

Form **990** (2016)

**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

GOOD SAMARITAN HOSPITAL, CORVALLIS (GSH) ACHIEVES ITS MISSION OF IMPROVING THE HEALTH AND WELL BEING OF THE COMMUNITY THROUGH ITS MEDICAL AND SURGICAL HOSPITAL AND HEALTHCARE CLINICS PROVIDING OUTPATIENT CARE SERVICES AT SEVERAL AREA LOCATIONS GSH IS A MEMBER OF SAMARITAN HEALTH SERVICES (SHS), A REGIONAL NETWORK OF HOSPITALS, PHYSICIANS AND SENIOR CARE FACILITIES THE NETWORK, FORMED IN THE LATE 1990'S, SERVES APPROXIMATELY 290,000 RESIDENTS IN LINN, BENTON, LINCOLN AND PORTIONS OF POLK AND MARION COUNTIES IN OREGON IT IS LOCALLY OWNED, AND ITS BOARDS OF DIRECTORS INCLUDE HOSPITAL LEADERS, PHYSICIANS AND COMMUNITY REPRESENTATIVES GSH PROVIDES HEALTHCARE SERVICES REGARDLESS OF RACE, COLOR, CREED, SEX, NATIONAL ORIGIN, DISABILITY OR AGE THE MISSION OF GSH IS TO ENHANCE COMMUNITY HEALTH AND ACHIEVE HIGH VALUE THROUGH QUALITY SERVICES ACROSS A CONTINUUM OF CARE THE COLLECTIVE VISION OF THE SHS SYSTEM IS TO BE A VALUES-DRIVEN ORGANIZATION GOVERNED BY COMMUNITY MEMBERS, PHYSICIANS AND 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

<b>4a</b>	(Code )	(Expenses \$ 375,921,647	including grants of \$	(Revenue \$ 400,537,481 )
See Additional Data				

<b>4b</b>	(Code )	(Expenses \$ 386,807	including grants of \$ 386,807 )	(Revenue \$ )
See Additional Data				

<b>4c</b>	(Code )	(Expenses \$	including grants of \$	(Revenue \$ )
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







<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	including grants of \$	(Revenue \$ )
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<b>4e</b>	<b>Total program service expenses ▶</b>	376,308,454
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**Part IV Checklist of Required Schedules**

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

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

	Yes	No
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i> . . . . . 	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? 	<b>20b</b> Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> . . . . . 	<b>21</b> Yes	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> . . . . . 	<b>22</b> Yes	
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> . . . . . 	<b>23</b> Yes	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> . . . . .	<b>24a</b>	No
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	<b>24b</b>	
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	<b>24c</b>	
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	<b>24d</b>	
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25a</b>	No
<b>b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i> . . . . .	<b>25b</b>	No
<b>26</b> 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? <i>If "Yes," complete Schedule L, Part II</i> . . . . .	<b>26</b>	No
<b>27</b> 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? <i>If "Yes," complete Schedule L, Part III</i> . . . . .	<b>27</b>	No
<b>28</b> 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) <b>a</b> A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28a</b>	No
<b>b</b> A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28b</b>	No
<b>c</b> 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? <i>If "Yes," complete Schedule L, Part IV</i> . . . . .	<b>28c</b>	No
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>29</b>	No
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> . . . . .	<b>30</b>	No
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> . . . . .	<b>31</b>	No
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> . . . . .	<b>32</b>	No
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i> . . . . . 	<b>33</b>	No
<b>34</b> Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i> . . . . . 	<b>34</b> Yes	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	<b>35a</b> Yes	
<b>b</b> If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . . 	<b>35b</b> Yes	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> . . . . . 	<b>36</b> Yes	
<b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i> 	<b>37</b>	No
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	<b>38</b> 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	0
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	
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	2,647
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	Yes
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	Yes
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	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	
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
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year	12	
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>b</b>	Enter the number of voting members included in line 1a, above, who are independent	10	
<b>2</b>	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?	<b>2</b>	No
<b>3</b>	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?	<b>3</b>	No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>	No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>	No
<b>6</b>	Did the organization have members or stockholders?	<b>6</b>	Yes
<b>7a</b>	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?	<b>7a</b>	Yes
<b>b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>	Yes
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b>	The governing body?	<b>8a</b>	Yes
<b>b</b>	Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes
<b>9</b>	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	<b>9</b>	No

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

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates?	<b>10a</b>	No
<b>b</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?	<b>10b</b>	
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	<b>11a</b>	Yes
<b>b</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13	<b>12a</b>	Yes
<b>b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	<b>12b</b>	Yes
<b>c</b>	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	<b>12c</b>	Yes
<b>13</b>	Did the organization have a written whistleblower policy?	<b>13</b>	Yes
<b>14</b>	Did the organization have a written document retention and destruction policy?	<b>14</b>	Yes
<b>15</b>	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?		
<b>a</b>	The organization's CEO, Executive Director, or top management official	<b>15a</b>	Yes
<b>b</b>	Other officers or key employees of the organization	<b>15b</b>	Yes
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)			
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	<b>16a</b>	Yes
<b>b</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?	<b>16b</b>	Yes

**Section C. Disclosure**

**17** List the States with which a copy of this Form 990 is required to be filed: OR

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**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.

►SAMARITAN HEALTH SERVICES PO BOX 3000 CORVALLIS, OR 973393000 (541) 768-4773

**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			
(1) RICHARD CRONK MD ..... BOARD CHAIR	1 00 ..... 1 00	X		X				0	0	0
(2) JUDY LIST ..... BOARD VICE CHAIR	1 00 ..... 1 00	X		X				0	0	0
(3) REVEREND SIMON JUSTICE ..... BOARD SECRETARY	1 00 .....	X		X				0	0	0
(4) NANCY SEIFERT ..... BOARD TREASURER	1 00 .....	X		X				0	0	0
(5) CLIFFORD HALL MD ..... BOARD MEMBER	1 00 .....	X						0	1,300	0
(6) BISHOP MICHAEL HANLEY ..... BOARD MEMBER	1 00 .....	X						0	0	0
(7) TIM HENNESSY ..... BOARD MEMBER	1 00 .....	X						0	0	0
(8) SHIRLEY PETERSON ..... BOARD MEMBER	1 00 ..... 1 00	X						0	0	0
(9) STEFAN SPANN MD ..... BOARD MEMBER	1 00 .....	X						0	2,000	0
(10) ERIC THOMPSON ..... BOARD MEMBER	1 00 .....	X						0	0	0
(11) STEVE UERLINGS ..... BOARD MEMBER	1 00 ..... 2 00	X						0	0	0
(12) LYLE HUTCHENS ..... BOARD MEMBER	1 00 .....	X						0	0	0
(13) BECKY PAPE ..... CEO	39 00 ..... 1 00			X				0	357,704	55,331
(14) DANIEL SMITH ..... VP FINANCE / CFO	2 00 ..... 38 00			X				0	414,292	90,454
(15) RYAN COMBS ..... VP PRIMARY CARE SPEC PRACTICES	40 00 .....				X			207,157	0	38,369
(16) SCOTT WILSON ..... VP ANCILLARY SUPPORT SVCS	40 00 .....				X			193,852	0	44,174
(17) WILLIAM HOWDEN ..... VP NURSING GSRMC	40 00 .....				X			192,309	0	39,043

**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			
(18) MARK TAYLOR MD PHYSICIAN	40 00					X		1,221,608	0	51,271
(19) LUIS VELA DO PHYSICIAN	40 00					X		843,892	0	52,599
(20) J CHRISTOPHER NOONAN MD PHYSICIAN	40 00					X		736,582	0	52,401
(21) DONALD PENNINGTON DO PHYSICIAN	40 00					X		726,496	0	52,557
(22) JEFF HSING MD PHYSICIAN	40 00					X		747,123	0	51,973
(23) STEVEN JASPERSON FORMER CEO / VP SO CALIFORNIA OPS	0 00 40 00						X	0	457,459	48,135
(24) LARRY MULLINS DHA FORMER CEO / SHS CEO	0 00 40 00						X	0	1,180,286	299,346

<b>1b Sub-Total</b> . . . . .	▶			
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .	▶			
<b>d Total (add lines 1b and 1c)</b> . . . . .	▶	4,869,019	2,413,041	875,653

<b>2</b>	Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 383			
<b>3</b>	Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual . . . . .	<b>3</b>	Yes	
<b>4</b>	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 . . . . .	<b>4</b>	Yes	
<b>5</b>	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 . . . . .	<b>5</b>		No

**Section B. Independent Contractors**

<b>1</b>	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
<b>2</b>	Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 0		



**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
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . .	<b>1a</b>				
	<b>b</b> Membership dues . . .	<b>1b</b>				
	<b>c</b> Fundraising events . . .	<b>1c</b>				
	<b>d</b> Related organizations	<b>1d</b>	1,514,702			
	<b>e</b> Government grants (contributions)	<b>1e</b>	24,095			
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	41,269			
	<b>g</b> Noncash contributions included in lines 1a-1f \$ _____					
	<b>h Total.</b> Add lines 1a-1f . . . . .		1,580,066			
<b>Program Service Revenue</b>			Business Code			
	<b>2a</b> NET PATIENT REVENUE		622110	388,879,012	388,879,012	
	<b>b</b> RETAIL PHARMACY		446110	9,210,338	9,210,338	
	<b>c</b> OTHER PATIENT REVENUE		622110	1,742,512	1,742,512	
	<b>d</b> MEDICAL DIRECTOR FEES		900099	328,033	328,033	
	<b>e</b> OTHER PROGRAM SVC REV		900099	305,342	305,342	
	<b>f</b> All other program service revenue			72,244	72,244	
	<b>g Total.</b> Add lines 2a-2f . . . . .		400,537,481			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		564,702			564,702
	<b>4</b> Income from investment of tax-exempt bond proceeds					
	<b>5</b> Royalties . . . . .					
			(i) Real	(ii) Personal		
	<b>6a</b> Gross rents		963,791			
	<b>b</b> Less rental expenses		159,264			
	<b>c</b> Rental income or (loss)		804,527			
	<b>d</b> Net rental income or (loss) . . . . .		804,527			804,527
			(i) Securities	(ii) Other		
	<b>7a</b> Gross amount from sales of assets other than inventory		98,075	81,925		
	<b>b</b> Less cost or other basis and sales expenses		23,435	99,395		
	<b>c</b> Gain or (loss)		74,640	-17,470		
	<b>d</b> Net gain or (loss) . . . . .		57,170			57,170
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . .		<b>a</b>			
	<b>b</b> Less direct expenses . . . . .		<b>b</b>			
	<b>c</b> Net income or (loss) from fundraising events . . . . .					
	<b>9a</b> Gross income from gaming activities See Part IV, line 19 . . . . .		<b>a</b>			
<b>b</b> Less direct expenses . . . . .		<b>b</b>				
<b>c</b> Net income or (loss) from gaming activities . . . . .						
<b>10a</b> Gross sales of inventory, less returns and allowances . . .		<b>a</b>				
		386,270				
<b>b</b> Less cost of goods sold . . .		<b>b</b>				
		83,155				
<b>c</b> Net income or (loss) from sales of inventory . . . . .		303,115			303,115	
Miscellaneous Revenue		Business Code				
<b>11a</b> CAFETERIA		722210		2,129,133	2,129,133	
<b>b</b> _____						
<b>c</b> _____						
<b>d</b> All other revenue . . . . .						
<b>e Total.</b> Add lines 11a-11d . . . . .		2,129,133				
<b>12 Total revenue.</b> See Instructions . . . . .		405,976,194		400,537,481	303,115	3,555,532

