEMENT BASED ON THESE RECOMMENDATIONS, WE HAVE DEVELOPED THE FOLLOWING MEA SURES TO ADDRESS THOSE AREAS FOR IMPROVEMENT THAT REQUIRE MORE ATTENTION AND COLLABORATION DRUG ABUSE CVMC IS WORKING WITH COMMUNITY PARTNERS INCLUDING THE VERMONT DEPARTMENT OF H EALTH ALCOHOL AND DRUG ABUSE PROGRAM, WASHINGTON COUNTY MENTAL HEALTH SERVICES, CENTRAL VE RMONT SUBSTANCE ABUSE SERVICES AND CENTRAL VERMONT ADDICTION MEDICINE TO INCREASE ACCESS T O CARE AND SUPPORT TRANSITIONS OF CARE AS INDIVIDUALS MOVE THROUGH THE TREATMENT CYCLE IT IS IMPORTANT THAT COMMUNITY MEMBERS HAVE KNOWLEDGE OF THE RESOURCES THAT ARE CURRENTLY AV AILABLE TO THEM CURRENT INITIATIVES -SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATME NT (SBIRT) MODEL INTO EIGHT MEDICAL HOMES THROUGHOUT THE CVMC MEDICAL GROUP PRACTICES INC REASE COMMUNICATION AND INTEGRATED CARE AT EACH MEDICAL HOME WITH THREE MASTERS LEVEL BEHA VIORAL HEALTH COUNSELORS, OFFERING ONSITE COUNSELING SERVICES WITH DOCUMENTATION IN THEIR MEDICAL RECORD -INTERNAL AND COMMUNITY OUTREACH ABOUT SBIRT SERVICES AVAILABLE IN THE MED ICAL HOMES THROUGH NEWSLETTERS, DATA BRIEFS, RACK CARDS, EDUCATION AND PROGRAM BROCHURES -EXPANDED SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) MODEL IN OUR WOME NS HEALTH CLINIC AT CVMC INCO

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, 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.

Form and Line Reference	Explanation
PART V, LINE 11	RPORATION OF ADDITIONAL SOCIAL DETERMINATES OF HEALTH (DEPRESSION, INTIMATE PARTNER VIOLEN CE, ADVERSE CHILDHOOD EVENTS, FOOD AND HOUSING INSECURITY) SCREENING, TREATMENT AND REFERR ALS ACCESS TO SAME DAY LONG ACTING REVERSIBLE CONTRACEPTIVES (LARC) FOR WOMEN OF AGES 15- 44, COMBINED WITH AN ENHANCED PROCESS OF COMPREHENSIVE FAMILY PLANNING INCREASE COMMUNICA TION AND INTEGRATED CARE WITH IMMEDIATE ACCESS TO A LICENSED BEHAVIORAL HEALTH COUNSELOR F OR INTERVENTIONS -CVMC PROVIDES SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) IN ITS EMERGENCY DEPARTMENT, HOSPITAL INPATIENT UNITS, AND IN ITS PRIMARY CARE PRA CTICES INCLUDING WOMENS HEALTH TRAINED SOCIAL WORKERS OR PSYCHOLOGISTS ARE EMBEDDED IN TH OSE LOCATIONS TO HANDLE THIS WORK O THE WOMENS HEALTH PROJECT INCLUDES A COMPREHENSIVE FO CUS ON PREGNANCY AND FAMILY PLANNING IMPACTED BY SUBSTANCE ABUSE -CVMC SPONSORS THE WASHIN GTON COUNTY SUBSTANCE ABUSE REGIONAL PARTNERSHIP (WCSARP) WHICH MEETS MONTHLY TO COORDINAT E SERVICES, SOLVE ACCESS AND CARE MANAGEMENT PROBLEMS, AND ERASE BOUNDARIES OF CARE THE G ROUP INCLUDES, AMONG OTHERS, THE AGENCY FOR HUMAN SERVICES BARRE HSA, VERMONT DEPARTMENT O F HEALTH, LOCAL HUB-AND-SPOKE PARTNERS, THE DESIGNATED AGENCIES FOR MENTAL HEALTH AND SUBS TANCE ABUSE (WASHINGTON COUNTY MENTAL HEALTH, CENTRAL VERMONT SUBSTANCE ABUSE SERVICES), P REVENTION PARTNERS, THE TURNING POINT RECOVERY CENTER, THE YOUTH SERVICES BUREAU, RESIDENT IAL CARE PROVIDERS, AND LOCAL LAW ENFORCEMENT, -THREE IMPORTANT PROGRAMS GREW OUT OF GAPS IDENTIFIED BY WCSARP O CVMCS EMERGENCY DEPARTMENT INITIATED AN ALCOHOL WITHDRAWAL PROTOCO L IN COLLABORATION WITH WASHINGTON COUNTY MENTAL HEALTH AND THE TURNING POINT RECOVERY CEN TER TO PROVIDE 24/7 COMMUNITY- LOCATED SUPERVISED MEDICALLY ASSISTED WITHDRAWAL (MAW), O T HE EMERGENCY DEPARTMENT HAS ALSO INITIATED THE STATES FIRST RAPID ACCESS TO MAT (RAM) TO P ROVIDE IMMEDIATE 24/7 INDUCTION WITH BUPRENORPHINE LINKED TO RAPID HUB-AND-SPOKE ACCESS, O THE TURNING POINT CENTER IS CURRENTLY MANAGING A VERMONT OPIOID STATE RESPONSE PROJECT TO BRING PEER RECOVERY SUPPORTS INTO THE EMERGENCY DEPARTMENT HOSPITAL INPATIENT UNITS TO AS SURE STABLE TRANSITIONS TO THE COMMUNITY -CLINICAL OVERSIGHT OF CLINICAL INTERVENTIONS, O NGOING TRAINING AND SUPPORT TO MEDICAL STAFF, QUALITY IMPROVEMENT AND DATA MANAGEMENT -DE VELOPMENT OF CLINICAL INTERVENTION TOOLS FOR MEDICAL PROVIDERS TO USE DURING BRIEF INTERVE NTIONS AND GIVE TO PATIENTS AS RESOURCES -CONTINUE TO COORDINATE EFFORTS WITH CENTRAL VER MONT ADDICTION MEDICINE (CVAM) THE STAFF OF THE CENTRAL VERMONT MEDICATION ASSISTED TREAT MENT (MAT) TEAM HAS BEEN WORKING WITH THE STAFF AT CVAM TO ENSURE THAT THERE IS NO WAIT LI ST FOR INDIVIDUALS WHO ARE SEEKING MAT CURRENTLY, NEW PATIENTS ARE SEEN AND INDUCTED ON B UPRENORPHINE OR METHADONE BY THE THIRD MAT PROVIDER VISIT ADVANCE ACTION EXPAND FACILITAT ION AND LEADERSHIP OF THE WASHINGTON COUNTY SUBSTANCE ABUSE REGIONAL PARTNERSHIP COMMITTEE TO IDENTIFY BARRIERS TO TREAT

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, 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.

