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| | | |
|---|--|------------------|
|  Form 990  Department of the Treasury Internal Revenue Service | <h1>Return of Organization Exempt From Income Tax</h1> <p>Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)</p> <p>▶ The organization may have to use a copy of this return to satisfy state reporting requirements</p> | OMB No 1545-0047 |
| | <p>2009</p> <p>Open to Public Inspection</p> | |

| | | | | |
|--|--|---|-------------------------------------|---|
| A For the 2009 calendar year, or tax year beginning 01-01-2009 and ending 12-31-2009 | | | | |
| B Check if applicable <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | Please use IRS label or print or type. See Specific Instructions. | C Name of organization GOOD SAMARITAN HOSPITAL CORVALLIS | | D Employer identification number 93-0391573 |
| | | Doing Business As | | E Telephone number (541) 768-4773 |
| | | Number and street (or P O box if mail is not delivered to street address) C/O SHS ACCOUNTING PO BOX 3000 | Room/suite | G Gross receipts \$ 279,301,404 |
| | | City or town, state or country, and ZIP + 4 CORVALLIS, OR 97339 | | |
| | | F Name and address of principal officer STEVEN W JASPERSON 3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 | | |
| I Tax-exempt status <input checked="" type="checkbox"/> 501(c) (3) (Insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | H(b) Are all affiliates included? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "No," attach a list (see instructions) | | |
| J Website: WWW.SAMHEALTH.ORG | | H(c) Group exemption number | | |
| K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other | | L Year of formation 1948 | M State of legal domicile OR | |

| Part I | | Summary | | |
|-----------------------------|-----|---|--------------------|----------------------|
| Activities & Governance | 1 | Briefly describe the organization's mission or most significant activities 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 | | |
| | 2 | Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets | | |
| | 3 | Number of voting members of the governing body (Part VI, line 1a) | 3 1 | |
| | 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | |
| | 5 | Total number of employees (Part V, line 2a) | 5 1,96 | |
| | 6 | Total number of volunteers (estimate if necessary) | 6 29 | |
| | 7a | Total gross unrelated business revenue from Part VIII, column (C), line 12 | 7a 1,076,98 | |
| | 7b | Net unrelated business taxable income from Form 990-T, line 34 | 7b -91,94 | |
| Revenue | 8 | Contributions and grants (Part VIII, line 1h) | Prior Year 335,587 | Current Year 656,158 |
| | 9 | Program service revenue (Part VIII, line 2g) | 261,144,229 | 272,591,212 |
| | 10 | Investment income (Part VIII, column (A), lines 3, 4, and 7d) | -1,167,326 | 1,009,824 |
| | 11 | Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | 2,797,451 | 2,742,860 |
| | 12 | Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | 263,109,941 | 277,000,054 |
| Expenses | 13 | Grants and similar amounts paid (Part IX, column (A), lines 1–3) | 517,260 | 377,389 |
| | 14 | Benefits paid to or for members (Part IX, column (A), line 4) | | 0 |
| | 15 | Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 130,410,303 | 144,491,639 |
| | 16a | Professional fundraising fees (Part IX, column (A), line 11e) | 2,530 | 2,571 |
| | b | Total fundraising expenses (Part IX, column (D), line 25) | | |
| | 17 | Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f) | 125,296,602 | 123,394,093 |
| | 18 | Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 256,226,695 | 268,265,692 |
| | 19 | Revenue less expenses Subtract line 18 from line 12 | 6,883,246 | 8,734,362 |
| Net Assets or Fund Balances | | Beginning of Current Year | End of Year | |
| | 20 | Total assets (Part X, line 16) | 182,889,469 | 217,038,102 |
| | 21 | Total liabilities (Part X, line 26) | 93,663,303 | 115,843,135 |
| | 22 | Net assets or fund balances Subtract line 21 from line 20 | 89,226,166 | 101,194,967 |

| Part II | | Signature Block | | | |
|--------------------------|---|-----------------|--------------------|---|--|
| Sign Here | 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 | | | | |
| | ***** Signature of officer | | 2010-11-09 Date | | |
| | DANIEL B SMITH VP FINANCE/CFO Type or print name and title | | | | |
| Paid Preparer's Use Only | Preparer's signature | | Date | Check if self-employed <input type="checkbox"/> | Preparer's identifying number (see instructions) |
| | Firm's name (or yours if self-employed), address, and ZIP + 4 | | | | EIN |
| | | | | | Phone no |

Part III

Statement of Program Service Accomplishments

1

Briefly describe the organization’s mission

Good Samaritan Hospital, Corvallis (GSH) is a member of Samaritan Health Services (SHS), a regional network of hospitals, physicians and senior care facilities. The network, formed in the late 1990’s, serves approximately 290,000 residents in Linn, Benton, Lincoln and portions of Polk and Marion counties in Oregon. It is locally owned, and its boards of directors include hospital leaders, physicians and community representatives. GSH provides healthcare services regardless of race, color, creed, sex, national origin, disability or age. The mission of GSH is to enhance community health and achieve high value through quality services across a continuum of care. The collective vision of the SHS system is to be a values-driven organization governed by community members, physicians and other health care providers. 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 exempt purpose achievements for each of the organization’s three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts 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 \$ 228,176,274 including grants of \$) (Revenue \$ 271,754,280)

Good Samaritan Hospital Corvallis (GSH), the largest hospital in Linn, Benton and Lincoln counties, offers more than 22 medical specialties including comprehensive cancer care, a full-service cardiology and vascular surgery program, a sleep lab, neurosurgery and other regional services. GSH has more than 1,700 employees and 290 volunteers serving the medical needs of the community. It is licensed to operate 188 beds and is one of only three 'Level 2' trauma centers in the state. During 2009, GSH served 8,735 inpatients, had 21,062 emergency department visits, performed 9,096 surgeries and delivered 1,102 babies. In addition, GSH performed 73,420 imaging procedures, had 34,943 home health visits, and had 171,225 physician clinic visits.

4b

(Code) (Expenses \$ 377,389 including grants of \$ 377,389) (Revenue \$)

GRANTS AND ASSISTANCE PROVIDED BY GOOD SAMARITAN HOSPITAL CORVALLIS TO VARIOUS ORGANIZATIONS AND INDIVIDUALS TO BENEFIT THE COMMUNITY. SEE PART IX, LineS 1 AND 2 and related Schedule I FOR more DETAILS.

4c

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

4d










Other program services (Describe in Schedule O)

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

4e

Total program service expenses \$ 228,553,663

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?  | 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? If "Yes," complete Schedule C, Part II | 4 | No |
| 5 | Section 501(c)(4), 501(c)(5), and 501(c)(6) organizations. Is the organization subject to the section 6033(e) notice and reporting requirement and proxy tax? If "Yes," complete Schedule C, Part III | 5 | No |
| 6 | Did the organization maintain any donor advised funds or any similar funds or accounts where 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, 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 term, permanent, or quasi-endowments? If "Yes," complete Schedule D, Part V  | 10 | Yes |
| 11 | Is the organization's answer to any of the following questions "Yes"? If so, complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable. | 11 | Yes |
| | • Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI. | | |
| | • 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. | | |
| | • 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. | | |
| | • 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. | | |
| | • Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X. | | |
| | • 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? If "Yes," complete Schedule D, Part X. | | |
| 12 | Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII  | 12 | No |
| 12A | Was the organization included in consolidated, independent audited financial statements for the tax year? | Yes | No |
| | If "Yes," completing Schedule D, Parts XI, XII, and XIII is optional | 12A | 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 |
| 14b | Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, and program service activities outside the United States? If "Yes," complete Schedule F, Part I | 14b | No |
| 15 | Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the U S ? If "Yes," complete Schedule F, Part II | 15 | No |
| 16 | Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the U S ? If "Yes," complete Schedule F, Part III | 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 | 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 |
| 20 | Did the organization operate one or more hospitals? If "Yes," complete Schedule H  | 20 | Yes |


Part IV

Checklist of Required Schedules (continued)

| | | | | |
|-----|--|-----|-----|----|
| 21 | Did the organization report more than \$5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> | 21 | Yes | |
| 22 | Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> | 22 | Yes | |
| 23 | Did the organization answer "Yes" to Part VII, Section A, questions 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i> | 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? <i>If "Yes," answer questions 24b-24d and complete Schedule K. If "No," go to line 25</i> | 24a | | No |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | | No |
| c | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | | No |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | | No |
| 25a | Section 501(c)(3) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i> | 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? <i>If "Yes," complete Schedule L, Part I</i> | 25b | | No |
| 26 | Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? <i>If "Yes," complete Schedule L, Part II</i> | 26 | | No |
| 27 | Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? <i>If "Yes," complete Schedule L, Part III</i> | 27 | | No |
| 28 | Was the organization a party to a business transaction with one of the following parties? (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) | | | |
| a | A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28a | | No |
| b | A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i> | 28b | | No |
| c | An entity of which a current or former officer, director, trustee, or key employee of the organization (or a family member) was an officer, director, trustee, or owner? <i>If "Yes," complete Schedule L, Part IV</i> | 28c | | No |
| 29 | Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i> | 29 | | No |
| 30 | Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i> | 30 | | No |
| 31 | Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i> | 31 | | No |
| 32 | Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i> | 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? <i>If "Yes," complete Schedule R, Part I</i> | 33 | | No |
| 34 | Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1</i> | 34 | Yes | |
| 35 | Is any related organization a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35 | Yes | |
| 36 | Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 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? <i>If "Yes," complete Schedule R, Part VI</i> | 37 | | No |
| 38 | Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? Note. All Form 990 filers are required to complete Schedule O | 38 | Yes | |