**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 ☐

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>				
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	286,052	286,052		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	100,755	100,755		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	714,904	476,878	238,026	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).				
<b>7</b> Other salaries and wages.	163,202,315	159,389,854	3,751,130	61,331
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	12,003,854	11,724,663	274,700	4,491
<b>9</b> Other employee benefits.	27,361,882	26,725,487	626,157	10,238
<b>10</b> Payroll taxes.	11,602,239	11,332,389	265,509	4,341
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.				
<b>b</b> Legal.	45,441		45,441	
<b>c</b> Accounting.	55,585	2,400	53,185	
<b>d</b> Lobbying.				
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.				
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	12,540,923	12,396,855	142,601	1,467
<b>12</b> Advertising and promotion.	42,883	16,100	23,308	3,475
<b>13</b> Office expenses.	13,810,908	13,290,847	482,044	38,017
<b>14</b> Information technology.	16,757,508	16,156,370	601,138	
<b>15</b> Royalties.				
<b>16</b> Occupancy.	5,195,414	5,059,059	135,855	500
<b>17</b> Travel.	709,053	683,834	22,049	3,170
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	844,822	832,666	11,705	451
<b>20</b> Interest.	5,292,228	5,102,381	189,847	
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	9,959,631	9,749,473	209,542	616
<b>23</b> Insurance.	4,618,210	4,211,654	406,556	
<b>24</b> 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):				
<b>a</b> MEDICAL SUPPLIES	66,541,943	66,541,943		
<b>b</b> PURCHASED SERVICES	42,556,471	14,137,779	28,383,784	34,908
<b>c</b> DUES, TAXES, & LICENSES	18,124,244	18,091,015	32,368	861
<b>d</b>				
<b>e</b> All other expenses				
<b>25</b> Total functional expenses. Add lines 1 through 24e.	412,367,265	376,308,454	35,894,945	163,866
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**Check if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		11,109	<b>1</b>	9,883
	<b>2</b>	Savings and temporary cash investments . . . . .		823,575	<b>2</b>	459,260
	<b>3</b>	Pledges and grants receivable, net . . . . .			<b>3</b>	
	<b>4</b>	Accounts receivable, net . . . . .		48,289,711	<b>4</b>	46,673,873
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			<b>5</b>	
	<b>6</b>	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			<b>6</b>	
	<b>7</b>	Notes and loans receivable, net . . . . .		196,114	<b>7</b>	460,026
	<b>8</b>	Inventories for sale or use . . . . .		7,468,394	<b>8</b>	7,623,030
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		1,676,419	<b>9</b>	1,847,880
	<b>10a</b>	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 233,203,638			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b> 137,175,157	99,968,656	<b>10c</b>	96,028,481
	<b>11</b>	Investments—publicly traded securities . . . . .		16,486,395	<b>11</b>	17,677,211
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		281,180	<b>12</b>	330,614
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .			<b>13</b>	
	<b>14</b>	Intangible assets . . . . .			<b>14</b>	
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		6,050,822	<b>15</b>	5,217,732
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		181,252,375	<b>16</b>	176,327,990	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		25,831,630	<b>17</b>	25,505,171
	<b>18</b>	Grants payable . . . . .			<b>18</b>	
	<b>19</b>	Deferred revenue . . . . .		1,257,377	<b>19</b>	967,440
	<b>20</b>	Tax-exempt bond liabilities . . . . .		3,708,000	<b>20</b>	
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D			<b>21</b>	
	<b>22</b>	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .			<b>22</b>	
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		1,126,425	<b>23</b>	68,695
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .			<b>24</b>	
	<b>25</b>	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		56,153,589	<b>25</b>	58,834,053
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		88,077,021	<b>26</b>	85,375,359
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>					
	<b>27</b>	Unrestricted net assets		93,175,354	<b>27</b>	90,952,631
	<b>28</b>	Temporarily restricted net assets . . . . .			<b>28</b>	
	<b>29</b>	Permanently restricted net assets			<b>29</b>	
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>					
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds			<b>32</b>	
	<b>33</b>	<b>Total net assets or fund balances</b> . . . . .		93,175,354	<b>33</b>	90,952,631
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		181,252,375	<b>34</b>	176,327,990	

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☒

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	405,976,194
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	412,367,265
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	-6,391,071
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	93,175,354
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	622,343
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	3,546,005
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	90,952,631

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>b</b> Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
<b>c</b> If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
<b>3a</b> 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?		No
<b>b</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		

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 93-0391573  
**Name:** GOOD SAMARITAN HOSPITAL CORVALLIS

Form 990 (2016)

**Form 990, Part III, Line 4a:**

GOOD SAMARITAN HOSPITAL CORVALLIS (GSH), THE LARGEST HOSPITAL IN LINN, BENTON AND LINCOLN COUNTIES, OFFERS MORE THAN 22 MEDICAL SPECIALTIES INCLUDING COMPREHENSIVE CANCER CARE, A FULL-SERVICE CARDIOLOGY AND VASCULAR SURGERY PROGRAM, A SLEEP LAB, NEUROSURGERY AND OTHER REGIONAL SERVICES GSH HAS MORE THAN 2,100 EMPLOYEES AND 250 VOLUNTEERS SERVING THE MEDICAL NEEDS OF THE COMMUNITY IT IS LICENSED TO OPERATE 188 BEDS AND IS ONE OF ONLY THREE 'LEVEL 2' TRAUMA CENTERS IN THE STATE DURING 2016, GSH SERVED 9,181 INPATIENTS, HAD 27,912 EMERGENCY DEPARTMENT VISITS, PERFORMED 9,692 SURGERIES AND DELIVERED 1,090 BABIES IN ADDITION, GSH PERFORMED 88,131 IMAGING PROCEDURES, HAD 33,243 HOME HEALTH VISITS, AND HAD 221,562 PHYSICIAN CLINIC VISITS

**Form 990, Part III, Line 4b:**

GRANTS AND ASSISTANCE PROVIDED BY GOOD SAMARITAN HOSPITAL CORVALLIS TO VARIOUS ORGANIZATIONS AND INDIVIDUALS TO BENEFIT THE COMMUNITY SEE  
PART IX, LINES 1 AND 2 AND RELATED SCHEDULE I FOR MORE DETAILS

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<b>SCHEDULE A</b> (Form 990 or 990-EZ)	<b>Public Charity Status and Public Support</b> 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 <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .	OMB No 1545-0047 <b>2016</b> <b>Open to Public Inspection</b>
	Department of the Treasury Internal Revenue Service <b>Name of the organization</b> GOOD SAMARITAN HOSPITAL CORVALLIS	<b>Employer identification number</b> 93-0391573

**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<sup>1</sup>/<sub>3</sub>% 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<sup>1</sup>/<sub>3</sub>% 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?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<b>Total</b>						

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						
<div>Calendar year (or fiscal year beginning in) ▶</div>	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>4 Total.</b> Add lines 1 through 3						
<b>5</b> The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
<b>6 Public support.</b> Subtract line 5 from line 4						
Section B. Total Support						
<div>Calendar year (or fiscal year beginning in) ▶</div>	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>7</b> Amounts from line 4						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on						
<b>10</b> Other income (Do not include gain or loss from the sale of capital assets (Explain in Part VI.))						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions)					<b>12</b>	
<b>13 First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage						
<b>14</b> Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))					<b>14</b>	
<b>15</b> Public support percentage for 2015 Schedule A, Part II, line 14					<b>15</b>	
<b>16a 33 1/3% support test—2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
<b>b 33 1/3% support test—2015.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
<b>17a 10%-facts-and-circumstances test—2016.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
<b>b 10%-facts-and-circumstances test—2015.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>						
<b>18 Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ <input type="checkbox"/>						



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

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

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b> <b>Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8</b> <b>Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

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

<b>15</b> Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2015 Schedule A, Part III, line 15	<b>16</b>	

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

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

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> Did the 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? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
<b>1</b>		
<b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.</i>		
<b>2</b>		

**Section C. Type II Supporting Organizations**

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

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

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

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

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
<b>2a</b>		
<b>b</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? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>2b</b>		
<b>3</b> Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>3a</b>		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
<b>3b</b>		

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

- 1** ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. **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)
<b>1</b> Net short-term capital gain	<b>1</b>	
<b>2</b> Recoveries of prior-year distributions	<b>2</b>	
<b>3</b> Other gross income (see instructions)	<b>3</b>	
<b>4</b> Add lines 1 through 3	<b>4</b>	
<b>5</b> Depreciation and depletion	<b>5</b>	
<b>6</b> 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)	<b>6</b>	
<b>7</b> Other expenses (see instructions)	<b>7</b>	
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	

**Section B - Minimum Asset Amount**

	(A) Prior Year	(B) Current Year (optional)
<b>1</b> Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>	
<b>a</b> Average monthly value of securities	<b>1a</b>	
<b>b</b> Average monthly cash balances	<b>1b</b>	
<b>c</b> Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e Discount</b> claimed for blockage or other factors (explain in detail in Part VI)		
<b>2</b> Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b> Subtract line 2 from line 1d	<b>3</b>	
<b>4</b> Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>	
<b>5</b> Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b> Multiply line 5 by .035	<b>6</b>	
<b>7</b> Recoveries of prior-year distributions	<b>7</b>	
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	

**Section C - Distributable Amount**

		Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b> Enter 85% of line 1	<b>2</b>	
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b> Income tax imposed in prior year	<b>5</b>	
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b> <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
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).

<b>Facts And Circumstances Test</b>

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493318066107	
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► 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.</div> <div>Information about Schedule D (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>
Name of the organization GOOD SAMARITAN HOSPITAL CORVALLIS				Employer identification number 93-0391573	
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?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> 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				
a	Total number of conservation easements	Held at the End of the Year			
b	Total acreage restricted by conservation easements	2a			
c	Number of conservation easements on a certified historic structure included in (a)	2b			
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2c			
		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?				<input type="checkbox"/> Yes <input type="checkbox"/> 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)?				<input type="checkbox"/> Yes <input type="checkbox"/> 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				► \$
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			Cat No 52283D	Schedule D (Form 990) 2016	

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
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.

1a

Beginning of year balance

b

Contributions

c

Net investment earnings, gains, and losses

d

Grants or scholarships

e

Other expenditures for facilities and programs

f

Administrative expenses

g

End of year balance

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a	5,732,176	6,118,410	6,035,183	5,430,883	4,758,581
b	141,344	136,267	61,783	269,432	316,843
c	449,896	-233,344	214,664	578,249	543,063
d	238,106	289,157	193,220	243,381	187,604
e					
f					
g	6,085,310	5,732,176	6,118,410	6,035,183	5,430,883

2

Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

a

Board designated or quasi-endowment

19 480 %

b

Permanent endowment

80 520 %

c

Temporarily restricted endowment

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

3a

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

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

3b

Yes

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		2,096,814		2,096,814
b Buildings		150,609,155	76,934,422	73,674,733
c Leasehold improvements		2,364,049	773,202	1,590,847
d Equipment		69,182,119	54,335,730	14,846,389
e Other		8,951,501	5,131,803	3,819,698
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				96,028,481



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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	
PROFESSIONAL LIABILITY RESERVE	2,777,000
OTHER LIABILITIES	1,326,858
PAYABLE TO CONTRACTUAL AGENCIES	3,806,251
MINIMUM PENSION LIABILITY	34,079,246
ACCRUED INTEREST	933,869
ACCOUNTS PAYABLE-AFFILIATES	15,910,829
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25 ) ▶	58,834,053

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.

