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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2019

Open to Public Inspection

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.

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

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
CO SHS ACCOUNTING PO BOX 3000

City or town, state or province, country, and ZIP or foreign postal code
CORVALLIS, OR 973393000

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?
☐ Yes ☒ No

H(b) Are all subordinates included?
☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

D Employer identification number
93-0391573

E Telephone number
(541) 768-4857

G Gross receipts \$ 456,950,716

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.SAMHEALTH.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

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.

2 Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3 Number of voting members of the governing body (Part VI, line 1a)

4 Number of independent voting members of the governing body (Part VI, line 1b)

5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)

6 Total number of volunteers (estimate if necessary)

7a Total unrelated business revenue from Part VIII, column (C), line 12

b Net unrelated business taxable income from Form 990-T, line 39

Revenue

8 Contributions and grants (Part VIII, line 1h)

9 Program service revenue (Part VIII, line 2g)

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

14 Benefits paid to or for members (Part IX, column (A), line 4)

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

16a Professional fundraising fees (Part IX, column (A), line 11e)

b Total fundraising expenses (Part IX, column (D), line 25) ▶0

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)

19 Revenue less expenses. Subtract line 18 from line 12

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

22 Net assets or fund balances. Subtract line 21 from line 20

Prior Year

Current Year

Beginning of Current Year

End of Year

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

DANIEL SMITH SVP / CFO
Type or print name and title

2020-10-31
Date

PTIN
P00366587

Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

Firm's name ▶ ALDRICH CPAS AND BUSINESS ADVISORS LLP

Firm's address ▶ 5665 SW MEADOWS RD SUITE 200
LAKE OSWEGO, OR 97035

Firm's EIN ▶ 93-0623286

Phone no. (503) 620-4489

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2019)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

GOOD SAMARITAN HOSPITAL, CORVALLIS (GSH) ACHIEVES ITS MISSION OF IMPROVING THE HEALTH AND WELL BEING OF THE COMMUNITY THROUGH ITS MEDICAL AND SURGICAL HOSPITAL AND HEALTHCARE CLINICS PROVIDING OUTPATIENT CARE SERVICES AT SEVERAL AREA LOCATIONS. GSH IS A MEMBER OF SAMARITAN HEALTH SERVICES (SHS), A REGIONAL NETWORK OF HOSPITALS, PHYSICIANS AND SENIOR CARE FACILITIES. THE NETWORK, FORMED IN THE LATE 1990'S, SERVES APPROXIMATELY 290,000 RESIDENTS IN LINN, BENTON, LINCOLN AND PORTIONS OF POLK AND MARION COUNTIES IN OREGON. IT IS LOCALLY OWNED, AND ITS BOARDS OF DIRECTORS INCLUDE HOSPITAL LEADERS, PHYSICIANS AND COMMUNITY REPRESENTATIVES. 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 ☒ No
If "Yes," describe these new services on Schedule O.

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

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

4a	(Code:) (Expenses \$ 418,682,829 including grants of \$) (Revenue \$ 451,538,639)
See Additional Data	


















4b	(Code:) (Expenses \$ 279,494 including grants of \$ 279,494) (Revenue \$)
See Additional Data	

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

4e	Total program service expenses ▶ 418,962,323
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Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a 0	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b 0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	

Part V **Statements Regarding Other IRS Filings and Tax Compliance** *(continued)*

Form **990** (2019)

Part VI

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

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

Section A. Governing Body and Management

		Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a 13		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.			
b Enter the number of voting members included in line 1a, above, who are independent	1b 11		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		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?	3		No
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6 Did the organization have members or stockholders?	6	Yes	
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes	
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a The governing body?	8a	Yes	
b Each committee with authority to act on behalf of the governing body?	8b	Yes	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9		No

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

	Yes	No
10a Did the organization have local chapters, branches, or affiliates?	10a	No
b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes
b Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
12a Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	12c	Yes
13 Did the organization have a written whistleblower policy?	13	Yes
14 Did the organization have a written document retention and destruction policy?	14	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?		
a The organization's CEO, Executive Director, or top management official	15a	Yes
b Other officers or key employees of the organization	15b	Yes
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	Yes
b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	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) 768-4857

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.