Part V

Statements Regarding Other IRS Filings and Tax Compliance

| | | | Yes | No |
|---|--|----|-------|-----|
| 1a | Enter the number reported in Box 3 of Form 1096, <i>Annual Summary and Transmittal of U.S. Information Returns</i> . Enter -0- if not applicable | 1a | 8 | |
| | | 1b | 0 | |
| b Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable | | | 1c | Yes |
| c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? | | | | |
| 2a | Enter the number of employees reported on Form W-3, <i>Transmittal of Wage and Tax Statements</i> filed for the calendar year ending with or within the year covered by this return | 2a | 1,965 | |
| | b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note: If the sum of lines 1a and 2a is greater than 250, you may be required to e-file this return (see instructions) | | | |
| 3a Did the organization have unrelated business gross income of \$1,000 or more during the year covered by this return? | | | 3a | Yes |
| b If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O | | | 3b | Yes |
| 4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? | | | 4a | No |
| b If "Yes," enter the name of the foreign country  _____ See the instructions for exceptions and filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts | | | | |
| 5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . | | | 5a | No |
| b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? | | | 5b | No |
| c If "Yes" to line 5a or 5b, did the organization file Form 8886-T, Disclosure by Tax-Exempt Entity Regarding Prohibited Tax Shelter Transaction? | | | 5c | No |
| 6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible? | | | 6a | No |
| b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? | | | 6b | No |
| 7 Organizations that may receive deductible contributions under section 170(c). | | | | |
| a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? | | | 7a | No |
| b If "Yes," did the organization notify the donor of the value of the goods or services provided? | | | 7b | No |
| c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? | | | 7c | No |
| d If "Yes," indicate the number of Forms 8282 filed during the year | | | 7d | 0 |
| e Did the organization, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? | | | 7e | No |
| f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . | | | 7f | No |
| g For all contributions of qualified intellectual property, did the organization file Form 8899 as required? . . . | | | 7g | No |
| h For contributions of cars, boats, airplanes, and other vehicles, did the organization file a Form 1098-C as required? | | | 7h | No |
| 8 Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year? | | | 8 | No |
| 9 Sponsoring organizations maintaining donor advised funds. | | | | |
| a Did the organization make any taxable distributions under section 4966? | | | 9a | No |
| b Did the organization make a distribution to a donor, donor advisor, or related person? | | | 9b | No |
| 10 Section 501(c)(7) organizations. Enter | | | | |
| a Initiation fees and capital contributions included on Part VIII, line 12 | | | 10a | |
| b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities | | | 10b | |
| 11 Section 501(c)(12) organizations. Enter | | | | |
| a Gross income from members or shareholders | | | 11a | |
| b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) | | | 11b | |
| 12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? | | | 12a | No |
| b If "Yes," enter the amount of tax-exempt interest received or accrued during the year | | | 12b | |

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.

Section A. Governing Body and Management

| | | | | |
|----|---|----|-----|----|
| | | | Yes | No |
| 1a | Enter the number of voting members of the governing body | 1a | 12 | |
| b | Enter the number of voting members that are independent | 1b | 9 | |
| 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 organizational documents since the prior Form 990 was filed? | 4 | Yes | |
| 5 | Did the organization become aware during the year of a material diversion of the organization's assets? | 5 | | No |
| 6 | Does the organization have members or stockholders? | 6 | Yes | |
| 7a | Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body? | 7a | Yes | |
| b | Are any decisions of the governing body subject to approval by members, stockholders, or other persons? | 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 | Does the organization have local chapters, branches, or affiliates? | 10a | | No |
| b | If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization? | 10b | | No |
| 11 | Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form? | 11 | Yes | |
| 11A | Describe in Schedule O the process, if any, used by the organization to review the Form 990 | | | |
| 12a | Does the organization have a written conflict of interest policy? If "No," go to line 13 | 12a | Yes | |
| b | Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts? | 12b | Yes | |
| c | Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done | 12c | Yes | |
| 13 | Does the organization have a written whistleblower policy? | 13 | Yes | |
| 14 | Does 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 | | No |
| b | Other officers or key employees of the organization | 15b | | No |
| | If "Yes" to line a or b, 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," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken 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▶ |
| 18 | Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c) (3)s only) available for public inspection. Indicate how you make these available. Check all that apply. <input type="checkbox"/> Own website <input checked="" type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request |
| 19 | Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public. See Additional Data Table. |
| 20 | State the name, physical address, and telephone number of the person who possesses the books and records of the organization ▶ SAMARITAN HEALTH SERVICES PO BOX 3000 CORVALLIS,OR 973393000 (541) 768-4773 |

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

• 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

☐ Check this box if the organization did not compensate any current or former officer, director, trustee or key employee

Form **990** (2009)

| | | | | |
|-----------|------------------------|-----------|---------|---------|
| 1b | Total | 4,022,484 | 816,736 | 448,100 |
|-----------|------------------------|-----------|---------|---------|

2

Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization▶194

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

Section B. Independent Contractors

1

Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization

| (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 in compensation from the organization ▶0

Part VIII

Statement of Revenue

| | | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512, 513, or 514 | |
|---|--|---|---------------|----------------------|--|---|---|--|
| Contributions, gifts, grants and other similar amounts | 1a | Federated campaigns . . . | 1a | | | | | |
| | b | Membership dues | 1b | | | | | |
| | c | Fundraising events | 1c | | | | | |
| | d | Related organizations | 1d | 629,961 | | | | |
| | e | Government grants (contributions) | 1e | 13,723 | | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above | 1f | 12,474 | | | | |
| | g | Noncash contributions included in lines 1a-1f \$ _____ | | | | | | |
| | h | Total. Add lines 1a-1f | | 656,158 | | | | |
| Program Service Revenue | | | Business Code | | | | | |
| | 2a | RETAIL PHARMACY | 446,110 | 5,730,744 | 4,690,924 | 1,039,820 | | |
| | b | NET PATIENT REVENUE | 900,099 | 266,860,468 | 266,860,468 | | | |
| | c | | | | | | | |
| | d | | | | | | | |
| | e | | | | | | | |
| | f | All other program service revenue | | | | | | |
| | g | Total. Add lines 2a-2f | | 272,591,212 | | | | |
| Other Revenue | 3 | Investment income (including dividends, interest and other similar amounts) | | 600,776 | | | 600,776 | |
| | 4 | Income from investment of tax-exempt bond proceeds . . . | | 0 | | | | |
| | 5 | Royalties | | 0 | | | | |
| | 6a | (i) Real | | (ii) Personal | | | | |
| | | Gross Rents | 958,838 | | | | | |
| | | b Less rental expenses | 420,446 | | | | | |
| | | c Rental income or (loss) | 538,392 | | | | | |
| | d | Net rental income or (loss) | | 538,392 | | 37,164 | 501,228 | |
| | 7a | (i) Securities | | (ii) Other | | | | |
| | | Gross amount from sales of assets other than inventory | 1,844,348 | 316,300 | | | | |
| | | b Less cost or other basis and sales expenses | 1,726,240 | 25,360 | | | | |
| | | c Gain or (loss) | 118,108 | 290,940 | | | | |
| | d | Net gain or (loss) | | 409,048 | | | 409,048 | |
| | 8a | Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 | | | | | | |
| | | a | | | | | | |
| | | b Less direct expenses | b | | | | | |
| | c | Net income or (loss) from fundraising events . . . | | 0 | | | | |
| | 9a | Gross income from gaming activities See Part IV, line 19 | | | | | | |
| | | a | | | | | | |
| | | b Less direct expenses | b | | | | | |
| c | Net income or (loss) from gaming activities . . . | | 0 | | | | | |
| 10a | Gross sales of inventory, less returns and allowances | | | | | | | |
| | a | 266,295 | | | | | | |
| | b Less cost of goods sold | b | 129,304 | | | | | |
| c | Net income or (loss) from sales of inventory . . . | | 136,991 | 136,991 | | | | |
| Miscellaneous Revenue | | Business Code | | | | | | |
| 11a | WELLNESS INSTRUCTION | 611,600 | 14,758 | 14,758 | | | | |
| b | RELEASE OF INFO | 561,000 | 40,828 | 40,828 | | | | |
| c | CAFETERIA | 722,210 | 2,001,580 | | | 2,001,580 | | |
| d | All other revenue | | 10,311 | 10,311 | | | | |
| e | Total. Add lines 11a-11d | | 2,067,477 | | | | | |
| 12 | Total revenue. See Instructions | | 277,000,054 | 271,754,280 | 1,076,984 | 3,512,632 | | |

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) but are not required to complete columns (B), (C), and (D).

