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Form **990**
 Department of the Treasury
 Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public
 ▶ Information about Form 990 and its instructions is at www.irs.gov/form990

OMB No 1545-0047
2014
Open to Public Inspection

A For the 2014 calendar year, or tax year beginning 01-01-2014, and ending 12-31-2014

| | | |
|--|---|--|
| B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending | C Name of organization GOOD SAMARITAN HOSPITAL CORVALLIS <hr/> Doing business as GOOD SAMARITAN REGIONAL MEDICAL CTR <hr/> Number and street (or P O box if mail is not delivered to street address) Room/suite C/O SHS ACCOUNTING PO BOX 3000 <hr/> City or town, state or province, country, and ZIP or foreign postal code CORVALLIS, OR 973393000 | D Employer identification number 93-0391573 <hr/> E Telephone number (541) 768-4773 <hr/> G Gross receipts \$ 331,654,464 |
| F Name and address of principal officer LARRY A MULLINS DHA 3600 NW SAMARITAN DR CORVALLIS, OR 97330 | | H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions) H(c) Group exemption number ▶ |
| I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () (insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527 | | |
| J Website: ▶ WWW.SAMHEALTH.ORG | | |
| 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

| | | | | |
|---|---|---|----------------------------------|---------------------|
| 1 | Briefly describe the organization's mission or most significant activities TO IMPROVE THE HEALTH AND WELL BEING OF THE COMMUNITY THROUGH ITS MEDICAL AND SURGICAL HOSPITAL | | | |
| | 2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets | | | |
| Activities & Governance | 3 Number of voting members of the governing body (Part VI, line 1a) | 3 | | 13 |
| | 4 Number of independent voting members of the governing body (Part VI, line 1b) | 4 | | 13 |
| | 5 Total number of individuals employed in calendar year 2014 (Part V, line 2a) | 5 | | 2,357 |
| | 6 Total number of volunteers (estimate if necessary) | 6 | | 272 |
| | 7a Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | | 0 |
| | 7b Net unrelated business taxable income from Form 990-T, line 34 | 7b | | 0 |
| | Revenue | 8 Contributions and grants (Part VIII, line 1h) | Prior Year | Current Year |
| 9 Program service revenue (Part VIII, line 2g) | | 1,454,369 | 1,054,619 | |
| 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | | 319,361,967 | 325,920,895 | |
| 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | | 967,032 | 973,496 | |
| 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | | 2,621,305 | 3,464,197 | |
| 13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) | | 324,404,673 | 331,413,207 | |
| 14 Benefits paid to or for members (Part IX, column (A), line 4) | | 255,095 | 334,474 | |
| Expenses | 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | 0 | 0 | |
| | 16a Professional fundraising fees (Part IX, column (A), line 11e) | 176,436,353 | 177,147,666 | |
| | b Total fundraising expenses (Part IX, column (D), line 25) ▶ 215,693 | 0 | 0 | |
| | 17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | 155,882,852 | 156,824,903 | |
| | 18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25) | 332,574,300 | 334,307,043 | |
| | 19 Revenue less expenses Subtract line 18 from line 12 | -8,169,627 | -2,893,836 | |
| | Net Assets or Fund Balances | 20 Total assets (Part X, line 16) | Beginning of Current Year | End of Year |
| 21 Total liabilities (Part X, line 26) | | 181,709,661 | 170,488,288 | |
| 22 Net assets or fund balances Subtract line 21 from line 20 | | 81,812,689 | 93,703,835 | |

Part II Signature Block

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

| | | |
|------------------|---|--------------------|
| Sign Here | ***** Signature of officer | 2015-11-13 Date |
| | DANIEL B SMITH VP FINANCE/CFO Type or print name and title | |

| | | | | | |
|-------------------------------|----------------------------|----------------------|------|---|--------------|
| Paid Preparer Use Only | Print/Type preparer's name | Preparer's signature | Date | Check <input type="checkbox"/> if self-employed | PTIN |
| | Firm's name ▶ | | | | Firm's EIN ▶ |
| | Firm's address ▶ | | | | Phone no |

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

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

1 Briefly describe the organization's mission

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

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses \$ 301,342,838 including grants of \$) (Revenue \$ 326,887,505)
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 1,900 EMPLOYEES AND 250 VOLUNTEERS SERVING THE MEDICAL NEEDS OF THE COMMUNITY IT IS LICENSED TO OPERATE 188 BEDS AND IS ONE OF ONLY THREE 'LEVEL 2' TRAUMA CENTERS IN THE STATE DURING 2014, GSH SERVED 8,743 INPATIENTS, HAD 25,459 EMERGENCY DEPARTMENT VISITS, PERFORMED 9,612 SURGERIES AND DELIVERED 1,012 BABIES IN ADDITION, GSH PERFORMED 78,321 IMAGING PROCEDURES, HAD 34,096 HOME HEALTH VISITS, AND HAD 198,659 PHYSICIAN CLINIC VISITS

4b (Code) (Expenses \$ 334,474 including grants of \$ 334,474) (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 301,677,312

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

Part IV Checklist of Required Schedules *(continued)*

| | | | | |
|------------|--|------------|-----|----|
| 21 | Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i> | 21 | Yes | |
| 22 | Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i> | 22 | Yes | |
| 23 | Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <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 lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i> | 24a | | No |
| b | Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? | 24b | | |
| c | Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? | 24c | | |
| d | Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? | 24d | | |
| 25a | Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <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 | Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If "Yes," complete Schedule L, Part II</i> | 26 | | No |
| 27 | Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <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 | Yes | |
| c | An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? <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, Part II, III, or IV, and Part V, line 1</i> | 34 | Yes | |
| 35a | Did the organization have a controlled entity within the meaning of section 512(b)(13)? | 35a | Yes | |
| b | If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i> | 35b | 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 11b and 19? Note. All Form 990 filers are required to complete Schedule O | 38 | Yes | |

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question number, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited transactions, and charitable contributions.