See instructions for the order in which to list the persons above.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(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 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 1.00	X		X				0	0	0
(5) CLIFFORD HALL MD BOARD MEMBER	1.00	X						0	0	0
(6) BISHOP MICHAEL HANLEY BOARD MEMBER	1.00	X						0	0	0
(7) TIM HENNESSY BOARD MEMBER	1.00	X						0	5,789	0
(8) KELLY GALLAGHER BOARD MEMBER	1.00 1.00	X						0	0	0
(9) ERIC THOMPSON BOARD MEMBER	1.00	X						0	0	0
(10) STEVE UERLINGS BOARD MEMBER	1.00 2.00	X						0	0	0
(11) LYLE HUTCHENS BOARD MEMBER	1.00	X						0	0	0
(12) MARY OCHADLIK MD BOARD MEMBER	1.00	X						0	4,500	0
(13) KATHARINE HARRIS BOARD MEMBER	1.00	X						0	0	0
(14) DANIEL SMITH SVP / CFO	2.00 38.00			X				0	555,745	73,969
(15) BECKY PAPE CEO	39.00 1.00			X				0	426,168	52,407
(16) KIMBERLY CLIFT VP OPERATIONS	40.00				X			283,942	0	30,816
(17) TIMOTHY EIXENBERGER VP PATIENT CARE SERVICES	40.00				X			193,648	0	16,414

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) WILLIAM HOWDEN VP NURSING / NURSE EDUCATOR	40.00				X			180,523	0	35,563
(19) SCOTT WILSON VP FINANCIAL STRATEGY / SUP SVCS	40.00				X			171,513	0	26,422
(20) JEFF HSING MD PHYSICIAN	40.00					X		806,557	0	57,546
(21) DONALD PENNINGTON DO PHYSICIAN	40.00					X		797,241	0	61,141
(22) J CHRISTOPHER NOONAN MD PHYSICIAN	40.00					X		771,449	0	59,135
(23) LUIS VELA DO PHYSICIAN	40.00					X		760,155	0	61,172
(24) LAYRON LONG MD PHYSICIAN	40.00					X		733,510	0	46,906
(25) LARRY MULLINS DHA FORMER CEO / CEO SAM SOLUTIONS	0.00 20.00						X	0	536,967	52,546

1b Sub-Total			
c Total from continuation sheets to Part VII, Section A			
d Total (add lines 1b and 1c)	4,698,538	1,529,169	574,037

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 ▶ 479		
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>	Yes	No
	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>	Yes	
	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>		No
	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		

Form 990 (2019)		Page 9			
Part VIII		Statement of Revenue			
Check if Schedule O contains a response or note to any line in this Part VIII <input type="checkbox"/>					
		(A)	(B)	(C)	(D)
		Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . .	1a			
	b Membership dues . .	1b			
	c Fundraising events . .	1c			
	d Related organizations	1d	857,502		
	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:\$	1g			
	h Total. Add lines 1a-1f ▶		857,502		
Program Service Revenue	Business Code				
	2a NET PATIENT REVENUE	622110	420,347,572	420,347,572	
	b RETAIL PHARMACY	446110	27,115,384	27,115,384	
	c QUALITY INCENTIVES	622110	1,721,805	1,721,805	
	d OTHER PROGRAM SVC REV	900099	1,040,411	1,026,889	13,522
	e OTHER PATIENT REVENUE	622110	856,494	856,494	
	f All other program service revenue.		470,495	470,495	
	g Total. Add lines 2a-2f. ▶		451,552,161		
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		984,311		984,311
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties ▶				
	6a Gross rents	(i) Real	(ii) Personal		
		6a	943,227		
		b Less: rental expenses	6b	87,664	
	c Rental income or (loss)	6c	855,563		
	d Net rental income or (loss) ▶		855,563		855,563
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other		
		7a		3,000	
		b Less: cost or other basis and sales expenses	7b	40,020	
	c Gain or (loss)	7c	-37,020		
	d Net gain or (loss) ▶		-37,020		-37,020
	8a Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18		8a		
	b Less: direct expenses		8b		
	c Net income or (loss) from fundraising events . . ▶				
	9a Gross income from gaming activities. See Part IV, line 19		9a		
	b Less: direct expenses		9b		
c Net income or (loss) from gaming activities . . ▶					
10aGross sales of inventory, less returns and allowances . .		10a	425,854		
b Less: cost of goods sold . .		10b	174,811		
c Net income or (loss) from sales of inventory . . ▶		251,043		251,043	
Miscellaneous Revenue		Business Code			
11aCAFETERIA		722210	2,184,661		2,184,661
b					
c					
d All other revenue					
e Total. Add lines 11a-11d ▶		2,184,661			
12 Total revenue. See instructions ▶		456,648,221	451,538,639	264,565	3,987,515

Form 990 (2019)