| 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 governments and organizations in the U S See Part IV, line 21 | 217,295 | 217,295 | | |
| 2 | Grants and other assistance to individuals in the U S See Part IV, line 22 | 160,094 | 160,094 | | |
| 3 | Grants and other assistance to governments, organizations, and individuals outside the U S See Part IV, lines 15 and 16 | 0 | | | |
| 4 | Benefits paid to or for members | 0 | | | |
| 5 | Compensation of current officers, directors, trustees, and key employees | 867,958 | 867,958 | | |
| 6 | Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | 0 | | | |
| 7 | Other salaries and wages | 109,379,183 | 105,005,456 | 4,304,254 | 69,473 |
| 8 | Pension plan contributions (include section 401(k) and section 403(b) employer contributions) | 8,664,065 | 8,320,344 | 338,261 | 5,460 |
| 9 | Other employee benefits | 17,503,989 | 16,809,572 | 683,387 | 11,030 |
| 10 | Payroll taxes | 8,076,444 | 7,756,037 | 315,318 | 5,089 |
| 11 | Fees for services (non-employees) | | | | |
| a | Management | 91,956 | | 91,956 | |
| b | Legal | 120,512 | | 120,512 | |
| c | Accounting | 4,450 | | 4,450 | |
| d | Lobbying | 0 | | | |
| e | Professional fundraising See Part IV, line 17 | 2,571 | | | 2,571 |
| f | Investment management fees | 0 | | | |
| g | Other | 4,304,179 | 4,229,816 | 67,614 | 6,749 |
| 12 | Advertising and promotion | 68,136 | 31,294 | 29,313 | 7,529 |
| 13 | Office expenses | 8,843,427 | 8,394,307 | 351,460 | 97,660 |
| 14 | Information technology | 9,569,708 | | 9,569,708 | |
| 15 | Royalties | 0 | | | |
| 16 | Occupancy | 3,480,423 | 3,452,400 | 24,711 | 3,312 |
| 17 | Travel | 335,947 | 323,023 | 12,859 | 65 |
| 18 | Payments of travel or entertainment expenses for any federal, state, or local public officials | 0 | | | |
| 19 | Conferences, conventions, and meetings | 730,300 | 685,941 | 43,371 | 988 |
| 20 | Interest | 1,084,914 | 116,102 | 968,812 | |
| 21 | Payments to affiliates | 0 | | | |
| 22 | Depreciation, depletion, and amortization | 9,128,356 | 8,829,794 | 297,818 | 744 |
| 23 | Insurance | 4,396,522 | 4,068,096 | 328,426 | |
| 24 | Other expenses Itemize expenses not covered above (Expenses grouped together and labeled miscellaneous may not exceed 5% of total expenses shown on line 25 below) | | | | |
| a | PURCHASED SERVICES | 32,327,048 | 10,418,002 | 21,894,290 | 14,756 |
| b | MEDICAL SUPPLIES | 42,341,363 | 42,341,363 | | |
| c | DUES, TAXES, & LICENSING | 2,502,658 | 2,462,575 | 39,634 | 449 |
| d | BAD DEBTS | 4,064,194 | 4,064,194 | | |
| e | | | | | |
| f | All other expenses | 0 | | | |
| 25 | Total functional expenses. Add lines 1 through 24f | 268,265,692 | 228,553,663 | 39,486,154 | 225,875 |
| 26 | Joint costs. Check here <input type="checkbox"/> if following SOP 98-2 Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation | | | | |

Part X

Balance Sheet

| | | | | | (A) | | (B) |
|-----------------------------|---|--|-----|-------------|-------------------|-----|-------------|
| | | | | | Beginning of year | | End of year |
| Assets | 1 | Cash—non-interest-bearing | | | 135,707 | 1 | 10,344 |
| | 2 | Savings and temporary cash investments | | | 2,160,916 | 2 | 2,212,097 |
| | 3 | Pledges and grants receivable, net | | | | 3 | 0 |
| | 4 | Accounts receivable, net | | | 39,193,600 | 4 | 36,845,024 |
| | 5 | Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L | | | 100,449 | 5 | 0 |
| | 6 | Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). Complete Part II of Schedule L | | | | 6 | 0 |
| | 7 | Notes and loans receivable, net | | | 380,199 | 7 | 614,588 |
| | 8 | Inventories for sale or use | | | 4,861,078 | 8 | 4,521,414 |
| | 9 | Prepaid expenses and deferred charges | | | 1,474,262 | 9 | 1,665,863 |
| | 10a | Land, buildings, and equipment, cost or other basis. Complete Part VI of Schedule D | 10a | 200,173,293 | | | |
| | b | Less accumulated depreciation | 10b | 93,409,990 | 87,397,263 | 10c | 106,763,303 |
| | 11 | Investments—publicly traded securities | | | 9,336,414 | 11 | 11,476,673 |
| | 12 | Investments—other securities. See Part IV, line 11 | | | | 12 | 0 |
| | 13 | Investments—program-related. See Part IV, line 11 | | | | 13 | 0 |
| | 14 | Intangible assets | | | 341,869 | 14 | 302,869 |
| | 15 | Other assets. See Part IV, line 11 | | | 37,507,712 | 15 | 52,625,927 |
| | 16 | Total assets. Add lines 1 through 15 (must equal line 34) | | | 182,889,469 | 16 | 217,038,102 |
| Liabilities | 17 | Accounts payable and accrued expenses | | | 24,302,017 | 17 | 23,352,447 |
| | 18 | Grants payable | | | | 18 | |
| | 19 | Deferred revenue | | | 62,478 | 19 | 58,045 |
| | 20 | Tax-exempt bond liabilities | | | 17,040,000 | 20 | 16,440,000 |
| | 21 | Escrow or custodial account liability. Complete Part IV of Schedule D | | | | 21 | |
| | 22 | Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L | | | | 22 | |
| | 23 | Secured mortgages and notes payable to unrelated third parties | | | 23,567,727 | 23 | 41,871,626 |
| | 24 | Unsecured notes and loans payable to unrelated third parties | | | | 24 | |
| | 25 | Other liabilities. Complete Part X of Schedule D | | | 28,691,081 | 25 | 34,121,017 |
| | 26 | Total liabilities. Add lines 17 through 25 | | | 93,663,303 | 26 | 115,843,135 |
| Net Assets or Fund Balances | Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | | | | |
| | 27 | Unrestricted net assets | | | 89,226,166 | 27 | 101,194,967 |
| | 28 | Temporarily restricted net assets | | | | 28 | |
| | 29 | Permanently restricted net assets | | | | 29 | |
| | Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34. | | | | | | |
| | 30 | Capital stock or trust principal, or current funds | | | | 30 | |
| | 31 | Paid-in or capital surplus, or land, building or equipment fund | | | | 31 | |
| | 32 | Retained earnings, endowment, accumulated income, or other funds | | | | 32 | |
| | 33 | Total net assets or fund balances | | | 89,226,166 | 33 | 101,194,967 |
| | 34 | Total liabilities and net assets/fund balances | | | 182,889,469 | 34 | 217,038,102 |

Part XI **Financial Statements and Reporting**

| | 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? . . | | No |
| b Were the organization's financial statements audited by an independent accountant? | Yes | |
| c If "Yes," to 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 | |
| d If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a consolidated basis, separate basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separated basis | | |
| 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 . . | | No |

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. ▶ See separate instructions.

OMB No 1545-0047

2009

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 11, check only one box)

1

☐

A church, convention of churches, or association of churches **section 170(b)(1)(A)(i).**

2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E)

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 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)

10

☐

An organization organized and operated exclusively to test for public safety See**section 509(a)(4).**

11

☐

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 that describes the type of supporting organization and complete lines 11e through 11h

a

☐

Type I

b

☐

Type II

c

☐

Type III - Functionally integrated

d

☐

Type III - Other

e

☐

By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2)

f

☐

If the organization received a written determination from the IRS that it is a Type I, Type II or Type III supporting organization, check this box

g

☐

Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

(i)

a person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the the supported organization?

(ii)

a family member of a person described in (i) above?

(iii)

a 35% controlled entity of a person described in (i) or (ii) above?

h

☐

Provide the following information about the supported organization(s)

| | Yes | No |
|----------|-----|----|
| 11g(i) | | |
| 11g(ii) | | |
| 11g(iii) | | |

| (i) Name of supported organization | (ii) EIN | (iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions)) | (iv) Is the organization in col (i) listed in your governing document? | | (v) Did you notify the organization in col (i) of your support? | | (vi) Is the organization in col (i) organized in the U S ? | | (vii) Amount of support? |
|---------------------------------------|-------------|---|---|----|--|----|---|----|-----------------------------|
| | | | Yes | No | Yes | No | Yes | No | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Total | | | | | | | | | |

Part II

Support Schedule for Organizations Described in IRC 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.)

| Section A. Public Support | | | | | | |
|---|----------|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2005 | (b) 2006 | (c) 2007 | (d) 2008 | (e) 2009 | (f) Total |
| 1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.") | | | | | | |
| 2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf | | | | | | |
| 3 The value of services or facilities furnished by a governmental unit to the organization without charge | | | | | | |
| 4 Total. Add lines 1 through 3 | | | | | | |
| 5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) | | | | | | |
| 6 Public Support. Subtract line 5 from line 4 | | | | | | |

| Section B. Total Support | | | | | | |
|---|----------|----------|----------|----------|----------|-----------|
| Calendar year (or fiscal year beginning in) | (a) 2005 | (b) 2006 | (c) 2007 | (d) 2008 | (e) 2009 | (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 (Explain in Part IV) Do not include gain or loss from the sale of capital assets | | | | | | |
| 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 501(c)(3) organization, check this box and stop here | | | | | | |

| Section C. Computation of Public Support Percentage | | | | | | |
|--|--|----|--|--|--|--|
| 14 Public Support Percentage for 2009 (line 6 column (f) divided by line 11 column (f)) | | 14 | | | | |
| 15 Public Support Percentage for 2008 Schedule A, Part II, line 14 | | 15 | | | | |
| 16a 33 1/3% support test—2009. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | | | | | |
| b 33 1/3% support test—2008. If the organization did not check the box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization | | | | | | |
| 17a 10%-facts-and-circumstances test—2009. 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 IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization | | | | | | |
| b 10%-facts-and-circumstances test—2008. 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 IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization | | | | | | |
| 18 Private Foundation If the organization did not check a box on line 13, 16a, 16b, 17a or 17b, check this box and see instructions | | | | | | |

Part IIISupport Schedule for Organizations Described in IRC 509(a)(2)
(Complete only if you checked the box on line 9 of Part I.)

