

Form 990
Department of the Treasury
Internal Revenue Service

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

OMB No 1545-0047
2018
Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2018, and ending 12-31-2018

- B Check if applicable
Address change
Name change
Initial return
Final return/terminated
Amended return
Application pending

C Name of organization
GOOD SAMARITAN HOSPITAL CORVALLIS
Doing business as
GOOD SAMARITAN REGIONAL MEDICAL CTR
Number and street (or P O box if mail is not delivered to street address) Room/suite
C/O SHS ACCOUNTING PO BOX 3000
City or town, state or province, country, and ZIP or foreign postal code
CORVALLIS, OR 973393000

D Employer identification number
93-0391573
E Telephone number
(541) 768-4773

F Name and address of principal officer
BECKY PAPE
3600 NW SAMARITAN DR
CORVALLIS, OR 97330

H(a) Is this a group return for subordinates?
H(b) Are all subordinates included?
H(c) Group exemption number

I Tax-exempt status
501(c)(3)
Website: WWW.SAMHEALTH.ORG

K Form of organization
Corporation
L Year of formation 1948
M State of legal domicile OR

Part I Summary

1 Briefly describe the organization's mission or most significant activities
TO IMPROVE THE HEALTH AND WELL BEING OF THE COMMUNITY THROUGH ITS MEDICAL AND SURGICAL HOSPITAL

Table with 2 columns: Description, Amount. Rows include: 2 Check this box, 3 Number of voting members, 4 Number of independent voting members, 5 Total number of individuals employed, 6 Total number of volunteers, 7a Total unrelated business revenue, 7b Net unrelated business taxable income.

Table with 3 columns: Description, Prior Year, Current Year. Rows include: 8 Contributions and grants, 9 Program service revenue, 10 Investment income, 11 Other revenue, 12 Total revenue, 13 Grants and similar amounts paid, 14 Benefits paid to or for members, 15 Salaries, other compensation, 16a Professional fundraising fees, 16b Total fundraising expenses, 17 Other expenses, 18 Total expenses, 19 Revenue less expenses.

Table with 3 columns: Description, Beginning of Current Year, End of Year. Rows include: 20 Total assets, 21 Total liabilities, 22 Net assets or fund balances.

Part II Signature Block

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

Sign Here
Signature of officer: *****
Date: 2019-11-08
Type or print name and title: DANIEL SMITH SVP FINANCE/CFO

Paid Preparer Use Only
Print/Type preparer's name, Preparer's signature, Date, Check if self-employed, PTIN, Firm's name, Firm's EIN, Firm's address, Phone no.

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

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 THE MISSION OF SHS IS "BUILDING HEALTHIER COMMUNITIES TOGETHER " THE COLLECTIVE VISION OF THE SHS SYSTEM IS TO SERVE OUR COMMUNITIES WITH PRIDE (PASSION, RESPECT, INTEGRITY, DEDICATION, AND EXCELLENCE) SHS SEEKS TO BE THE FIRST CHOICE OF CONSUMERS IN THE REGION AND TO LEAD COLLABORATIVE EFFORTS AMONG THOSE WHO SHARE SIMILAR GOALS

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No
If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No
If "Yes," describe these changes on Schedule O

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a (Code) (Expenses \$ 411,745,256 including grants of \$) (Revenue \$ 429,777,129)
See Additional Data

4b (Code) (Expenses \$ 287,857 including grants of \$ 287,857) (Revenue \$)
See Additional Data

4c (Code) (Expenses \$ including grants of \$) (Revenue \$)

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

4e Total program service expenses 412,033,113

Part IV Checklist of Required Schedules

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1 through 22 regarding organizational requirements, such as political activities, lobbying, and financial reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 23 through 38 regarding compensation, bond issues, escrow accounts, excess benefit transactions, and controlled entities.

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 []

Table with 3 columns: Question ID, Question Text, Yes, No. Rows include questions 1a, 1b, and 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

<p>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</p>	2a	2,644		
<p>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)</p>			2b	Yes
<p>3a Did the organization have unrelated business gross income of \$1,000 or more during the year?</p>			3a	Yes
<p>b If "Yes," has it filed a Form 990-T for this year?<i>If "No" to line 3b, provide an explanation in Schedule O</i></p>			3b	Yes
<p>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)?</p>			4a	No
<p>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)</p>				
<p>5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?</p>			5a	No
<p>b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?</p>			5b	No
<p>c If "Yes," to line 5a or 5b, did the organization file Form 8886-T?</p>			5c	
<p>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?</p>			6a	No
<p>b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?</p>			6b	
7 Organizations that may receive deductible contributions under section 170(c).				
<p>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?</p>			7a	No
<p>b If "Yes," did the organization notify the donor of the value of the goods or services provided?</p>			7b	
<p>c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?</p>			7c	No
<p>d If "Yes," indicate the number of Forms 8282 filed during the year</p>	7d			
<p>e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?</p>			7e	No
<p>f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?</p>			7f	No
<p>g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?</p>			7g	
<p>h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?</p>			7h	
8 Sponsoring organizations maintaining donor advised funds.				
<p>Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?</p>			8	
<p>9a Did the sponsoring organization make any taxable distributions under section 4966?</p>			9a	
<p>b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?</p>			9b	
10 Section 501(c)(7) organizations. Enter				
<p>a Initiation fees and capital contributions included on Part VIII, line 12</p>	10a			
<p>b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities</p>	10b			
11 Section 501(c)(12) organizations. Enter				
<p>a Gross income from members or shareholders</p>	11a			
<p>b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)</p>	11b			
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?				
<p>b If "Yes," enter the amount of tax-exempt interest received or accrued during the year</p>	12b			
13 Section 501(c)(29) qualified nonprofit health insurance issuers.				
<p>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</p>			13a	
<p>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</p>	13b			
<p>c Enter the amount of reserves on hand</p>	13c			
<p>14a Did the organization receive any payments for indoor tanning services during the tax year?</p>			14a	No
<p>b If "Yes," has it filed a Form 720 to report these payments?<i>If "No," provide an explanation in Schedule O</i></p>			14b	
<p>15 Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N</p>			15	No
<p>16 Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O</p>			16	No