Form and Line Reference	Explanation
PART V, LINE 11	MENT AND GAPS IN SERVICES THIS MULTIDISCIPLINARY TEAM, CONSISTING OF PHYSICIANS, DRUG TRE ATMENT FACILITIES LEADERSHIP, DRUG COUNSELORS, ADAP REPRESENTATIVES, AND OUR COMMUNITY MEN TAL HEALTH AGENCY, MEETS MONTHLY AT CVMC TO STRENGTHEN WASHINGTON COUNTYS RESPONSE TO OUR CURRENT DRUG EPIDEMIC -CONTINUE DEVELOPMENT OF PARENTING GROUPS IN CONJUNCTION WITH TREAT MENT ASSOCIATES AND CENTRAL VERMONT ADDICTION MEDICINE -EXPAND SUPPORTS FOR PATIENTS UNDE R THE AGE OF 18 THAT MAY BE IN NEED OF MEDICATION-ASSISTED TREATMENT -ENGAGE PRACTITIONER S BY INCREASING THE MAT TEAM SUPPORT, WE ARE HOPEFUL THAT WE CAN ENCOURAGE MORE PRACTITIO NERS TO PROVIDE MAT TO THEIR PATIENTS -ONGOING EDUCATION BY CONTINUING WITH THE OFFICE B ASED OPIOID TREATMENT (OBOT) LEARNING COLLABORATIVE IN CONJUNCTION WITH DARTMOUTH HITCHCOC K MEDICAL CENTER, WE CAN CONTINUE TO EDUCATE PROVIDERS ON NEW FORMS OF TREATMENT, WHICH WI LL HELP IMPROVE ACCESS TO CARE ONE EXAMPLE OF THIS IS THE USE OF VIVITROL, AN INJECTABLE MEDICATION THAT BLOCKS THE OPIOID RECEPTORS FOR AN INDIVIDUAL FOR 30 DAYS PATIENTS RECEIV ING THIS TYPE OF TREATMENT CAN BE SUPPORTED BY THE MAT TEAM -THROUGH PROMOTION ON HOSPITA L BULLETINS AND MEDIA CENTERS, ENSURE THAT THE PUBLIC IS AWARE OF ORGANIZATIONS SUCH AS CE NTRAL VERMONT SUBSTANCE ABUSE SERVICES, AND ONLINE RESOURCES BEING CREATED BY GROUPS SUCH AS THE CENTRAL VERMONT OPIOID ADDICTION STEERING COMMITTEE AND WASHINGTON COUNTY REGIONAL SUBSTANCE ABUSE PARTNERSHIP -CONTINUE DEVELOPMENT OF A LOCAL SAFE HARBOR BRIDGE PROGRAM T HAT OFFERS 24/7 REFERRAL, SCREENING, AND ASSESSMENT SERVICES FOR INDIVIDUALS NEEDING MEDIC ALLY ASSISTED WITHDRAWAL AND/OR SUBSTANCE ABUSE TREATMENT -CONTINUE DEVELOPMENT AND SUPPO RT OF PROJECT SAFE CATCH, WHICH IS A DRUG AMNESTY PROGRAM THAT OFFERS ADDICTS IMMEDIATE AC CESS TO SUBSTANCE ABUSE TREATMENT IN LIEU OF AN ARREST OR PENALTY -PARTICIPATION IN THE G OVERNORS SUBSTANCE ABUSE WORKFORCE DEVELOPMENT WORKGROUPS -WOMENS HEALTH INITIATIVE LEARN ING COLLABORATIVE THROUGH THE VERMONT BLUEPRINT FOR HEALTH TO SUPPORT INTEGRATION OF EXPAN DED SBIRT SERVICES IN WOMENS HEALTH CLINICS THROUGHOUT THE STATE OF VERMONT MENTAL HEALTH CURRENT INITIATIVES -FAMILY PSYCHIATRY, A CVMC MEDICAL GROUP PRACTICE, ADOPTED FORMAL STA NDARDIZED DEPRESSION SCREENING FOR PATIENTS 12 AND OLDER -CONTINUE TO OFFER THE WELLNESS RECOVERY ACTION PLAN (WRAP) IS A WELLNESS AND RECOVERY APPROACH THAT HELPS PEOPLE TO DECRE ASE AND PREVENT INTRUSIVE OR TROUBLING FEELINGS AND BEHAVIORS, INCREASE PERSONAL EMPOWERME NT, IMPROVE QUALITY OF LIFE, AND ACHIEVE THEIR OWN LIFE GOALS AND DREAMS -CVMC, IN PARTNE RSHIP WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES, IS WORKING TO INTEGRATE BEHAVIORAL HE ALTH PRACTITIONERS INTO EVERY PRIMARY CARE PRACTICE -CVMC HAS PILOTED STANDARDIZED TRAUMA SCREENING IN COLLABORATION WITH WASHINGTON COUNTY MENTAL HEALTH INTO ONE OF ITS PRIMARY C ARE PRACTICES, IDENTIFYING PATIENTS WITH A HISTORY OF TRAUMA AND CONNECTING THEM WITH SERV ICES

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, 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.

Form and Line Reference	Explanation
-CVMC IS PARTNERING WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES	TO PILOT AN INTEGRATED HEALTH HOME THAT PROMOTES A MODEL OF HEALTH CARE THAT INTEGRATES TH E SOCIAL DETERMINANTS OF HEALTH WITH SPECIALIZED TREATMENT FOR INDIVIDUALS WITH COMPLEX PH YSICAL HEALTH, MENTAL HEALTH, DEVELOPMENTAL AND SUBSTANCE ABUSE CHALLENGES -CVMC HAS DEVE LOPED A DOULA PROJECT TO SUPPORT EVERY PRENATAL PATIENT SEEN THROUGH CENTRAL VERMONT WOMEN S HEALTH EACH PRENATAL PATIENT IS OFFERED DOULA SUPPORT AS RESEARCH SHOWS THAT DOULA LABO R SUPPORT DECREASES THE RISK FOR POSTPARTUM DEPRESSION -CVMC, IN COLLABORATION WITH WASHI NGTON COUNTY MENTAL HEALTH SERVICES, IS OFFERING ADDITIONAL PRENATAL AND POSTPARTUM SUPPOR T FOR WOMEN WITH A HISTORY OF DEPRESSION OR ARE AT RISK OF POSTPARTUM DEPRESSION THOSE SE RVICES INCLUDE O CASE MANAGEMENT O COLLABORATION WITH OTHER COMMUNITY AGENCIES O PRENATAL YOGA O CHILDBIRTH EDUCATION O REFERRAL TO OTHER WASHINGTON COUNTY MENTAL HEALTH SERVICES PROGRAMS AND COUNSELING O ADDITIONAL POSTPARTUM SUPPORT UP TO ONE YEAR POSTPARTUM O LABOR SUPPORT -ADVERSE CHILDHOOD EXPERIENCES (ACES) PILOT PROJECT WAS INITIATED WITH A THE GOAL USE FAMILY SUPPORT SPECIALISTS EMBEDDED IN ONE OF CVMCS LOCAL PEDIATRIC PRACTICES, TARGETI NG AGE GROUPS 0-36 MONTHS TO PROMOTE CHILD AND FAMILY PROTECTIVE FACTORS, PREVENT AND MITI GATE TOXIC STRESS, AND PROMOTE HEALTHY CHILD DEVELOPMENT FOR A PERIOD OF ONE YEAR -CVMC I N PARTNERSHIP WITH STATE AND LOCAL ORGANIZATION FOR RECURRENT VIEWINGS OF THE FILM RESILIE NCE INCLUDING A PANEL OF EXPERTS FOR AN IN-DEPTH DISCUSSION ON THE IMPACT OF ADVERSE CHILD HOOD EVENTS TOBACCO USE CURRENT INITIATIVES -CONTINUE TO COORDINATE EFFORTS WITH LARGE AN D SMALL LOCAL BUSINESSES CVMC OFFERS A TOBACCO CESSATION PROGRAM ON AND OFF SITE THROUGHO UT THE YEAR CURRENTLY, WE ARE ABLE TO ASSIST PARTICIPANTS WITH SUPPORT AND FREE NICOTINE REPLACEMENT THERAPY SUCH AS GUM, PATCHES AND LOZENGES -CONTINUE TO ATTEND LOCAL EMPLOYERS WELLNESS FAIRS, INCLUDING STATE EMPLOYEE WELLNESS, WASHINGTON COUNTY MENTAL HEALTH SERVI CES AND COMMUNITY BASED OUTREACH (BARRE HERITAGE FESTIVAL, MONTPELIER ALIVE) THIS ALSO SE RVES AS A TOOL FOR EDUCATING AND NETWORKING WITH COMMUNITY MEMBERS -ADDED FRESHSTART (TOB ACCO CESSATION) LEADERS IN ORDER TO INCREASE CESSATION SERVICES TO WASHINGTON COUNTY RESID ENTS INCLUDING OUTLYING AREAS -SBIRT CLINICIANS ARE TRAINED AS TOBACCO TREATMENT SPECIALI ST AND ACCESSIBLE FOR INDIVIDUAL COUNSELING TO PROMOTE SUCCESSFUL QUIT ATTEMPTS PATIENTS IN THE MEDICAL HOMES CAN ACCESS FREE BRIEF TREATMENT FOR TOBACCO CESSATION WITH A MASTERS LEVEL COUNSELOR THROUGH PARTNERSHIP WITH THE TOBACCO CONTROL PROGRAM, PATIENTS ENGAGED WI TH AN SBIRT CLINICIAN ARE ELIGIBLE FOR FREE NICOTINE REPLACEMENT THERAPY SUCH AS PATCHES, GUM AND LOZENGES ALL TREATMENT IS DOCUMENTED IN THE SHARED MEDICAL EMR ADVANCE ACTION -C ONTINUING EDUCATION VIA WEBINAR INVITATIONS THROUGH THE VERMONT DEPARTMENT OF HEALTH -THR OUGH PROMOTION ON CVMC/MEDICAL GROUP PRACTICES BULLETINS AND CVMCS WEB SITE, ENSURE THAT T HE GENERAL PUBLIC IS AWARE OF