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

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

Section A. Governing Body and Management

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

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


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

Section C. Disclosure

- 17** List the States with which a copy of this Form 990 is required to be filed OR
- 18** Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain in Schedule O)
- 19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records
 SAMARITAN HEALTH SERVICES

PO BOX 3000
 CORVALLIS, OR 973393000 (541) 768-4773

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

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

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

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

• List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid

• List all of the organization's **current** key employees, if any See instructions for definition of "key employee "

• List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations

• List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations

• List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|-----------------------|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| | | | | | | | | | | |

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|-----------------------|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |

| | | | | |
|-----------|--|-----------|-----------|---------|
| 1b | Sub-Total | | | |
| c | Total from continuation sheets to Part VII, Section A | | | |
| d | Total (add lines 1b and 1c) | 4,233,143 | 2,231,163 | 608,573 |

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **297**

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

Section B. Independent Contractors

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

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

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

Part VIII Statement of Revenue

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

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512-514 | | |
|---|--|---|--|--|---|---|--|--|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a | Federated campaigns 1a | | | | | | |
| | b | Membership dues 1b | | | | | | |
| | c | Fundraising events 1c | | | | | | |
| | d | Related organizations 1d | 1,054,619 | | | | | |
| | e | Government grants (contributions) 1e | | | | | | |
| | f | All other contributions, gifts, grants, and similar amounts not included above 1f | | | | | | |
| | g | Noncash contributions included in lines 1a-1f \$ | | | | | | |
| | h | Total. Add lines 1a-1f | 1,054,619 | | | | | |
| Program Service Revenue | 2a | NET PATIENT REVENUE | | | | | | |
| | | Business Code | | | | | | |
| | | 622110 | 319,229,282 | 319,229,282 | | | | |
| | b | RETAIL PHARMACY | | | | | | |
| | | 446110 | 5,893,626 | 5,893,626 | | | | |
| | c | OTHER PATIENT REVENUE | | | | | | |
| | | 622110 | 797,987 | 797,987 | | | | |
| d | | | | | | | | |
| e | | | | | | | | |
| f | All other program service revenue | | | | | | | |
| g | Total. Add lines 2a-2f | 325,920,895 | | | | | | |
| Other Revenue | 3 | Investment income (including dividends, interest, and other similar amounts) | 694,151 | | | 694,151 | | |
| | 4 | Income from investment of tax-exempt bond proceeds | | | | | | |
| | 5 | Royalties | | | | | | |
| | 6a | Gross rents | (i) Real | 894,709 | | | | |
| | | | (ii) Personal | | | | | |
| | | | b | Less rental expenses | 162,169 | | | |
| | | | c | Rental income or (loss) | 732,540 | | | |
| | d | Net rental income or (loss) | 732,540 | | | 732,540 | | |
| | 7a | Gross amount from sales of assets other than inventory | (i) Securities | 273,622 | 9,255 | | | |
| | | | (ii) Other | | 0 | | | |
| | | | b | Less cost or other basis and sales expenses | 3,532 | | | |
| | | | c | Gain or (loss) | 270,090 | 9,255 | | |
| | d | Net gain or (loss) | 279,345 | | | 279,345 | | |
| | 8a | Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18 | | | | | | |
| | a | | | | | | | |
| b | Less direct expenses b | | | | | | | |
| c | Net income or (loss) from fundraising events | | | | | | | |
| 9a | Gross income from gaming activities See Part IV, line 19 | | | | | | | |
| a | | | | | | | | |
| b | Less direct expenses b | | | | | | | |
| c | Net income or (loss) from gaming activities | | | | | | | |
| 10a | Gross sales of inventory, less returns and allowances | a | 287,975 | | | | | |
| | | b | Less cost of goods sold b | 75,556 | | | | |
| | | c | Net income or (loss) from sales of inventory | 212,419 | 212,419 | | | |
| Miscellaneous Revenue | | Business Code | | | | | | |
| 11a | CAFETERIA | 722210 | 1,765,047 | | | 1,765,047 | | |
| b | MEDICAL DIRECTOR FEES | 900099 | 331,435 | 331,435 | | | | |
| c | PEDIATRICS PILOT PROG | 900099 | 155,000 | 155,000 | | | | |
| d | All other revenue | | 267,756 | 267,756 | | | | |
| e | Total. Add lines 11a-11d | | 2,519,238 | | | | | |
| 12 | Total revenue. See Instructions | | 331,413,207 | 326,887,505 | 0 | 3,471,083 | | |