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

- 17** List the States with which a copy of this Form 990 is required to be filed OR
- 18** Section 6104 requires an organization to make its Form 1023 (or 1024-A 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	X		X				0	0	0
(2) JUDY LIST BOARD VICE CHAIR	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	450	0
(6) BISHOP MICHAEL HANLEY BOARD MEMBER	1 00	X						0	0	0
(7) TIM HENNESSY BOARD MEMBER	1 00	X						0	7,075	0
(8) KELLY GALLAGHER BOARD MEMBER	1 00	X						0	0	0
(9) ERIC THOMPSON BOARD MEMBER	1 00	X						0	0	0
(10) STEVE UERLINGS BOARD MEMBER	1 00	X						0	0	0
(11) LYLE HUTCHENS BOARD MEMBER	2 00	X						0	0	0
(12) LINDA FOX MD BOARD MEMBER / PHYSICIAN	1 00	X						0	0	0
(13) KATHARINE HARRIS BOARD MEMBER	40 00	X						396,945	0	38,037
(14) BECKY PAPE CEO	39 00			X				0	436,913	52,426
(15) DANIEL SMITH SVP FINANCE / CFO	2 00			X				0	442,412	94,657
(16) SCOTT WILSON VP ANCILLARY SUPPORT SVCS	38 00				X			212,222	0	29,901
(17) WILLIAM HOWDEN VP NURSING GSRMC	40 00				X			217,903	0	45,636

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) KIMBERLY CLIFT VP OPS(AUG-DEC)/VP REV CYC(JAN-JULY)	17 00 23 00				X			102,594	185,668	30,463
(19) LUIS VELA DO PHYSICIAN	40 00					X		939,016	0	61,303
(20) DONALD PENNINGTON DO PHYSICIAN	40 00					X		801,173	0	59,255
(21) J CHRISTOPHER NOONAN MD PHYSICIAN	40 00					X		786,495	0	59,280
(22) JEFF HSING MD PHYSICIAN	40 00					X		758,720	0	57,168
(23) DANIELA ALEXANDRU-ABRAMS MD PHYSICIAN	40 00					X		721,056	0	59,331
(24) STEVEN JASPERSON FORMER CEO / VP SO CALIFORNIA OPS	0 00 0 00						X	0	610,824	17,992
(25) LARRY MULLINS DHA FORMER CEO / CEO SAM SOLUTIONS INST	0 00 20 00						X	0	1,068,916	52,610
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								4,936,124	2,752,258	658,059

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 502

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

Section B. Independent Contractors

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

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

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 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
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a			
	b Membership dues . . .	1b			
	c Fundraising events . . .	1c			
	d Related organizations	1d	909,077		
	e Government grants (contributions)	1e			
	f All other contributions, gifts, grants, and similar amounts not included above	1f			
	g Noncash contributions included in lines 1a - 1f \$ _____				
	h Total. Add lines 1a-1f		909,077		

Program Service Revenue			Business Code				
	2a NET PATIENT REVENUE		622110	407,825,565	407,825,565		
	b RETAIL PHARMACY		446110	15,111,234	15,111,234		
	c QUALITY INCENTIVES		622110	4,424,100	4,424,100		
	d OTHER PATIENT REVENUE		622110	1,432,807	1,432,807		
	e OTHER PROGRAM SVC REV		900099	523,254	510,034	13,220	
	f All other program service revenue			473,389	473,389		
	g Total. Add lines 2a-2f			429,790,349			

Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			772,612			772,612	
	4 Income from investment of tax-exempt bond proceeds							
	5 Royalties							
	6a Gross rents	(i) Real	(ii) Personal					
			943,918					
		b Less rental expenses		128,196				
		c Rental income or (loss)		815,722				
	d Net rental income or (loss)			815,722			815,722	
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other					
			2,870,193	144,100				
		b Less cost or other basis and sales expenses		2,707,354	3,502			
		c Gain or (loss)		162,839	140,598			
	d Net gain or (loss)			303,437			303,437	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a						
		b Less direct expenses	b					
c Net income or (loss) from fundraising events								
9a Gross income from gaming activities See Part IV, line 19	a							
	b Less direct expenses	b						
	c Net income or (loss) from gaming activities							
10a Gross sales of inventory, less returns and allowances	a		433,103					
	b Less cost of goods sold	b	194,885					
	c Net income or (loss) from sales of inventory			238,218		238,218		
Miscellaneous Revenue		Business Code						
11a CAFETERIA		722210	2,192,393			2,192,393		
b								
c								
d All other revenue								
e Total. Add lines 11a-11d			2,192,393					
12 Total revenue. See Instructions			435,021,808	429,777,129	251,438	4,084,164		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	271,406	271,406		
2 Grants and other assistance to domestic individuals See Part IV, line 22	16,451	16,451		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,053,048	810,926	242,122	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	175,121,171	171,455,609	3,665,562	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	12,613,776	12,351,328	262,448	
9 Other employee benefits	31,474,410	30,819,539	654,871	
10 Payroll taxes	12,168,023	11,914,850	253,173	
11 Fees for services (non-employees)				
a Management				
b Legal	12,001		12,001	
c Accounting	56,235	3,050	53,185	
d Lobbying				
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	14,068,141	13,921,629	146,512	
12 Advertising and promotion	22,325	7,468	14,857	
13 Office expenses	11,665,023	11,192,378	472,645	
14 Information technology	23,295,464	22,540,031	755,433	
15 Royalties				
16 Occupancy	5,543,640	5,370,458	173,182	
17 Travel	555,945	541,850	14,095	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	813,883	807,785	6,098	
20 Interest	4,520,890	4,374,285	146,605	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	9,160,195	9,003,197	156,998	
23 Insurance	6,100,333	5,717,445	382,888	
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	78,840,677	78,840,677		
b PURCHASED SERVICES	46,933,785	11,461,695	35,472,090	
c DUES, TAXES, & LICENSES	20,623,569	20,611,056	12,513	
d				
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	454,930,391	412,033,113	42,897,278	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <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
Assets	1	Cash—non-interest-bearing	9,333	1	9,250
	2	Savings and temporary cash investments	663,772	2	1,032,319
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net	47,721,916	4	46,456,289
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		6	
	7	Notes and loans receivable, net	1,216,963	7	1,027,988
	8	Inventories for sale or use	7,648,449	8	7,571,583
	9	Prepaid expenses and deferred charges	1,819,838	9	2,478,519
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	235,550,830		
	b	Less accumulated depreciation	139,344,858		
	11	Investments—publicly traded securities	20,205,305	11	19,086,798
	12	Investments—other securities See Part IV, line 11	348,723	12	384,020
	13	Investments—program-related See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets See Part IV, line 11	5,440,916	15	5,019,861
16	Total assets. Add lines 1 through 15 (must equal line 34)	180,179,878	16	179,272,599	
Liabilities	17	Accounts payable and accrued expenses	24,298,650	17	27,479,145
	18	Grants payable		18	
	19	Deferred revenue	703,356	19	1,018,946
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	386,005
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D	67,267,679	25	80,891,456
	26	Total liabilities. Add lines 17 through 25	92,269,685	26	109,775,552
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.				
	27	Unrestricted net assets	87,910,193	27	69,497,047
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
33	Total net assets or fund balances	87,910,193	33	69,497,047	
34	Total liabilities and net assets/fund balances	180,179,878	34	179,272,599	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	435,021,808
2	Total expenses (must equal Part IX, column (A), line 25)	2	454,930,391
3	Revenue less expenses Subtract line 2 from line 1	3	-19,908,583
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	87,910,193
5	Net unrealized gains (losses) on investments	5	-1,638,158
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	3,133,595
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	69,497,047