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

**Part XIII** Supplemental Information *(continued)*

Return Reference	Explanation

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 93-0391573  
**Name:** GOOD SAMARITAN HOSPITAL CORVALLIS

**Supplemental Information**

Return Reference	Explanation
PART V, LINE 4	THE BOARD-DESIGNATED AND GENERAL ENDOWMENTS ARE USED FOR GENERAL HOSPITAL SUPPORT THE BER NIER ENDOWMENT IS USED FOR STAFF CONTINUING EDUCATION THE ERKKILA ENDOWMENT IS USED FOR H EALTH AND HUMAN PERFORMANCE RESEARCH AND REHABILITATION THE MULLINS SCHOLARSHIP ENDOWMENT IS USED TO SUPPORT EDUCATIONAL SCHOLARSHIPS THE PASTEGA HOUSE ENDOWMENT IS USED TO HELP UNDERWRITE THE OPERATING COSTS OF THE MARIO PASTEGA GUEST HOUSE THE VRTISKA ENDOWMENT IS USED TO SUPPORT THE HOSPITAL'S LABORATORY FOR EDUCATIONAL PURPOSES THE WISH ENDOWMENT IS USED FOR HOSPITAL-BASED PROGRAMS SUPPORTING WOMEN'S AND CHILDREN'S HEALTH THE HALL ENDOWM ENT IS USED TO PROVIDE GRADUATE MEDICAL EDUCATIONAL OPPORTUNITIES IN THE AREA OF PRIMARY A ND INTERNAL MEDICINE

**Supplemental Information**

Return Reference	Explanation
PART X, LINE 2	<p>FOOTNOTE DISCLOSURE FROM THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS U S GENERALLY ACC EPTED ACCOUNTING PRINCIPLES REQUIRE THE SHS' MANAGEMENT TO EVALUATE TAX POSITIONS AND RECO GNIZE A TAX LIABILITY (OR ASSET) IF SHS HAS TAKEN AN UNCERTAIN POSITION THAT MORE LIKELY T HAN NOT WOULD NOT BE SUSTAINED UPON EXAMINATION BY THE INTERNAL REVENUE SERVICE</p> <p>MANAGEMENT</p> <p>T HAS ANALYZED TAX POSITIONS TAKEN BY SHS AND HAS CONCLUDED THAT AS OF DECEMBER 31, 2016, THERE ARE NO UNCERTAIN POSITIONS TAKEN OR EXPECTED TO BE TAKEN THAT WOULD REQUIRE RECOGNIT ION OF A LIABILITY (OR ASSET) OR DISCLOSURE IN THE FINANCIAL STATEMENTS SHS IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS, HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TA X PERIODS IN PROGRESS SHS' MANAGEMENT BELIEVES IT IS NO LONGER SUBJECT TO INCOME TAX EXAM INATIONS FOR YEARS PRIOR TO 2013</p>

SCHEDULE H  
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

► 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](http://www.irs.gov/form990).

Department of the Treasury

Internal Revenue Service

Name of the organization

GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

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		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities		
<input type="checkbox"/> Applied uniformly to most hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 22500 0000000000 %		
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	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> 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 eligible 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)	16	15,299	4,478,117		4,478,117	1 090 %
b Medicaid (from Worksheet 3, column a)	12	88,461	83,249,986	60,838,303	22,411,683	5 430 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	28	103,760	87,728,103	60,838,303	26,889,800	6 520 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	12	26,849	870,903	8,921	861,982	0 210 %
f Health professions education (from Worksheet 5)	4	19,365	17,546,889	9,147,899	8,398,990	2 040 %
g Subsidized health services (from Worksheet 6)	20	93,081	42,482,051	24,861,925	17,620,126	4 270 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	11	25,462	739,603	172,903	566,700	0 140 %
j Total. Other Benefits	47	164,757	61,639,446	34,191,648	27,447,798	6 660 %
k Total. Add lines 7d and 7j	75	268,517	149,367,549	95,029,951	54,337,598	13 180 %

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Cat No 50192T

Schedule H (Form 990) 2016

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support	1	749	15,326		15,326	0 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development	1	336	116,994		116,994	0 030 %
<b>9</b> Other						
<b>10 Total</b>	2	1,085	132,320		132,320	0 030 %

**Part III****Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

**1** Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?

**1**

No

**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**

4,013,261

**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**

1,098,554

**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**

62,050,469

**6** Enter Medicare allowable costs of care relating to payments on line 5.

**6**

69,479,753

**7** Subtract line 6 from line 5. This is the surplus (or shortfall).

**7**

-7,429,284

**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 %
<b>1</b> 1 CORVALLIS MED BLDGS LLC	REAL PROPERTY RENTAL	54 500 %		21 500 %
<b>2</b> 2 HULL IMAGING LLC	IMAGING SERVICES	60 000 %		40 000 %
<b>3</b> 3 SAMARITAN ENDOSCOPY CENTER	MEDICAL SERVICES	66 670 %		33 330 %
<b>4</b> 4 CORVALLIS MRI A JV	IMAGING SERVICES	50 000 %		50 000 %
<b>5</b> 5 CASCADE VIEW MEDICAL OFFICE BUILDING LLC	REAL PROPERTY RENTAL	26 300 %		73 700 %
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

Schedule H (Form 990) 2016

**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)

	Other (Describe)	ER-other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	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)  
GOOD SAMARITAN HOSPITAL CORVALLIS**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</b> 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 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>16</u>		
<b>5</b> 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 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</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 . . . . .	<b>6b</b>	Yes
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW.SAMHEALTH.ORG/COMMUNITYSUPPORT</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>HTTP //WWW.SAMHEALTH.ORG/COMMUNITYSUPPORT</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</b> 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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> 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)

GOOD SAMARITAN HOSPITAL CORVALLIS																																																																																								
Name of hospital facility or letter of facility reporting group																																																																																								
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**Part V Facility Information** (continued)**Billing and Collections**

GOOD SAMARITAN HOSPITAL CORVALLIS

**Name of hospital facility or letter of facility reporting group**

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

**Policy Relating to Emergency Medical Care**

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

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

GOOD SAMARITAN HOSPITAL CORVALLIS

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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.

[illegible]

**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? 39

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

**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

Form and Line Reference	Explanation
PART I, LINE 6A	THE FILING ORGANIZATION SUBMITS AN ANNUAL COMMUNITY BENEFIT REPORT TO THE STATE OF OREGON IN ADDITION, THE PARENT ORGANIZATION, SAMARITAN HEALTH SERVICES (SHS) PROVIDES AN ANNUAL REPORT TO THE COMMUNITY THAT INCLUDES COMMUNITY BENEFIT REPORTING FOR THE SYSTEM AS A WHOLE

Form and Line Reference	Explanation
PART I, LINE 7	THE COSTING METHODOLOGY USED TO CALCULATE THE AMOUNTS REPORTED IN SCHEDULE H, PART I, LINE 7A AND 7B IS A COST-TO-CHARGE RATIO DERIVED USING WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES FROM THE SCHEDULE H INSTRUCTIONS FOR LINE 7G, A COMBINATION OF THE COST-TO-CHARGE RATIO AND COST ACCOUNTING SYSTEM CALCULATIONS IS USED SINCE NOT ALL SERVICES ARE TRACKED IN THE COST ACCOUNTING SYSTEM



Form and Line Reference	Explanation
PART I, LINE 7G	PHYSICIAN CLINICS MEETING THE DEFINITION OF SUBSIDIZED HEALTH SERVICES WERE INCLUDED IN THE REPORTING FOR LINE 7G CONSISTENT WITH THE SCHEDULE H INSTRUCTIONS, PHYSICIAN CLINIC ACTIVITY HAS BEEN COMBINED WITH ASSOCIATED HOSPITAL SERVICES IN DETERMINING WHETHER THE SERVICES WERE PROVIDED AT A LOSS THE PORTION OF NET COMMUNITY BENEFIT EXPENSE RELATED TO PHYSICIAN CLINICS, COMBINED WITH ASSOCIATED HOSPITAL ACTIVITY, THAT IS BEING COUNTED AS SUBSIDIZED HEALTH SERVICES IN 2016 IS 12,515,817

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	<p>GSH PROVIDES SERVICES AND ACTIVITIES THAT ARE CLASSIFIED AS COMMUNITY BUILDING TO PROMOTE THE HEALTH OF BENTON COUNTY. RECOGNIZING THAT THE HEALTH OF A COMMUNITY ENCOMPASSES MULTIPLE FACTORS, GSH LEADERSHIP AND STAFF ARE INVOLVED IN A VARIETY OF ACTIONS THAT WORK TO IMPROVE COMMUNITY OUTCOMES. DURING 2016, GSH SERVED AS THE LEAD AGENCY TO CONDUCT DISASTER PREPAREDNESS DRILLS WITH LOCAL AGENCIES IN BENTON COUNTY. THIS INCLUDED HOLDING REGULAR COMMUNITY MEETINGS TO REVIEW AND UPDATE THE COMMUNITY DISASTER PREPAREDNESS PLAN, IDENTIFYING DISASTER DRILL DATES, ORGANIZING THE DISASTER PREPAREDNESS DRILL AND RECRUITING AND TRAINING COMMUNITY VOLUNTEERS TO SERVE AS VICTIMS DURING THE DRILL. GSH BELIEVES THAT TRAINED AND COMPETENT STAFF IN ALL ASPECTS OF THE ORGANIZATION PROMOTES COMMUNITY HEALTH. GSH ACTIVELY PARTICIPATES IN WORKFORCE DEVELOPMENT IN PARTNERSHIP WITH OREGON STATE UNIVERSITY, LINN-BENTON COMMUNITY COLLEGE AND WESTERN UNIVERSITY-COMP NW TO RECRUIT, TRAIN AND RETAIN HEALTHCARE WORKERS AT ALL LEVELS. GSH ALSO HOSTS LOCAL EVENTS SUPPORTED BY THE HOSPITAL'S FOUNDATION AND OTHER DEPARTMENTS IN THE ORGANIZATION. ANNUAL EVENTS SUCH AS SENIOR HEALTH FAIRS, FESTIVAL LATINO, CHILDREN'S HEALTH FAIRS, BENTON COUNTY FAIR AND PROJECT HOMELESS CONNECT ARE A FEW EXAMPLES OF HOW GSH PROMOTES THE HEALTH OF THE COMMUNITY. GSH ALSO PROVIDES OPPORTUNITIES FOR COMMUNITY MEMBERS TO OBTAIN TRAINING ON CIVIC AND CULTURAL ISSUES THAT IMPACT HEALTH. SOME OF THE TRAINING OPPORTUNITIES INCLUDE HEALTHY LIFESTYLES, FITNESS, AND HEALTH EQUITY. GSH STAFF SERVED ON MANY LOCAL COALITIONS AND BOARDS THAT PROMOTE THE HEALTH OF THE COMMUNITY. BOARD AFFILIATIONS INCLUDE, BUT ARE NOT LIMITED TO, COMMUNITY OUTREACH INC., OREGON CASCADES WEST COUNCIL OF GOVERNMENTS, AND THE UNITED WAY OF BENTON AND LINCOLN COUNTIES. ADDITIONALLY GSH STAFF SERVED ON THE OREGON HEALTH POLICY ADVISORY BOARD, THE OREGON HEALTH RESOURCES COMMISSION, THE MEDICAID ADVISORY COMMITTEE, THE OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS AND REGIONAL BOARDS THAT ADDRESS HEALTH CARE ISSUES.</p>

Form and Line Reference	Explanation
PART III, LINE 2	BAD DEBT EXPENSE IS RECORDED FOR THOSE PATIENTS WHO DO NOT QUALIFY FOR FINANCIAL ASSISTANCE AND DO NOT PAY AFTER REPEATED ATTEMPTS TO COLLECT PAYMENT, INCLUDING INFORMING THEM OF THE OPPORTUNITY TO COMPLETE A FINANCIAL ASSISTANCE APPLICATION IF INDEPENDENT EVIDENCE INDICATES THAT THE PATIENT IS UNABLE TO PAY, SHS MAY CHOOSE TO CLASSIFY DELINQUENT ACCOUNTS AS "PRESUMPTIVE CHARITY" RATHER THAN BAD DEBT PATIENT PAYMENTS (OR RECOVERIES) ON ACCOUNTS THAT WERE PREVIOUSLY WRITTEN OFF AS BAD DEBT ARE RECORDED AS A REDUCTION TO BAD DEBT EXPENSE