Part IX Statement of Functional Expenses

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

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

| Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII. | | (A) Total expenses | (B) Program service expenses | (C) Management and general expenses | (D) Fundraising expenses |
|--|---|-----------------------|---------------------------------|--|-----------------------------|
| 1 | Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 | 254,899 | 254,899 | | |
| 2 | Grants and other assistance to domestic individuals. See Part IV, line 22 | 79,575 | 79,575 | | |
| 3 | Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16 | | | | |
| 4 | Benefits paid to or for members | | | | |
| 5 | Compensation of current officers, directors, trustees, and key employees | 675,753 | 480,106 | 195,647 | |
| 6 | Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) | | | | |
| 7 | Other salaries and wages | 135,379,186 | 132,106,320 | 3,180,885 | 91,981 |
| 8 | Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) | 8,702,511 | 8,493,168 | 203,460 | 5,883 |
| 9 | Other employee benefits | 22,456,365 | 21,916,166 | 525,017 | 15,182 |
| 10 | Payroll taxes | 9,933,851 | 9,694,887 | 232,248 | 6,716 |
| 11 | Fees for services (non-employees) | | | | |
| a | Management | | | | |
| b | Legal | 47,579 | | 47,579 | |
| c | Accounting | 4,450 | 3,450 | 1,000 | |
| d | Lobbying | | | | |
| e | Professional fundraising services. See Part IV, line 17 | | | | |
| f | Investment management fees | 2,214 | 2,214 | | |
| g | Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) | 8,982,813 | 8,897,713 | 82,500 | 2,600 |
| 12 | Advertising and promotion | 54,615 | 12,619 | 35,060 | 6,936 |
| 13 | Office expenses | 10,883,465 | 10,510,887 | 316,712 | 55,866 |
| 14 | Information technology | 13,252,391 | 12,344,444 | 907,947 | |
| 15 | Royalties | | | | |
| 16 | Occupancy | 4,346,819 | 4,210,891 | 135,004 | 924 |
| 17 | Travel | 442,790 | 428,429 | 14,133 | 228 |
| 18 | Payments of travel or entertainment expenses for any federal, state, or local public officials | | | | |
| 19 | Conferences, conventions, and meetings | 845,149 | 834,698 | 10,251 | 200 |
| 20 | Interest | 5,185,406 | 4,830,147 | 355,259 | |
| 21 | Payments to affiliates | | | | |
| 22 | Depreciation, depletion, and amortization | 10,406,108 | 10,017,879 | 387,613 | 616 |
| 23 | Insurance | 4,271,270 | 3,847,626 | 423,644 | |
| 24 | Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O) | | | | |
| a | MEDICAL SUPPLIES | 44,927,111 | 44,927,111 | | |
| b | PURCHASED SERVICES | 38,199,421 | 12,827,820 | 25,344,084 | 27,517 |
| c | DUES, TAXES, & LICENSES | 14,973,302 | 14,956,263 | 15,995 | 1,044 |
| d | | | | | |
| e | All other expenses | | | | |
| 25 | Total functional expenses. Add lines 1 through 24e | 334,307,043 | 301,677,312 | 32,414,038 | 215,693 |
| 26 | Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) | | | | |

Part X Balance Sheet

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

| | | (A) | | (B) |
|---|---|------------------------|-------------|-----------------------|
| | | Beginning of year | | End of year |
| Assets | 1 Cash—non-interest-bearing | 11,603 | 1 | 12,102 |
| | 2 Savings and temporary cash investments | 1,520,458 | 2 | 1,071,389 |
| | 3 Pledges and grants receivable, net | | 3 | |
| | 4 Accounts receivable, net | 49,227,560 | 4 | 42,347,735 |
| | 5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L | | 5 | |
| | 6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L | | 6 | |
| | 7 Notes and loans receivable, net | 176,184 | 7 | 182,919 |
| | 8 Inventories for sale or use | 5,901,094 | 8 | 6,556,040 |
| | 9 Prepaid expenses and deferred charges | 1,541,634 | 9 | 1,899,245 |
| | 10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D | 10a 215,588,326 | | |
| | b Less accumulated depreciation | 10b 119,513,580 | 102,230,068 | 10c 96,074,746 |
| | 11 Investments—publicly traded securities | 16,000,496 | 11 | 16,845,632 |
| | 12 Investments—other securities See Part IV, line 11 | 281,180 | 12 | 281,180 |
| | 13 Investments—program-related See Part IV, line 11 | | 13 | |
| | 14 Intangible assets | | 14 | |
| | 15 Other assets See Part IV, line 11 | 4,819,384 | 15 | 5,217,300 |
| 16 Total assets. Add lines 1 through 15 (must equal line 34) | 181,709,661 | 16 | 170,488,288 | |
| Liabilities | 17 Accounts payable and accrued expenses | 20,847,504 | 17 | 19,678,063 |
| | 18 Grants payable | | 18 | |
| | 19 Deferred revenue | 73,422 | 19 | 1,192,186 |
| | 20 Tax-exempt bond liabilities | 3,708,000 | 20 | 3,708,000 |
| | 21 Escrow or custodial account liability Complete Part IV of Schedule D | | 21 | |
| | 22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L | | 22 | |
| | 23 Secured mortgages and notes payable to unrelated third parties | 3,861,840 | 23 | 2,340,607 |
| | 24 Unsecured notes and loans payable to unrelated third parties | | 24 | |
| | 25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D | 53,321,923 | 25 | 66,784,979 |
| | 26 Total liabilities. Add lines 17 through 25 | 81,812,689 | 26 | 93,703,835 |
| Net Assets or Fund Balances | Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. | | | |
| | 27 Unrestricted net assets | 99,896,972 | 27 | 76,784,453 |
| | 28 Temporarily restricted net assets | | 28 | |
| | 29 Permanently restricted net assets | | 29 | |
| | Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. | | | |
| | 30 Capital stock or trust principal, or current funds | | 30 | |
| | 31 Paid-in or capital surplus, or land, building or equipment fund | | 31 | |
| | 32 Retained earnings, endowment, accumulated income, or other funds | | 32 | |
| 33 Total net assets or fund balances | 99,896,972 | 33 | 76,784,453 | |
| 34 Total liabilities and net assets/fund balances | 181,709,661 | 34 | 170,488,288 | |

Part XI Reconciliation of Net Assets

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

| | | | |
|-----------|---|-----------|-------------|
| 1 | Total revenue (must equal Part VIII, column (A), line 12) | 1 | 331,413,207 |
| 2 | Total expenses (must equal Part IX, column (A), line 25) | 2 | 334,307,043 |
| 3 | Revenue less expenses Subtract line 2 from line 1 | 3 | -2,893,836 |
| 4 | Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) | 4 | 99,896,972 |
| 5 | Net unrealized gains (losses) on investments | 5 | 105,505 |
| 6 | Donated services and use of facilities | 6 | |
| 7 | Investment expenses | 7 | |
| 8 | Prior period adjustments | 8 | |
| 9 | Other changes in net assets or fund balances (explain in Schedule O) | 9 | -20,324,188 |
| 10 | Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B)) | 10 | 76,784,453 |