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990 Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- 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

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

Additional Data

Software ID:

Software Version:

EIN: 93-0391573

Name: GOOD SAMARITAN HOSPITAL CORVALLIS

Form 990 (2018)

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, 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 FOUR 'LEVEL 2' TRAUMA CENTERS IN THE STATE. DURING 2018, GSH SERVED 8,182 INPATIENTS, HAD 29,238 EMERGENCY DEPARTMENT VISITS, PERFORMED 10,167 SURGERIES AND DELIVERED 949 BABIES. IN ADDITION, GSH PERFORMED 94,716 IMAGING PROCEDURES, HAD 28,885 HOME HEALTH VISITS, AND HAD 251,247 PHYSICIAN CLINIC VISITS.

Form 990, Part III, Line 4b:

GRANTS AND ASSISTANCE PROVIDED BY GOOD SAMARITAN HOSPITAL CORVALLIS TO VARIOUS ORGANIZATIONS AND INDIVIDUALS TO SUPPORT THE MEDICAL, DENTAL, MENTAL HEALTH AND OTHER NEEDS OF COMMUNITY MEMBERS, CONSISTENT WITH PRIORITIES IDENTIFIED IN THE HOSPITAL'S COMMUNITY HEALTH NEEDS ASSESSMENT SEE PART IX, LINES 1 AND 2 AND RELATED SCHEDULE I FOR MORE DETAILS

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
 Attach to Form 990 or Form 990-EZ.
 Go to www.irs.gov/Form990 for the latest information.

2018

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

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 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)
- 11 An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
 - f Enter the number of supported organizations _____
 - g Provide the following information about the supported organization(s)

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

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

	Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant")						
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	Total. Add lines 1 through 3						
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6	Public support. Subtract line 5 from line 4						

Section B. Total Support

	Calendar year (or fiscal year beginning in) ▶	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
7	Amounts from line 4						
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9	Net income from unrelated business activities, whether or not the business is regularly carried on						
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11	Total support. Add lines 7 through 10						
12	Gross receipts from related activities, etc (see instructions)					12	

13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

Section C. Computation of Public Support Percentage

14	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2017 Schedule A, Part II, line 14	15	

- 16a 33 1/3% support test—2018.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶
- b 33 1/3% support test—2017.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶
- 17a 10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶
- b 10%-facts-and-circumstances test—2017.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization ▶
- 18 Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c	Add lines 7a and 7b						
8	Public support. (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►		(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
9	Amounts from line 6						
10a	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c	Add lines 10a and 10b						
11	Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13	Total support. (Add lines 9, 10c, 11, and 12.)						

14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ►

Section C. Computation of Public Support Percentage

15	Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2017 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for 2018 (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from 2017 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2018. 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—2017. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

		Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?		
a	A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
b	A family member of a person described in (a) above?		
c	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>		

Section B. Type I Supporting Organizations

		Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <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>		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <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>		

Section C. Type II Supporting Organizations

		Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <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>		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a	<input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b	<input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c	<input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2	Activities Test Answer (a) and (b) below.		
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>	Yes	No
b	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>		
3	Parent of Supported Organizations Answer (a) and (b) below.		
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
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>		

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI)		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<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 2018 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-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7			
\$			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2018 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 Excess distributions carryover to 2019. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

Additional Data

Software ID:

Software Version:

EIN: 93-0391573

Name: GOOD SAMARITAN HOSPITAL CORVALLIS

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

Facts And Circumstances Test

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No 1545-0047
2018
Open to Public Inspection

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)

Preservation of land for public use (e.g., recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

	Held at the End of the Year	
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

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

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

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

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

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

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

b Assets included in Form 990, Part X ▶ \$ _____

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange programs
 - e** Other
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII
- 5** During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- | | Amount |
|--|--------|
| c Beginning balance | |
| d Additions during the year | |
| e Distributions during the year | |
| f Ending balance | |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . Yes No
- b** If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	5,044,051	4,478,316	4,237,438	4,497,010	4,427,981
b Contributions	123,741	31,737	66,044	132,523	47,952
c Net investment earnings, gains, and losses	-318,594	699,206	348,421	-174,642	161,199
d Grants or scholarships	139,384	165,208	173,587	217,453	140,122
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	4,709,814	5,044,051	4,478,316	4,237,438	4,497,010