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, 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.

Form and Line Reference	Explanation
-CVMC IS PARTNERING WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES	802QUITS ORG, AN IN-PERSON, PHONE LINE AND ONLINE SUPPORT FOR TOBACCO CESSATION SERVICES -EXPAND ACCESS TO SBIRT CLINICIANS FOR TOBACCO CESSATION TREATMENT TO CVMC SPECIALTY PRACT ICES HEALTHY DIETS CURRENT INITIATIVES -TRANSITION OF FITNESS4WELLNESS FROM A PILOT INTO A TWICE OFFERED ANNUAL PROGRAM CVMC REHAB AND COMMUNITY HEALTH TEAM COLLABORATION PROJECT TWELVE- WEEK WELLNESS PROGRAM FOR PATIENTS TO IMPROVE THEIR PHYSICAL ABILITIES THROUGH PHY SICAL THERAPY, NUTRITION EDUCATION TO ASSIST WITH HEALTHIER EATING BEHAVIORS, HEALTH COACH ING INCLUDING GOAL SETTING, AND BEHAVIOR MODIFICATION TECHNIQUES -HEALTH CARE SHARE IN P ARTNERSHIP WITH VERMONT YOUTH CONSERVATION CORPS, CVMC PROVIDES FUNDING FOR THE DELIVERY O F FRESHLY HARVESTED, ORGANIC VEGETABLES TO 150 RECIPIENTS WHICH IMPACTED 382 CHILDREN, ADU LTS, AND SENIORS IN NEED FOR 15 WEEKS AN EDUCATIONAL BINDER WITH INFORMATION ON THE NUTRI TIONAL VALUE AND PREPARATION OF THE VEGETABLES IS DISTRIBUTED ON THE INITIAL DELIVERY IN E ARLY JULY IN ADDITION, WEEKLY NEWSLETTERS ACCOMPANY THE SHARE INCLUDING RECIPES AND STAFF PROFILES FROM VYCC -TRANSITION YMCA DIABETES PREVENTION PROGRAM TO T2 A YEAR-LONG PROGRA M, HOURLY FOR 24-26 SESSIONS TARGETED FOR PEOPLE WITH PRE-DIABETES AND/OR A BMI > 25 OVE RALL GOAL IS TO PREVENT DEVELOPING DIABETES WITH A POPULATION THAT IS AT HIGH RISK FOR THI S CHRONIC DISEASE FOCUS IS ON MODEST WEIGHT LOSS OF 5-7% BODY WEIGHT, AND INCREASING WEEK LY ACTIVITY TO 150 MINUTES STATISTICS SHOW A 58% REDUCTION IN DEVELOPING DIABETES IF OVER ALL GOALS MET -VEGGIE VANGO PROGRAM PARTNERSHIP WITH THE VERMONT FOOD BANK PROVIDED FREE , FRESH PRODUCE TO LOCAL COMMUNITY MEMBERS APPROXIMATELY 4900 POUNDS OF FOOD WERE PROVIDE D TO AN INCREASED 230 (ADDITIONAL 30) COMMUNITY MEMBERS AT EACH OF THE MONTHLY DISTRIBUTIO NS YOUTH PARTICIPATION IN PHYSICAL ACTIVITIES CVMCS POPULATION HEALTH MANAGEMENT GOALS RE VOLVE AROUND THE IDENTIFICATION OF RISK FACTORS THAT, IF ADDRESSED EARLY, CAN REDUCE THE P REVALENCE OF CHRONIC MEDICAL CONDITIONS LATER IN LIFE CURRENT INITIATIVES -CONTINUE OUR P ANEL MANAGEMENT EFFORTS WITHIN OUR CVMC PEDIATRIC PRIMARY CARE PRACTICES TO IDENTIFY CHILD REN THAT ARE OVERDUE FOR WELL-CHILD VISITS AND PROVIDE OUTREACH TO ENCOURAGE THEM TO ATTEN D BODY MASS INDEX IS CALCULATED AT EACH WELL-CHILD VISIT AND EDUCATION IS PROVIDED AROUND THE IMPORTANCE OF PHYSICAL ACTIVITY FOR OUR PEDIATRIC PATIENTS -THE CVMC SCHOOL-BASED HE ALTH CENTER IS AN EXTENSION OF OUR PEDIATRIC PRIMARY CARE PRACTICES AND OPERATES TWO DAYS EACH WEEK AT THE BARRE CITY ELEMENTARY AND MIDDLE SCHOOL ONE BENEFIT OF BEING EMBEDDED IN THE SCHOOL SETTING IS THAT IT PROVIDES MORE OPPORTUNITIES FOR OUR PEDIATRIC CLINICIANS TO DISCUSS AND PROMOTE THE IMPORTANCE OF PHYSICAL ACTIVITY AND HOW IT IMPACTS OVERALL HEALTH AND WELL-BEING WITH OUR PEDIATRIC PATIENTS -THE ANNUAL CVMC FUN RUN AND WALK OFFERS OUR COMMUNITYS YOUTH POPULATION AN OPPORTUNITY TO PARTICIPATE IN A FIVE-MILE RACE AROUND BERLI N POND, THE PROCEEDS OF WHICH

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, 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.

Form and Line Reference	Explanation
-CVMC IS PARTNERING WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES	GO TO THE HEALTH CARE SHARE PROGRAM ADVANCE ACTION -WORK WITH OUR TWO PEDIATRICS PRACTICE S TO FURTHER INCORPORATE PATIENT SELF-MANAGEMENT GOALS AND QUALITY MEASURES PERTAINING TO INCREASED PHYSICAL ACTIVITY FOR OUR PEDIATRIC PATIENT POPULATION -INCREASE OUR INVOLVEMEN T IN THE CREATION AND PROMOTION OF NEW COMMUNITY PROGRAMS THAT TARGET YOUTH PARTICIPATION IN PHYSICAL ACTIVITIES

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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, 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.