Part XII Financial Statements and Reporting

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

| | | Yes | No |
|-----------|--|-----|----|
| 1 | Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O | | |
| 2a | Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | | No |
| 2b | Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis | Yes | |
| 2c | If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O | Yes | |
| 3a | As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133? | | No |
| 3b | If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits | | |

Additional Data

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

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

| (A) Name and Title | (B) Average hours per week (list any hours for related organizations below dotted line) | (C) Position (do not check more than one box, unless person is both an officer and a director/trustee) | | | | | | (D) Reportable compensation from the organization (W-2/1099-MISC) | (E) Reportable compensation from related organizations (W-2/1099-MISC) | (F) Estimated amount of other compensation from the organization and related organizations |
|--|--|---|-----------------------|---------|--------------|------------------------------|--------|--|---|---|
| | | Individual trustee or director | Institutional Trustee | Officer | Key employee | Highest compensated employee | Former | | | |
| (1) BISHOP MICHAEL HANLEY BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| (1) STEVE UERLINGS BOARD MEMBER | 1 00 2 00 | X | | | | | | 0 | 0 | 0 |
| (2) NANCY SEIFERT BOARD TREASURER | 1 00 | X | | X | | | | 0 | 0 | 0 |
| (3) GILBERT BECK BOARD MEMBER | 1 00 2 00 | X | | | | | | 0 | 0 | 0 |
| (4) CLIFFORD A HALL MD BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| (5) RICHARD CRONK MD BOARD CHAIR | 1 00 2 00 | X | | X | | | | 0 | 0 | 0 |
| (6) REVEREND SIMON JUSTICE BOARD SECRETARY | 1 00 | X | | X | | | | 0 | 0 | 0 |
| (7) SHIRLEY PETERSON BOARD MEMBER | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (8) JUDY LIST BOARD VICE-CHAIR | 1 00 1 00 | X | | X | | | | 0 | 0 | 0 |
| (9) ERIC THOMPSON BOARD MEMBER | 1 00 | X | | | | | | 0 | 0 | 0 |
| (10) MICHAEL CHEN MD BOARD MEMBER | 1 00 | X | | | | | | 2,000 | 0 | 0 |
| (11) TIM HENNESSY BOARD MEMBER | 1 00 1 00 | X | | | | | | 0 | 0 | 0 |
| (12) STEFAN SPANN MD BOARD MEMBER | 1 00 | X | | | | | | 10,000 | 0 | 0 |
| (13) LARRY A MULLINS DHA CEO/CEO SHS | 10 00 30 00 | | | X | | | | 0 | 909,836 | 46,017 |
| (14) DANIEL B SMITH VP FINANCE/CFO | 2 00 38 00 | | | X | | | | 0 | 371,615 | 71,523 |
| (15) BECKY PAPE COO/CEO MVH | 30 00 10 00 | | | X | | | | 0 | 328,798 | 51,610 |
| (16) MICHAEL A MAY MD VP SMH MEDICAL DIRECTOR | 39 00 1 00 | | | | X | | | 203,293 | 0 | 42,777 |
| (17) WILLIAM HOWDEN VP NURSING | 40 00 | | | | X | | | 159,222 | 0 | 32,701 |
| (18) RYAN COMBS VP PRIMARY CARE SPEC PRACTICES | 8 00 32 00 | | | | X | | | 35,218 | 156,367 | 31,855 |
| (19) SCOTT WILSON VP ANCILLARY & SUPPORT SERVICES | 40 00 | | | | X | | | 158,187 | 0 | 37,460 |
| (20) JAMES RYAN MD PHYSICIAN | 40 00 | | | | | X | | 607,634 | 0 | 50,965 |
| (21) DONALD PENNINGTON DO PHYSICIAN | 40 00 | | | | | X | | 794,518 | 0 | 51,026 |
| (22) TOSHIO NAGAMOTO MD PHYSICIAN | 40 00 | | | | | X | | 766,944 | 0 | 49,197 |
| (23) DANA PENNER MD PHYSICIAN | 40 00 | | | | | X | | 601,451 | 0 | 48,362 |
| (24) LUIS VELA DO PHYSICIAN | 40 00 | | | | | X | | 894,676 | 0 | 50,276 |

SCHEDULE A
(Form 990 or 990EZ)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.

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

2014

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is (For lines 1 through 11, check only one box)

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E)
- 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 in lines 11a through 11d that describes the type of supporting organization and complete lines 11e, 11f, and 11g
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
 - f Enter the number of supported organizations _____
 - g Provide the following information about the supported organization(s)

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

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|---|----------|----------|----------|----------|-----------|-----------|
| 7 Amounts from line 4 | | | | | | |
| 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| 9 Net income from unrelated business activities, whether or not the business is regularly carried on | | | | | | |
| 10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI) | | | | | | |
| 11 Total support Add lines 7 through 10 | | | | | | |
| 12 Gross receipts from related activities, etc (see instructions) | | | | | 12 | |
| 13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <input type="checkbox"/> | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 14 Public support percentage for 2014 (line 6, column (f) divided by line 11, column (f)) | 14 | |
| 15 Public support percentage for 2013 Schedule A, Part II, line 14 | 15 | |
| 16a 33 1/3% support test—2014. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization <input type="checkbox"/> | | |
| b 33 1/3% support test—2013. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization <input type="checkbox"/> | | |
| 17a 10%-facts-and-circumstances test—2014. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <input type="checkbox"/> | | |
| b 10%-facts-and-circumstances test—2013. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization <input type="checkbox"/> | | |
| 18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <input type="checkbox"/> | | |