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	264,763	264,763		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	14,731	14,731		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	938,840	740,906	197,934	
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	180,400,434	176,645,936	3,754,498	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	11,360,833	11,125,615	235,218	
9 Other employee benefits	30,973,404	30,332,122	641,282	
10 Payroll taxes	12,613,860	12,352,699	261,161	
11 Fees for services (non-employees):				
a Management				
b Legal	38,056		38,056	
c Accounting	39,480	3,420	36,060	
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)	13,350,590	13,284,976	65,614	
12 Advertising and promotion	27,548	8,161	19,387	
13 Office expenses	10,805,217	10,399,814	405,403	
14 Information technology	23,575,109	22,915,255	659,854	
15 Royalties				
16 Occupancy	5,136,606	4,947,409	189,197	
17 Travel	431,336	416,420	14,916	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	908,162	901,841	6,321	
20 Interest	4,406,521	4,283,185	123,336	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	9,906,587	9,761,850	144,737	
23 Insurance	6,231,268	5,796,144	435,124	
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	80,942,779	80,942,779		
b PURCHASED SERVICES	47,743,307	10,146,980	37,596,327	
c PROVIDER TAXES	20,934,594	20,934,594		
d DUES, TAXES, & LICENSES	3,186,904	2,742,723	444,181	
e All other expenses				
25 Total functional expenses. Add lines 1 through 24e	464,230,929	418,962,323	45,268,606	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 SheetCheck 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		9,250	1	11,700
	2	Savings and temporary cash investments		1,032,319	2	932,102
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		46,456,289	4	46,313,077
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net		1,027,988	7	925,000
	8	Inventories for sale or use		7,571,583	8	8,636,748
	9	Prepaid expenses and deferred charges		2,478,519	9	1,624,193
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	241,703,359		
	b	Less: accumulated depreciation	10b	147,554,999		
				96,205,972	10c	94,148,360
	11	Investments—publicly traded securities		19,086,798	11	22,341,744
	12	Investments—other securities. See Part IV, line 11		384,020	12	423,287
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
15	Other assets. See Part IV, line 11		5,019,861	15	5,958,386	
16	Total assets. Add lines 1 through 15 (must equal line 34)		179,272,599	16	181,314,597	
Liabilities	17	Accounts payable and accrued expenses		27,479,145	17	24,581,879
	18	Grants payable			18	
	19	Deferred revenue		1,018,946	19	251,062
	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 any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties		386,005	23	848,193
	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		80,891,456	25	91,855,697
	26	Total liabilities. Add lines 17 through 25		109,775,552	26	117,536,831
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.					
	27	Net assets without donor restrictions		69,497,047	27	63,777,766
	28	Net assets with donor restrictions			28	
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.					
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		69,497,047	32	63,777,766
33	Total liabilities and net assets/fund balances		179,272,599	33	181,314,597	

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	456,648,221
2	Total expenses (must equal Part IX, column (A), line 25)	2	464,230,929
3	Revenue less expenses. Subtract line 2 from line 1	3	-7,582,708
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	69,497,047
5	Net unrealized gains (losses) on investments	5	2,376,334
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	-512,907
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	63,777,766

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

	Yes	No
1 Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain 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: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
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.	Yes	
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?		No
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		

Additional Data

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

Form 990 (2019)

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 200 VOLUNTEERS SERVING THE MEDICAL NEEDS OF THE COMMUNITY. IT IS LICENSED TO OPERATE 188 BEDS AND IS ONE OF FIVE 'LEVEL 2' TRAUMA CENTERS IN OREGON. DURING 2019, GSH SERVED 8,199 INPATIENTS, HAD 29,489 EMERGENCY DEPARTMENT VISITS, PERFORMED 10,384 SURGERIES AND DELIVERED 973 BABIES. IN ADDITION, GSH PERFORMED 94,072 IMAGING PROCEDURES, HAD 5,538 HOME HEALTH VISITS, AND HAD 255,450 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 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

OMB No. 1545-0047

2019

Open to Public Inspection

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) and 170(b)(1)(A)(vi)

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

Section A. Public Support							
Calendar year (or fiscal year beginning in) ▶		(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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 ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage							
14	Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))					14	
15	Public support percentage for 2018 Schedule A, Part II, line 14					15	
16a	33 1/3% support test—2019. 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 ▶ <input type="checkbox"/>						
b	33 1/3% support test—2018. 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 ▶ <input type="checkbox"/>						
17a	10%-facts-and-circumstances test—2019. 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 ▶ <input type="checkbox"/>						
b	10%-facts-and-circumstances test—2018. 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 ▶ <input type="checkbox"/>						
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 ▶ <input type="checkbox"/>						

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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. ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2019 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2018 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2019. 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—2018. 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? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
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)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
2		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
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)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
3b		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
3c		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>		
4a		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
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)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
4c		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
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? <i>If "Yes," provide detail in Part VI.</i>		
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? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ) .</i>		
7		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
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))? <i>If "Yes," provide detail in Part VI.</i>		
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? <i>If "Yes," provide detail in Part VI.</i>		
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? <i>If "Yes," provide detail in Part VI.</i>		
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)? <i>If "Yes," answer line 10b below.</i>		
10a		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).</i>		
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>		
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

1		<input type="checkbox"/> 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 2019 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-2019	(iii) Distributable Amount for 2019
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7:			
\$			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, 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 2019. 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 2020. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

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

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SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2019

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?

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II

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

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

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

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

	Held at the End of the Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 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 ► \$

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

Cat. No. 52283D Schedule D (Form 990) 2019

Part III

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

3

Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

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

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? . . .

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

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

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . .

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	4,709,814	5,044,051	4,478,316	4,237,438	4,497,010
b Contributions	132,666	123,741	31,737	66,044	132,523
c Net investment earnings, gains, and losses	802,651	-318,594	699,206	348,421	-174,642
d Grants or scholarships	173,711	139,384	165,208	173,587	217,453
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	5,471,420	4,709,814	5,044,051	4,478,316	4,237,438

2

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

a

Board designated or quasi-endowment ▶ 25.240 %

b

Permanent endowment ▶ 68.050 %

c

Temporarily restricted endowment ▶ 6.710 %

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

3a

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

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

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

3b

Yes

4

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

Part VI

Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land	1,700,000	358,114		2,058,114
b Buildings	1,482,945	156,460,791	86,504,569	71,439,167
c Leasehold improvements		3,726,386	2,050,333	1,676,053
d Equipment		67,637,162	52,742,099	14,895,063
e Other		10,337,961	6,257,998	4,079,963
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				94,148,360

Schedule D (Form 990) 2019

Part VII

Investments—Other Securities.

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

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

Part VIII

Investments—Program Related.

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

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

Part IX

Other Assets.

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

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

Part X

Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	91,855,697

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 ☒

Schedule D (Form 990) 2019

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, 2019, 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 2016.</p>

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2019

Open to Public Inspection

► 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.

Department of the Treasury

Internal Revenue Service

Name of the organization

GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

Part I

Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes
b	If "Yes," was it a written policy?	1b	Yes
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <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> 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 _____ % 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.	3a	Yes
		3b	Yes
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	No
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	
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)	18	21,402	4,859,536		4,859,536	1.050 %
b Medicaid (from Worksheet 3, column a)	11	93,734	81,610,730	59,754,043	21,856,687	4.710 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	29	115,136	86,470,266	59,754,043	26,716,223	5.760 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).	10	23,312	1,208,892	32,416	1,176,476	0.250 %
f Health professions education (from Worksheet 5)	4	7,009	21,516,493	9,825,725	11,690,768	2.520 %
g Subsidized health services (from Worksheet 6)	27	133,062	58,659,361	32,583,872	26,075,489	5.620 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	9	50,121	733,952	187,681	546,271	0.120 %
j Total. Other Benefits	50	213,504	82,118,698	42,629,694	39,489,004	8.510 %
k Total. Add lines 7d and 7j	79	328,640	168,588,964	102,383,737	66,205,227	14.270 %

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						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development	1	14	43,868		43,868	0.010 %
9 Other						
10 Total	1	14	43,868		43,868	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?	1	No
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	4,053,886
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	
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	75,651,561
6	Enter Medicare allowable costs of care relating to payments on line 5	6	73,957,736
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	1,693,825
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

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(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 1 CORVALLIS MED BLDGS LLC	REAL PROPERTY RENTAL	54.500 %		21.500 %
2 2 HULL IMAGING LLC	IMAGING SERVICES	60.000 %		40.000 %
3 3 SAMARITAN ENDOSCOPY CENTER	MEDICAL SERVICES	66.670 %		33.330 %
4 4 CORVALLIS MRI LLC	IMAGING SERVICES	50.000 %		50.000 %
5 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)

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
See Additional Data Table										

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
GOOD SAMARITAN HOSPITAL CORVALLIS**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____

1

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	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: 20 <u>19</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C.	6b	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):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, PAGE 8</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.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>17</u>	10	Yes
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>WWW.SAMHEALTH.ORG/ABOUT-SAMARITAN/COMMUNITY-BENEFIT-INITIATIVES</u>	10b	
a 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)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

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: <div><div>a</div><div><input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 225.000000000000 % and FPG family income limit for eligibility for discounted care of 300.000000000000 %</div><div>b</div><div><input type="checkbox"/> Income level other than FPG (describe in Section C)</div><div>c</div><div><input type="checkbox"/> Asset level</div><div>d</div><div><input checked="" type="checkbox"/> Medical indigency</div><div>e</div><div><input checked="" type="checkbox"/> Insurance status</div><div>f</div><div><input checked="" type="checkbox"/> Underinsurance discount</div><div>g</div><div><input type="checkbox"/> Residency</div><div>h</div><div><input type="checkbox"/> Other (describe in Section C)</div></div>	13	Yes
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): <div><div>a</div><div><input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application</div><div>b</div><div><input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application</div><div>c</div><div><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</div><div>d</div><div><input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications</div><div>e</div><div><input checked="" type="checkbox"/> Other (describe in Section C)</div></div>	15	Yes
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): <div><div>a</div><div><input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.SAMHEALTH.ORG/FINANCIALASSISTANCE</div><div>b</div><div><input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.SAMHEALTH.ORG/FINANCIALASSISTANCE</div><div>c</div><div><input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.SAMHEALTH.ORG/FINANCIALASSISTANCE</div><div>d</div><div><input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)</div><div>e</div><div><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)</div><div>f</div><div><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)</div><div>g</div><div><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</div><div>h</div><div><input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP</div><div>i</div><div><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</div><div>j</div><div><input type="checkbox"/> Other (describe in Section C)</div></div>	16	Yes