Section A. Public Support

| Calendar year (or fiscal year beginning in) | (a) 2005 | (b) 2006 | (c) 2007 | (d) 2008 | (e) 2009 | (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) 2005 | (b) 2006 | (c) 2007 | (d) 2008 | (e) 2009 | (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 IV) | | | | | | |
| 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 501(c)(3) organization, check this box and stop here | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|---|----|--|
| 15 Public Support Percentage for 2009 (line 8 column (f) divided by line 13 column (f)) | 15 | |
| 16 Public support percentage from 2008 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|----|--|
| 17 Investment income percentage for 2009 (line 10c column (f) divided by line 13 column (f)) | 17 | |
| 18 Investment income percentage from 2008 Schedule A, Part III, line 17 | 18 | |
| 19a 33 1/3% support tests—2009. 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—2008. 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

Supplemental Information. Supplemental Information. Complete this part to provide the explanation required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. Provide any other additional information. See instructions

Additional Data

Software ID:

Software Version:

EIN: 93-0391573

Name: GOOD SAMARITAN HOSPITAL CORVALLIS

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

| (A) Name and Title | (B) Average hours per week | (C) Position (check all that apply) | | | | | | (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 | | | |
| TOSHIO NAGAMOTO MD PHYSICIAN | 40 00 | | | | | X | | 563,066 | 0 | 40,779 |
| STEVEN W JASPERSON CEO | 40 00 | | | X | | | | 0 | 361,386 | 54,413 |
| STEVEN GOODWIN MD PHYSICIAN | 40 00 | | | | | X | | 806,114 | 0 | 38,478 |
| SHIRLEY PETERSON BOARD CHAIR | 1 00 | X | | X | | | | 0 | 0 | 0 |
| RYAN STEVENS MD BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| RITA CAVIN PHD BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| RICHARD CRONK MD BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| REVEREND SIMON JUSTICE BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| RANDALL V BREAM MD PHYSICIAN | 40 00 | | | | | X | | 632,699 | 0 | 37,564 |
| MICHAEL A MAY MD VP-SMH MED DIR | 40 00 | | | | X | | | 251,225 | 0 | 54,211 |
| KEVIN EWANCHYNA MD BRD MBR/VP-CMO | 6 00 | X | | | | | | 0 | 230,969 | 41,017 |
| KATHRYN M HALE VP-NURSING | 40 00 | | | | X | | | 158,032 | 0 | 39,349 |
| JUDY LIST BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| JAY Y PARK MD PHYSICIAN | 0 | | | | | X | | 551,874 | 0 | 19,533 |
| JAY MCHENRY BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| GILBERT BECK BOARD TREASURER | 1 00 | X | | X | | | | 0 | 0 | 0 |
| FREDERICK W WEISENSEE MD BRD MEMBER/PHYS | 40 00 | X | | | | | | 299,996 | 0 | 32,810 |
| DONALD PENNINGTON DO PHYSICIAN | 40 00 | | | | | X | | 734,941 | 0 | 41,047 |
| DANIEL B SMITH VP FIN/CFO | 8 00 | | | X | | | | 0 | 224,381 | 41,101 |
| CLIFFORD A HALL MD BRD MBR/PHYS | 1 00 | X | | | | | | 24,537 | 0 | 7,798 |
| CARLYN ROY BOARD SECRETARY | 1 00 | X | | X | | | | 0 | 0 | 0 |

SCHEDULE D

(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► **Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.**
► **Attach to Form 990. ► See separate instructions.**

OMB No 1545-0047

2009

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" to Form 990, Part IV, line 6.

| | | |
|---|---|------------------------------|
| | (a) Donor advised funds | (b) Funds and other accounts |
| 1 | Total number at end of year | |
| 2 | Aggregate contributions to (during year) | |
| 3 | Aggregate 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? <div><input type="checkbox"/> Yes<input type="checkbox"/> No</div> | |
| 6 | Did the organization inform all grantees, donors, and donor advisors in writing that grant funds may 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 <div><input type="checkbox"/> Yes<input type="checkbox"/> No</div> | |

Part II

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

| | | | | | | | | | | | | |
|---|---|--|--|-----------------------------|---|--|---|--|---|--|---|---|
| 1 | Purpose(s) of conservation easements held by the organization (check all that apply) <div><input type="checkbox"/> Preservation of land for public use (e g , recreation or pleasure)<input type="checkbox"/> Preservation of an historically importantly land area<input type="checkbox"/> Protection of natural habitat<input type="checkbox"/> Preservation of a certified historic structure<input type="checkbox"/> Preservation of open space</div> | | | | | | | | | | | |
| 2 | Complete lines 2a–2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year | | | | | | | | | | | |
| | | <table><tr><td></td><td>Held at the End of the Year</td></tr><tr><td>a</td><td>Total number of conservation easements</td></tr><tr><td>b</td><td>Total acreage restricted by conservation easements</td></tr><tr><td>c</td><td>Number of conservation easements on a certified historic structure included in (a)</td></tr><tr><td>d</td><td>Number of conservation easements included in (c) acquired after 8/17/06</td></tr></table> | | Held at the End of the Year | a | Total number of conservation easements | b | Total acreage restricted by conservation easements | c | Number of conservation easements on a certified historic structure included in (a) | d | Number of conservation easements included in (c) acquired after 8/17/06 |
| | Held at the End of the Year | | | | | | | | | | | |
| a | Total number of conservation easements | | | | | | | | | | | |
| b | Total acreage restricted by conservation easements | | | | | | | | | | | |
| c | Number of conservation easements on a certified historic structure included in (a) | | | | | | | | | | | |
| d | Number of conservation easements included in (c) acquired after 8/17/06 | | | | | | | | | | | |
| 3 | Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the taxable 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? <div><input type="checkbox"/> Yes<input type="checkbox"/> No</div> | | | | | | | | | | | |
| 6 | Staff and volunteer hours devoted to monitoring, inspecting and enforcing conservation easements during the year ► _____ | | | | | | | | | | | |
| 7 | Amount of expenses incurred in monitoring, inspecting, 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 170(h)(4)(B)(ii)? <div><input type="checkbox"/> Yes<input type="checkbox"/> No</div> | | | | | | | | | | | |
| 9 | In Part XIV, 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" to Form 990, Part IV, line 8.

| | | |
|----|--|------------|
| 1a | If the organization elected, as permitted under SFAS 116, 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 XIV, the text of the footnote to its financial statements that describes these items | |
| b | If the organization elected, as permitted under SFAS 116, 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) Revenues included in 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 relating to these items | |
| a | Revenues included in Form 990, Part VIII, line 1 | ► \$ _____ |
| b | Assets included in Form 990, Part X | ► \$ _____ |

Part III

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

3

Using the organization's 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 XIV

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" to 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 XIV 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?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIV

Part V

Endowment Funds. Complete if the organization answered "Yes" to 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 | | | | |
| b | Contributions | | | | |
| c | Investment earnings or losses | | | | |
| d | Grants or scholarships | | | | |
| e | Other expenditures for facilities and programs | | | | |
| f | Administrative expenses | | | | |
| g | End of year balance | | | | |

2

Provide the estimated percentage of the year end balance held as

a

Board designated or quasi-endowment ▶ %

b

Permanent endowment ▶ %

c

Term endowment ▶ %

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

| | | |
|--------|-----|----|
| | Yes | No |
| 3a(i) | | No |
| 3a(ii) | | No |
| 3b | Yes | |

4

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

Part VI

Investments—Land, Buildings, and Equipment. See Form 990, Part X, line 10.