Form and Line Reference	Explanation
NEEDS NOT BEING ADDRESSED	OUR COMMUNITY HEALTH NEEDS ASSESSMENT IDENTIFIED ADDITIONAL DETERMINANTS OF HEALTH THAT FALL OUTSIDE THE REALM OF OUR CAPABILITIES AT CVMC A PROMINENT NEED THAT WE ARE NOT DIRECTLY ADDRESSING IS ORAL HEALTH SEVERAL OF OUR PHYSICIANS HAVE UNDERGONE FLUORIDE TREATMENT TRAINING, AND ARE ABLE TO PROVIDE THIS SERVICE FOR CHILDREN UP TO FOUR YEARS OF AGE WHO DO NOT HAVE ACCESS TO DENTAL CARE HOWEVER, ONE OUT OF FOUR ADULTS IN WASHINGTON COUNTY HAS NOT VISITED A DENTIST IN THE LAST YEAR AS A MEDICAL HOSPITAL, WE DO NOT HAVE THE FACILITIES OR EXPERTISE TO ADDRESS THIS NEED DIRECTLY WITH THIS SAID, IT IS IMPORTANT THAT WE RECOGNIZE ALL FACTORS THAT MAY BE AFFECTING THE OVERALL HEALTH OF PATIENTS WALKING THROUGH OUR DOORS AT CVMC WE INTEND TO CONTINUE COLLABORATION WITH COMMUNITY FACILITIES SUCH AS THE HEALTH CENTER IN PLAINFIELD AND THE PEOPLES HEALTH AND WELLNESS CENTER IN BARRE THAT OFFER DENTAL CARE OTHER AREAS WERE IDENTIFIED WHICH WE HAVE CHOSEN TO ACKNOWLEDGE, BUT NOT ADDRESS DIRECTLY AS PART OF OUR STRATEGIC PLAN SOME OF THOSE NEEDS WERE - INCREASE AVAILABLE HOUSING FOR THOSE IN NEED - DECREASE TEENAGE PREGNANCIES - DECREASE UNPLANNED PREGNANCIES - EXPAND SERVICES TARGETING THE ELDERLY IN OUR COMMUNITY - INCREASE THE NUMBER OF WALKING PATHS AND/OR BIKE LANES IN OUR COMMUNITY - INCREASE AVAILABILITY TO MENTAL HEALTH SERVICES MENTAL HEALTH HAS BEEN IDENTIFIED AS THE COSTLIEST MEDICAL CONDITION IN THE COUNTRY AND AN AREA THAT SUFFERS FROM INADEQUATE CAPACITY - CVMC IS WORKING ALONGSIDE WASHINGTON COUNTY MEDICAL HEALTH SERVICES TO INTEGRATE MENTAL HEALTH PRACTITIONERS INTO EVERY PRIMARY CARE PRACTICE - FAMILY PSYCHIATRY ADOPTED A FORMAL STANDARDIZED DEPRESSION SCREENING FOR PATIENTS AGED 12 AND OLDER - CVMC, IN COLLABORATION WITH WASHINGTON COUNTY MENTAL HEALTH SERVICES, IS OFFERING ADDITIONAL PRE-NATAL AND POSTPARTUM SUPPORT FOR WOMEN WITH A HISTORY OF, OR AT RISK FOR DEPRESSION A NEW 25-BED INTENSIVE-CARE PSYCHIATRIC HOSPITAL WAS CONSTRUCTED ADJACENT TO CVMC IN BERLIN THIS $28 5 MILLION FACILITY IS PART OF A STATEWIDE NETWORK OF MENTAL HEALTH FACILITIES WHICH REPLACE THE VERMONT STATE HOSPITAL IN WATERBURY AND OPENED TO PATIENTS IN 2014 MENTAL HEALTH HAS BEEN ACKNOWLEDGED AS A PRESSING ISSUE STATEWIDE OUR COMMUNITY HOPES THIS NEW FACILITY WILL CONTINUE TO ALLEVIATE SOME OF THE CURRENT DEMAND FOR INPATIENT CARE FOR SEVERE MENTAL HEALTH NEED PART V, LINE 16A & 16B https //www cvmc org/sites/default/files/documents/CVMC-Financial-Assistan ce-Policy pdf HTTPS //WWW CVMC ORG/SITES/DEFAULT/FILES/DOCUMENTS/FINANCIAL-ASSISTANCE-AP PLICATION-JANUARY-2018 PDF

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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, 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.

Form and Line Reference	Explanation
PART V, LINE 16C - FAP PLAIN LANGUAGE SUMMARY	HTTPS //WWW CVMC ORG/SITES/DEFAULT/FILES/DOCUMENTS/FINANCIAL-ASSISTANCE-PO LICY-V2016 PDF

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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, 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.

Form and Line Reference	Explanation
PART V, LINE 16J	IN ADDITION TO HAVING THE APPLICATION FOR FINANCIAL ASSISTANCE AS WELL AS THE SLIDING SCALE GRID OF HOW FINANCIAL ASSISTANCE IS AWARDED CVMC HAS COMPREHENSIVE INFORMATION ON THE WEBSITE ABOUT THE POLICY, MATERIALS REQUIRED TO APPLY AND CONTACT INFORMATION FOR THE FINANCIAL COUNSELORS SO THAT INTERESTED INDIVIDUALS CAN APPLY ADDITIONALLY, THERE IS REFERENCE MADE TO THE POLICY ON PATIENT'S BILLS AS WELL AS APPLICATIONS AND INFORMATION AVAILABLE IN REGISTRATION AREAS IN THE HOSPITAL AND CLINIC LOCATIONS CVMC ALSO EMPLOYS A TEAM OF FINANCIAL COUNSELORS THAT WORK WITH PATIENTS THROUGHOUT THEIR VISIT TO ENSURE THAT WE COMMUNICATE WITH AS MANY ELIGIBLE INDIVIDUALS AS POSSIBLE THESE FINANCIAL COUNSELORS ALSO WORK WITH PATIENTS TO EXPLORE THE OTHER OPPORTUNITIES AVAILABLE TO INDIVIDUALS IN NEED THROUGHOUT THE STATE OF VERMONT

Form 990 Part V Section C Supplemental Information for Part V, Section B.

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, 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.

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

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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? _____

Name and address	Type of Facility (describe)
CVMC - WOODRIDGE NURSING HOME 142 Woodridge Drive BERLIN, VT 05602	SKILLED NURSING FACILITY
CVMC WOMEN'S HEALTH 130 FISHER ROAD SUITE 1-4 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC PEDIATRICS PRIMARY CARE - BERLIN 246 GRANGER ROAD SUITE 1 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC FAMILY MEDICINE - WATERBURY 130 SOUTH MAIN STREET WATERBURY, VT 05676	MEDICAL GROUP PRACTICE
CVMC ADULT PRIMARY CARE - BERLIN 130 FISHER ROAD MOB-B SUITE 3 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC INTEGRATIVE FAM MED - MONTPELIER 156 MAIN STREET MONTPELIER, VT 05602	MEDICAL GROUP PRACTICE
CVMC FAMILY MEDICINE - BERLIN 246 GRANGER ROAD SUITE 2 BERLIN, VT 05641	MEDICAL GROUP PRACTICE
CVMC ADULT PRIMARY CARE - BARRE 225 SOUTH MAIN STREET BARRE, VT 05641	MEDICAL GROUP PRACTICE
CVMC CARDIOLOGY 130 FISHER ROAD MOB-A SUITE 2-1 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
GREEN MOUNTAIN FAMILY PRACTICE 87 PAINE MOUNTAIN DRIVE NORTHFIELD, VT 05663	MEDICAL GROUP PRACTICE
CVMC PEDIATRICS PRIMARY CARE - BARRE 225 SOUTH MAIN STREET BARRE, VT 05641	MEDICAL GROUP PRACTICE
CVMC FAMILY PSYCHIATRY 82 EAST VIEW LANE SUITE 3 BERLIN, VT 05641	MEDICAL GROUP PRACTICE
CVMC FAMILY MEDICINE - MAD RIVER 859 OLD COUNTY ROAD WAITSFIELD, VT 05673	MEDICAL GROUP PRACTICE
CVMC UROLOGY 130 FISHER ROAD MOB-A SUITE 3 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC NEUROLOGY 130 FISHER ROAD MOB-A SUITE 1-6 BERLIN, VT 05602	MEDICAL GROUP PRACTICE

Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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? _____

Name and address	Type of Facility (describe)
NORWICH UNIVERSITY HEALTH SERVICES 63 CRESCENT AVENUE NORTHFIELD, VT 05663	MEDICAL INFIRMARY
CVMC ORTHOPEDICS & SPINE MEDICINE 1311 BARRE MONTPELIER RD SUITE 400 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC ORTHOPEDICS & SPORTS MEDICINE 1311 BARRE MONTPELIER RD SUITE 400 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC RHEUMATOLOGY 130 FISHER ROAD MOB-B SUITE 2-3 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC EXPRESS CARE - BERLIN 1311 BARRE MONTPELIER RD SUITE 200 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC ORTHOPAEDICS & PODIATRY 1311 BARRE MONTPELIER RD SUITE 400 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC ENDOCRINOLOGY 130 FISHER ROAD MOB-A SUITE 3 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
CVMC WOUND CARE CENTER 1311 BARRE MONTPELIER RD SUITE 200 BERLIN, VT 05602	MEDICAL GROUP PRACTICE
GRANITE CITY PRIMARY CARE 14 NORTH MAIN STREET SUITE 4002 BARRE, VT 05641	MEDICAL GROUP PRACTICE
CVMC EXPRESS CARE - WATERBURY 76 MCNEIL ROAD SUITE 1 WATERBURY CTR, VT 05677	MEDICAL GROUP PRACTICE
CVMC ORTHOPEDICS & SPINE MEDICINE 76 MCNEIL ROAD SUITE 2 WATERBURY CTR, VT 05677	MEDICAL GROUP PRACTICE
CVMC OCCUPATIONAL MEDICINE 244 GRANGER ROAD BERLIN, VT 05602	MEDICAL GROUP PRACTICE

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

▶ **Information about Schedule I (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

Employer identification number
22-2547186

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☑ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000 Part II can be duplicated if additional space is needed

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 4

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

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.

Return Reference	Explanation
DESCRIPTION OF ORGANIZATION'S PROCEDURES FOR MONITORING THE USE OF GRANTS	SCHEDULE I, PART I, LINE 2 CENTRAL VERMONT MEDICAL CENTER OCCASIONALLY GRANTS FUNDS TO ORGANIZATIONS THAT SUPPORT CVMC'S EXEMPT PURPOSE OF SERVING THE HEALTHCARE NEEDS OF CENTRAL VERMONT RESIDENTS GRANT FUNDS ARE APPROVED AND OVERSEEN BY THE BOARD

Additional Data

Software ID:
Software Version:
EIN: 22-2547186
Name: CENTRAL VERMONT MEDICAL CENTER INC

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
PEOPLES HEALTH AND WELLNESS CENTER 553 North Main St Suite 5 Barre, VT 05641	03-0343290	501(c)(3)	20,000				HEALTH CARE FOR THE UNINSURED
AREA HLTH EDU CNTRS PRM UNIV VT COL OF MED UHC CMP Arnld 51 SPrpct Brlngtn, VT 05401	03-0179440	501(c)(3)	26,000				EDU LOAN RPMT TO HLTHCR PRFSNLS

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
GREEN MOUNTAIN TRANSIT 15 INDUSTRIAL PARKWAY BURLINGTON, VT 05401	03-0231413	GOVERNMENT	81,141				TRANSPORTATION
Washington County Mental Health Services Inc PO Box 647 Montpelier, VT 056010647	03-0215872	501(c)(3)	501,500				Support mission for mental health and substance abuse treatment services

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Schedule J (Form 990)

Department of the Treasury Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

▶ **Information about Schedule J (Form 990) and its instructions is at *www.irs.gov/form990*.**

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

Employer identification number
22-2547186

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate 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 idemnification and gross-up payments ☐ Health or social club dues or initiation fees ☐ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)			
b	If any of the boxes in 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	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**		
3	Indicate which, if any, of the following the filing 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?	**4a**	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 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?	**5a**		No
b	Any related organization?	**5b**		No
	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?	**6a**		No
b	Any related organization?	**6b**		No
	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 non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported on Form 990, Part VII, paid or accured 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	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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 are not 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 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				
See Additional Data Table							

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

Return Reference	Explanation
SEVERANCE PAYMENTS	SCHEDULE J, PART I, LINE 4A IN CONNECTION WITH HER DEPARTURE FROM THE ORGANIZATION IN DECEMBER OF 2016, KARIN MORROW RECEIVED $6,689 IN SEVERANCE THIS AMOUNT IS INCLUDED ON SCHEDULE J, PART II, COLUMN B(III)
EXECUTIVE BENEFITS	SCHEDULE J, PART I, LINE 4B CERTAIN LISTED INDIVIDUALS PARTICIPATED IN THE UVM MEDICAL CENTER EXECUTIVE BENEFIT PLAN UNDER WHICH PARTICIPANTS ARE CREDITED A BENEFIT ALLOWANCE EQUAL TO A SPECIFIED PERCENTAGE OF BASE PAY UNDER THE PLAN, PARTICIPANTS MAY ELECT TO HAVE THE AMOUNT OF THE BENEFIT ALLOWANCE DEFERRED TO A CAPITAL ACCUMULATION ACCOUNT SUBJECT TO SECTION 457(F) NO AMOUNTS WERE DEFERRED TO OR PAID FROM A CAPITAL ACCUMULATION ACCOUNT IN CALENDAR 2016 DURING CALENDAR YEAR 2015, THE UNIVERSITY OF VERMONT MEDICAL CENTER, INC ENTERED INTO A SUPPLEMENTAL RETIREMENT BENEFIT PLAN (SRP) WITH PRESIDENT BRUMSTED UNDER THE TERMS OF THE SRP, UVM MEDICAL CENTER MAKES ANNUAL CREDITS EQUAL TO 15% OF THE PRESIDENT'S BASE SALARY FOR EACH YEAR THROUGH THE PLAN YEAR ENDING SEPTEMBER 30, 2019 THE AMOUNT DEFERRED FOR CY16 IS REPORTED ON SCHEDULE J, PART II, COLUMN C AMOUNTS DEFERRED REMAIN SUBJECT TO FORFEITURE IF CERTAIN CONDITIONS ARE NOT MET

Additional Data

Software ID:
Software Version:
EIN: 22-2547186
Name: CENTRAL VERMONT MEDICAL CENTER INC