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶ 24 370 %
 - b** Permanent endowment ▶ 75 630 %
 - 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
- | | Yes | No |
|--|-----|----|
| (i) unrelated organizations | | No |
| (ii) related organizations | Yes | |
| b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? | 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	1,700,000	358,114		2,058,114
b Buildings	1,631,572	153,293,160	81,578,149	73,346,583
c Leasehold improvements		3,029,561	1,165,723	1,863,838
d Equipment		65,029,719	50,738,315	14,291,404
e Other		10,508,704	5,862,671	4,646,033
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				96,205,972

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	3,421,000
OTHER LIABILITIES	1,496,980
PAYABLE TO CONTRACTUAL AGENCIES	4,050,458
MINIMUM PENSION LIABILITY	24,946,782
ACCRUED INTEREST	1,226,995
ACCOUNTS PAYABLE-AFFILIATES	45,749,241
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25.)	80,891,456

2. Liability for uncertain tax positions In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740) Check here if the text of the footnote has been provided in Part XIII

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 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 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 ENDOWMENT IS USED TO HOST VISITING PHYSICIAN EDUCATORS, WITH AN EMPHASIS ON MEDICAL ETHICS AND END OF LIFE DECISIONS THE CARDIOLOGY ENDOWMENT IS FOR SUPPORT AND ADVANCEMENT OF CARDIOVASCULAR CARE INCLUDING EDUCATION, EQUIPMENT AND FACILITIES THE BETH RAY ENDOWMENT IS FOR PEDIATRIC AND OB PATIENT SUPPORT SERVICES AND PATIENT CARE PROGRAMS THESE INCLUDE THERAPEUTIC DEVICES, NEW TECHNOLOGY AND EQUIPMENT FOR SHS DEPARTMENTS THAT SUPPORT PEDIATRIC AND OB CARE

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, 2018, 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 2015</p>

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service

Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Go to www.irs.gov/Form990EZ for instructions and the latest information.**

Name of the organization
 GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
 93-0391573

OMB No 1545-0047
2018
 Open to Public Inspection

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 <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>22500 0000000000</u> %	3a	Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	3b	Yes	
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)	17	20,868	5,356,279		5,356,279	1 180 %
b Medicaid (from Worksheet 3, column a)	12	91,115	82,707,064	60,038,474	22,668,590	4 980 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	29	111,983	88,063,343	60,038,474	28,024,869	6 160 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	11	20,657	1,045,328	58,435	986,893	0 220 %
f Health professions education (from Worksheet 5)	4	5,068	16,054,647	9,270,562	6,784,085	1 490 %
g Subsidized health services (from Worksheet 6)	26	140,970	60,166,301	35,535,326	24,630,975	5 410 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	8	44,167	565,215		565,215	0 120 %
j Total. Other Benefits	49	210,862	77,831,491	44,864,323	32,967,168	7 240 %
k Total. Add lines 7d and 7j	78	322,845	165,894,834	104,902,797	60,992,037	13 400 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support	1	614	9,072		9,072	0 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development	1	8	58,870		58,870	0 010 %
9 Other						
10 Total	2	622	67,942		67,942	0 010 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15?		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		
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		
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	68,322,338
6 Enter Medicare allowable costs of care relating to payments on line 5	6	73,444,869
7 Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-5,122,531
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		
<input type="checkbox"/> Cost accounting system	<input checked="" type="checkbox"/> Cost to charge ratio	<input type="checkbox"/> Other

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1 CORVALLIS MED BLDGS LLC	REAL PROPERTY RENTAL	54 500 %		21 500 %
2 HULL IMAGING LLC	IMAGING SERVICES	60 000 %		40 000 %
3 SAMARITAN ENDOSCOPY CENTER	MEDICAL SERVICES	66 670 %		33 330 %
4 CORVALLIS MRI LLC	IMAGING SERVICES	50 000 %		50 000 %
5 CASCADE VIEW MEDICAL OFFICE BUILDING LLC	REAL PROPERTY RENTAL	26 300 %		73 700 %
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information**Section A. Hospital Facilities**

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

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

1

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

See Additional Data Table	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

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

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA <u>20 16</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		No
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	Yes	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	Yes	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW SAMHEALTH ORG/COMMUNITYSUPPORT</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input checked="" type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10	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>	Yes	
a			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)**Financial Assistance Policy (FAP)**

GOOD SAMARITAN HOSPITAL CORVALLIS

Name of hospital facility or letter of facility reporting group _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>225 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>300 000000000000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input checked="" type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW SAMHEALTH ORG/FINANCIALASSISTANCE</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW SAMHEALTH ORG/FINANCIALASSISTANCE</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW SAMHEALTH ORG/FINANCIALASSISTANCE</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)**Billing and Collections**

GOOD SAMARITAN HOSPITAL CORVALLIS

Name of hospital facility or letter of facility reporting group _____

		Yes	No	
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	Yes	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP			
a	<input type="checkbox"/> Reporting to credit agency(ies)			
b	<input type="checkbox"/> Selling an individual's debt to another party			
c	<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			
d	<input type="checkbox"/> Actions that require a legal or judicial process			
e	<input type="checkbox"/> Other similar actions (describe in Section C)			
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted			
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged	19		No
a	<input type="checkbox"/> Reporting to credit agency(ies)			
b	<input type="checkbox"/> Selling an individual's debt to another party			
c	<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			
d	<input type="checkbox"/> Actions that require a legal or judicial process			
e	<input type="checkbox"/> Other similar actions (describe in Section C)			
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)			
a	<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	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process			
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications			
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations			
e	<input type="checkbox"/> Other (describe in Section C)			
f	<input type="checkbox"/> None of these efforts were made			