Form and Line Reference	Explanation
PART III, LINE 3	LINE 3 REPRESENTS AN ESTIMATE OF THE AMOUNT INCLUDED IN BAD DEBT EXPENSE (LINE 2) THAT REASONABLY COULD BE ATTRIBUTABLE TO PATIENTS WHO LIKELY WOULD QUALIFY FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, BUT FOR WHOM THE ORGANIZATION WAS NOT ABLE TO OBTAIN SUFFICIENT INFORMATION TO MAKE A DETERMINATION THE METHODOLOGY USED TO ESTIMATE THIS POTENTIAL FINANCIAL ASSISTANCE IS BASED ON FINANCIAL ASSISTANCE APPLICATIONS DENIED DUE TO INCOMPLETE DOCUMENTATION, MULTIPLIED BY THE AVERAGE FINANCIAL ASSISTANCE WRITE-OFF FOR APPROVED APPLICATIONS

Form and Line Reference	Explanation
PART III, LINE 4	GOOD SAMARITAN HOSPITAL (GSH) IS THE LARGEST OF FIVE HOSPITALS OF SAMARITAN HEALTH SERVICES (SHS) AS A NETWORK, SHS PREPARES ITS FINANCIAL STATEMENTS ON A CONSOLIDATED BASIS BAD DEBT EXPENSE IS DESCRIBED IN FOOTNOTE 2(O) ENTITLED "PROVISION FOR BAD DEBTS AND ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS", FOUND ON PAGES 11 & 12 OF THE 2016 SHS CONSOLIDATED FINANCIAL STATEMENTS

Form and Line Reference	Explanation						
PART III, LINE 8	<p>TOTAL MEDICARE ALLOWABLE COSTS REPORTED ON PART III, SECTION B, LINE 6 IS CALCULATED BY UTILIZING WORKSHEET A IN THE SCHEDULE H INSTRUCTIONS IN CONJUNCTION WITH AMOUNTS TAKEN DIRECTLY FROM THE FILING ORGANIZATION'S MEDICARE COST REPORT (CALCULATED BASED ON A COST-TO-CHARGE RATIO) CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED, AS THESE PATIENTS TYPICALLY HAVE LOW OR FIXED INCOMES AND GOVERNMENT REIMBURSEMENT IS NOT SUFFICIENT TO COVER THE COSTS OF PROVIDING CARE FOR THESE PATIENTS MEDICARE PATIENTS ARE A GROWING SEGMENT OF THE LOCAL POPULATION, AND MANY ARE BECOMING INCREASINGLY DEPENDENT ON OUR HOSPITAL AND NON-PROFIT AFFILIATES TO PROVIDE FOR THEIR CARE, ESPECIALLY AS OTHER FOR-PROFIT HEALTHCARE PROVIDERS IN THE COMMUNITY DISCONTINUE ACCEPTING MEDICARE PATIENTS THE AMOUNT OF MEDICARE SHORTFALL SHOWN ON LINE 7 OF PART III, SECTION B, IS UNDERSTATED THIS IS PRIMARILY DUE TO THE FACT THAT THE MEDICARE COST REPORT INCLUDES ACTIVITY FOR MEDICARE FEE-FOR-SERVICE PATIENTS BUT NOT MEDICARE MANAGED CARE PATIENTS MEDICARE MANAGED CARE ACCOUNTS FOR ROUGHLY HALF OF OUR MEDICARE ACTIVITY IN ADDITION, CERTAIN COSTS OF PROVIDING HEALTHCARE SERVICES, SUCH AS PHYSICIAN COMPENSATION, ARE NOT ALLOWABLE ON THE MEDICARE COST REPORTS THEREFORE, THE AMOUNT OF MEDICARE SHORTFALL SHOWN ON LINE 7 IS SMALLER THAN THE SHORTFALL CALCULATION USING REVENUE AND COST DATA FOR ALL MEDICARE PATIENT ACTIVITY, AS FOLLOWS</p> <table> <tr> <td>NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS)</td> <td>121,028,109</td> </tr> <tr> <td>MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO)</td> <td>138,026,009</td> </tr> <tr> <td>UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS</td> <td>-16,997,900</td> </tr> </table>	NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS)	121,028,109	MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO)	138,026,009	UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS	-16,997,900
NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS)	121,028,109						
MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO)	138,026,009						
UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS	-16,997,900						

Form and Line Reference	Explanation
PART III, LINE 9B	PER HOSPITAL GUIDELINES, IF A PATIENT IS DETERMINED TO QUALIFY FOR FINANCIAL ASSISTANCE PRIOR TO SENDING AN ACCOUNT TO COLLECTIONS, THE FINANCIAL ASSISTANCE WRITE-OFF IS PROCESSED AND NO COLLECTION ATTEMPT IS MADE IF AN ACCOUNT IS ALREADY IN COLLECTIONS AND MEDICAID ELIGIBILITY IS DEEMED ACTIVE DURING THE ACCOUNT DATE OF SERVICE, NO FURTHER COLLECTION ATTEMPT WILL BE MADE

Form and Line Reference	Explanation
PART VI, LINE 2	<p>GOOD SAMARITAN HOSPITAL (GSH) ACTIVELY PARTICIPATES IN ASSESSING THE HEALTH NEEDS OF THE COMMUNITY EVERY THREE YEARS, AS REQUIRED BY FEDERAL AND STATE LAW, GSH CONDUCTS A COUNTYWIDE HEALTH NEEDS ASSESSMENT IN CONJUNCTION WITH THE UNITED WAY OF BENTON COUNTY, THE CITY OF CORVALLIS, BENTON COUNTY HEALTH DEPARTMENT, BENTON COUNTY FEDERALLY QUALIFIED HEALTH CENTER, OREGON STATE UNIVERSITY, WESTERN UNIVERSITY-COMP NORTHWEST, LINN-BENTON COMMUNITY COLLEGE AND OTHER COMMUNITY PARTNERS THE PROCESS INCLUDES EXAMINING PRIMARY DATA COLLECTED THROUGH SURVEYS, FOCUS GROUPS, COMMUNITY FORUMS AND PERSONAL INTERVIEWS WITH COMMUNITY MEMBERS WHO RESIDE THROUGHOUT BENTON COUNTY SECONDARY DATA IS GATHERED FROM FEDERAL, STATE AND LOCAL AGENCIES THAT ADDRESS HEALTH NEEDS OF CHILDREN, YOUTH AND FAMILIES THE INFORMATION IS REVIEWED BY THE STAFF, PARTNERS AND COMMUNITY MEMBERS TO PRIORITIZE THE HEALTH CARE NEEDS FOR BENTON COUNTY EACH YEAR GSH BOARD AND VARIOUS INTERNAL AND EXTERNAL COMMITTEES REVIEW THE PRIORITIES TO ENSURE WE ARE CONTINUING TO ADDRESS THE NEEDS OF THE COMMUNITY</p>



Form and Line Reference	Explanation
PART VI, LINE 3	<p>GSH IS COMMITTED TO PROVIDING THE HIGHEST QUALITY HEALTH CARE SERVICES TO ALL, REGARDLESS OF THEIR ABILITY TO PAY IF QUALIFICATIONS ARE MET, PATIENTS' CARE MAY BE PROVIDED FREE OR AT A REDUCED COST THE DETERMINATION IS BASED IN PART ON POVERTY INCOME GUIDELINES ISSUED BY THE U S DEPARTMENT OF HEALTH AND HUMAN SERVICES PATIENTS WHO REGISTER FOR AN INPATIENT, OUTPATIENT, CLINICAL OR EMERGENCY SERVICE RECEIVE BOTH VERBAL AND WRITTEN INFORMATION ON FINANCIAL ASSISTANCE PATIENTS WHO ARE IDENTIFIED AS SELF-PAY OR UNINSURED ARE SCREENED THROUGH PRESUMPTIVE ELIGIBILITY QUESTIONS TO DETERMINE IF THEY ARE ELIGIBLE FOR THE OREGON HEALTH PLAN MEDICAID ASSISTANCE PROGRAM(OHP) EXTENDED STAY AND INPATIENTS THAT ARE DEEMED ELIGIBLE FOR OHP ARE AUTOMATICALLY ASSIGNED TO A FINANCIAL COUNSELOR AS PART OF THE CHECK-IN PROCESS DURING THE PATIENT STAY OR PRIOR TO DISCHARGE, THE FINANCIAL COUNSELOR MEETS WITH THE PATIENT TO ASSIST WITH COMPLETING AND SUBMITTING THEIR OHP APPLICATION PACKET TO THE OREGON HEALTH AUTHORITY OFFICE OUTPATIENT, CLINICAL AND EMERGENCY SERVICE PATIENTS WHO ARE DEEMED ELIGIBLE FOR OHP ARE ALSO ASSIGNED A FINANCIAL COUNSELOR WHO PROVIDES THEM WITH THE OHP APPLICATION PACKET AND THEIR CONTACT INFORMATION IF THEY REQUIRE ASSISTANCE TO COMPLETE THE FORMS THE FINANCIAL COUNSELOR CONTACTS THE PATIENT VIA TELEPHONE OR EMAIL AFTER 24 HOURS TO ANSWER QUESTIONS, PROVIDE SUPPORT AND ENSURE THAT THE APPLICATION HAS BEEN SUBMITTED ANY PATIENT WHO IS SELF-PAY OR UNINSURED AND NOT DEEMED ELIGIBLE FOR OHP IS PROVIDED A FINANCIAL ASSISTANCE APPLICATION PACKET AND ASSIGNED A FINANCIAL COUNSELOR THE FINANCIAL COUNSELOR REVIEWS THE APPLICATION PACKET AND PROVIDES INFORMATION TO THE PATIENT ON MULTIPLE FINANCIAL SUPPORT OPTIONS INCLUDING A NO-INTEREST PAYMENT PLAN OR FINANCIAL ASSISTANCE FOR THOSE AT OR BELOW 300% OF THE FEDERAL POVERTY LEVEL GUIDELINES ALL APPLICATION MATERIALS ARE AVAILABLE IN BOTH ENGLISH AND SPANISH AND INTERPRETATIVE SERVICES ARE AVAILABLE FOR NON-ENGLISH SPEAKING PATIENTS THROUGH VARIOUS ELECTRONIC DEVICES GSH ALSO INFORMS AND EDUCATES PATIENTS AND COMMUNITY MEMBERS REGARDING FINANCIAL ASSISTANCE THROUGH A VARIETY OF METHODS PAMPHLETS ARE AVAILABLE IN THE HOSPITAL WAITING AREAS, CLINIC WAITING ROOMS, VISITING ROOMS AND AT THE INFORMATION DESKS FLYERS ARE POSTED AT THE SPECIALTY CLINICS, THE MAIN ENTRANCE OF THE HOSPITAL AND IN THE EMERGENCY DEPARTMENT FINANCIAL ASSISTANCE INFORMATION IS ALSO POSTED ON THE HOSPITAL'S WEBSITE, INCLUDING THE FINANCIAL ASSISTANCE POLICY AND APPLICATION</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>GSH PRIMARILY SERVE RESIDENTS OF BENTON COUNTY ESTABLISHED BY THE PROVISIONAL LEGISLATURE IN 1847, BENTON COUNTY OCCUPIES 679 SQUARE MILES OF THE CENTRAL WILLAMETTE VALLEY BENTON COUNTY IS BORDERED ON THE EAST BY THE WILLAMETTE RIVER AND LINN COUNTY, WITH LINCOLN COUNTY ON THE WEST, POLK COUNTY ON THE NORTH, AND BY LANE COUNTY ON THE SOUTH THE CITY OF CORVALLIS IS THE COUNTY SEAT FOR BENTON COUNTY AND IS HOME TO OREGON STATE UNIVERSITY ALTHOUGH THE MAJORITY OF RESIDENTS LIVE IN CORVALLIS OR OTHER INCORPORATED CITIES IN THE COUNTY, APPROXIMATELY 21% OF RESIDENTS LIVE IN RURAL BENTON COUNTY THESE RURAL COMMUNITIES INCLUDE ALSEA, KINGS VALLEY, WREN, BLODGETT, SUMMIT AND BELLFOUNTAIN PORTIONS OF BENTON COUNTY HAVE DESIGNATIONS OF MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS ACCORDING TO THE HEALTH RESOURCES AND SERVICES ADMINISTRATION, WITH GSH BEING THE ONLY HOSPITAL LOCATED IN BENTON COUNTY THE CHARTS BELOW DESCRIBE THE DEMOGRAPHICS OF BENTON COUNTY RACE/ETHNICITY</p> <p>POPULATIONWHITE/CAUCASIAN 87 9%BLACK/AFRICAN AMERICAN 1 2%AMERICAN INDIAN/ALASKA NATIVE 0 9%ASIAN 6 2%HISPANIC 7 3%NATIVE HAWAIIAN/PACIFIC ISLANDER 3%REPORTING TWO OR MORE RACES 3 6%SOURCE U S CENSUS BUREAU, 2016 CENSUS QUICK FACTS, PUBLIC LAW 94-171 SUMMARY FILEHEALTH AND SOCIAL INDICATORS ARE USED TO GENERALIZE THE CONDITIONS OF BENTON COUNTY HEALTH AND SOCIAL INDICATORS TOTALSMEDIAN INCOME \$49,802UNEMPLOYMENT 4 3%POVERTY 18 3%HOMELESSNESS(ADULTS) 918*EARLY PRENATAL CARE 82 8%IMMUNIZATIONS 60 4%UNINSURED CHILDREN 4 6%CHILD CARE SLOTS 22/100CHILD ABUSE 7 9/1000EARLY CHILDHOOD OBESITY 20 6%CHILDREN ON FREE AND REDUCED LUNCH 38 3%CHILDREN ENROLLED WITH A DENTAL CARE ORGANIZATION 89 3%HOMELESS STUDENTS 254TEEN PREGNANCY 8 1/1000HIGH SCHOOL GRADUATION RATES 85 7%JUVENILE ARRESTS 11/10008TH GRADE ALCOHOL USE 13 7%8TH GRADE DRUG USE 6 4%*THERE IS NO ACCURATE WAY TO COUNT THE NUMBER OF HOMELESS PEOPLE IN A COUNTY HOMELESS DATA IS BASED ON LOCAL AGENCIES SERVING BENTON COUNTY DURING 2016 NUMBERS MAY BE DUPLICATED THE INFORMATION LISTED ABOVE WAS OBTAINED FROM VARIOUS LOCAL, STATE AND FEDERAL DATABASES USING THE MOST RECENT AVAILABLE DATA BETWEEN THE YEARS 2012 - 2016</p>