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?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
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 (if not, describe in Section C) b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C) c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C) d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C) 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?	21 Yes	
If "No," indicate why:		
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
22		
23		No
24		No

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

[illegible]

Part V **Facility Information** *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? 45

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

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
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 2019 IS 17,608,653.
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 SERVE 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 13, 14 AND 15 OF THE 2019 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 ON LINE 7 OF PART III, SECTION B SHOWS A SURPLUS FOR MEDICARE REVENUES LESS ALLOWABLE COSTS. 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 ON LINE 7 WOULD RESULT IN A SHORTFALL, AND NOT A SURPLUS, IF WE USED ALL OF THE REVENUE AND COST DATA FOR ALL MEDICARE PATIENT ACTIVITY, AS FOLLOWS: NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS): 127,180,835 MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO): 153,309,262 UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS: -26,128,427
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>

990 Schedule H, Supplemental Information

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 2019 POPULATION ESTIMATES, BENTON COUNTY HAS A POPULATION OF 93,053 RESIDENTS OF WHICH APPROXIMATELY 25,000 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 POPULATION WHITE/CAUCASIAN 86.5% BLACK/AFRICAN AMERICAN 1.2% AMERICAN INDIAN/ALASKA NATIVE 0.9% ASIAN 7.1% HISPANIC 7.8% NATIVE HAWAIIAN/PACIFIC ISLANDER 0.3% REPORTING TWO OR MORE RACES 4.1% SOURCE: U.S. CENSUS BUREAU, 2019 CENSUS QUICK FACTS, PUBLIC LAW 94-171 SUMMARY FILE HEALTH AND SOCIAL INDICATORS ARE USED TO GENERALIZE THE CONDITIONS OF BENTON COUNTY: HEALTH AND SOCIAL INDICATORS TOTALS MEDIAN INCOME \$58,655 UNEMPLOYMENT 2.5% POVERTY 15.8% ADEQUATE PRENATAL CARE 81.7% IMMUNIZATIONS 67.0% UNINSURED CHILDREN 3.3% CHILD ABUSE 10.6/1000 CHILDREN ON FREE AND REDUCED LUNCH 37.1% HOMELESS STUDENTS 4.3% TEEN PREGNANCY 0.6% HIGH SCHOOL GRADUATION RATES 84.8% JUVENILE JUSTICE REFERRALS 10.7/1000 SOURCE: OREGON EMPLOYMENT DEPARTMENT DECEMBER 2019, OREGON DEPARTMENT OF EDUCATION, U.S. CENSUS BUREAU, 2019 CENSUS QUICK FACTS, PUBLIC LAW 94-171 SUMMARY FILE, 2019 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 (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
1	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 A PRIVATE CONSULTANT TO CONDUCT THE 2019 COMMUNITY HEALTH NEEDS ASSESSMENT FOR GOOD SAMARITAN REGIONAL MEDICAL CENTER. THE STAFF AND THE CONSULTANT CONDUCTED SURVEYS BOTH ON-LINE AND ON PAPER WITH OVER 200 RESIDENTS IN BENTON COUNTY. THE STAFF AND THE CONSULTANT ALSO COLLECTED SECONDARY DATA FROM VARIOUS STATE AND NATIONAL ORGANIZATIONS SUCH AS THE OREGON DEPARTMENT OF EDUCATION, THE OREGON HEALTH AUTHORITY, THE U.S. CENSUS BUREAU AND THE CENTERS FOR DISEASE CONTROL. THE CONSULTANT HELD FOCUS GROUPS AND CONDUCTED KEY-INFORMANT INTERVIEWS TO OBTAIN INPUT FROM COMMUNITY MEMBERS AND PEOPLE WITH SPECIAL KNOWLEDGE AND EXPERTISE. FINALLY, SHS STAFF AND THE CONSULTANT HELD LISTENING SESSIONS TO OBTAIN ADDITIONAL INFORMATION REGARDING COMMUNITY NEEDS AND PRIORITIES. 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 PLANS, INC., THE DEPARTMENT OF HUMAN SERVICES, THE OREGON HEALTH AUTHORITY, THE OREGON OFFICE OF RURAL HEALTH, COMMUNITY SERVICES CONSORTIUM, THE 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: BRANDAN KEARNEY, LLC - CONSULTANT

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 TO LOCAL LIBRARIES, COUNTY OFFICES, SCHOOL DISTRICT OFFICES AND 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, 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.
PART V, SECTION B, LINE 7, CHNA REPORT WEBSITE:	WWW.SAMHEALTH.ORG/ABOUT-SAMARITAN/COMMUNITY-BENEFIT-INITIATIVES