Policy Relating to Emergency Medical Care

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

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? 44

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

Part VI Supplemental Information

Provide the following information

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

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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
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 COST-TO-CHARGE RATIO IS ALSO USED, BUT IT IS CALCULATED AT THE DEPARTMENT OR SERVICE LINE LEVEL FOR THOSE SERVICES THAT QUALIFY AS SUBSIDIZED HEALTH SERVICES

990 Schedule H, Supplemental Information

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 2018 IS 15,742,760
PART II, COMMUNITY BUILDING ACTIVITIES	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 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 SERVE 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

990 Schedule H, Supplemental Information

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
PART III, LINE 4	GOOD SAMARITAN HOSPITAL, CORVALLIS (GSH) IS ONE OF FIVE HOSPITALS OF SAMARITAN HEALTH SERVICES (SHS) AS A NETWORK, SHS PREPARES ITS FINANCIAL STATEMENTS ON A CONSOLIDATED BASIS AS OF JANUARY 1, 2018, SHS IMPLEMENTED THE NEW REVENUE RECOGNITION STANDARD (ASU NO 2014-09) ISSUED BY THE FINANCIAL ACCOUNTING STANDARDS BOARD (FASB) UNDER THIS NEW STANDARD, RATHER THAN REPORTING A BAD DEBT ALLOWANCE FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDE PATIENTS WITHOUT INSURANCE), BEGINNING IN 2018, SHS RECORDS AN IMPLICIT PRICE CONCESSION IN THE PERIOD OF SERVICE ON THE BASIS OF ITS PAST EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE (SEE FOOTNOTE 3, "NET PATIENT SERVICE REVENUE" ON PAGES 14 AND 15 OF THE 2018 CONSOLIDATED FINANCIAL STATEMENTS) WITH THIS CHANGE, PATIENT SERVICE REVENUE CONTINUES TO BE REPORTED NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS AT THE ESTIMATED NET REALIZABLE AMOUNT FROM PATIENTS, THIRD-PARTY PAYORS, AND OTHERS FOR SERVICES RENDERED

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	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 NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS) 123,064,806 MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO) 152,722,662 UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS -29,657,856
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

990 Schedule H, Supplemental Information

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>
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, FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY, AND APPLICATION</p>

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Form and Line Reference	Explanation
PART VI, LINE 4	<p>GSH PRIMARILY SERVES 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 ACCORDING TO THE US CENSUS 2018 POPULATION ESTIMATES, BENTON COUNTY HAS A POPULATION OF 92,101 RESIDENTS OF WHICH APPROXIMATELY 22,000 ARE STUDENTS AT OREGON STATE UNIVERSITY 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 CHART BELOW SUMMARIZES THE RACIAL & ETHNIC DEMOGRAPHICS OF BENTON COUNTY RACE/ETHNICITY POPULATIONWHITE/CAUCASIAN 86 5%BLACK/AFRICAN AMERICAN 1 2% AMERICAN INDIAN/ALASKA NATIVE 0 8%ASIAN 7 1%HISPANIC 7 3%NATIVE HAWAIIAN/PACIFIC ISLANDER 0 3%REPORTING TWO OR MORE RACES 4 1%SOURCE U S CENSUS BUREAU, 2018 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 \$54,682UNEMPLOYMENT 4 3%POVERTY 16 0%ADEQUATE PRENATAL CARE 81 7% IMMUNIZATIONS 65 0%UNINSURED CHILDREN 3 3%CHILD ABUSE 8 8/1000CHILDREN ON FREE AND REDUCED LUNCH 37 1%HOMELESS STUDENTS 4 3%TEEN PREGNANCY 5 6/1000HIGH SCHOOL GRADUATION RATES 84 8%JUVENILE JUSTICE REFERRALS 10 7/1000SOURCE OREGON EMPLOYMENT DEPARTMENT DECEMBER 2018, OREGON DEPARTMENT OF EDUCATION, U S CENSUS BUREAU, 2018 CENSUS QUICK FACTS, PUBLIC LAW 94-171 SUMMARY FILE, 2018 CHILD WELL-BEING IN OREGON COUNTY DATA BOOK</p>
PART VI, LINE 5	<p>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</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	<p>"BUILDING HEALTHIER COMMUNITIES TOGETHER" IS THE MISSION OF 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, THEY WERE DRAWN BY A SHARED DESIRE "TO ENHANCE COMMUNITY HEALTH AND ACHIEVE HIGH VALUE THROUGH QUALITY SERVICES ACROSS THE CONTINUUM OF CARE " WITH THE MISSION OF "BUILDING HEALTHIER COMMUNITIES TOGETHER," 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 SERVE OUR COMMUNITIES WITH PRIDE (PASSION, RESPECT, INTEGRITY, DEDICATION, AND EXCELLENCE) SHS IS 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>
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? <u>1</u>											
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	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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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
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