Form and Line Reference	Explanation
PART VI, LINE 5	GSH'S GOVERNING BOARD IS COMPRISED OF LOCAL-AREA RESIDENTS THE MAJORITY OF THE BOARD MEMBERS ARE INDEPENDENT, MEANING THEY AND THEIR FAMILY MEMBERS ARE NOT EMPLOYEES OF GSH NOR DO THEY HAVE ANY SIGNIFICANT BUSINESS RELATIONSHIPS WITH GSH GSH EXTENDS ITS MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN THE COMMUNITY GSH APPLIES SURPLUS FUNDS TO IMPROVE PATIENT CARE, MEDICAL EDUCATION AND RESEARCH GSH INVESTS IN UPDATING EQUIPMENT, TECHNOLOGY AND FACILITIES TO IMPROVE PATIENT CARE GSH IS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AND OFFERS WEEKLY PROGRAMS FOR AREA PHYSICIANS AND OTHER HEALTH PROFESSIONALS THE CENTER FOR HEALTH RESEARCH AND QUALITY, A DEPARTMENT OF GSH'S PARENT COMPANY, SAMARITAN HEALTH SERVICES (SHS), PROVIDES ADMINISTRATIVE OVERSIGHT FOR HEALTH AND CLINICAL RESEARCH, QUALITY IMPROVEMENT PROJECTS AND STUDIES, AND OTHER SPONSORED ACTIVITIES FOR GSH AND ITS AFFILIATED HOSPITALS

Form and Line Reference	Explanation
PART VI, LINE 6	<p>"BUILDING HEALTHIER COMMUNITIES TOGETHER" IS THE COMMITMENT OF, AND THE MOTIVATION FOR, SAMARITAN HEALTH SERVICES (SHS), A NETWORK OF OREGON HOSPITALS, PHYSICIANS, AND SENIOR CARE FACILITIES THAT SERVES THE HEALTH CARE NEEDS OF PEOPLE IN THE MID-WILLAMETTE VALLEY AND THE CENTRAL OREGON COAST AS THE INDIVIDUAL ENTITIES OF SHS CAME TOGETHER TO BUILD HEALTHIER COMMUNITIES, THEY WERE DRAWN BY A SHARED MISSION "TO ENHANCE COMMUNITY HEALTH AND ACHIEVE HIGH VALUE THROUGH QUALITY SERVICES ACROSS THE CONTINUUM OF CARE " THAT MEANS SHS LOOKS CAREFULLY AT LOCAL HEALTH CARE NEEDS, AND IT GIVES THOUGHTFUL CONSIDERATION TO THE MOST EFFECTIVE WAYS TO MEET THOSE NEEDS THE RESULT IS A RICH MIX OF LOCAL AND CENTRALIZED REGIONAL SERVICES WHICH PROVIDE HIGH VALUE AND EXCELLENT HEALTHCARE FOR PEOPLE AT ALL STAGES OF THEIR LIVES SERVICES ARE PROVIDED TO ALL INDIVIDUALS, REGARDLESS OF THEIR ABILITY TO PAY THE COLLECTIVE VISION OF SHS IS TO SUCCESSFULLY OPERATE AS A VALUES-DRIVEN, CHURCH-RELATED ORGANIZATION GOVERNED BY A PARTNERSHIP OF COMMUNITY MEMBERS, PHYSICIANS AND OTHER HEALTH CARE PROVIDERS SHS SEEKS TO LEAD COLLABORATIVE EFFORTS AMONG PROVIDERS, EMPLOYERS, HEALTH PLANS AND CONSUMERS WHO SHARE SIMILAR GOALS AND VALUES TO MEET THE CHALLENGES OF THE FUTURE GSH IS THE FLAGSHIP HOSPITAL OF SHS IT PRIMARILY SERVES RESIDENTS OF BENTON COUNTY OTHER AFFILIATED HOSPITALS ARE ALBANY GENERAL HOSPITAL AND SAMARITAN LEBANON COMMUNITY HOSPITAL, SERVING RESIDENTS OF LINN COUNTY, AND SAMARITAN NORTH LINCOLN HOSPITAL AND SAMARITAN PACIFIC COMMUNITIES HOSPITAL, SERVING RESIDENTS OF LINCOLN COUNTY</p>

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	OR

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 93-0391573  
**Name:** GOOD SAMARITAN HOSPITAL CORVALLIS

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

Section A. Hospital Facilities		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
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>											
Name, address, primary website address, and state license number											
1	GOOD SAMARITAN HOSPITAL CORVALLIS 3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 WWW.SAMHEALTH.ORG STATE LICENSE 14-1074	X	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
GOOD SAMARITAN HOSPITAL, CORVALLIS	PART V, SECTION B, LINE 5 THE STAFF FROM SAMARITAN HEALTH SERVICES COMMUNITY HEALTH PROMOTION DEPARTMENT PARTNERED WITH THE LINN-BENTON-LINCOLN RURAL HEALTH ASSESSMENT TEAM (RHAT) TO CONDUCT THE 2016 COMMUNITY HEALTH NEEDS ASSESSMENT FOR GOOD SAMARITAN REGIONAL MEDICAL CENTER THE STAFF AND RHAT CONDUCTED SURVEYS BOTH ON-LINE AND PAPER TO OVER 700 RESIDENTS IN BENTON COUNTY THE STAFF AND RHAT ALSO COLLECTED SECONDARY DATA FROM VARIOUS STATE AND NATIONAL ORGANIZATIONS SUCH AS THE OREGON DEPARTMENT OF EDUCATION, OREGON HEALTH AUTHORITY, U S CENSUS BUREAU AND CENTER FOR DISEASE CONTROL SAMARITAN HEALTH SERVICES ALSO CONTRACTED WITH A LOCAL CONSULTANT TO HOLD FOCUS GROUPS AND CONDUCT KEY-INFORMANT INTERVIEWS TO OBTAIN INPUT FROM COMMUNITY MEMBERS AND PEOPLE WITH SPECIAL KNOWLEDGE AND EXPERTISE PERSONS CONSULTED FOR THE HOSPITAL'S CHNA WERE FROM THE FOLLOWING ORGANIZATIONS BENTON COUNTY HEALTH DEPARTMENT, COMMUNITY OUTREACH INC , BENTON EAST LINN HEALTH CENTER, OREGON STATE UNIVERSITY, SAMARITAN HEALTH PLANS, WESTERN UNIVERSITY-COMP NORTHWEST, LINN-BENTON COMMUNITY COLLEGE, CORVALLIS SCHOOL DISTRICT, LINN-BENTON COUNTY HEALTH EQUITY ALLIANCE, OLD MILL CENTER FOR CHILDREN AND FAMILIES, STRENGTHENING RURAL FAMILIES, LOVE INC, CHURCH OF THE GOOD SAMARITAN, OREGON CASCADES WEST COUNCIL OF GOVERNMENTS, INTERCOMMUNITY HEALTH NETWORK, DEPARTMENT OF HUMAN SERVICES, OREGON HEALTH AUTHORITY, OREGON OFFICE OF RURAL HEALTH, COMMUNITY SERVICES CONSORTIUM, CORVALLIS CLINIC, MONROE SCHOOL DISTRICT, ALSEA SCHOOL DISTRICT, PHILOMATH SCHOOL DISTRICT, LINN-BENTON-LINCOLN EARLY LEARNING HUB, LINN-BENTON HISPANIC ADVISORY COUNCIL, BENTON COUNTY ORAL HEALTH COALITION, AND COMMUNITY MEMBERS

<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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
GOOD SAMARITAN HOSPITAL, CORVALLIS	PART V, SECTION B, LINE 6B BENTON COUNTY HEALTH DEPARTMENT - REGIONAL HEALTH ASSESSMENT TEAM, BRANDAN KEARNEY, LLC - CONSULTANT, COMMUNITY SERVICES CONSORTIUM



<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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
GOOD SAMARITAN HOSPITAL, CORVALLIS	PART V, SECTION B, LINE 7D COPIES OF THE CHNA WERE EMAILED TO KEY COMMUNITY PARTNERS AND DISTRIBUTED DURING LOCAL COALITION MEETINGS

**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
GOOD SAMARITAN HOSPITAL, CORVALLIS	PART V, SECTION B, LINE 11 GSH IS ADDRESSING THE SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENTS THROUGH MULTIPLE STRATEGIES FIRST, GSH PROVIDES GRANT FUNDING TO LOCAL COMMUNITY AGENCIES THAT ADDRESS ONE OR MORE OF THE PRIORITIES IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT AND IS INCLUDED IN THE HOSPITAL'S COMMUNITY BENEFIT PLAN IMPLEMENTATION STRATEGY SECOND, THE HOSPITAL STAFF SERVE ON COMMUNITY ADVISORY BOARDS AND COALITIONS TO ADDRESS THE MOST PRESSING NEEDS IN THE COMMUNITY AND FINALLY, THE HOSPITAL IS PROVIDING WORKSHOPS, CLASSES AND SUPPORT GROUPS TO ADDRESS THE HIGHEST HEALTH CONCERNS IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT BECAUSE SEVERAL NEEDS TO IMPROVE HEALTH WERE IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT, GSH DOES NOT HAVE THE FINANCES, RESOURCES OR THE EXPERTISE TO ADDRESS ALL THE NEEDS