| Description of investment | (a) Cost or other basis (investment) | (b)Cost or other basis (other) | (c) Accumulated depreciation | (d) Book value |
|--|--------------------------------------|--------------------------------|------------------------------|----------------|
| 1a Land | | 2,608,871 | | 2,608,871 |
| b Buildings | | 105,512,870 | 50,436,272 | 55,076,598 |
| c Leasehold improvements | | 1,667,980 | 178,028 | 1,489,952 |
| d Equipment | | 56,683,000 | 39,764,361 | 16,918,639 |
| e Other | | 33,700,572 | 3,031,329 | 30,669,243 |
| Total. Add lines 1a-1e (Column (d) should equal Form 990, Part X, column (B), line 10(c).) | | | | 106,763,303 |

| Part XI Reconciliation of Change in Net Assets from Form 990 to Financial Statements | | |
|--|---|--------------|
| 1 | Total revenue (Form 990, Part VIII, column (A), line 12) | 1277,000,054 |
| 2 | Total expenses (Form 990, Part IX, column (A), line 25) | 2268,265,692 |
| 3 | Excess or (deficit) for the year Subtract line 2 from line 1 | 38,734,362 |
| 4 | Net unrealized gains (losses) on investments | 41,615,016 |
| 5 | Donated services and use of facilities | 5 |
| 6 | Investment expenses | 6 |
| 7 | Prior period adjustments | 7 |
| 8 | Other (Describe in Part XIV) | 81,619,423 |
| 9 | Total adjustments (net) Add lines 4 - 8 | 93,234,439 |
| 10 | Excess or (deficit) for the year per financial statements Combine lines 3 and 9 | 1011,968,801 |

| Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return | | |
|---|--|--------------|
| 1 | Total revenue, gains, and other support per audited financial statements | 1276,824,801 |
| 2 | Amounts included on line 1 but not on Form 990, Part VIII, line 12 | |
| a | Net unrealized gains on investments2a | |
| b | Donated services and use of facilities2b | |
| c | Recoveries of prior year grants2c | |
| d | Other (Describe in Part XIV)2d207,488 | |
| e | Add lines 2a through 2d | 2e207,488 |
| 3 | Subtract line 2e from line 1 | 3276,617,313 |
| 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 7b4a | |
| b | Other (Describe in Part XIV)4b382,741 | |
| c | Add lines 4a and 4b | 4c382,741 |
| 5 | Total Revenue Add lines 3 and 4c. (This should equal Form 990, Part I, line 12) | 5277,000,054 |

| Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return | | |
|--|---|--------------|
| 1 | Total expenses and losses per audited financial statements | 1268,473,180 |
| 2 | Amounts included on line 1 but not on Form 990, Part IX, line 25 | |
| a | Donated services and use of facilities2a | |
| b | Prior year adjustments2b | |
| c | Other losses2c | |
| d | Other (Describe in Part XIV)2d207,488 | |
| e | Add lines 2a through 2d | 2e207,488 |
| 3 | Subtract line 2e from line 1 | 3268,265,692 |
| 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 7b4a | |
| b | Other (Describe in Part XIV)4b | |
| c | Add lines 4a and 4b | 4c |
| 5 | Total expenses Add lines 3 and 4c. (This should equal Form 990, Part I, line 18) | 5268,265,692 |

| Part XIV Supplemental Information | | |
|--|--|---|
| Complete this part to 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, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information. | | |
| Identifier | Return Reference | Explanation |
| Part XIII, Line 2d | Part XIII, Line 2d Other expenses and losses per audited F/S | EXPENSES NETTED W/ REV PER AFS \$207488 |
| Part XII, Line 4b | Part XII, Line 4b Other revenue amounts included on 990 but not included in F/S | CONTRIB REV - CHG IN NET ASSETS PER AFS \$382741 |
| Part XII, Line 2d | Part XII, Line 2d Other revenue amounts included in F/S but not included on form 990 | EXPENSES NETTED W/ REV PER AFS \$207488 |
| Part XI, Line 8 | Part XI, Line 8 Other Changes in Net Assets or Fund Balances | DECREASE IN PENSION LIABILITY \$1587887 OTHER CHANGES IN FUND BALANCE \$31536 |
| Part V, Line 4 | Part V, Line 4 Intended uses of the endowment fund | The Good Samaritan Hospital Foundation (GSHF) holds endowment funds that will ultimately benefit the hospital. GSHF's board-designated Bernier and General Endowments are used for general Hospital support. GSHF's Erkkila endowment is used for health and human performance research and rehabilitation. GSHF's Mullins Scholarship endowment supports educational scholarships. GSHF's Pastega House endowment helps underwrite the operating costs of the Mario Pastega Guest House. GSHF's Vrtiska endowment supports the Hospital's laboratory for educational purposes. |

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**
▶ **Attach to Form 990.**
▶ **See separate instructions.**

OMB No 1545-0047

2009

Open to Public Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

Part I

Charity Care and Certain Other Community Benefits at Cost

| | | | | |
|--|---|-----|-----|----|
| | | Yes | No | |
| 1a | Does the organization have a charity care policy? If "No," skip to question 6a | 1a | Yes | |
| b | If "Yes," is it a written policy? | 1b | Yes | |
| 2 | If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals <div><input checked="" type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Generally tailored to individual hospitals</div> <div><input type="checkbox"/> Applied uniformly to most hospitals</div> | | | |
| 3 | Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients a Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for free care <div><input type="checkbox"/> 100%<input checked="" type="checkbox"/> 150%<input type="checkbox"/> 200%<input type="checkbox"/> Other _____</div> b Does the organization use FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care <div><input checked="" type="checkbox"/> 200%<input type="checkbox"/> 250%<input type="checkbox"/> 300%<input type="checkbox"/> 350%<input type="checkbox"/> 400%<input type="checkbox"/> Other _____</div> c If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care 4 Does the organization's policy provide free or discounted care to the "medically indigent"? | 3a | Yes | |
| 5a | Does the organization budget amounts for free or discounted care provided under its charity care policy? | 5a | Yes | |
| b | If "Yes," did the organization's charity care expenses exceed the budgeted amount? | 5b | Yes | |
| c | If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? | 5c | | No |
| 6a | Does the organization prepare an annual community benefit report? | 6a | Yes | |
| 6b | If "Yes," does 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 Charity Care and Certain Other Community Benefits at Cost | | | | | | |
|---|---|-------------------------------|-------------------------------------|-------------------------------|-----------------------------------|------------------------------|
| Charity Care 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 Charity care at cost (from Worksheets 1 and 2) | 7 | 5,705 | 5,755,590 | | 5,755,590 | 2 150 % |
| b Unreimbursed Medicaid (from Worksheet 3, column a) | 6 | 58,411 | 24,143,917 | 14,206,335 | 9,937,582 | 3 700 % |
| c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b) | | | | | | |
| d Total Charity Care and Means-Tested Government Programs | 13 | 64,116 | 29,899,507 | 14,206,335 | 15,693,172 | 5 850 % |
| Other Benefits | | | | | | |
| e Community health improvement services and community benefit operations (from Worksheet 4) | 45 | 12,600 | 586,186 | 15,071 | 571,115 | 0 210 % |
| f Health professions education (from Worksheet 5) | 9 | 10,672 | 2,973,103 | 367,445 | 2,605,658 | 0 970 % |
| g Subsidized health services (from Worksheet 6) | 24 | 178,318 | 53,595,871 | 31,643,448 | 21,952,423 | 8 180 % |
| h Research (from Worksheet 7) | 1 | 17 | 107,486 | | 107,486 | 0 040 % |
| i Cash and in-kind contributions to community groups (from Worksheet 8) | 20 | 9,340 | 618,361 | 204,687 | 413,674 | 0 150 % |
| j Total Other Benefits | 99 | 210,947 | 57,881,007 | 32,230,651 | 25,650,356 | 9 560 % |
| k Total. Add lines 7d and 7j | 112 | 275,063 | 87,780,514 | 46,436,986 | 41,343,528 | 0 |

Part IICommunity Building Activities

Complete this table if the organization conducted any community building activities.

| | (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 |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1Physical improvements and housing | | | | | | |
| 2Economic development | | | | | | |
| 3Community support | 4 | 1,090 | 30,586 | | 30,586 | 0 010 % |
| 4Environmental improvements | | | | | | |
| 5Leadership development and training for community members | 1 | 40 | 5,474 | | 5,474 | |
| 6Coalition building | 1 | 19 | 16,265 | | 16,265 | 0 010 % |
| 7Community health improvement advocacy | 1 | 1 | 294 | | 294 | |
| 8Workforce development | | | | | | |
| 9Other | | | | | | |
| 10Total | 7 | 1,150 | 52,619 | | 52,619 | 0 020 % |

Part IIIBad Debt, Medicare, & Collection Practices

Section A.Bad Debt Expense

| | | Yes | No |
|--|------------|-----|----|
| 1Does the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No. 15? | 1 | | No |
| 2Enter the amount of the organization's bad debt expense (at cost) | 22,024,116 | | |
| 3Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy | 3109,471 | | |
| 4Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including other bad debt amounts in community benefit. | | | |

Section B.Medicare

| | | | |
|--|-------------|--|--|
| 5Enter total revenue received from Medicare (including DSH and IME) | 537,510,396 | | |
| 6Enter Medicare allowable costs of care relating to payments on line 5 | 641,236,579 | | |
| 7Subtract line 6 from line 5. This is the surplus or (shortfall) | 7-3,726,183 | | |
| 8Describe 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

| | | | |
|--|----|-----|--|
| 9aDoes the organization have a written debt collection policy? | 9a | Yes | |
| 9bIf "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI. | 9b | Yes | |

Part IVManagement Companies and Joint Ventures

| (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership% | (e) Physicians' profit % or stock ownership % |
|-----------------------------|---|--|---|---|
| 1CORVALLIS MRI A JV | IMAGING SERVICES | 50 000 % | | 50 000 % |
| 2VALLEY MOBILE IMAGING LLC | IMAGING SERVICES | 60 000 % | | 40 000 % |
| 3COASTAL MOBILE IMAGING LLC | IMAGING SERVICES | 55 000 % | | 35 000 % |
| 4SAMARITAN ENDOSCOPY CENTER | MEDICAL SERVICES | 66 667 % | | 33 333 % |
| 5HULL IMAGING LLC | IMAGING SERVICES | 60 000 % | | 40 000 % |
| 6CORVALLIS MED BLDGS LLC | REAL PROPERTY RENTAL | 54 500 % | | 18 500 % |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |

Part V **Facility Information**

| Name and address | Other (Describe) |
|------------------|----------------------------|
| | ER-other |
| | ER-24 hours |
| | Research facility |
| | Critical access hospital |
| | Teaching hospital |
| | Children's hospital |
| | General medical & surgical |
| | Licensed hospital |

See Additional Data Table

Part VI

Supplemental Information

Complete this part to provide the following information

1

Provide the description required for Part I, line 3c, Part I, line 6a, Part I, line 7g, Part I, line 7, column (f), Part I, line 7, Part III, line 4, Part III, line 8, Part III, line 9b, and Part V See Instructions

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

Physician clinics meeting the definition of subsidized health services were included in the reporting for line 7g The portion of net community benefit expense related to these clinics is \$16,691,003

The costing methodology used to calculate the amounts reported in Schedule H, Part I, line 7a and 7b is a cost-to-charge ratio derived using Worksheet 2, Ratio of Patient Care Cost-to-Charges from the Schedule H instructions For line 7g, a combination of the cost-to-charge ratio and cost accounting system calculations is used since not all services are tracked in the cost accounting system

The costing methodology used to calculate bad debt expense (at cost) on line 2 of Part III is based on the facility cost-to-charge ratio, in conjunction with Worksheet A from the Schedule H, Part III instructions Line 3 represents an estimate of the amount of cost included in Line 2 (bad debt expense at cost) that reasonably could be attributable to patients who likely would qualify for financial assistance under the organization's charity care policy, but for whom the organization was not able to obtain sufficient information to make a determination The methodology used to estimate this potential charity care cost is based on financial assistance applications denied due to incomplete documentation, multiplied by the average charity care write-off for approved applications Good Samaritan Hospital (GSH) is the largest of five hospitals of Samaritan Health Services (SHS) As a network, SHS prepares its financial statements on a consolidated basis Footnote 1(r) from the audited consolidated financial statements entitled "Provision for Uncollectible Accounts" describes bad debt expense as follows "SHS provides for an allowance against patient accounts receivable for amounts that could become uncollectible SHS estimates this allowance based on the aging of accounts receivable, historical collection experience by payor, and other relevant factors There are various factors that can impact the collection trends, such as changes in the economy, which in turn have an impact on unemployment rates and the number of uninsured and underinsured patients, the increased burden of copayments to be made by patients with insurance coverage and business practices related to collection efforts These factors continuously change and can have an impact on collection trends and the estimation process used by SHS "

Total Medicare allowable costs reported on Part III, Section B, line 6 is calculated by utilizing Worksheet B in the Schedule H instructions in conjunction with amounts taken directly from the filing organization's Medicare cost report The cost report includes activity for Medicare fee-for-service patients but not Medicare managed care patients In addition, certain costs of providing healthcare services, such as physician compensation, are not allowable on the Medicare cost reports Therefore, the amount of Medicare shortfall shown on Line 7 is smaller than the shortfall calculation using revenue and cost data for ALL Medicare patient activity, as follows Net revenue received from Medicare (all Medicare patient programs) 72,207,003Medicare costs (based on a cost-to-charge ratio) 82,939,893Unpaid cost of providing services to ALL Medicare patients (10,732,890)

Per hospital guidelines, if a patient is determined to qualify for financial assistance prior to sending an account to collections, the charity 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

None

2 Needs assessment. Describe how the organization assesses the health care needs of the communities it serves

Good Samaritan Hospital (GSH) actively participates in assessing the health care needs of the community GSH partners with United Way, the City of Corvallis, Benton County government, Oregon State University, and other non-profit organizations in the community every three years to conduct a comprehensive needs assessment Both quantitative and qualitative data are collected by researchers from county residents to help identify needs and establish priorities for the community This process includes telephone surveys, focus groups, community forums and personal interviews with several community members from throughout Benton County

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 charity care policy

The organization is committed to providing highest quality healthcare 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 Once a completed financial questionnaire has been submitted, individuals/families at or below 200 percent of the established Federal Poverty Level (FPL) could be eligible to receive free or discounted care (charity care) The organization informs and educates patients and community members by publishing information regarding all financial assistance options on its website, in addition to in person at the Registration area, and through clearly identified materials located in the Registration area

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

GSH primarily serves the residents of Benton County However, residents from the adjoining communities of Lincoln and Linn counties are also seen at GSH With a total population of 86,725 (US Census Bureau), Benton County is designated as an urban county The County includes the cities of Corvallis and Philomath as well as the small incorporated townships of Monroe and Adair Village Approximately 21% of Benton County residents live in rural areas of the county The median household income for Benton County is \$70,800, and 15 6% of the residents live below the federal poverty level According to the Oregon Office of Rural Health, 17 1% of Benton County residents are uninsured 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

5 Community building activities. Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves

GSH provides services and activities that are classified as community building This includes leading disaster preparedness drills with local agencies and staff participating in one-on-one mentoring programs at a local school GSH also provides opportunities for community members to obtain training on civic and cultural issues that impact health Some of the training opportunities included grant writing and board development GSH staff serve on many local coalitions and boards that promote the health of the community Board affiliation includes, but is not limited to Community Outreach Inc, the Grace Center, the Center for Healthy Aging Research/Scientific Advisory Board, and the Caring Place Additionally GSH staff serve on the Oregon Health Policy Advisory Board, the Oregon Health Resources Commission, the Medicaid Advisory Committee and regional boards that address health care issues

6 Provide any other information important to describing how the organization's hospitals 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)

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 GSH also contributes financially to the Linn-Benton Community College nursing program

7 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

"Building Healthier Communities Together" is the commitment of, and the motivation for, Samaritan Health Services (SHS), a network of Oregon hospitals, physicians, and senior care facilities that serves the health care needs of people in the mid-Willamette Valley and the Central Oregon Coast As the individual entities of SHS came together to build healthier communities, they were drawn by a shared mission "to enhance community health and achieve high value through quality services across the continuum of care " That means SHS looks carefully at local health care needs, and it gives thoughtful consideration to the most effective ways to meet those needs The result is a rich mix of local and centralized regional services which provide high value and excellent healthcare for people at all stages of their lives Services are provided to all individuals, regardless of their ability to pay The collective vision of SHS is to successfully operate as a values-driven, church-related organization governed by a partnership of community members, physicians and other health care providers SHS seeks to lead collaborative efforts among providers, employers, health plans and consumers who share similar goals and values to meet the challenges of the future GSH is the flagship hospital of SHS It primarily serves residents of Benton County Other affiliated hospitals are Samaritan 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

8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report

OR

Additional Data

Software ID:

Software Version:

EIN: 93-0391573

Name: GOOD SAMARITAN HOSPITAL CORVALLIS

Form 990 Schedule H, Part V - Facility Informaiton

| Name and address | Licensed hospital | General medical & surgical | Children's hospital | Teaching hospital | Critical access hospital | Research facility | ER-24 hours | ER-other | Other (Describe) |
|---|-------------------|----------------------------|---------------------|-------------------|--------------------------|-------------------|-------------|----------|------------------------------|
| SAMARITAN RHEUMATOLOGY 990 NW CIRCLE BLVD STE 101 CORVALLIS,OR 97330 | | | | | | | | | MEDICAL OFFICES |
| SAMARITAN UROLOGY 2292 NW KINGS BLVD CORVALLIS,OR 97330 | | | | | | | | | MEDICAL OFFICES |
| VALLEY MOBILE IMAGING 3615 NW SAMARITAN DR CORVALLIS,OR 97330 | | | | | | | | | MOBILE IMAGING |
| HULL IMAGING 3600 NW SAMARITAN DR CORVALLIS,OR 97330 | | | | | | | | | IMAGING SERVICES |
| CORVALLIS MRI 3615 NW SAMARITAN DRSUITE 100 CORVALLIS,OR 97330 | | | | | | | | | IMAGING SERVICES |
| CORV HEARTSPRING WELLNESS CTR 990 NW CIRCLE BLVD SUITE 201 CORVALLIS,OR 97330 | | | | | | | | | MEDICAL OFFICES |
| SAMARITAN URGENT CARE CENTER 5234 SW PHILOMATH BLVD CORVALLIS,OR 97333 | | | | | | | | | MEDICAL OFFICES |
| SAM PLASTICRECON SURG-HAVARD 996 NW CIRCLE BLVD STE 103 CORVALLIS,OR 97330 | | | | | | | | | MEDICAL OFFICE |
| SAMARITAN GYN & SURG ASSOC 400 NW WALNUT BLVD SUITE 300 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN ENDOSCOPY CENTER 3509 NW SAMARITAN DRSUITE 201 CORVALLIS,OR 97330 | | | | | | | | | ENDOSCOPY CENTER |
| SAMARITAN MENTAL HLTH-NEWPORT 1600 N COAST HWY 101 NEWPORT,OR 97365 | | | | | | | | | PHYSICIAN CLINIC |
| COASTAL MOBILE IMAGING 930 SW ABBEY ST NEWPORT,OR 97365 | | | | | | | | | MOBILE IMAGING |
| SAMARITAN MENTAL HEALTH-ALBANY 1052 SW 29TH ST ALBANY,OR 97321 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN DERMATOLOGY 2358 NW KINGS BLVD SUITE 100 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN MENTAL HEALTH-CORV 3509 NW SAMARITAN DR CORVALLIS,OR 97330 | | | | | | | | | PATIENT & OUTPATIENT SERVICE |
| SAM PLASTICRECON SURG-WILCOX 3517 NW SAMARITAN DRSUITE 100 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN PEDIATRICS 3517 NW SAMARITAN DR SUITE C CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN FAMILY MEDICINE 3517 NW SAMARITAN DRSUITE 201 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| MAMMOGRAPHY CLINIC 444 NW ELKS DR CORVALLIS,OR 97330 | | | | | | | | | MAMMOGRAPHY |
| SAMARITAN REGIONAL CANCER CTR 501 NW ELKS DR CORVALLIS,OR 97330 | | | | | | | | | RADIATION ONCOLOGY |
| SAMARITAN HEMATOLOGYONCOLOGY 501 NW ELKS DR CORVALLIS,OR 97330 | | | | | | | | | RADIATION ONCOLOGY |
| SAMARITAN ORTHOSPORTS MED CTR 3640 NW SAMARITAN DR CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN OBSTETRICS & GYN 3640 NW SAMARITAN DRSUITE 270 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN INFECTIOUS DISEASE 3640 NW SAMARITAN DRSUITE 210 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN HAND THERAPY 3640 NW SAMARITAN DR CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN SURGICAL SPECIALISTS 3615 SAMARITAN DRSUITE 201 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAM NEUROSURG-DR ROBERSON 3615 NW SAMARITAN DRSUITE 210 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN NEUROSURG-DR GOODWIN 3615 NW SAMARITAN DRSUITE 211 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN KIDNEY SPECIALISTS 3615 NW SAMARITAN DRSUITE 203 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAMARITAN INTERNAL MEDICINE 3615 NW SAMARITAN DRSUITE 100 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAM HEART & VASC - CARDIOLOGY 3600 NW SAMARITAN DR STE E350 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAM HEART & VASC - VASC SURG 3615 NW SAMARITAN DRSUITE 201 CORVALLIS,OR 97330 | | | | | | | | | PHYSICIAN CLINIC |
| SAM HEART & VASC-CARDIAC SURG 3600 NW SAMARITAN DRSUITE 227 CORVALLIS,OR 97330 | | | | | | | | | INPATIENT SURGERY |
| GOOD SAMARITAN HOSPITAL CORV 3600 NW SAMARITAN DR CORVALLIS,OR 97330 | X | X | | | | | | X | |

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DLN: 93493313015160

Schedule I
(Form 990)

Department of the Treasury
Internal Revenue Service

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

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

OMB No 1545-0047

2009

Open to Public
Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

Part I

General Information on Grants and Assistance

1

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

Yes

No

2

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

Part II

Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21 for any recipient that received more than \$5,000. Check this box if no one recipient received more than \$5,000. Use Part IV and Schedule I-1 (Form 990) if additional space is needed ▶

| (a) Name and address of organization or government | (b) EIN | (c) IRC Code 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 |
|---|-----------|------------------------------------|--------------------------|-----------------------------------|---|--|--|
| Linn Benton Community College-Nursing6500 SW PACIFIC BLVD ALBANY,OR 97321 | 237212073 | 501(c)(3) | 42,500 | 0 | | | NURSING PROGRAM SUPPORT |
| HOMELESS ALTERNATIVES4541 n congress ave portland,OR 97217 | 262855117 | 501(c)(3) pending | 8,980 | 0 | | | Homeless transition assistance |
| Community Outreach865 REIMAN AVE CORVALLIS,OR 97330 | 930602094 | 501(c)(3) | 73,000 | 0 | | | MEDICAL, DENTAL, MENTAL HEALTH CLINICS |
| BENTON COUNTYPO BOX 579 CORVALLIS,OR 97339 | 936002285 | gov't | 85,020 | 0 | | | HEALTHY START PROGRAM |

2

Enter total number of section 501(c)(3) and government organizations

4

3

Enter total number of other organizations

0

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

Cat No 50055P

Schedule I (Form 990) 2009

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

2009

Open to Public Inspection

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

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 23.

▶ Attach to Form 990. ▶ See separate instructions.

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 in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items | | |
| | <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div></div> <div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input checked="" type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div> | | |
| b | If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all the expenses described above? If "No," complete Part III to explain | Yes | |
| 2 | Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a? | Yes | |
| 3 | Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply | | |
| | <div><div><input type="checkbox"/> Compensation committee</div><div><input checked="" type="checkbox"/> Independent compensation consultant</div><div><input checked="" type="checkbox"/> Form 990 of other organizations</div></div> <div><div><input checked="" type="checkbox"/> Written employment contract</div><div><input checked="" type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div> | | |
| 4 | During the year, did any person listed in 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? | | No |
| b | Participate in, or receive payment from, a supplemental nonqualified retirement plan? | | No |
| c | Participate in, or receive payment from, an equity-based compensation arrangement? | | No |
| | If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III | | |
| | Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9. | | |
| 5 | For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of | | |
| a | The organization? | Yes | |
| b | Any related organization? | | No |
| | If "Yes," to line 5a or 5b, describe in Part III | | |
| 6 | For persons listed in 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? | | No |
| b | Any related organization? | | No |
| | If "Yes," to line 6a or 6b, describe in Part III | | |
| 7 | For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III | | No |
| 8 | Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III | | No |
| 9 | If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)? | | No |

Part II

Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use Schedule J-1 if additional space needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions on row (ii) Do not list any individuals that are not listed on Form 990, Part VII

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a

| (A) Name | | (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 reported in prior Form 990 or Form 990-EZ |
|--------------------------|-------------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|--|
| | | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| TOSHIO NAGAMOTO MD | (i) (ii) | 527,198 | 18,376 | 17,492 | 18,471 | 22,308 | 603,845 | |
| STEVEN W JASPERSON | (i) (ii) | 259,075 | | 102,311 | 31,996 | 22,417 | 415,799 | |
| STEVEN GOODWIN MD | (i) (ii) | 804,268 | | 1,846 | 20,981 | 17,497 | 844,592 | |
| RANDALL V BREAM MD | (i) (ii) | 613,892 | | 18,807 | 18,928 | 18,636 | 670,263 | |
| MICHAEL A MAY MD | (i) (ii) | 244,113 | | 7,112 | 29,069 | 25,142 | 305,436 | |
| KEVIN EWANCHYNA MD | (i) (ii) | 229,926 | | 1,043 | 16,247 | 24,770 | 271,986 | |
| KATHRYN M HALE | (i) (ii) | 150,026 | | 8,006 | 22,884 | 16,465 | 197,381 | |
| JAY Y PARK MD | (i) (ii) | 549,574 | | 2,300 | 15,328 | 4,205 | 571,407 | |
| FREDERICK W WEISENSEE MD | (i) (ii) | 282,087 | 3,837 | 14,072 | 18,765 | 14,045 | 332,806 | |
| DONALD PENNINGTON DO | (i) (ii) | 734,201 | | 740 | 18,755 | 22,292 | 775,988 | |
| DANIEL B SMITH | (i) (ii) | 203,379 | | 21,002 | 15,895 | 25,206 | 265,482 | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Part III

Supplemental Information

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

| Identifier | Return Reference | Explanation |
|------------------------|---|---|
| Sch J, Part I, Line 1a | Part I, Line 1a. Relevant information in regards to selections on 1a. | In connection with its employee wellness program, the organization has a gym reimbursement benefit that is available to all employees who work at least 32 hours per month. The employee must attend the gym for 6 consecutive months, at least 50 times, in order to qualify for reimbursement. This gym reimbursement benefit is included in the employees taxable wages and is subject to state/federal withholding tax. Three of the listed employees received the benefit in 2009. |

SCHEDULE O
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990

OMB No 1545-0047

2009

Open to Public Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

| Identifier | Return Reference | Explanation |
|-----------------------------|--|---|
| Form 990, Part VI, Line 19 | Form 990, Part VI, Line 19 Other Organization Documents Publicly Available | Financial statements are made available upon request. System-wide summarized data is also provided in the Annual Report to the Community. This report is made available in all kiosks and high-traffic areas of all hospitals and physician clinics, as well as community places such as the public library. It is also distributed to the Boards of Directors and directly mailed to donors and new residents in the community. Additionally, the report is made available at all events, community outreach projects, and screenings attended throughout the year. Governing documents are available to the public upon request. |
| Form 990, Part VI, Line 12c | Form 990, Part VI, Line 12c Explanation of Monitoring and Enforcement of Conflicts | 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 Ethics and Conduct 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. |
| Form 990, Part VI, Line 11 | Form 990, Part VI, Line 11 Form 990 Review Process | 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. |
| Form 990, Part VI, Line 7a | Form 990, Part VI, Line 7a How Members or Shareholders Elect Governing Body | Good Samaritan Hospital Corvallis elects members of its Board of Directors. Those elected members are then submitted to the sole corporate member for approval. |
| Form 990, Part VI, Line 6 | Form 990, Part VI, Line 6 Explanation of Classes of Members or Shareholder | Good Samaritan Hospital Corvallis has a sole corporate member, Samaritan Health Services, Inc., which is a Section 501(c)(3) tax-exempt organization. |
| Form 990, Part VI, Line 4 | Form 990, Part VI, Line 4 Description of Significant Changes to Organizational Documents | THE BYLAWS WERE AMENDED BY REMOVING THE REFERENCES TO THE EXPIRATION DATE OF THE TERM OF EACH DIRECTOR. |

Related Organizations and Unrelated Partnerships

2009

Open to Public Inspection

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**

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 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.)