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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
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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1 1 - SAMARITAN MENTAL HEALTH - ALBANY 1052 SW 29TH ST ALBANY, OR 97321	MENTAL HEALTH SERVICES
1 2 - SAMARITAN OCC MED - ALBANY 1100 7TH AVE SW 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 INSTITUTE 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 MED RESIDENT CLINIC 3517 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 8 - SAMARITAN INTERNAL MEDICINE - CORVALLIS 3521 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 9 - SAMARITAN PHY REHAB SPEC - CORVALLIS 815 NW 9TH ST STE 180 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
9 10 - NEVILLE BUILDING IMAGING 3615 NW SAMARITAN DR CORVALLIS, OR 97330	IMAGING SERVICES
10 11 - SAMARITAN ENDOCRINOLOGY 3615 NW SAMARITAN DR STE G2 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 12 - SAMARITAN DIABETES EDUCATION 3615 NW SAMARITAN DR STE G1 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
12 13 - CORVALLIS MRI 3615 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330	IMAGING SERVICES
13 14 - SAMARITAN SURGICAL SPECIALISTS 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
14 15 - SAMARITAN KIDNEY SPECIALISTS 3615 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
16 16 - SAMARITAN NEUROSURGERY 3615 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
1 17 - OUTPATIENT SURGERY 3620 NW SAMARITAN DR CORVALLIS, OR 97330	AMBULATORY SURGERY
2 18 - SAMARITAN ORTHOPEDICS - LUIS VELA DO 3620 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 19 - SAMARITAN ORTHOPEDICS & SPORTS MED CTR 3620 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
4 20 - SAMARITAN RHEUMATOLOGY 3620 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
5 21 - SAMARITAN NEUROMUSCULAR MED RESIDENT CL 3620 NW SAMARITAN DR STE 203A CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
6 22 - SAMARITAN INFECTIOUS DISEASE 3640 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 23 - SAMARITAN OBSTETRICS & GYN 3640 NW SAMARITAN DR STE 220 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 24 - SAMARITAN GYN & SURGICAL ASSOCIATES 400 NW WALNUT BLVD STE 300 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
9 25 - SAMARITAN PASTEGA REGIONAL CANCER CTR 441 NW ELKS DR CORVALLIS, OR 97330	CANCER TREATMENT
10 26 - SAMARITAN HEMATOLOGY & ONCOLOGY 441 NW ELKS DR SUITE 100 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 27 - SAMARITAN CANCER RES CTR - CORVALLIS 501 NW ELKS DR CORVALLIS, OR 97330	CANCER RESOURCE CENTER
12 28 - SAMARITAN URGENT CARE - CORVALLIS 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
13 29 - SAMARITAN FAMILY MEDICINE SOUTHWEST 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
14 30 - SAMARITAN OCC MED - CORVALLIS 5234 SW PHILOMATH BLVD STE B CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT

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

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

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
31 31 - SAMARITAN PEDIATRICS 777 NW 9TH ST STE 320 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
1 32 - SAMARITAN ATHLETIC MEDICINE CENTER 845 SW 30TH ST CORVALLIS, OR 97331	MEDICAL CLINIC - OUTPATIENT
2 33 - SAM CARE EXPRESS - CORVALLIS 990 NW CIRCLE BLVD STE 101 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 34 - SAMARITAN UROLOGY 990 NW CIRCLE BLVD STE 102 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
4 35 - SAMARITAN PLASTIC RECONST & HAND SURG 996 NW CIRCLE BLVD STE 103 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
5 36 - SAMARITAN OCC MED - LEBANON 100 MULLINS DRIVE STE B2 LEBANON, OR 97355	MEDICAL CLINIC - OUTPATIENT
6 37 - NEVILLE BUILDING LABORATORY 3615 NW SAMARITAN DR STE 102 CORVALLIS, OR 97330	LABORATORY SERVICES
7 38 - SAMARITAN PEDIATRICS - CIRCLE BLVD 1112 NW CIRCLE BLVD CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 39 - SAMARITAN MENTAL HEALTH - CIRCLE BLVD 1112 NW CIRCLE BLVD CORVALLIS, OR 97330	MENTAL HEALTH SERVICES
9 40 - SAMCARE MOBILE MEDICINE 2555 NE BELVUE ST CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 41 - SAMARITAN FAMILY MEDICINE 3517 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 42 - SAMARITAN OB & GYN RESIDENT CLINIC 3517 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
12 43 - SAMARITAN CARDIOLOGY - CORVALLIS 3640 NW SAMARITAN DR STE 100A CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
13 44 - SAMARITAN CARDIOVASCULAR SURGERY 3640 NW SAMARITAN DR STE 100B CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I (Form 990)

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

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

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...
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

Table with 8 columns: (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 noncash assistance, (h) Purpose of grant or assistance. Rows 1-12.

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table. 14
3 Enter total number of other organizations listed in the line 1 table.

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
(1) PATIENT TRANSPORTATION	378	15,066			
(2) MEALS	122		1,187	BOOK	MEALS FOR FAMILY MEMBERS OF PATIENTS
(3) SHELTER	1	197			
(3)					
(4)					
(5)					
(6)					
(7)					

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

Return Reference	Explanation
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)	115,596				MEDICAL, DENTAL, MENTAL HEALTH CLINICS
ALBANY HELPING HANDS PO BOX 2252 ALBANY, OR 97321	93-1244271	501(C)(3)	9,600				SUPPORT FOR HOMELESS PEOPLE

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
CENTER AGAINST RAPE & DOMESTIC VIOLENCE PO BOX 914 CORVALLIS, OR 97339	93-0792125	501(C)(3)	13,334				PROVIDED FUNDING TO SUPPORT THE EMERGENCY SHELTER PROGRAM
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	10,668				FUNDING FOR PEOPLE ENTERING THE DRUG COURT 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
CASA LATINOS UNIDOS DE BENTON COUNTY 128 SW 9TH ST CORVALLIS, OR 97333	26-3639798	501(C)(3)	10,668				FUNDING FOR AN AFTER SCHOOL PROGRAM TO HELP SPANISH SPEAKING STUDENTS WITH MATH AND WRITING
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	18,634				FUNDING TO SUPPORT THE BENTON COUNTY ORAL HEALTH COALITION ADULT EMERGENCY VOUCHER DENTAL 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
JACKSON STREET YOUTH SHELTER INC PO BOX 285 CORVALLIS, OR 97339	93-1269503	501(C)(3)	13,334				FUNDING FOR TRANSITIONAL HOUSING TO HOMELESS YOUTH
OLD MILL CENTER FOR CHILDREN AND FAMILIES INC 1650 SW 45TH PLACE CORVALLIS, OR 97333	93-0722603	501(C)(3)	6,668				PARENT/CAREGIVER SUPPORT, EDUCATION, OUTREACH, AND RESPITE SERVICES