**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
GOOD SAMARITAN HOSPITAL, CORVALLIS	PART V, SECTION B, LINE 15E REGISTRATION REFERS UNINSURED AND/OR LOW INCOME PATIENTS TO THE ONSITE PATIENT FINANCIAL ADVOCATE AND A THIRD PARTY VENDOR WHO CONTACTS THE PATIENTS TO ASSESS THEIR FINANCIAL STATUS AND NEEDS

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)
1 1 - SAMARITAN MENTAL HEALTH - ALBANY 1052 SW 29TH ST ALBANY, OR 97321	MENTAL HEALTH SERVICES
1 2 - SAMARITAN OCC MED - ALBANY 2615 WILLETTA ST SW STE C2 ALBANY, OR 97321	MEDICAL CLINIC - OUTPATIENT
2 3 - SAMARITAN MENTAL HEALTH - CORVALLIS 3509 NW SAMARITAN DR STE 215 CORVALLIS, OR 97330	MENTAL HEALTH SERVICES
3 4 - SAMARITAN ENDOSCOPY CENTER 3509 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	ENDOSCOPY CENTER
4 5 - SAMARITAN WEIGHT MGMT & METABOLIC SURG 3517 NW SAMARITAN DR STE 100 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
5 6 - SAMARITAN MENTAL HEALTH FAMILY CTR 3517 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330	MENTAL HEALTH SERVICES
6 7 - SAMARITAN FAMILY MEDICINE 3517 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 8 - SAMARITAN FAMILY MED RESIDENT CLINIC 3517 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 9 - SAMARITAN OB & GYN RESIDENT CLINIC 3517 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
9 10 - SAMARITAN INTERNAL MEDICINE 3521 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 11 - SAMARITAN PHYSICAL REHAB - CORVALLIS 815 NW 9TH ST STE 180 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 12 - MAMMOGRAPHY CLINIC 3615 NW SAMARITAN DR CORVALLIS, OR 97330	IMAGING SERVICES
12 13 - SAMARITAN ENDOCRINOLOGY 3615 NW SAMARITAN DR STE G2 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
13 14 - SAMARITAN DIABETES EDUCATION 3615 NW SAMARITAN DR STE G1 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
14 15 - CORVALLIS MRI 3615 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330	IMAGING SERVICES

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)
16 16 - SAMARITAN HEART & VASC - SURGERY 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
1 17 - SAMARITAN SURGICAL SPECIALISTS 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
2 18 - SAMARITAN KIDNEY SPECIALISTS 3615 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 19 - SAMARITAN NEUROSURGERY 3615 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
4 20 - OUTPATIENT SURGERY 3620 NW SAMARITAN DR CORVALLIS, OR 97330	AMBULATORY SURGERY
5 21 - SAMARITAN ORTHOPEDICS - DR VELA 3620 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
6 22 - SAMARITAN ORTHOPEDICS CLINIC 3620 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 23 - SAMARITAN RHEUMATOLOGY 3620 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 24 - SAMARITAN NEUROMUSCULAR MED RESIDENT CL 3620 NW SAMARITAN DR STE 203A CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
9 25 - SAMARITAN INFECTIOUS DISEASE 3640 NW SAMARITAN DR CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 26 - SAMARITAN OBSTETRICS & GYN 3640 NW SAMARITAN DR CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 27 - SAMARITAN GYN & SURGICAL ASSOCIATES 400 NW WALNUT BLVD STE 300 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
12 28 - SAMARITAN PASTEGA REGIONAL CANCER CTR 441 NW ELKS DR CORVALLIS, OR 97330	CANCER TREATMENT
13 29 - SAMARITAN HEMATOLOGY & ONCOLOGY CONSULT 501 NW ELKS DR CORVALLIS, OR 97330	CANCER TREATMENT
14 30 - SAMARITAN CANCER RESOURCE CTR CORVALLIS 501 NW ELKS DR CORVALLIS, OR 97330	CANCER RESOURCE CENTER

**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)
<b>31</b> 31 - SAMARITAN URGENT CARE CENTER 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
<b>1</b> 32 - SAMARITAN FAMILY MEDICINE SOUTHWEST 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
<b>2</b> 33 - SAMARITAM OCC MED - CORVALLIS 5234 SW PHILOMATH BLVD STE B CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
<b>3</b> 34 - SAMARITAN PEDIATRICS 777 NW 9TH ST STE 320 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
<b>4</b> 35 - SAMARITAN ATHLETIC MEDICINE 845 SW 30TH ST CORVALLIS, OR 97331	MEDICAL CLINIC - OUTPATIENT
<b>5</b> 36 - SAM CARE EXPRESS - CORVALLIS 990 NW CIRCLE BLVD STE 101 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
<b>6</b> 37 - SAMARITAN UROLOGY 990 NW CIRCLE BLVD STE 102 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
<b>7</b> 38 - SAMARITAN PLASTICRECON SURG - HAVARD 996 NW CIRCLE BLVD STE 103 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
<b>8</b> 39 - SAMARITAN OCC MED - LEBANON 100 MULLINS DRIVE STE B2 LEBANON, OR 97355	MEDICAL CLINIC - OUTPATIENT

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As Filed Data -

DLN: 93493318066107

Schedule I  
(Form 990)

Department of the  
Treasury  
Internal Revenue Service

OMB No 1545-0047

2016

Open to Public  
Inspection

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](http://www.irs.gov/form990).

Name of the organization  
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number  
93-0391573

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
See Additional Data Table							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . 13

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

**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) TRANSPORTATION	410	42,749			
(2) PATIENT ASSISTANCE	1	300			
(3) MEALS	390		3,812	BOOK	MEALS FOR FAMILY MEMBERS OF PATIENTS
(4) ACCOMMODATIONS - PASTEGA HOUSE	6946		53,894	BOOK	TEMPORARY HOUSING FOR PATIENTS AND THEIR FAMILY MEMBERS
(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
PART I, LINE 2	AGENCIES IN THE COMMUNITY ARE INVITED TO SUBMIT GRANT PROPOSALS THROUGH AN APPLICATION PROCESS A COMMITTEE REVIEWS THE APPLICATIONS TO DETERMINE IF THE FUNDS REQUESTED WILL BE USED TO ADDRESS THE ORGANIZATION'S ESTABLISHED COMMUNITY HEALTH PRIORITIES, IDENTIFIED NEEDS, AND SUPPORTS THE ORGANIZATION'S MISSION ONCE APPROVED AND FUNDED, AGENCIES MUST SUBMIT A COMPLETE ANNUAL REPORT DESCRIBING HOW THE FUNDS WERE USED, THE NUMBER OF CLIENTS SERVED, AND HOW OUTCOMES WERE ACHIEVED



Additional Data

Software ID:  
Software Version:  
EIN: 93-0391573  
Name: GOOD SAMARITAN HOSPITAL CORVALLIS

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
COMMUNITY OUTREACH 865 REIMAN AVENUE CORVALLIS, OR 97330	93-0602094	501(C)(3)	107,796				MEDICAL, DENTAL, MENTAL HEALTH CLINICS
OLD MILL CENTER 1650 SW 45TH PLACE CORVALLIS, OR 97333	93-0722603	501(C)(3)	10,000				FUNDING FOR RESPITE SERVICES TO FAMILIES ENROLLED IN THE RELIEF NURSERY PROGRAM

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
ALBANY HELPING HANDS PO BOX 2252 ALBANY, OR 97321	93-1244271	501(C)(3)	9,600				SUPPORT FOR HOMELESS PEOPLE
CENTER AGAINST RAPE & DOMESTIC VIOLENCE PO BOX 914 CORVALLIS, OR 97339	93-0792125	501(C)(3)	21,000				PROVIDED FUNDING TO SUPPORT THE EMERGENCY SHELTER PROGRAM

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
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	10,656				FUNDING FOR PEOPLE ENTERING THE DRUG COURT PROGRAM
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	20,000				FUNDING FOR A 10 YR PLAN TO END HOMELESSNESS IN BENTON COUNTY OREGON

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
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	20,100				FUNDING TO SUPPORT THE BENTON COUNTY ORAL HEALTH COALITION ADULT EMERGENCY VOUCHER DENTAL PROGRAM
STRENGTHENING RURAL FAMILIES PO BOX 1528 PHILOMATH, OR 97370	20-2934930	501(C)(3)	7,800				PROVIDED FUNDING FOR DENTAL VANS FOR RURAL BENTON COUNTY OREGON

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
LOVE IN THE NAME OF CHRIST OF BENTON COUNTY PO BOX 270 CORVALLIS, OR 97339	93-1326307	501(C)(3)	6,100				FUNDING FOR ADULT EMERGENCY VOUCHER DENTAL PROG AND DENTAL VANS IN THE CORVALLIS OREGON AREA
JACKSON STREET YOUTH SHELTER INC PO BOX 285 CORVALLIS, OR 97339	93-1269503	501(C)(3)	15,000				FUNDING FOR TRANSITIONAL HOUSING TO HOMELESS YOUTH

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
ABC HOUSE PO BOX 68 ALBANY, OR 97321	93-1163555	501(C)(3)	7,500				FUNDING FOR A MEDICAL DIRECTOR POSITION TO CONDUCT CHILD ABUSE ASSESSMENTS
COMMUNITY SERVICES CONSORTIUM 545 SW SECOND ST A CORVALLIS, OR 97333	93-6118438	115(1)	12,000				FUNDING FOR A MENTAL HEALTH COUNSELOR TO SUPPORT YOUTH IN BENTON COUNTY OREGON

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
CORVALLIS DAYTIME DROP-IN CENTER 316 SW WASHINGTON AVE CORVALLIS, OR 97333	80-0019915	501(C)(3)	6,000				FUNDING FOR TRANSPORTATION AND CO-PAY FOR MEDICAL TREATMENT
CORVALLIS ENVIRONMENTAL CENTER PO BOX 2189 CORVALLIS, OR 97339	93-1140056	501(C)(3)	7,500				FUNDING TO SUPPORT SCHOOL AND COMMUNITY GARDENS IN CORVALLIS OREGON

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
OREGON CASCADES WEST SENIOR SERVICES FOUNDATION 1400 QUEEN AVENUE SE 206 ALBANY, OR 97322	93-1213218	501(C)(3)	10,000				FUNDING TO PURCHASE MEALS FOR SENIORS AND PEOPLE WITH DISABILITIES IN BENTON COUNTY OREGON
VINA MOSES WELFARE CENTER 968 NW GARFIELD AVE CORVALLIS, OR 97330	93-0615775	501(C)(3)	7,000				FUNDING TO SUPPORT RENTAL AND UTILITY ASSISTANCE TO FAMILIES IN BENTON COUNTY OREGON



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](http://www.irs.gov/form990).

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization GOOD SAMARITAN HOSPITAL CORVALLIS	Employer identification number 93-0391573
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Part I

Questions Regarding Compensation

	Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
<b>b</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	Yes	
<b>2</b> 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?	Yes	
<b>3</b> 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. <div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>		
<b>4</b> 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:		
<b>a</b> Receive a severance payment or change-of-control payment?	Yes	
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	Yes	
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?		No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III		
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> 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:		
<b>a</b> The organization?	Yes	
<b>b</b> Any related organization?		No
If "Yes," on line 5a or 5b, describe in Part III		
<b>6</b> 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:		
<b>a</b> The organization?		No
<b>b</b> Any related organization?		No
If "Yes," on line 6a or 6b, describe in Part III		
<b>7</b> 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		No
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III		No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?		