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 MED - 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 - GSRMC 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

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 - HAND TO SHOULDER ORTHO - CORVALLIS 3620 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
2 18 - SMG ORTHOPEDICS - CORVALLIS 3620 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 19 - SAMARITAN RHEUMATOLOGY 3620 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
4 20 - SMG OSTEOPATHIC MEDICINE - CORVALLIS 3620 NW SAMARITAN DR STE 203A CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
5 21 - SAMARITAN INFECTIOUS DISEASE 3640 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
6 22 - SAMARITAN OBSTETRICS & GYN 3640 NW SAMARITAN DR STE 220 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 23 - SAMARITAN GYN & SURGICAL ASSOCIATES 400 NW WALNUT BLVD STE 300 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 24 - SAMARITAN PASTEGA REGIONAL CANCER CTR 501 NW ELKS DR CORVALLIS, OR 97330	CANCER TREATMENT
9 25 - SAMARITAN HEMATOLOGY & ONCOLOGY 501 NW ELKS DR STE 100 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 26 - SAMARITAN CANCER RES CTR - CORVALLIS 501 NW ELKS DR CORVALLIS, OR 97330	CANCER RESOURCE CENTER
11 27 - SAMARITAN URGENT CARE - CORVALLIS 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
12 28 - SAMARITAN FAMILY MEDICINE SOUTHWEST 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
13 29 - SAMARITAN OCC MED - CORVALLIS 5234 SW PHILOMATH BLVD STE B CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
14 30 - SAMARITAN PEDIATRICS 777 NW 9TH ST STE 320 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT

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 ATHLETIC MEDICINE CENTER 845 SW 30TH ST CORVALLIS, OR 97331	MEDICAL CLINIC - OUTPATIENT
1 32 - SAM CARE EXPRESS - CORVALLIS 990 NW CIRCLE BLVD STE 101 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
2 33 - SAMARITAN UROLOGY 990 NW CIRCLE BLVD STE 102 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 34 - SAMARITAN PLASTIC RECONST & HAND SURG 996 NW CIRCLE BLVD STE 103 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
4 35 - SAMARITAN OCC MED - LEBANON 100 MULLINS DRIVE STE B2 LEBANON, OR 97355	MEDICAL CLINIC - OUTPATIENT
5 36 - NEVILLE BUILDING LABORATORY 3615 NW SAMARITAN DR STE 102 CORVALLIS, OR 97330	LABORATORY SERVICES
6 37 - SAMARITAN PEDIATRICS - CIRCLE BLVD 1112 NW CIRCLE BLVD CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 38 - SAMARITAN MENTAL HEALTH - CIRCLE BLVD 1112 NW CIRCLE BLVD CORVALLIS, OR 97330	MENTAL HEALTH SERVICES
8 39 - SAMCARE MOBILE MEDICINE 2555 NE BELVUE ST CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
9 40 - SAMARITAN CARDIOLOGY - CORVALLIS 3640 NW SAMARITAN DR STE 100A CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 41 - SAMARITAN CARDIOVASCULAR SURGERY 3640 NW SAMARITAN DR STE 100B CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 42 - GOOD SAMARITAN HOME INFUSION SERVICE 501 NW ELKS DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
12 43 - SMG BREAST CENTER - CORVALLIS 501 NW ELKS DR STE 101 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
13 44 - OUTPATIENT NUTRITION CLINIC 3517 NW SAMARITAN DR STE 200 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
14 45 - SAMARITAN AMBULATORY INFUSION 501 NW ELKS DR STE 200 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)

Department of the Treasury
Internal Revenue Service

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number
93-0391573

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?

☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States.

Part II

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 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	260	12,582			
(2) MEALS	92		881	BOOK	MEALS FOR FAMILY MEMBERS OF PATIENTS
(3) PATIENT SUPPORT	2	268			
(4) SCHOLARSHIP	1	1,000			
(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)	105,963				FUNDING FOR MEDICAL, DENTAL, AND MENTAL HEALTH CLINICS
ALBANY HELPING HANDS PO BOX 2252 ALBANY, OR 97321	93-1244271	501(C)(3)	8,800				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)	14,000				PROVIDED FUNDING TO SUPPORT THE EMERGENCY SHELTER PROGRAM
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	10,000				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
BENTON COUNTY PO BOX 3020 CORVALLIS, OR 97339	93-6002285	GOV'T	14,600				FUNDING FOR FREE HEALTH CLINICS IN BENTON AND LINN COUNTIES
JACKSON STREET YOUTH SHELTER INC PO BOX 285 CORVALLIS, OR 97339	93-1269503	501(C)(3)	14,000				FUNDING FOR TRANSITIONAL HOUSING TO HOMELESS YOUTH