(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

See Additional Data Table

Part III

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

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

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 |
|---|--|---|-------------------------------------|--|------------------------------|--|--------------------------------|
| Samaritan Health Plans Inc 3600 NW SAMARITAN DRIVE Corvallis, OR97330 93-0860860 | Health Insurance Carrier for the Community | OR | NA | C-CORP | | | |

Part V

Transactions With Related Organizations (Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III or IV

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

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

b Gift, grant, or capital contribution to other organization(s)

c Gift, grant, or capital contribution from other organization(s)

d Loans or loan guarantees to or for other organization(s)

e Loans or loan guarantees by other organization(s)

f Sale of assets to other organization(s)

g Purchase of assets from other organization(s)

h Exchange of assets

i Lease of facilities, equipment, or other assets to other organization(s)

j Lease of facilities, equipment, or other assets from other organization(s)

k Performance of services or membership or fundraising solicitations for other organization(s)

l Performance of services or membership or fundraising solicitations by other organization(s)

m Sharing of facilities, equipment, mailing lists, or other assets

n Sharing of paid employees

o Reimbursement paid to other organization for expenses

p Reimbursement paid by other organization for expenses

q Other transfer of cash or property to other organization(s)

r Other transfer of cash or property from other organization(s)

Yes

No

1a Yes

1b No

1c Yes

1d No

1e No

1f No

1g No

1h No

1i Yes

1j Yes

1k Yes

1l Yes

1m Yes

1n Yes

1o Yes

1p Yes

1q No

1r 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

| | (a) Name of other organization | (b) Transaction type(a-r) | (c) Amount involved |
|-----|-----------------------------------|---------------------------------|------------------------|
| (1) | See Additional Data Table | | |
| (2) | | | |
| (3) | | | |
| (4) | | | |
| (5) | | | |
| (6) | | | |

Schedule R (Form 990) 2009

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

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

| (a) Name, address, and EIN of entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Are all partners section 501(c)(3) organizations? | | (e) Share of end-of-year assets | (f) Disproportionate allocations? | | (g) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065) | (h) General or managing partner? | |
|---|-------------------------|--|--|----|--|---|----|---|---|----|
| | | | Yes | No | | Yes | No | | Yes | No |

Software ID: 09000047

Software Version: 2009v1.3

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 501(c)(3)) | (f) Direct Controlling Entity |
|--|--|---|----------------------------|--|----------------------------------|
| Samaritan Senior Care Inc PO Box 3000 Corvallis, OR973393000 93-1245534 | Provide Health Care for Seniors | OR | 501(c)(3) | 9 | NA |
| Samaritan Pacific Health Services 930 SW Abbey Street Newport, OR97365 93-1329784 | Hospital Services for the Community | OR | 501(c)(3) | 3 | NA |
| Samaritan North Lincoln Hospital 3043 NE 28th Street Lincoln City, OR97367 93-1305493 | Hospital Services for the Community | OR | 501(c)(3) | 3 | NA |
| Samaritan Health Services Inc PO Box 3000 Corvallis, OR973393000 93-0951989 | Provide Healthcare Support Services | OR | 501(c)(3) | 11c, III-FI | NA |
| Paradigm Indemnity Corporation PO Box 3000 Corvallis, OR973393000 73-1668317 | Pure non-profit captive insurance company | HI | 501(c)(3) | 11a, I | NA |
| Mid-Valley HealthCare Inc PO Box 3000 Corvallis, OR973393000 93-0396847 | Hospital Services for the Community | OR | 501(c)(3) | 3 | NA |
| Lebanon Community Hospital Foundation PO Box 739 Lebanon, OR97355 93-1260080 | To support Lebanon Community Hospital | OR | 501(c)(3) | 7 | NA |
| InterCommunity Health Plans Inc PO box 3000 Corvallis, OR973393000 93-1124326 | Serve Oregon Health Plan for Medicaid | OR | 501(c)(4) | N/A | NA |
| Good Samaritan Hospital Foundation PO Box 1068 Corvallis, OR97339 23-7252406 | To support Good Samaritan Hospital | OR | 501(c)(3) | 7 | NA |
| Good Samaritan Hospital Auxiliary 3600 NW Samaritan Drive Corvallis, OR973303737 93-6024034 | Support Good Samaritan Hospital | OR | 501(c)(3) | 11d, III-O | NA |
| FirstCare Medical Foundation PO Box 3000 Corvallis, OR973393000 93-0932697 | Provider of Medical Services for the Community | OR | 501(c)(3) | 9 | NA |
| FirstCare Health Foundation PO Box 3000 Corvallis, OR973393000 93-0900124 | To support affiliated exempt entities | OR | 501(c)(3) | 11b, II | NA |
| Albany General Hospital Foundation 1046 Sixth Avenue SW Albany, OR97321 93-0712890 | To support Albany General Hospital | OR | 501(c)(3) | 7 | NA |
| Albany General Hospital PO Box 3000 Corvallis, OR973393000 93-0110095 | Hospital Services for the Community | OR | 501(c)(3) | 3 | NA |

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal Domicile (State or Foreign Country) | | (d) Direct Controlling Entity | (e) Predominant income(related, unrelated, excluded from tax under sections 512-514) | (f) Share of total income (\$) | (g) Share of end-of-year assets (\$) | (h) Dispropportionate allocations? | | (i) Code V-UBI amount on Box 20 of K-1 (\$) | (j) General or Managing Partner? | |
|---|-------------------------|---|-----|--|---|--------------------------------------|---|--|----|---|---|----|
| | | | | | | | | Yes | No | | Yes | No |
| MID-VALLEY MEDICAL BUILDINGS LLC PO BOX 557 LEBANON, OR97355 93-1126353 | RE RENTAL | OR | NA | | N/A | | | | No | | | No |
| Mid-Valley Medical Properties Assoc LLC 1046 Sixth Ave SW Albany, OR97321 30-0508747 | RE Rental | OR | N/A | | N/A | | | | No | | | No |
| Corvallis MRI A Joint Venture 3615 NW Samaritan Drive Corvallis, OR973303737 93-0949704 | Imaging | OR | N/A | | RELATED | 340,444 | 1,079,276 | | No | | Yes | |
| CBA-SAM LLC PO BOX 433 Lincoln City, OR97367 93-1314523 | RE RENTAL | OR | NA | | N/A | | | | No | | | No |
| Valley Mobile Imaging LLC 3600 NW Samaritan Drive Corvallis, OR97330 93-1299195 | Imaging | OR | NA | | RELATED | 388,306 | | | No | | | No |
| Samaritan Open MRI LLC 3600 NW Samaritan Drive Corvallis, OR97330 20-8346225 | Imaging | OR | N/A | | N/A | | | | No | | | No |
| Hull Imaging LLC 3600 NW Samaritan Drive Corvallis, OR97330 20-3255479 | Imaging | OR | N/A | | RELATED | 391,030 | 231,572 | | No | | | No |
| East Linn MRI LLC 3600 NW Samaritan Drive Corvalli, OR97330 32-0229399 | Imaging | OR | N/A | | N/A | | | | No | | | No |
| Corvallis Medical Buildings LLC 3600 NW Samaritan Drive Corvallis, OR97330 93-1257913 | RE RENTAL | OR | NA | | EXCLUDED | 103,661 | 1,476,243 | | No | | | No |
| Coastal Mobile Imaging LLC 3615 NW Samaritan Drive Corvallis, OR973303737 33-1023186 | Imaging | OR | NA | | RELATED | -5,191 | | | No | | | No |
| SAMARITAN ENDOSCOPY CENTER LLC 3600 NW Samaritan Drive Corvallis, OR97330 20-2860067 | Medical Svc | OR | N/A | | RELATED | 621,886 | 925,365 | | No | | | No |

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

| (a) Name of other organization | | (b) Transaction type(a-r) | (c) Amount Involved (\$) |
|-----------------------------------|---------------------------------|---------------------------------|--------------------------------|
| (1) | Valley Mobile Imaging LLC | r | 396,209 |
| (2) | Valley Mobile Imaging LLC | n | 120,873 |
| (3) | Hull Imaging LLC | r | 348,000 |
| (4) | Hull Imaging LLC | n | 601,426 |
| (5) | Hull Imaging LLC | a | 407,887 |
| (6) | Corvallis Medical Buildings LLC | j | 401,796 |
| (7) | Corvallis Medical Buildings LLC | a | 44,950 |
| (8) | Coastal Mobile Imaging LLC | r | 64,007 |
| (9) | SAMARITAN ENDOSCOPY CENTER LLC | r | 650,943 |
| (10) | SAMARITAN ENDOSCOPY CENTER LLC | n | 136,950 |
| (11) | SAMARITAN ENDOSCOPY CENTER LLC | a | 363,860 |
| (12) | InterCommunity Health Plans Inc | k | 9,494,055 |