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation (i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable 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
1JOHN BRUMSTED MD TRUSTEE	(I)	0	0	0	0	0	0	0
	(II)	1,024,109	694,095	168,835	186,083	27,069	2,100,191	0
1JEREMIAH ECKHAUS MD TRUSTEE, PRES-ELECT MED STAFF	(I)	191,467	28,187	293	12,736	25,665	258,348	0
	(II)	0	0	0	0	0	0	0
2MARK DEPMAN MD TRUSTEE, REGNAL PHYS LEADER	(I)	309,431	31,500	14,301	0	21,255	376,487	0
	(II)	0	0	0	0	0	0	0
3ANNA T NOONAN TRUSTEE, PRESIDENT/COO 7/2017	(I)	0	0	0	0	0	0	0
	(II)	239,785	47,475	22,337	30,757	29,522	369,876	0
4CATHY PALMER MDTRUSTEE	(I)	0	0	15,000	0	0	15,000	0
	(II)	215,029		20,997	16,485	26,252	278,763	
5JUDITH TARR TARTAGLIA TRUSTEE, PRES/CEO UNTIL 3/2017	(I)	420,835	219,074	8,583	0	20,620	669,112	0
	(II)	0	0	0	0	0	0	0
6CHEYENNE HOLLAND TREASURER, CFO/VP FISCAL SRVS	(I)	257,702	25,759	3,928	15,836	29,016	332,241	0
	(II)	0	0	0	0	0	0	0
7NANCY LOTHIAN CHIEF OPERATING OFFICER,9/2017	(I)	313,070	30,882	7,707	0	19,495	371,154	0
	(II)	0	0	0	0	0	0	0
8PHILIP BROWN DO CHIEF MEDICAL OFFICER	(I)	305,378	30,883	0	0	29,463	365,724	0
	(II)	0	0	0	0	0	0	0
9RICHARD MORLEY VP SUPPORT SERVICES	(I)	193,773	20,062	4,065	0	27,960	245,860	0
	(II)	0	0	0	0	0	0	0
10MATTHEW CHOATE CNO, AS OF 12/2016	(I)	123,156	2,187	1,789	7,734	18,934	153,800	0
	(II)	0	0	0	0	0	0	0
11MAHLON BRADLEY MD PHYSICIAN	(I)	403,215	97,287	2,921	15,900	31,297	550,620	0
	(II)	0	0	0	0	0	0	0
12CHRISTIAN BEAN MD PHYSICIAN	(I)	326,348	85,595	791	0	21,511	434,245	0
	(II)	0	0	0	0	0	0	0
13JOHN BRAUN MD PHYSICIAN	(I)	460,377	46,434	426	12,558	3,792	523,587	0
	(II)	0	0	0	0	0	0	0
14 CHRISTOPHER MERIAM MD PHYSICIAN	(I)	325,894	83,477	1,092	0	21,965	432,428	0
	(II)	0	0	0	0	0	0	0
15SARA GRAVES MD PHYSICIAN	(I)	396,744	81,197	0	5,455	24,275	507,671	0
	(II)	0	0	0	0	0	0	0
16KARIN MORROW CNO, UNTIL 12/2016	(I)	167,153	17,043	46,575	0	8,632	239,403	0
	(II)	0	0	0	0	0	0	0
17DAVID TURNER VP PHYSICIAN SERVICES	(I)	168,085	0	10,083	10,368	2,620	191,156	0
	(II)	0	0	0	0	0	0	0

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

Employer identification number
22-2547186

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	VT Educational & Health Bldgs Finance Authority	23-7154467	000000000	05-13-2009	21,023,997	SEE SCH K, PART VI		X		X	X	

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	20,346,757			
2	Amount of bonds legally defeased	0			
3	Total proceeds of issue	21,028,838			
4	Gross proceeds in reserve funds	0			
5	Capitalized interest from proceeds	0			
6	Proceeds in refunding escrows	0			
7	Issuance costs from proceeds	144,996			
8	Credit enhancement from proceeds	0			
9	Working capital expenditures from proceeds	0			
10	Capital expenditures from proceeds	8,000,000			
11	Other spent proceeds	12,879,001			
12	Other unspent proceeds	0			
13	Year of substantial completion	2009			

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X							
15	Were the bonds issued as part of an advance refunding issue?		X						
16	Has the final allocation of proceeds been made?	X							
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X							

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X						
2	Are there any lease arrangements that may result in private business use of bond-financed property?	X							

Part III Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use of bond-financed property?	X							
b	If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X							
c	Are there any research agreements that may result in private business use of bond-financed property?		X						
d	If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		0 %						
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6	Total of lines 4 and 5								
7	Does the bond issue meet the private security or payment test?								
8a	Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?								
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?								

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X						
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X						
b	Exception to rebate?		X						
c	No rebate due?	X							
	If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?		X						
4a	Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X						
b	Name of provider	0							
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was the hedge terminated?								

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b	Name of provider	0							
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X						
7	Has the organization established written procedures to monitor the requirements of section 148? . . .	X							

Part V Procedures To Undertake Corrective Action

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

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

Return Reference	Explanation
SCHEDULE K, PART I, LINE A, COLUMN F	DESCRIPTION OF PURPOSE THE VEHBFA 2009 SERIES A&B BOND ISSUANCE WAS ISSUED ON 5/13/2009 TO SATISFY (REFINANCE) 2005 DEBT WITH VEHBFA THE 2005 DEBT FINANCED THE CONSTRUCTION AND EQUIPMENT OF A RENOVATION AND MODERNIZATION PROJECT $12,879,001 OF THE VEHBFA 2009 SERIES A&B BOND ISSUANCE WAS USED TO REFUND THE 2005 DEBT THE REFUND OCCURRED ON MAY 31, 2009 THE REMAINDER WAS USED TO CONSTRUCT AND EQUIP A CANCER TREATMENT CENTER SCHEDULE K, PART IV, COLUMN A, LINE 2C REBATE COMPUTATION DATE A REBATE COMPUTATION WAS PERFORMED IN AUGUST, 2014 SCHEDULE K, PART II, LINE B, COLUMN A TOTAL PROCEEDS OF ISSUE INCLUDE $4,841 OF INTEREST INCOME

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 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.
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

Employer identification number
22-2547186

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

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

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

2 Enter the amount of tax incurred by 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? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
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

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) MATT TARR	See Schedule L, Part V	40,797	WAGES & BENEFITS		No
(2) SUBSTANTIAL DONOR	SUBSTANTIAL CONTRIBUTOR	2,349,053	SERVICES		No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L, PART IV, COLUMN B	RELATIONSHIP BETWEEN PARTIES MATT TARR IS AN EMPLOYEE OF CVMC AND IS THE SON OF JUDITH TARTAGLIA, AN OFFICER OF THE ORGANIZATION

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization
CENTRAL VERMONT MEDICAL CENTER INC

Employer identification number
22-2547186

990 Schedule O, Supplemental Information

Return Reference	Explanation
DESCRIPTION OF THE ORGANIZATION'S MISSION	FORM 990, PART III, LINE 1 CENTRAL VERMONT MEDICAL CENTER TRUSTEES AND ITS STAFF ARE COMMI TTED TO PROVIDING EXCELLENT CARE TO CENTRAL VERMONTERS TO STAY ABREAST OF BEST PRACTICES, CVMC COLLABORATES WITH MANY HEALTHCARE ENTITIES TO ENSURE THIS COMMITMENT PARTICIPATING IN THE JOINT COMMISSION ACCREDITATIONS PROCESS IS ONE MEASURE OF HOW CVMC CONTINUOUSLY STR IVES TO IMPROVE THE SAFETY AND QUALITY OF CARE PROVIDED TO ITS PATIENTS THE HOSPITAL AND THE PHYSICIAN PRACTICE GROUPS (CVMGP, CENTRAL VERMONT MEDICAL GROUP PRACTICES) WERE ACCRED ITED IN JANUARY 2016 FOR A THREE YEAR PERIOD JOINT COMMISSION ACCREDITATION IS THE EQUIVA LENT OF THE GOOD HOUSEKEEPING "SEAL OF APPROVAL" FOR MEDICAL CENTERS THE JOINT COMMISSION EVALUATES THE QUALITY AND SAFETY OF CARE PROVIDED BY HEALTH CARE ORGANIZATIONS TO EARN A ND MAINTAIN ACCREDITATION, ORGANIZATIONS MUST HAVE AN EXTENSIVE ON-SITE REVIEW BY A TEAM O F JOINT COMMISSION HEALTH CARE PROFESSIONALS AT LEAST ONCE EVERY THREE YEARS THE PURPOSE OF THE REVIEW IS TO EVALUATE THE ORGANIZATION'S PERFORMANCE IN AREAS THAT AFFECT PATIENT C ARE ACCREDITATION IS AWARDED BASED ON HOW WELL THE ORGANIZATION MEETS THE JOINT COMMISSIO N STANDARDS CVMC PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CA RE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES ALL OF CVMC'S SERV ICES, INCLUDING EMERGENCY CARE, ARE PROVIDED TO ALL PERSONS REGARDLESS OF ABILITY TO PAY FORM 990, PART VI, LINE 2 THERE IS A BUSINESS RELATIONSHIP BETWEEN DR JOHN BRUMSTED AN OF FICER OF THE UNIVERSTIY OF VERMONT MEDICAL CENTER (UVMMC) AND DR CATHY PALMER AN EMPLOYEE OF UVMMC 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 VERMON T NON-PROFIT CORPORATION WHICH HAS BEEN RECOGNIZED BY THE IRS AS A 501(C)(3) ORGANIZATION THAT IS NOT A PRIVATE FOUNDATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
ELECTION OF GOVERNING BODY & GOVERNANCE DECISIONS	FORM 990, PART VI, LINE 7A & 7B THE UNIVERSITY OF VERMONT HEALTH NETWORK HOLDS THE POWER T O ELECT CVMC'S BOARD OF TRUSTEES AND TO APPROVE SIGNIFICANT CORPORATE ACTIONS, INCLUDING A NNUAL OPERATING AND CAPITAL BUDGETS, STRATEGIC PLANS, THE APPOINTMENT OF THE CEO, THE INCU RRENCE OF LONG-TERM INDEBTEDNESS, AND AMENDMENTS TO CVMC'S BYLAWS AND ARTICLES OF ORGANIZA TION OFFICERS MAILING ADDRESSES FORM 990, PART VI, LINE 9 RICHARD MORLEY 141 CROSSFIELD D RIVE COLCHESTER, VT 05446 KARIN MORROW 39 GRANDVIEW FARM ROAD BARRE, VT 05641 JUDITH TARTA GLIA 4811 COQUINA ROAD FT MYERS BEACH, FL 33931 KATHERINE BORNE 1826 HILL STREET EXTENSIO N BERLIN, VT 05602 NANCY LOTHIAN 195 PARTRIDGE HILL ROAD BARRE, VT 05641 PHILIP BROWN 359 POTASH HILL TUNBRIDGE, VT 05077