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

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

Section A. Public Support

| Calendar year (or fiscal year beginning in) ▶ | (a) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (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) 2010 | (b) 2011 | (c) 2012 | (d) 2013 | (e) 2014 | (f) Total |
|--|----------|----------|----------|----------|----------|-----------|
| 9 Amounts from line 6 | | | | | | |
| 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources | | | | | | |
| b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 | | | | | | |
| c Add lines 10a and 10b | | | | | | |
| 11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on | | | | | | |
| 12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) | | | | | | |
| 13 Total support. (Add lines 9, 10c, 11, and 12.) | | | | | | |
| 14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ | | | | | | |

Section C. Computation of Public Support Percentage

| | | |
|--|-----------|--|
| 15 Public support percentage for 2014 (line 8, column (f) divided by line 13, column (f)) | 15 | |
| 16 Public support percentage from 2013 Schedule A, Part III, line 15 | 16 | |

Section D. Computation of Investment Income Percentage

| | | |
|--|-----------|--|
| 17 Investment income percentage for 2014 (line 10c, column (f) divided by line 13, column (f)) | 17 | |
| 18 Investment income percentage from 2013 Schedule A, Part III, line 17 | 18 | |

- 19a 33 1/3% support tests—2014.** 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—2013.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶
- 20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶

Part IV Supporting Organizations

(Complete only if you checked a box on line 11 of Part I. If you checked 11a of Part I, complete Sections A and B. If you checked 11b of Part I, complete Sections A and C. If you checked 11c of Part I, complete Sections A, D, and E. If you checked 11d of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

| | Yes | No |
|---|-----|----|
| 1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain. | | |
| 2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2). | | |
| 3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below. | | |
| b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination. | | |
| c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use. | | |
| 4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked 11a or 11b in Part I, answer (b) and (c) below. | | |
| b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations. | | |
| c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes. | | |
| 5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document). | | |
| b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document? | | |
| c Substitutions only. Was the substitution the result of an event beyond the organization's control? | | |
| 6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (a) its supported organizations, (b) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (c) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI . | | |
| 7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in IRC 4958(c)(3)(C)), a family member of a substantial contributor, or a 35-percent controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990). | | |
| 8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part II of Schedule L (Form 990). | | |
| 9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI . | | |
| b Did one or more disqualified persons (as defined in line 9(a)) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI . | | |
| c Did a disqualified person (as defined in line 9(a)) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI . | | |
| 10a Was the organization subject to the excess business holdings rules of IRC 4943 because of IRC 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer b below. | | |
| b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings). | | |
| 11 Has the organization accepted a gift or contribution from any of the following persons? | | |
| a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization? | | |
| b A family member of a person described in (a) above? | | |
| c A 35% controlled entity of a person described in (a) or (b) above? If "Yes" to a, b, or c, provide detail in Part VI. | | |

Part IV Supporting Organizations (continued)**Section B. Type I Supporting Organizations**

- 1** Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.*
- 2** Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.*

| | Yes | No |
|----------|-----|----|
| 1 | | |
| 2 | | |

Section C. Type II Supporting Organizations

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

| | Yes | No |
|----------|-----|----|
| 1 | | |

Section D. All Type III Supporting Organizations

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

| | Yes | No |
|----------|-----|----|
| 1 | | |
| 2 | | |
| 3 | | |

Section E. Type III Functionally-Integrated Supporting Organizations

- 1** Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (**see instructions**)
- a** The organization satisfied the Activities Test. Complete **line 2** below.
- b** The organization is the parent of each of its supported organizations. Complete **line 3** below.
- c** The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).

2 Activities Test **Answer (a) and (b) below.**

- a** Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*
- b** Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*

3 Parent of Supported Organizations **Answer (a) and (b) below.**

- a** Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in Part VI.*
- b** Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in Part VI the role played by the organization in this regard.*

| | Yes | No |
|-----------|-----|----|
| 2a | | |
| 2b | | |
| 3a | | |
| 3b | | |

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

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

Section A - Adjusted Net Income

| | (A) Prior Year | (B) Current Year (optional) |
|---|----------------|--------------------------------|
| 1 Net short-term capital gain | 1 | |
| 2 Recoveries of prior-year distributions | 2 | |
| 3 Other gross income (see instructions) | 3 | |
| 4 Add lines 1 through 3 | 4 | |
| 5 Depreciation and depletion | 5 | |
| 6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions) | 6 | |
| 7 Other expenses (see instructions) | 7 | |
| 8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4) | 8 | |

Section B - Minimum Asset Amount

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

Section C - Distributable Amount

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

| Section D - Distributions | Current Year |
|---|---------------------|
| 1 Amounts paid to supported organizations to accomplish exempt purposes | |
| 2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity | |
| 3 Administrative expenses paid to accomplish exempt purposes of supported organizations | |
| 4 Amounts paid to acquire exempt-use assets | |
| 5 Qualified set-aside amounts (prior IRS approval required) | |
| 6 Other distributions (describe in Part VI) See instructions | |
| 7 Total annual distributions. Add lines 1 through 6 | |
| 8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions | |
| 9 Distributable amount for 2014 from Section C, line 6 | |
| 10 Line 8 amount divided by Line 9 amount | |