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ABC HOUSE INC PO BOX 68 ALBANY, OR 97321	93-1163555	501(C)(3)	9,000				FUNDING FOR A MEDICAL DIRECTOR POSITION
CORVALLIS ENVIRONMENTAL CENTER 116 SW 4TH STREET CORVALLIS, OR 97333	93-1140056	501(C)(3)	10,000				FUNDING TO ENSURE VULNERABLE LOCAL FAMILIES HAVE ACCESS TO FRESH PRODUCE

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
STRENGTHENING RURAL FAMILIES PO BOX 1528 PHILOMATH, OR 97370	20-2934930	501(C)(3)	5,200				FUNDING FOR DENTAL VANS IN RURAL BENTON COUNTY
VINA MOSES WELFARE CENTER INC 968 NW GARFIELD AVE CORVALLIS, OR 97330	93-0615775	501(C)(3)	9,000				FUNDING TO SUPPORT RENTAL AND UTILITY ASSISTANCE TO FAMILIES IN 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
CORVALLIS HOMELESS SHELTER COALITION 316 SW WASHINGTON AVE CORVALLIS, OR 97333	26-0694904	501(C)(3)	10,000				CASE MANAGEMENT AND SUPPORT SERVICES FOR SENIORS WHO ARE EXPERIENCING HOMELESSNESS
LOVE IN THE NAME OF CHRIST OF BENTON CO 2330 NW PROFESSIONAL DR STE 102 CORVALLIS, OR 97330	93-1326307	501(C)(3)	5,200				SUPPORT FOR THE ADULT EMERGENCY DENTAL PROGRAM IN THE CORVALLIS AREA

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
OPTIONS PREGNANCY RESOURCE CENTER INC 1800 16TH AVE SE ALBANY, OR 97322	93-0919233	501(C)(3)	7,500				PROVIDING PREGNANT ADOLESCENTS INCREASED EARLY ACCESS TO MEDICAL SERVICES
OREGON STATE UNIVERSITY PO BOX 1086 CORVALLIS, OR 97339	61-1730890	GOV'T	6,000				FUNDING FOR YOUTH NUTRITION AND COOKING CLASSES

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
PHILOMATH SCHOOL DISTRICT 535 S 19TH ST PHILOMATH, OR 97370	93-6000208	GOV'T	7,500				FUNDING FOR AFTERSCHOOL STUDENT TRANSPORTATION

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2019
Department of the Treasury Internal Revenue Service	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.	
Name of the organization GOOD SAMARITAN HOSPITAL CORVALLIS		Employer identification number 93-0391573

Part I Questions Regarding Compensation		Yes	No
1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
<input type="checkbox"/> First-class or charter travel	<input type="checkbox"/> Housing allowance or residence for personal use		
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence		
<input type="checkbox"/> Tax idemnification 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)		
b If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain		1b Yes	
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 on Line 1a?		2 Yes	
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.			
<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		
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a Receive a severance payment or change-of-control payment?		4a	No
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?		4b Yes	
c Participate in, or receive payment from, an equity-based compensation arrangement?		4c	No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a The organization?		5a Yes	
b Any related organization?		5b	No
If "Yes," on line 5a or 5b, describe in Part III.			
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a The organization?		6a	No
b Any related organization?		6b	No
If "Yes," on line 6a or 6b, describe in Part III.			
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.		7	No
8 Were any amounts reported on Form 990, Part VII, paid or 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.		8	No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?		9	

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

[illegible]

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	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. EMPLOYEES CAN USE THEIR WELLNESS BENEFIT AT EITHER NON-SAMARITAN OR SAMARITAN (SAMFIT) GYM/FITNESS FACILITIES. 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 THEIR TAXABLE WAGES SUBJECT TO FEDERAL/STATE WITHHOLDING TAX. TWO KEY EMPLOYEES USED THE NON-SAMARITAN GYM REIMBURSEMENT DURING THE FILING YEAR. IF EMPLOYEES USE THEIR WELLNESS BENEFIT AT A SAMARITAN (SAMFIT) GYM/FITNESS FACILITY, THEN THE ANNUAL COST OF EMPLOYEE MEMBERSHIP, \$300, IS INCLUDED IN THE EMPLOYEE'S TAXABLE WAGES SUBJECT TO FEDERAL/STATE WITHHOLDING TAX. ONE FORMER OFFICER, AND ONE HIGHEST PAID EMPLOYEE USED THE SAMARITAN (SAMFIT) GYM/FITNESS FACILITY BENEFIT DURING THE FILING YEAR.
PART I, LINE 3	THE CHIEF EXECUTIVE OFFICER IS EMPLOYED AND PAID BY A RELATED ORGANIZATION. THE RELATED ORGANIZATION CONDUCTS A COMPENSATION ANALYSIS EACH YEAR TO COMPARE COMPENSATION OF ALL PAID POSITIONS TO MARKET SURVEYS OF COMPENSATION FOR SIMILAR POSITIONS IN OTHER ORGANIZATIONS. PERIODICALLY, THE RELATED ORGANIZATION WILL ALSO USE WRITTEN EMPLOYMENT CONTRACTS, FORM 990 OF OTHER ORGANIZATIONS, AND INDEPENDENT COMPENSATION CONSULTANTS TO DETERMINE THE COMPENSATION OF THE CHIEF EXECUTIVE OFFICER.
PART I, LINE 4B	A RELATED ORGANIZATION MAINTAINS A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN FOR DANIEL SMITH UNDER WHICH HE ACCRUED DEFERRED COMPENSATION BENEFITS DURING 2019. HE ALSO RECEIVED A PAYMENT FROM THIS PLAN WHICH IS INCLUDED IN HIS 2019 COMPENSATION AS REPORTED ON SCHEDULE J AND FORM 990.
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.