**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
See Additional Data	

Additional Data

Software ID:  
Software Version:  
EIN: 93-0391573  
Name: GOOD SAMARITAN HOSPITAL CORVALLIS

Part III, Supplemental Information

Return Reference	Explanation
PART I, LINE 1A	IN CONNECTION WITH ITS EMPLOYEE WELLNESS PROGRAM, THE ORGANIZATION HAS A GYM/FITNESS FACILITY BENEFIT THAT IS AVAILABLE TO ALL EMPLOYEES WHO WORK AT LEAST 32 HOURS PER MONTH IF AN EMPLOYEE PARTICIPATES AT A NON-SAMARITAN GYM, REIMBURSEMENT IS MADE FOR FEES REIMBURSEMENT DOES NOT EXCEED \$300 PER YEAR AND IS INCLUDED IN THE EMPLOYEE'S TAXABLE WAGES AND IS SUBJECT TO FEDERAL/STATE WITHHOLDING TAX NO PERSONS LISTED ON PART VII RECEIVED THIS TAXABLE GYM BENEFIT IN 2016 IF AN EMPLOYEE PARTICIPATES AT A SAMARITAN FITNESS CENTER (SAMFIT), MEMBERSHIP IS FREE OF CHARGE (PROVIDED AS A NONTAXABLE FRINGE BENEFIT) ONE KEY EMPLOYEE RECEIVED THE SAMFIT BENEFIT DURING 2016

**Part III, Supplemental Information**

Return Reference	Explanation
PART I, LINE 3	THE CHIEF EXECUTIVE OFFICER IS EMPLOYED AND PAID BY A RELATED ORGANIZATION THE RELATED ORGANIZATION CONDUCTS A COMPENSATION ANALYSIS EACH YEAR TO COMPARE COMPENSATION OF ALL PAID POSITIONS TO MARKET SURVEYS OF COMPENSATION FOR SIMILAR POSITIONS IN OTHER ORGANIZATIONS PERIODICALLY, THE RELATED ORGANIZATION WILL ALSO USE WRITTEN EMPLOYMENT CONTRACTS, FORM 990 OF OTHER ORGANIZATIONS, AND INDEPENDENT COMPENSATION CONSULTANTS TO DETERMINE THE COMPENSATION OF THE CHIEF EXECUTIVE OFFICER

**Part III, Supplemental Information**

Return Reference	Explanation
PART I, LINES 4A-B	4 A MARK TAYLOR, MD, A HIGHEST PAID EMPLOYEE, RECEIVED \$436,096 IN TAXABLE COMPENSATION PURSUANT TO HIS SEPARATION FROM THE FILING ORGANIZATION 4 B THE ORGANIZATION MAINTAINS SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS UNDER THESE PLANS, LARRY MULLINS, DHA, AND DANIEL SMITH ACCRUED DEFERRED COMPENSATION BENEFITS DURING 2016 LARRY MULLINS, DHA RECEIVED A PAYMENT IN 2016 FROM HIS PLAN, WHICH IS INCLUDED IN HIS 2016 COMPENSATION ON SCHEDULE J AND FORM 990 DANIEL SMITH RECEIVED NO PAYMENTS FROM HIS PLAN IN 2016

**Part III, Supplemental Information**

Return Reference	Explanation
PART I, LINE 5	VARIOUS PHYSICIAN COMPENSATION METHODOLOGIES ARE UTILIZED AND, DEPENDING ON SPECIALTY, RELATIVE VALUE UNITS (RVU'S) MAY BE USED IN DETERMINING A PORTION OF OR ALL OF THEIR COMPENSATION

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			(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				
1BECKY PAPECEO	(i)	0	0	0	0	0	0	0
	(ii)	349,757	0	7,947	21,760	-	-	0
						33,571	413,035	
1DANIEL SMITH VP FINANCE / CFO	(i)	0	0	0	0	0	0	0
	(ii)	367,808	37,506	8,978	56,906	-	-	0
						33,548	504,746	
2RYAN COMBS VP PRIMARY CARE SPEC PRACTICES	(i)	187,530	19,289	338	16,464	21,905	245,526	0
	(ii)	0	0	0	0	-	-	0
						0	0	
3SCOTT WILSON VP ANCILLARY SUPPORT SVCS	(i)	172,009	6,500	15,343	14,846	29,328	238,026	0
	(ii)	0	0	0	0	-	-	0
						0	0	
4WILLIAM HOWDEN VP NURSING GSRMC	(i)	180,656	8,000	3,653	14,630	24,413	231,352	0
	(ii)	0	0	0	0	-	-	0
						0	0	
5MARK TAYLOR MD PHYSICIAN	(i)	949,448	63,554	208,606	21,760	29,511	1,272,879	0
	(ii)	0	0	0	0	-	-	0
						0	0	
6LUIS VELA DOPHYSICIAN	(i)	842,493	0	1,399	19,229	33,370	896,491	0
	(ii)	0	0	0	0	-	-	0
						0	0	
7J CHRISTOPHER NOONAN MD PHYSICIAN	(i)	714,260	20,000	2,322	16,460	35,941	788,983	0
	(ii)	0	0	0	0	-	-	0
						0	0	
8DONALD PENNINGTON DO PHYSICIAN	(i)	586,130	126,833	13,533	21,760	30,797	779,053	0
	(ii)	0	0	0	0	-	-	0
						0	0	
9JEFF HSING MDPHYSICIAN	(i)	529,391	217,192	540	21,760	30,213	799,096	0
	(ii)	0	0	0	0	-	-	0
						0	0	
10STEVEN JASPERSON FORMER CEO / VP SO CALIFORNIA OPS	(i)	0	0	0	0	0	0	0
	(ii)	386,143	0	71,316	21,760	-	-	0
						26,375	505,594	
11LARRY MULLINS DHA FORMER CEO / SHS CEO	(i)	0	0	0	0	0	0	0
	(ii)	791,526	0	388,760	272,260	-	-	0
						27,086	1,479,632	



**SCHEDULE O**  
(Form 990 or 990-EZ)Department of the Treasury  
Internal Revenue ServiceName of the organization  
GOOD SAMARITAN HOSPITAL CORVALLIS**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](http://www.irs.gov/form990).

OMB No 1545-0047

**2016****Open to Public  
Inspection**

Employer identification number

93-0391573

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 1	TWO NON-EMPLOYEE BOARD MEMBERS OF THE FILING ORGANIZATION ARE NOT INDEPENDENT DUE TO BUSINESS TRANSACTIONS WITH A RELATED ORGANIZATION

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	GOOD SAMARITAN HOSPITAL CORVALLIS HAS A SOLE CORPORATE MEMBER, SAMARITAN HEALTH SERVICES, INC , WHICH IS A SECTION 501(C)(3) TAX-EXEMPT ORGANIZATION

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	GOOD SAMARITAN HOSPITAL CORVALLIS ELECTS MEMBERS OF ITS BOARD OF DIRECTORS THOSE ELECTED MEMBERS ARE THEN SUBMITTED TO THE SOLE CORPORATE MEMBER FOR APPROVAL

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	THE SOLE CORPORATE MEMBER HAS SEVERAL RESERVED POWERS OVER THE ORGANIZATION. THESE RESERVED POWERS INCLUDE, BUT ARE NOT LIMITED TO, APPROVAL AT CERTAIN THRESHOLD LEVELS OF THE BORROWING OF FUNDS, MERGERS AND ACQUISITIONS, AND SALES OR TRANSFERS OF ASSETS. IN ADDITION, THE SOLE CORPORATE MEMBER MUST APPROVE ANY CHANGE IN THE MISSION OF THE ORGANIZATION, THE ANNUAL BUDGET, AND ANY AMENDMENTS TO THE ARTICLES OF INCORPORATION OR BYLAWS.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	A COPY OF THE ORGANIZATION'S FINAL FORM 990 (INCLUDING REQUIRED SCHEDULES), AS ULTIMATELY FILED WITH THE IRS, WAS PROVIDED TO EACH VOTING MEMBER OF THE SAMARITAN HEALTH SERVICES (SHS) AUDIT AND COMPLIANCE COMMITTEE PRIOR TO ITS FILING WITH THE IRS. SHS IS A 501(C)(3) CORPORATION AND IS THE SOLE MEMBER OF THE FILING ORGANIZATION. SHS'S CHIEF FINANCIAL OFFICER CONDUCTED THE FORM 990 REVIEW WITH THE COMMITTEE AND PROVIDED TIME FOR QUESTIONS FROM THE GROUP. A FORMAL REPORT OF THIS COMMITTEE HAS BEEN MADE TO THE FULL BOARD OF DIRECTORS OF SHS. ADDITIONALLY, A COMPLETE COPY OF THE FILING ORGANIZATION'S FINALIZED FORM 990 AND RELATED SCHEDULES WAS PROVIDED ELECTRONICALLY TO ALL MEMBERS OF THE FILING ORGANIZATION'S GOVERNING BOARD PRIOR TO ITS FILING WITH THE IRS.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	<p>BOARD MEMBER CONFLICTS OF INTEREST THE MEMBERS OF THE BOARD MUST ANNUALLY COMPLETE A CONFLICT OF INTEREST QUESTIONNAIRE, WHICH REQUIRES DISCLOSURE OF ANY CONFLICTS OR POTENTIAL CONFLICTS OF INTEREST THE COMPLETED QUESTIONNAIRES ARE REVIEWED BY THE CHIEF FINANCIAL OFFICER AND CORPORATE COMPLIANCE OFFICER IF A CONFLICT IS DISCLOSED THAT COULD PROHIBIT A MEMBER FROM SERVING ON THE BOARD, THIS IS EVALUATED BY THE AUDIT AND COMPLIANCE COMMITTEE OF THE SAMARITAN HEALTH SERVICES (SHS) BOARD OF DIRECTORS TO DETERMINE WHETHER THE MEMBER SHOULD CONTINUE TO SERVE ON THE BOARD IF A CONFLICT IS DISCLOSED THAT DOES NOT PROHIBIT A MEMBER FROM SERVING ON THE BOARD, THE CONFLICT IS MANAGED THROUGH A PROCESS SET FORTH IN THE ORGANIZATION'S BYLAWS THE BYLAWS PROHIBIT ANY BOARD MEMBER FROM VOTING ON AN ACTION WHERE AN INDIVIDUAL MEMBER HAS A CONFLICT OF INTEREST EMPLOYEE CONFLICTS OF INTEREST THE SHS CODE OF CONDUCT AND BUSINESS ETHICS POLICY REQUIRES THAT ALL SHS EMPLOYEES COMPLETE AN ANNUAL DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST THROUGH THE HUMAN RESOURCES SOFTWARE, PERFORMANCE MANAGER, THE DISCLOSURE REQUIREMENT NOTICE IS ASSIGNED TO ALL EMPLOYEES AND BY YEAR END ALL TASKS ARE TO BE COMPLETED IF THERE IS A PERCEIVED CONFLICT OF INTEREST IT IS REVIEWED BY THE CORPORATE COMPLIANCE OFFICER, LEGAL COUNSEL AND/OR SENIOR MANAGEMENT ACTUAL CONFLICTS OF INTEREST ARE REVIEWED AND DISCUSSED BY THE AUDIT AND COMPLIANCE COMMITTEE OF THE SAMARITAN HEALTH SERVICES BOARD OF DIRECTORS</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	LINE 15A THE CEO OF THE PARENT COMPANY, SAMARITAN HEALTH SERVICES (SHS) USES PUBLICLY AVAILABLE INFORMATION TO DETERMINE THE COMPENSATION FOR THE TOP MANAGEMENT OFFICIAL OF THE FILING ORGANIZATION HE CONSULTS WITH THE INDEPENDENT CONSULTANT AS TO THE REASONABLENESS OF THIS DATA TO ENSURE THAT THE TOP MANAGEMENT OFFICIAL'S COMPENSATION IS REASONABLE AS COMPARED TO SIMILARLY QUALIFIED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS LINE 15B PHYSICIAN EMPLOYEE COMPENSATION, INCLUDING PHYSICIANS WHO ARE BOARD MEMBERS, IS REVIEWED AT LEAST ANNUALLY BY SENIOR MANAGEMENT THIS REVIEW INCLUDES COMPARISON WITH PUBLISHED PHYSICIAN COMPENSATION STUDIES FOR ALL OTHER EMPLOYEES, THE ORGANIZATION PERFORMS AN ANALYSIS EACH YEAR TO COMPARE COMPENSATION OF ALL PAID POSITIONS TO MARKET SURVEYS OF COMPENSATION FOR SIMILAR POSITIONS IN OTHER ORGANIZATIONS