| Section E - Distribution Allocations (see instructions) | (i) Excess Distributions | (ii) Underdistributions Pre-2014 | (iii) Distributable Amount for 2014 |
|--|-------------------------------------|---|--|
| 1 Distributable amount for 2014 from Section C, line 6 | | | |
| 2 Underdistributions, if any, for years prior to 2014 (reasonable cause required--see instructions) | | | |
| 3 Excess distributions carryover, if any, to 2014 | | | |
| a From 2009. _____ | | | |
| b From 2010. _____ | | | |
| c From 2011. _____ | | | |
| d From 2012. _____ | | | |
| e From 2013. _____ | | | |
| f Total of lines 3a through e | | | |
| g Applied to underdistributions of prior years | | | |
| h Applied to 2014 distributable amount | | | |
| i Carryover from 2009 not applied (see instructions) | | | |
| j Remainder Subtract lines 3g, 3h, and 3i from 3f | | | |
| 4 Distributions for 2014 from Section D, line 7 \$ _____ | | | |
| a Applied to underdistributions of prior years | | | |
| b Applied to 2014 distributable amount | | | |
| c Remainder Subtract lines 4a and 4b from 4 | | | |
| 5 Remaining underdistributions for years prior to 2014, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions) | | | |
| 6 Remaining underdistributions for 2014 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions) | | | |
| 7 Excess distributions carryover to 2015. Add lines 3j and 4c | | | |
| 8 Breakdown of line 7 | | | |
| a From 2010. _____ | | | |
| b From 2011. _____ | | | |
| c From 2012. _____ | | | |
| d From 2013. _____ | | | |
| e From 2014. _____ | | | |

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

Facts And Circumstances Test

Return Reference

Explanation

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No 1545-0047

2014

Open to Public Inspection

Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. Attach to Form 990.

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

Department of the Treasury Internal Revenue Service

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate value of contributions to (during year), 3 Aggregate value of grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors...?, 6 Did the organization inform all grantees...?

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

Table with 2 columns: Description, Held at the End of the Year. Rows include: 1 Purpose(s) of conservation easements..., 2 Complete lines 2a through 2d..., 3 Number of conservation easements..., 4 Number of states..., 5 Does the organization have a written policy..., 6 Staff and volunteer hours..., 7 Amount of expenses..., 8 Does each conservation easement..., 9 In Part XIII, describe how the organization reports...

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.

Table with 2 columns: Description, Amount. Rows include: 1a If the organization elected, as permitted under SFAS 116..., 1b If the organization elected, as permitted under SFAS 116..., 2 If the organization received or held works of art..., a Revenue included..., b Assets included...

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

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

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

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

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

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" 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 XIII and complete the following table

Table with 2 columns: Description (1c-1f) and Amount

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

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

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

Table with 6 columns: (a) Current year, (b) Prior year, (c) Two years back, (d) Three years back, (e) Four years back. Rows include 1a-1g.

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

- a Board designated or quasi-endowment 20.470%
b Permanent endowment 79.530%
c Temporarily restricted endowment
The percentages in lines 2a, 2b, and 2c should equal 100%

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

Table with 2 columns: Yes, No. Rows for 3a(i) unrelated organizations, 3a(ii) related organizations, and 3b.

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

Part VI Land, Buildings, and Equipment. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Table with 4 columns: (a) Cost or other basis (investment), (b) Cost or other basis (other), (c) Accumulated depreciation, (d) Book value. Rows include 1a-1e and Total.

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

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

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

| (a) Description of investment | (b) Book value | (c) Method of valuation Cost or end-of-year market value |
|--|----------------|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 13) | | |

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

| (a) Description | (b) Book value |
|--|----------------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.) | |

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

| 1 (a) Description of liability | (b) Book value |
|--|----------------|
| Federal income taxes | |
| PROFESSIONAL LIABILITY RESERVE | 2,350,000 |
| OTHER LIABILITIES | 512,891 |
| PAYABLE TO CONTRACTUAL AGENCIES | 6,810,570 |
| MINIMUM PENSION LIABILITY | 39,986,382 |
| ACCRUED INTEREST | 1,223,608 |
| TENANTS DEPOSITS | 23,583 |
| ACCOUNTS PAYABLE-AFFILIATES | 15,877,945 |
| | |
| | |
| Total. (Column (b) must equal Form 990, Part X, col (B) line 25) | 66,784,979 |

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return. Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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

Part XIII Supplemental Information

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

| Return Reference | Explanation |
|------------------|---|
| PART V, LINE 4 | THE BOARD-DESIGNATED AND GENERAL ENDOWMENTS ARE USED FOR GENERAL HOSPITAL SUPPORT THE BERNIER ENDOWMENT IS USED FOR STAFF CONTINUING EDUCATION THE ERKKILA ENDOWMENT IS USED FOR HEALTH AND HUMAN PERFORMANCE RESEARCH AND REHABILITATION THE MULLINS SCHOLARSHIP ENDOWMENT IS USED TO SUPPORT EDUCATIONAL SCHOLARSHIPS THE PASTEGA HOUSE ENDOWMENT IS USED TO HELP UNDERWRITE THE OPERATING COSTS OF THE MARIO PASTEGA GUEST HOUSE THE VRTISKA ENDOWMENT IS USED TO SUPPORT THE HOSPITAL'S LABORATORY FOR EDUCATIONAL PURPOSES THE WISH ENDOWMENT IS USED FOR HOSPITAL-BASED PROGRAMS SUPPORTING WOMEN'S AND CHILDREN'S HEALTH THE HALL ENDOWMENT IS USED TO PROVIDE GRADUATE MEDICAL EDUCATIONAL OPPORTUNITIES IN THE AREA OF PRIMARY AND INTERNAL MEDICINE |
| PART X, LINE 2 | FOOTNOTE DISCLOSURE FROM THE CONSOLIDATED AUDITED FINANCIAL STATEMENTS U S GENERALLY ACCEPTED ACCOUNTING PRINCIPLES REQUIRE THE SHS' MANAGEMENT TO EVALUATE TAX POSITIONS AND RECOGNIZE A TAX LIABILITY (OR ASSET) IF SHS HAS TAKEN AN UNCERTAIN POSITION THAT MORE LIKELY THAN NOT WOULD NOT BE SUSTAINED UPON EXAMINATION BY THE INTERNAL REVENUE SERVICE MANAGEMENT HAS ANALYZED TAX POSITIONS TAKEN BY SHS AND HAS CONCLUDED THAT AS OF DECEMBER 31, 2014, THERE ARE NO UNCERTAIN POSITIONS TAKEN OR EXPECTED TO BE TAKEN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY (OR ASSET) OR DISCLOSURE IN THE FINANCIAL STATEMENTS SHS IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS, HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS SHS' MANAGEMENT BELIEVES IT IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS FOR YEARS PRIOR TO 2010 |
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Part XIII Supplemental Information (*continued*)

| Return Reference | Explanation |
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SCHEDULE H (Form 990)