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
GRACE CENTER FOR ADULT DAY SERVICES 980 NW SPRUCE AVE CORVALLIS, OR 97330	93-0839745	501(C)(3)	8,000				FINANCIAL ASSISTANCE PROGRAM
ABC HOUSE INC PO BOX 68 ALBANY, OR 97321	93-1163555	501(C)(3)	7,500				FUNDING FOR A MEDICAL DIRECTOR POSITION

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 ENVIRONMENTAL CENTER 116 SW 4TH STREET CORVALLIS, OR 97333	93-1140056	501(C)(3)	7,334				FUNDING FOR THE CORVALLIS FARM TO SCHOOL FOOD PROGRAM
STRENGTHENING RURAL FAMILIES PO BOX 1528 PHILOMATH, OR 97370	20-2934930	501(C)(3)	7,334				FUNDING FOR DENTAL VANS IN RURAL BENTON COUNTY

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
VINA MOSES WELFARE CENTER INC 968 NW GARFIELD AVE CORVALLIS, OR 97330	93-0615775	501(C)(3)	10,000				FUNDING TO SUPPORT RENTAL AND UTILITY ASSISTANCE TO FAMILIES IN BENTON COUNTY
CORVALLIS NEIGHBORHOOD HOUSING SERVICES INC 257 SW MADISON AVE STE 113 CORVALLIS, OR 97333	93-1057296	501(C)(3)	7,334				FUNDING FOR A HEALTHY AND ACTIVE YOUTH 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
OREGON CASCADES WEST SENIOR SERVICES FOUNDATION 1400 QUEEN AVE STE 206 ALBANY, OR 97322	93-1213218	501(C)(3)	6,668				FUNDING FOR A MEALS ON WHEELS PROGRAM

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
▶ **Attach to Form 990.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

Part I Questions Regarding Compensation

		Yes	No								
<p>1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> First-class or charter travel</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Travel for companions</td> <td style="border: none;"><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td style="border: none;"><input checked="" type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Discretionary spending account</td> <td style="border: none;"><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input checked="" type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)			
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use										
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence										
<input type="checkbox"/> Tax indemnification and gross-up payments	<input checked="" type="checkbox"/> Health or social club dues or initiation fees										
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)										
<p>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</p>	1b	Yes									
<p>2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p>	2	Yes									
<p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Compensation committee</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Independent compensation consultant</td> <td style="border: none;"><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Form 990 of other organizations</td> <td style="border: none;"><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee					
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract										
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study										
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee										
<p>4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization</p>											
<p>a Receive a severance payment or change-of-control payment?</p>	4a	Yes									
<p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p>	4b	Yes									
<p>c Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</p>	4c		No								
<p>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</p>											
<p>5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of</p>											
<p>a The organization?</p>	5a	Yes									
<p>b Any related organization? If "Yes," on line 5a or 5b, describe in Part III</p>	5b		No								
<p>6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of</p>											
<p>a The organization?</p>	6a		No								
<p>b Any related organization? If "Yes," on line 6a or 6b, describe in Part III</p>	6b		No								
<p>7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III</p>	7		No								
<p>8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III</p>	8		No								
<p>9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	9										

Part III Supplemental Information

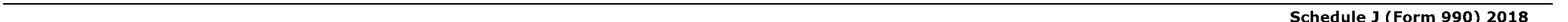
Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

Return Reference	Explanation
PART I, LINE 1A	<p>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. ONE OFFICER, ONE KEY EMPLOYEE, AND ONE HIGHEST PAID EMPLOYEE RECEIVED THIS TAXABLE GYM BENEFIT IN 2018. IF AN EMPLOYEE PARTICIPATES AT A SAMARITAN FITNESS CENTER (SAMFIT), MEMBERSHIP IS FREE OF CHARGE (PROVIDED AS A NONTAXABLE FRINGE BENEFIT). TWO HIGHEST PAID EMPLOYEES RECEIVED THE SAMFIT BENEFIT DURING 2018.</p>

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

Return Reference	Explanation
PART I, LINES 4A-B	4 A STEVE JASPERSON, A FORMER OFFICER, RECEIVED TAXABLE COMPENSATION OF 408,013 PURSUANT TO THE TERMINATION OF HIS EMPLOYMENT CONTRACT 4 B THE ORGANIZATION MAINTAINS SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS UNDER HIS PLAN, DANIEL SMITH ACCRUED DEFERRED COMPENSATION BENEFITS DURING 2018 LARRY MULLINS, DHA RECEIVED A PAYMENT FROM HIS PLAN DURING 2018 THIS PAYMENT WAS INCLUDED IN DR MULLIN'S 2018 COMPENSATION ON SCHEDULE J AND FORM 990

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



Schedule J (Form 990) 2018

Additional Data

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

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				
LINDA FOX MD BOARD MEMBER / PHYSICIAN	(i)	395,152	0	1,793	22,364	15,673	434,982	0
	(ii)	0	0	0	0	0	0	0
BECKY PAPE CEO	(i)	0	0	0	0	0	0	0
	(ii)	382,885	0	54,028	22,364	30,062	489,339	0
DANIEL SMITH SVP FINANCE / CFO	(i)	0	0	0	0	0	0	0
	(ii)	402,303	0	40,109	57,589	37,068	537,069	0
SCOTT WILSON VP ANCILLARY SUPPORT SVCS	(i)	195,515	6,709	9,998	16,071	13,830	242,123	0
	(ii)	0	0	0	0	0	0	0
WILLIAM HOWDEN VP NURSING GSRMC	(i)	202,456	10,094	5,353	16,724	28,912	263,539	0
	(ii)	0	0	0	0	0	0	0
KIMBERLY CLIFT VP OPS(AUG-DEC)/VP REV CYC(JAN-JULY)	(i)	102,221	0	373	7,001	2,810	112,405	0
	(ii)	171,815	13,437	416	15,363	5,289	206,320	0
LUIS VELA DO PHYSICIAN	(i)	926,310	10,384	2,322	22,364	38,939	1,000,319	0
	(ii)	0	0	0	0	0	0	0
DONALD PENNINGTON DO PHYSICIAN	(i)	750,644	36,687	13,842	22,364	36,891	860,428	0
	(ii)	0	0	0	0	0	0	0
J CHRISTOPHER NOONAN MD PHYSICIAN	(i)	762,931	20,000	3,564	22,364	36,916	845,775	0
	(ii)	0	0	0	0	0	0	0
JEFF HSING MD PHYSICIAN	(i)	544,791	212,744	1,185	22,364	34,804	815,888	0
	(ii)	0	0	0	0	0	0	0
DANIELA ALEXANDRU- ABRAMS MD PHYSICIAN	(i)	694,125	0	26,931	22,364	36,967	780,387	0
	(ii)	0	0	0	0	0	0	0
STEVEN JASPERSON FORMER CEO / VP SO CALIFORNIA OPS	(i)	0	0	0	0	0	0	0
	(ii)	24,913	0	585,911	14,898	3,094	628,816	0
LARRY MULLINS DHA FORMER CEO / CEO SAM SOLUTIONS INST	(i)	0	0	0	0	0	0	0
	(ii)	454,492	0	614,424	22,364	30,246	1,121,526	250,500