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	FINANCIAL STATEMENTS ARE MADE AVAILABLE UPON REQUEST. SYSTEM-WIDE SUMMARIZED DATA IS ALSO PROVIDED IN THE ANNUAL REPORT TO THE COMMUNITY. THIS REPORT IS MADE AVAILABLE IN ALL KIOSKS AND HIGH-TRAFFIC AREAS OF ALL HOSPITALS AND PHYSICIAN CLINICS, AS WELL AS COMMUNITY PLACES SUCH AS THE PUBLIC LIBRARY. IT IS ALSO DISTRIBUTED TO THE BOARDS OF DIRECTORS AND DIRECTLY MAILED TO DONORS AND NEW RESIDENTS IN THE COMMUNITY. ADDITIONALLY, THE REPORT IS MADE AVAILABLE AT ALL EVENTS, COMMUNITY OUTREACH PROJECTS, AND SCREENINGS ATTENDED THROUGHOUT THE YEAR. GOVERNING DOCUMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST.



## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	DISTRIBUTIONS TO MINORITY INTEREST CONSOLIDATED JVS -1,230,000 INCREASE IN MINIMUM PENSION LIABILITY 4,653,282 OTHER CHANGES 122,723

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493318066107	
SCHEDULE R (Form 990)	Related Organizations and Unrelated Partnerships				OMB No 1545-0047
					2016
	▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.				Open to Public Inspection
▶ Attach to Form 990. ▶ Information about Schedule R (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .					
Department of the Treasury Internal Revenue Service					
Name of the organization GOOD SAMARITAN HOSPITAL CORVALLIS				Employer identification number 93-0391573	

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	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.

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) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b) (13) controlled entity?	
								Yes	No
<b>(1)</b> SAMARITAN HEALTH PLANS INC 3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 93-0860860	HEALTH INSURANCE CARRIER FOR THE COMMUNITY	OR	N/A	C					No
<b>(2)</b> BOULDER FALLS PROPERTIES LLC PO BOX 3000 CORVALLIS, OR 973393000 46-5293120	EVENT CENTER & HOSPITALITY SVCS	OR	N/A	C					No
<b>(3)</b> SYNERGY SURGICALISTS INC 678 SIMMONS LANE BOZEMAN, MT 59715 45-4639673	ORTHOPEDIC & GENERAL SURGERY CARE	MT	N/A	S					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

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

**a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity . . . . .

**b** Gift, grant, or capital contribution to related organization(s) . . . . .

**c** Gift, grant, or capital contribution from related organization(s) . . . . .

**d** Loans or loan guarantees to or for related organization(s) . . . . .

**e** Loans or loan guarantees by related organization(s) . . . . .

**f** Dividends from related organization(s) . . . . .

**g** Sale of assets to related organization(s) . . . . .

**h** Purchase of assets from related organization(s) . . . . .

**i** Exchange of assets with related organization(s) . . . . .

**j** Lease of facilities, equipment, or other assets to related organization(s) . . . . .

**k** Lease of facilities, equipment, or other assets from related organization(s) . . . . .

**l** Performance of services or membership or fundraising solicitations for related organization(s) . . . . .

**m** Performance of services or membership or fundraising solicitations by related organization(s) . . . . .

**n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .

**o** Sharing of paid employees with related organization(s) . . . . .

**p** Reimbursement paid to related organization(s) for expenses . . . . .

**q** Reimbursement paid by related organization(s) for expenses . . . . .

**r** Other transfer of cash or property to related organization(s) . . . . .

**s** Other transfer of cash or property from related organization(s) . . . . .

Yes

No

1a

Yes

1b

Yes

1c

Yes

1d

No

1e

No

1f

No

1g

No

1h

No

1i

No

1j

Yes

1k

Yes

1l

Yes

1m

Yes

1n

Yes

1o

Yes

1p

Yes

1q

Yes

1r

Yes

1s

Yes

**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

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Schedule R (Form 990) 2016

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.

[illegible]

**Part VII**    **Supplemental Information**

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

Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 93-0391573

Name: GOOD SAMARITAN HOSPITAL CORVALLIS

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)  PO BOX 3000 CORVALLIS, OR 973393000 93-0110095	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
(1)  1046 SIXTH AVENUE SW ALBANY, OR 97321 93-0712890	TO SUPPORT ALBANY GENERAL HOSPITAL	OR	501(C)(3)	7	ALBANY GENERAL HOSPITAL		No
(2)  PO BOX 3000 CORVALLIS, OR 973393000 93-0900124	HEALTH SERVICES FOR LOW-INCOME PATIENTS	OR	501(C)(3)	7	SAMARITAN HEALTH SERVICES		No
(3)  PO BOX 3000 CORVALLIS, OR 973393000 93-0932697	FUTURE CHARITABLE HEALTHCARE INITIATIVES (NO CURRENT YEAR ACTIVITY)	OR	501(C)(3)	10	SAMARITAN HEALTH SERVICES		No
(4)  3600 NW SAMARITAN DRIVE CORVALLIS, OR 973393000 93-6024034	TO SUPPORT GOOD SAMARITAN HOSPITAL	OR	501(C)(3)	10	N/A		No
(5)  PO BOX 1068 CORVALLIS, OR 97339 23-7252406	TO SUPPORT GOOD SAMARITAN HOSPITAL	OR	501(C)(3)	7	GOOD SAMARITAN HOSPITAL	Yes	
(6)  PO BOX 3000 CORVALLIS, OR 973393000 93-1124326	CCO PROVIDING MGMT OF INTEGRATED HEALTH SVCS FOR MEDICAID/OHP ENROLLEES	OR	501(C)(4)	N/A	SAMARITAN HEALTH SERVICES		No
(7)  PO BOX 739 LEBANON, OR 97355 93-1260080	TO SUPPORT LEBANON COMMUNITY HOSPITAL	OR	501(C)(3)	7	MID-VALLEY HEALTHCARE INC		No
(8)  PO BOX 3000 CORVALLIS, OR 973393000 93-0396847	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
(9)  PO BOX 3000 CORVALLIS, OR 973393000 73-1668317	PURE NON-PROFIT CAPTIVE INSURANCE COMPANY	HI	501(C)(3)	12A, I	SAMARITAN HEALTH SERVICES		No
(10)  PO BOX 3000 CORVALLIS, OR 973393000 93-0951989	PROVIDE HEALTHCARE SUPPORT SERVICES	OR	501(C)(3)	12C, III-FI	N/A		No
(11)  3043 NE 28TH STREET LINCOLN CITY, OR 97367 93-1305493	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
(12)  930 SW ABBEY STREET NEWPORT, OR 97365 93-1329784	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
(13)  PO BOX 3000 CORVALLIS, OR 973393000 93-1245534	FUTURE CHARITABLE HEALTHCARE INITIATIVES (NO CURRENT YEAR ACTIVITY)	OR	501(C)(3)	10	SAMARITAN HEALTH SERVICES		No
(14)  PO BOX 767 LINCOLN CITY, OR 97367 93-0867677	TO SUPPORT SAMARITAN NORTH LINCOLN HOSPITAL	OR	501(C)(3)	7	SAMARITAN NORTH LINCOLN HOSPITAL		No

**Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in Box 20 of Schedule K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) SAMARITAN ENDOSCOPY CENTER LLC  3600 NW SAMARITAN DR CORVALLIS, OR 97330 20-2860067	MEDICAL SERVICES	OR	GOOD SAMARITAN HOSPITAL	RELATED	19,471	199,202		No		Yes		66 660 %
(1) CORVALLIS MEDICAL BUILDINGS LLC  3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 93-1257913	REAL ESTATE RENTAL	OR	GOOD SAMARITAN HOSPITAL	EXCLUDED	171,252	1,079,559		No		Yes		54 500 %
(2) EAST LINN MRI LLC  3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 32-0229399	IMAGING	OR	N/A									
(3) HULL IMAGING LLC  3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 20-3255479	IMAGING	OR	GOOD SAMARITAN HOSPITAL	RELATED	919,549	30,617		No		Yes		60 000 %
(4) CORVALLIS MRI A JOINT VENTURE  3615 NW SAMARITAN DRIVE CORVALLIS, OR 97330 93-0949704	IMAGING	OR	GOOD SAMARITAN HOSPITAL	RELATED	303,200	20,132		No		Yes		50 000 %
(5) MID-VALLEY MEDICAL PROPERTIES ASSOC LLC  1046 SIXTH AVE SW ALBANY, OR 97321 30-0508747	REAL ESTATE RENTAL	OR	N/A									
(6) MID-VALLEY MEDICAL BUILDINGS LLC  PO BOX 557 LEBANON, OR 97355 93-1126353	REAL ESTATE RENTAL	OR	N/A									
(7) NORTHWEST MEDICAL ISOTOPES LLC  815 NW 9TH ST STE 256 CORVALLIS, OR 97330 27-3007752	RESEARCH	OR	N/A									
(8) CASCADE VIEW MEDICAL OFFICE BUILDING LLC  PO BOX 3000 CORVALLIS, OR 973393000 30-0658805	REAL ESTATE RENTAL	OR	GOOD SAMARITAN HOSPITAL	EXCLUDED	47,709	1,526,082		No		Yes		26 300 %



**Form 990, Schedule R, Part V - Transactions With Related Organizations**

<b>(a)</b> Name of related organization		<b>(b)</b> Transaction type(a-s)	<b>(c)</b> Amount Involved	<b>(d)</b> Method of determining amount involved
<b>(1)</b>	INTERCOMMUNITY HEALTH PLANS INC	L	29,787,791	COST
<b>(1)</b>	SAMARITAN ENDOSCOPY CENTER LLC	A	412,773	COST
<b>(2)</b>	SAMARITAN ENDOSCOPY CENTER LLC	S	240,000	COST
<b>(3)</b>	CORVALLIS MEDICAL BUILDINGS LLC	A	49,300	COST
<b>(4)</b>	CORVALLIS MEDICAL BUILDINGS LLC	S	218,000	COST
<b>(5)</b>	CORVALLIS MEDICAL BUILDINGS LLC	K	562,075	COST
<b>(6)</b>	HULL IMAGING LLC	A	46,512	COST
<b>(7)</b>	HULL IMAGING LLC	O	605,478	COST
<b>(8)</b>	HULL IMAGING LLC	S	924,000	COST
<b>(9)</b>	HULL IMAGING LLC	L	460,883	COST
<b>(10)</b>	GOOD SAMARITAN HOSPITAL FOUNDATION	C	1,462,552	COST
<b>(11)</b>	GOOD SAMARITAN HOSPITAL FOUNDATION	O	215,285	COST
<b>(12)</b>	GOOD SAMARITAN HOSPITAL FOUNDATION	R	84,806	COST