Hospitals

OMB No 1545-0047

2014

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

Open to Public Inspection

Name of the organization: GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number: 93-0391573

Part I Financial Assistance and Certain Other Community Benefits at Cost

1a Did the organization have a financial assistance policy during the tax year? 1b If "Yes," was it a written policy? 2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy... 3a Did the organization use Federal Poverty Guidelines (FPG) as a factor... 3b Did the organization use FPG as a factor... 4 Did the organization's financial assistance policy... 5a Did the organization budget amounts... 5b If "Yes," did the organization's financial assistance expenses exceed... 5c If "Yes" to line 5b... 6a Did the organization prepare a community benefit report... 6b If "Yes," did the organization make it available to the public?

7 Financial Assistance and Certain Other Community Benefits at Cost

Table with 7 columns: (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. Rows include Financial Assistance and Means-Tested Government Programs and Other Benefits.

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

| | (a) Number of activities or programs (optional) | (b) Persons served (optional) | (c) Total community building expense | (d) Direct offsetting revenue | (e) Net community building expense | (f) Percent of total expense |
|--|---|-------------------------------|--------------------------------------|-------------------------------|------------------------------------|------------------------------|
| 1 Physical improvements and housing | | | | | | |
| 2 Economic development | | | | | | |
| 3 Community support | 1 | 322 | 5,089 | | 5,089 | 0 % |
| 4 Environmental improvements | | | | | | |
| 5 Leadership development and training for community members | | | | | | |
| 6 Coalition building | | | | | | |
| 7 Community health improvement advocacy | | | | | | |
| 8 Workforce development | 1 | 24 | 1,561 | | 1,561 | 0 % |
| 9 Other | | | | | | |
| 10 Total | 2 | 346 | 6,650 | | 6,650 | |

Part III Bad Debt, Medicare, & Collection Practices

| Section A. Bad Debt Expense | | Yes | No |
|--|----|-----|------------|
| 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? | | | No |
| 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. | 2 | | 6,964,144 |
| 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. | 3 | | 1,323,427 |
| 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements. | | | |
| Section B. Medicare | | | |
| 5 Enter total revenue received from Medicare (including DSH and IME). | 5 | | 52,576,767 |
| 6 Enter Medicare allowable costs of care relating to payments on line 5. | 6 | | 57,236,224 |
| 7 Subtract line 6 from line 5. This is the surplus (or shortfall). | 7 | | -4,659,457 |
| 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other | | | |
| Section C. Collection Practices | | | |
| 9a Did the organization have a written debt collection policy during the tax year? | 9a | Yes | |
| b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI. | 9b | Yes | |

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

| (a) Name of entity | (b) Description of primary activity of entity | (c) Organization's profit % or stock ownership % | (d) Officers, directors, trustees, or key employees' profit % or stock ownership % | (e) Physicians' profit % or stock ownership % |
|---|---|--|--|---|
| 1 1 CORVALLIS MED BLDGS LLC | REAL PROPERTY RENTAL | 54 500 % | | 18 500 % |
| 2 2 HULL IMAGING LLC | IMAGING SERVICES | 60 000 % | | 40 000 % |
| 3 3 SAMARITAN ENDOSCOPY CENTER | MEDICAL SERVICES | 66 670 % | | 33 330 % |
| 4 4 CORVALLIS MRI A JV | IMAGING SERVICES | 50 000 % | | 50 000 % |
| 5 5 CASCADE VIEW MEDICAL OFFICE BUILDING LLC | REAL PROPERTY RENTAL | 26 300 % | | 73 700 % |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)
 How many hospital facilities did the organization operate during the tax year?
1

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

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

Section B. Facility Policies and Practices

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

GOOD SAMARITAN HOSPITAL CORVALLIS

Name of hospital facility or letter of facility reporting group _____

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

1

| | | Yes | No |
|--|--|-----|----|
| Community Health Needs Assessment | | | |
| 1 | Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year? | | No |
| 2 | Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C | | No |
| 3 | During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply) | Yes | |
| a | <input checked="" type="checkbox"/> A definition of the community served by the hospital facility | | |
| b | <input checked="" type="checkbox"/> Demographics of the community | | |
| c | <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community | | |
| d | <input checked="" type="checkbox"/> How data was obtained | | |
| e | <input checked="" type="checkbox"/> The significant health needs of the community | | |
| f | <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | | |
| g | <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs | | |
| h | <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests | | |
| i | <input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs | | |
| j | <input type="checkbox"/> Other (describe in Section C) | | |
| 4 | Indicate the tax year the hospital facility last conducted a CHNA <u>20 13</u> | | |
| 5 | In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted | Yes | |
| 6a | Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C | | No |
| b | Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C | Yes | |
| 7 | Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply) | Yes | |
| a | <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTP //WWW.SAMHEALTH.ORG/COMMUNITYSUPPORT</u> | | |
| b | <input type="checkbox"/> Other website (list url) _____ | | |
| c | <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility | | |
| d | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 8 | Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 | Yes | |
| 9 | Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 14</u> | | |
| 10 | Is the hospital facility's most recently adopted implementation strategy posted on a website? | Yes | |
| a | If "Yes" (list url) <u>HTTP //WWW.SAMHEALTH.ORG/COMMUNITYSUPPORT</u> | | |
| b | If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? | | No |
| 11 | Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed | | |
| 12a | Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? | | No |
| b | If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? | | |
| c | If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____ | | |