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				
1DANIEL SMITH SVP / CFO	(i)	0	0	0	0	0	0	0
	(ii)	401,226	48,270	106,249	37,392	36,577	629,714	0
1BECKY PAPE CEO	(i)	0	0	0	0	0	0	0
	(ii)	377,504	41,529	7,135	22,684	29,723	478,575	0
2KIMBERLY CLIFT VP OPERATIONS	(i)	271,989	11,072	881	22,684	8,132	314,758	0
	(ii)	0	0	0	0	0	0	0
3TIMOTHY EIXENBERGER VP PATIENT CARE SERVICES	(i)	151,089	20,000	22,559	0	16,414	210,062	0
	(ii)	0	0	0	0	0	0	0
4WILLIAM HOWDEN VP NURSING / NURSE EDUCATOR	(i)	162,755	10,397	7,371	12,602	22,961	216,086	0
	(ii)	0	0	0	0	0	0	0
5SCOTT WILSON VP FINANCIAL STRATEGY / SUP SVCS	(i)	141,035	7,897	22,581	11,827	14,595	197,935	0
	(ii)	0	0	0	0	0	0	0
6JEFF HSING MD PHYSICIAN	(i)	506,547	280,200	19,810	22,684	34,862	864,103	0
	(ii)	0	0	0	0	0	0	0
7DONALD PENNINGTON DO PHYSICIAN	(i)	732,065	51,501	13,675	22,684	38,457	858,382	0
	(ii)	0	0	0	0	0	0	0
8J CHRISTOPHER NOONAN MD PHYSICIAN	(i)	747,885	20,000	3,564	22,684	36,451	830,584	0
	(ii)	0	0	0	0	0	0	0
9LUIS VELA DO PHYSICIAN	(i)	757,833	0	2,322	22,684	38,488	821,327	0
	(ii)	0	0	0	0	0	0	0
10LAYRON LONG MD PHYSICIAN	(i)	711,307	12,100	10,103	22,684	24,222	780,416	0
	(ii)	0	0	0	0	0	0	0
11LARRY MULLINS DHA FORMER CEO / CEO SAM SOLUTIONS	(i)	0	0	0	0	0	0	0
	(ii)	401,443	0	135,524	22,684	29,862	589,513	0

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

GOOD SAMARITAN HOSPITAL CORVALLIS

Supplemental Information to Form 990 or 990-EZ

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

► Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number

93-0391573

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	THE SOLE CORPORATE MEMBER HAS SEVERAL RESERVED POWERS OVER THE ORGANIZATION. THESE RESERVED POWERS INCLUDE, BUT ARE NOT LIMITED TO, APPROVAL AT CERTAIN THRESHOLD LEVELS: 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	<p>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.</p>

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 -1,362,750. CHANGE IN MINIMUM PENSION LIABILITY 713,404. OTHER CHANGES 136,439.

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493318128270	
SCHEDULE R (Form 990)	Related Organizations and Unrelated Partnerships				OMB No. 1545-0047
					2019
	Department of the Treasury Internal Revenue Service				Open to Public Inspection
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.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		Yes	No
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

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

[illegible]

Part VII

Supplemental Information

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

Return Reference	Explanation

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
INTERCOMMUNITY HEALTH PLANS INC	L	31,875,046	COST
SAMARITAN ENDOSCOPY CENTER LLC	A	462,171	COST
SAMARITAN ENDOSCOPY CENTER LLC	S	340,000	COST
CORVALLIS MEDICAL BUILDINGS LLC	A	52,354	COST
CORVALLIS MEDICAL BUILDINGS LLC	S	245,250	COST
CORVALLIS MEDICAL BUILDINGS LLC	K	577,110	COST
HULL IMAGING LLC	A	49,495	COST
HULL IMAGING LLC	O	810,917	COST
HULL IMAGING LLC	S	678,000	COST
HULL IMAGING LLC	L	542,767	COST
GOOD SAMARITAN HOSPITAL FOUNDATION	C	829,911	COST
GOOD SAMARITAN HOSPITAL FOUNDATION	O	300,161	COST
GOOD SAMARITAN HOSPITAL FOUNDATION	R	94,328	COST