SCHEDULE O
(Form 990 or 990-EZ)**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.

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

2018
Open to Public Inspection

Department of the Treasury

Name of the organization

GOOD SAMARITAN HOSPITAL CORVALLIS

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 4	SECTION 4.1 (PRINCIPAL OFFICERS) OF THE FILING ORGANIZATION'S BYLAWS WERE UPDATED AS FOLLOWS IN 2018. SAMARITAN HEALTH SERVICES (SHS), THE FILING ORGANIZATION'S SOLE MEMBER, APPOINTS THE FILING ORGANIZATION'S PRESIDENT/CEO, WHO IS RESPONSIBLE TO APPOINT ALL OTHER ADMINISTRATIVE OFFICERS. PREVIOUSLY, THIS POWER RESTED WITH THE FILING ORGANIZATION'S BOARD OF DIRECTORS.

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 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 KIOSKS AND HIGH-TRAFFIC AREAS OF THE 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 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 -1,095,650 INCREASE IN MINIMUM PENSION LIABILITY 4,106,523 OTHER CHANGES 122,722

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2018

**Open to Public
Inspection**

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

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
(1) SAMARITAN HEALTH PLANS INC 3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 93-0860860	HEALTH INSURANCE CARRIER FOR THE COMMUNITY	OR	N/A	C					No
(2) BOULDER FALLS PROPERTIES LLC PO BOX 3000 CORVALLIS, OR 973393000 46-5293120	EVENT CENTER & HOSPITALITY SVCS	OR	N/A	C					No
(3) 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

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

Part VII **Supplemental Information**

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

Return Reference	Explanation

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
PO BOX 3000 CORVALLIS, OR 973393000 93-0110095	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
1046 SIXTH AVENUE SW ALBANY, OR 97321 93-0712890	TO SUPPORT ALBANY GENERAL HOSPITAL	OR	501(C)(3)	7	ALBANY GENERAL HOSPITAL		No
PO BOX 3000 CORVALLIS, OR 973393000 93-0900124	HEALTH SERVICES FOR LOW-INCOME PATIENTS	OR	501(C)(3)	7	SAMARITAN HEALTH SERVICES		No
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
3600 NW SAMARITAN DRIVE CORVALLIS, OR 973393000 93-6024034	TO SUPPORT GOOD SAMARITAN HOSPITAL	OR	501(C)(3)	10	N/A		No
PO BOX 1068 CORVALLIS, OR 97339 23-7252406	TO SUPPORT GOOD SAMARITAN HOSPITAL	OR	501(C)(3)	7	GOOD SAMARITAN HOSPITAL	Yes	
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
PO BOX 739 LEBANON, OR 97355 93-1260080	TO SUPPORT LEBANON COMMUNITY HOSPITAL	OR	501(C)(3)	7	MID-VALLEY HEALTHCARE INC		No
PO BOX 3000 CORVALLIS, OR 973393000 93-0396847	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
PO BOX 3000 CORVALLIS, OR 973393000 73-1668317	PURE NON-PROFIT CAPTIVE INSURANCE COMPANY	HI	501(C)(3)	12A, I	SAMARITAN HEALTH SERVICES		No
PO BOX 3000 CORVALLIS, OR 973393000 93-0951989	PROVIDE HEALTHCARE SUPPORT SERVICES	OR	501(C)(3)	12C, III-FI	N/A		No
3043 NE 28TH STREET LINCOLN CITY, OR 97367 93-1305493	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
930 SW ABBEY STREET NEWPORT, OR 97365 93-1329784	HOSPITAL SERVICES FOR THE COMMUNITY	OR	501(C)(3)	3	SAMARITAN HEALTH SERVICES		No
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
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 V - Transactions With Related Organizations

	(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
(1)	INTERCOMMUNITY HEALTH PLANS INC	L	30,349,555	COST
(1)	SAMARITAN ENDOSCOPY CENTER LLC	A	448,106	COST
(2)	SAMARITAN ENDOSCOPY CENTER LLC	S	126,000	COST
(3)	CORVALLIS MEDICAL BUILDINGS LLC	A	51,239	COST
(4)	CORVALLIS MEDICAL BUILDINGS LLC	S	234,350	COST
(5)	CORVALLIS MEDICAL BUILDINGS LLC	K	591,032	COST
(6)	HULL IMAGING LLC	A	48,391	COST
(7)	HULL IMAGING LLC	O	770,769	COST
(8)	HULL IMAGING LLC	S	759,000	COST
(9)	HULL IMAGING LLC	L	483,231	COST
(10)	GOOD SAMARITAN HOSPITAL FOUNDATION	C	882,575	COST
(11)	GOOD SAMARITAN HOSPITAL FOUNDATION	O	289,058	COST
(12)	GOOD SAMARITAN HOSPITAL FOUNDATION	R	61,966	COST