990 Schedule O, Supplemental Information

Return Reference	Explanation
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 FINANCE COMMITTEE AND MAKES AVAILABLE TO THE FINANCE COMMITTEE THE FORM 990 ALONG WITH HIGHLIGHTS OF ALL SIGNIFICANT PARTS OF THE FORM 990 THE BOARD OF TRUSTEES IS ALSO PROVIDED VIA EMAIL A COPY OF THE "AS FILED" FORM 990 BEFORE IT IS FILED WITH THE IRS, WITH A STATEMENT NOTATING THAT SCHEDULE B IS NOT FOR PUBLIC VIEWING THE FORM 990 IS ALSO AVAILABLE IN HARD COPY FOR THOSE THAT DO NOT HAVE ACCESS TO EMAIL

990 Schedule O, Supplemental Information

Return Reference	Explanation
DESCRIPTION OF PROCESS TO MONITOR TRANSACTIONS FOR CONFLICTS OF INTEREST	FORM 990, PART VI, LINE 12C THE COMPLIANCE OFFICER FOR CVMC MAINTAINS THE CONFLICT OF INTE REST STATEMENTS AND REGULARLY MONITORS THEM AS WELL AS ANY OTHER ACTIVITIES THAT MAY CONST ITUTE A CONFLICT OF INTEREST THE ORGANIZATION'S PRACTICE IS TO SEND OUT ANNUAL DISCLOSURE QUESTIONNAIRES TO BOARD OF TRUSTEE MEMBERS, SENIOR OFFICERS, AND DIRECTORS OF THE ORGANIZ ATION OR OTHER INDIVIDUALS IN A POSITION TO EXERCISE SUBSTANTIAL INFLUENCE OVER THE AFFAIR S OF THE ORGANIZATION WHO HAVE A DIRECT OR INDIRECT FINANCIAL INTEREST, AS DEFINED BELOW, AS AN "INTERESTED PERSON " THIS DEFINITION SHALL ALSO INCLUDE MEMBERS OF THE ORGANIZATION' S LEADERSHIP GROUP, MEDICAL DIRECTORS AND ANY EMPLOYEES INVOLVED WITH RECOMMENDING OR PURC HASING PRODUCTS/SERVICES THE RESPONSES ARE TAKEN TO THE GOVERNANCE AND HUMAN RESOURCES CO MMITTEE OF THE BOARD OF TRUSTEES TO DETERMINE IF A CONFLICT OF INTEREST EXISTS THE GOVERN ANCE AND HUMAN RESOURCES COMMITTEE SHALL MAINTAIN A LIST OF INDIVIDUALS WHO MAY BE CONSIDE RED DISQUALIFIED PERSONS UNDER IRS REGULATIONS THE GOVERNANCE AND HUMAN RESOURCES COMMITT EE SHALL REPORT THE RESULTS OF ITS REVIEW ANNUALLY TO THE BOARD OF TRUSTEES IF THERE IS A NY POSSIBILITY OF FINANCIAL GAIN BY A TRUSTEE AND OR EMPLOYEE FROM ANY DECISION THAT IS TO BE DELIBERATED ON, THEN THAT TRUSTEE/EMPLOYEE MAY MAKE A PRESENTATION, BUT IS THEN REMOVE D FROM THOSE DISCUSSIONS TO ENSURE THAT THE TRUSTEE/EMPLOYEE WILL NOT TAKE PART IN ANY DEL IBERATIONS THAT HE OR SHE MIGHT PERSONALLY GAIN FROM THE TRUSTEE/EMPLOYEE OPERATING UNDER A CONFLICT IS PROHIBITED FROM VOTING ON ANY MATTER TO WHICH THE CONFLICT RELATES

990 Schedule O, Supplemental Information

Return Reference	Explanation
WHISTLEBLOWER & DOCUMENT RETENTION - DESTRUCTION POLICIES	FORM 990, PART VI, LINES 13 & 14 CVMC HAS BOTH A WHISTLEBLOWER AND A DOCUMENT RETENTION - DESTRUCTION POLICY THESE POLICIES ARE EFFECTIVE WITHOUT FORMAL BOARD APPROVAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
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 ORGANI ZATION'S PRESIDENT/COO AND CFO INCLUDES A REVIEW AND APPROVAL BY THE BOARD OF TRUSTEES AN INDEPENDENT COMPENSATION STUDY IS ALSO PERIODICALLY PERFORMED THE MOST RECENT STUDY WAS PERFORMED IN 2017 THIS STUDY INCLUDED COMPENSATION DATA FOR CHIEF EXECUTIVE OFFICERS AND VICE PRESIDENTS INDEPENDENT RESEARCH IS COMPLEMENTED BY A MARKET STUDY ANALYSIS PERFORMED BY THE HUMAN RESOURCES DEPARTMENT AND REVIEWED BY THE BOARD OF TRUSTEES MARKET STUDY DAT A COMES FROM, BUT IS NOT LIMITED TO, HFMA, VAHHS, NEAH, AHA, INDUSTRY SPECIFIC COMPENSATIO N SURVEYS AND OTHER HEALTHCARE SOURCES THE COMPENSATION OF OTHER KEY EMPLOYEES OF THE ORG ANIZATION IS DETERMINED THROUGH MARKET STUDY ANALYSIS PERFORMED BY THE HUMAN RESOURCES DEP ARTMENT AND REVIEWED BY THE BOARD OF TRUSTEES IF NECESSARY

990 Schedule O, Supplemental Information

Return Reference	Explanation
AVAIL OF GOV DOCS, CONFLICT OF INTEREST POLICY, & FIN STMTS TO GEN PUBLIC	FORM 990, PART VI, LINE 19 THE ORGANIZATION MAKES AVAILABLE GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICIES AND FINANCIAL STATEMENTS TO THE GENERAL PUBLIC UPON REQUEST THE FINA NCIAL STATEMENTS OF THE ORGANIZATION FOR FY2017 CAN ALSO BE FOUND ON THE WEBSITE WWW CVMC ORG FORM 990, PART VII THREE PHYSICIANS SERVING AS BOARD MEMBERS, DR PALMER, DR DEPMAN AND DR ECKHAUS, RECEIVE COMPENSATION FROM THE ORGANIZATION FOR THEIR SERVICES AS PHYSICIA NS THIS COMPENSATION IS NOT RELATED TO THEIR PARTICIPATION AS MEMBERS OF THE BOARD OF TRU STEES

990 Schedule O, Supplemental Information

Return Reference	Explanation
OTHER CHANGES IN NET ASSETS	FORM 990, PART XI, LINE 9 OTHER CHANGES IN NET ASSETS OR FUND BALANCES CHANGE IN MINIMUM PENSION LIABILITY $10,969,048 FUNDS RELEASED FROM THE CVMC ENDOWMENT ($516,252) GIFTS AND INVESTMENT INCOME 269,242 ---------- TOTAL $10,722,038

990 Schedule O, Supplemental Information

Return Reference	Explanation
CIRCULAR A-133 AUDIT	FORM 990, PART XII, LINE 3B DURING FY17, CVMC DID NOT REACH THE LEVEL REQUIRED TO WARRANT AN AUDIT UNDER OMB CIRCULAR A-133 HOWEVER, BECAUSE OF CVMC'S AFFILIATION WITH THE UNIVER SITY OF VERMONT MEDICAL CENTER, CVMC WAS INCLUDED IN THE A-133 THAT WAS PERFORMED FOR THE UNIVERSITY OF VERMONT MEDICAL CENTER

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493227012888

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990. ▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2016

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

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.

See Additional Data Table

(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	(g) Section 512(b)(13) controlled entity? No

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) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) ONECARE VERMONT ACCOUNTABLE CA 111 COLCHESTER AVENUE BURLINGTON, VT 05401 45-5399218	ACCOUNTABLE CARE	VT	NA	N/A								
(2) ADIRONDACKS ACO LLC 75 BEEKMAN STREET PLATTSBURGH, NY 12901 46-2840926	ACCOUNTABLE CARE	NY	NA	N/A								
(3) OBNET SERVICES LLC ONE MEDICAL CENTER DR LEBANON, NH 03756 04-3746287	HEALTH RESEARCH	NH	NA	N/A								

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

See Additional Data Table

(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	(i) No

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 orgranization 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		No
b Gift, grant, or capital contribution to related organization(s)	1b		No
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i	Yes	
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o	Yes	
p Reimbursement paid to related organization(s) for expenses	1p	Yes	
q Reimbursement paid by related organization(s) for expenses	1q	Yes	
r Other transfer of cash or property to related organization(s)	1r		No
s Other transfer of cash or property from related organization(s)	1s		No

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	IJMOQ	9,105,513	FMV

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) Disproprtionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

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

Return Reference	Explanation
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

Return Reference	Explanation
Schedule R, Part V, Transaction K	UVM Medical Center leases and shares facilities, equipment, and other assets with CVMC The value of these transactions is indeterminable

Additional Data

Software ID:
Software Version:
EIN: 22-2547186
Name: CENTRAL VERMONT MEDICAL CENTER INC

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) 111 COLCHESTER AVE BURLINGTON, VT 05401 03-0219309	HOSPITAL	VT	501(c)(3)	3	UVMHN	Yes	
(1) 111 COLCHESTER AVE BURLINGTON, VT 05401 45-2880726	HOLDING CO	VT	501(C)(3)	12A-I	NA		No
(2) 183 PARK STREET MALONE, NY 12953 20-3905216	PHYS SVCS	NY	501(C)(3)	3	UVMMG	Yes	
(3) 111 COLCHESTER AVE BURLINGTON, VT 05401 03-0225105	PHYS SVCS	VT	501(C)(3)	12A-I	UVMHN	Yes	
(4) 111 COLCHESTER AVE BURLINGTON, VT 05401 26-3159849	FUNDRAISING	VT	501(C)(3)	12A-I	UVMMC	Yes	
(5) 130 FISHER RD BERLIN, VT 05602 03-0264240	SERVICE	VT	501(C)(3)	12D-III-O	NA		No
(6) 75 BEEKMAN ST PLATTSBURGH, NY 12901 22-2544844	HLTH SVC COOR	NY	501(C)(3)	12A-I	UVMHN	Yes	
(7) 75 BEEKMAN STREET PLATTSBURGH, NY 12901 14-1338471	HOSPITAL	NY	501(C)(3)	3	CPI	Yes	
(8) 75 PARK STREET ELIZABETHTOWN, NY 12932 14-1364513	HOSPITAL	NY	501(C)(3)	3	CPI	Yes	
(9) 75 BEEKMAN ST PLATTSBURGH, NY 12901 06-1718419	AMBULANCE SVC	NY	501(C)(3)	12B-II	CPI	Yes	
(10) 75 BEEKMAN ST PLATTSBURGH, NY 12901 14-1727048	HLTH SVC SUPP	NY	501(c)(3)	12B-II	CVPH	Yes	
(11) 89 BEAUMONT AVE BURLINGTON, VT 05405 23-7107832	EDUCATIONAL	VT	501(C)(3)	11	UVMMG	Yes	
(12) 111 CoOLCHESTER AVE BURLINGTON, VT 05401 03-0229931	HOSPITAL	VT	501(C)(3)	12C-III-FI	UVMMG	Yes	
(13) 133 PARK STREET MALONE, NY 12953 15-0346515	HOSPITAL	NY	501(C)(3)	3	CPI	Yes	
(14) 115 PORTER DRIVE MIDDLEBURY, VT 05753 03-0310862	SUPPTG ORG	VT	501(C)(3)	12-BII	UVMHN	Yes	
(15) 37 PORTER DRIVE MIDDLEBURY, VT 05753 03-0306549	NURSING HOME	VT	501(C)(3)	3	PMC	Yes	
(16) 37 PORTER DRIVE MIDDLEBURY, VT 05753 23-7363227	SUPPORTG ORG	VT	501(C)(3)	12-B,II	PMC	Yes	
(17) 37 PORTER DRIVE MIDDLEBURY, VT 05753 03-0181058	HOSPITAL	VT	501(C)(3)	3	PMC	Yes	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	**No**
(1) CHARITABLE IRREVOCABLE TRUST (7)	SUPPORT	VT	UVMMCCVMC	TRUST				Yes	
(1) UNIV OF VT MED CTR HEALTH VENT INC 111 COLCHESTER AVE BURLINGTON, VT 05401 04-3380045	HOLDING COMPANY	VT	UVMMC	C CORP				Yes	
(2) VMC INDEMNITY COMPANY LTD PO BOX HM 3103 25 CHURCH ST HM F HAMILTON HM FX FR BD 99-9999999	CAPTIVE INSURANCE	BD	UVMMC	C CORP				Yes	
(3) VERMONT MANAGED CARE 111 COLCHESTER AVE BURLINGTON, VT 05401 03-0333056	ADMIN SERVICES	VT	UVMMCHV	C CORP				Yes	
(4) CHARITABLE REMAINDER TRUST (5)	SUPPORT	VT	UVMMCCVMC	TRUST				Yes	
(5) PERPETUAL TRUST (4)	SUPPORT	VT	UVMMC	TRUST				Yes	
(6) CHAMPLAIN VALLEY HEALTH NETWORK 75 BEEKMAN STREET PLATTSBURGH, NY 12901 16-1586102	ADMIN SERVICE	NY	NA	C CORP				Yes	
(7) MEDQUEST INC PO BOX 1656 PLATTSBURGH, NY 12901 14-1663061	MED OFFICE LEASE	NY	NA	C CORP				Yes	