Part V Facility Information (continued)

GOOD SAMARITAN HOSPITAL CORVALLIS

Name of hospital facility or letter of facility reporting group

| | | Yes | No |
|--|--|-----|----|
| Financial Assistance Policy (FAP) | | | |
| 13 | Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP | Yes | |
| a | <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>225 000000000000%</u> and FPG family income limit for eligibility for discounted care of <u>300 000000000000%</u> | | |
| b | <input type="checkbox"/> Income level other than FPG (describe in Section C) | | |
| c | <input checked="" type="checkbox"/> Asset level | | |
| d | <input checked="" type="checkbox"/> Medical indigency | | |
| e | <input checked="" type="checkbox"/> Insurance status | | |
| f | <input checked="" type="checkbox"/> Underinsurance discount | | |
| g | <input type="checkbox"/> Residency | | |
| h | <input type="checkbox"/> Other (describe in Section C) | | |
| 14 | Explained the basis for calculating amounts charged to patients? | Yes | |
| 15 | Explained the method for applying for financial assistance? | Yes | |
| | If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) | | |
| a | <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application | | |
| b | <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application | | |
| c | <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process | | |
| d | <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications | | |
| e | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 16 | Included measures to publicize the policy within the community served by the hospital facility? | Yes | |
| | If "Yes," indicate how the hospital facility publicized the policy (check all that apply) | | |
| a | <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) _____ | | |
| b | <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) _____ | | |
| c | <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) _____ | | |
| d | <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| e | <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| f | <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail) | | |
| g | <input checked="" type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility | | |
| h | <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP | | |
| i | <input type="checkbox"/> Other (describe in Section C) | | |
| Billing and Collections | | | |
| 17 | Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment? | Yes | |
| 18 | Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP | | |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| e | <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted | | |

Part V Facility Information *(continued)*

GOOD SAMARITAN HOSPITAL CORVALLIS

Name of hospital facility or letter of facility reporting group _____

| | | Yes | No |
|-----------|--|-----|----|
| 19 | Did the hospital facility or other authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged | | No |
| a | <input type="checkbox"/> Reporting to credit agency(ies) | | |
| b | <input type="checkbox"/> Selling an individual's debt to another party | | |
| c | <input type="checkbox"/> Actions that require a legal or judicial process | | |
| d | <input type="checkbox"/> Other similar actions (describe in Section C) | | |
| 20 | Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 18 (check all that apply) | | |
| a | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy on admission | | |
| b | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge | | |
| c | <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills | | |
| d | <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy | | |
| e | <input type="checkbox"/> Other (describe in Section C) | | |
| f | <input type="checkbox"/> None of these efforts were made | | |

Policy Relating to Emergency Medical Care

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

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

| | | | |
|-----------|--|--|----|
| 22 | Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care | | |
| a | <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged | | |
| b | <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged | | |
| c | <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged | | |
| d | <input checked="" type="checkbox"/> Other (describe in Section C) | | |
| 23 | During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C | | No |
| 24 | During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C | | No |

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

| Form and Line Reference | Explanation |
|---------------------------|-------------|
| See Additional Data Table | |
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Part V Facility Information *(continued)*

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

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

How many non-hospital health care facilities did the organization operate during the tax year? 34

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

Part VI Supplemental Information

Provide the following information

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

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

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

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART I, LINE 7G | PHYSICIAN CLINICS MEETING THE DEFINITION OF SUBSIDIZED HEALTH SERVICES WERE INCLUDED IN THE REPORTING FOR LINE 7G THE PORTION OF NET COMMUNITY BENEFIT EXPENSE RELATED TO THESE CLINICS IS \$14,337,257 |

| Form and Line Reference | Explanation |
|--|---|
| PART II, COMMUNITY BUILDING ACTIVITIES | 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 SERVES ON MANY LOCAL COALITIONS AND BOARDS THAT PROMOTE THE HEALTH OF THE COMMUNITY BOARD AFFILIATION INCLUDES, BUT IS NOT LIMITED TO, COMMUNITY OUTREACH INC , OLD MILL CENTER FOR CHILDREN AND FAMILIES AND THE UNITED WAY OF BENTON AND LINCOLN COUNTIES ADDITIONALLY GSH STAFF SERVES ON THE OREGON HEALTH POLICY ADVISORY BOARD, THE OREGON HEALTH RESOURCES COMMISSION, THE MEDICAID ADVISORY COMMITTEE, THE OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS AND REGIONAL BOARDS THAT ADDRESS HEALTH CARE ISSUES |

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

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

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART III, LINE 4 | GOOD SAMARITAN HOSPITAL (GSH) IS THE LARGEST OF FIVE HOSPITALS OF SAMARITAN HEALTH SERVICES (SHS) AS A NETWORK, SHS PREPARES ITS FINANCIAL STATEMENTS ON A CONSOLIDATED BASIS. BAD DEBT EXPENSE IS DESCRIBED IN FOOTNOTE 1(O) ENTITLED "PROVISION FOR BAD DEBTS AND ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS", FOUND ON PAGES 11 AND 12 OF THE 2014 SHS CONSOLIDATED FINANCIAL STATEMENTS. |

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART III, LINE 8 | <p>TOTAL MEDICARE ALLOWABLE COSTS REPORTED ON PART III, SECTION B, LINE 6 IS CALCULATED BY UTILIZING WORKSHEET A IN THE SCHEDULE H INSTRUCTIONS IN CONJUNCTION WITH AMOUNTS TAKEN DIRECTLY FROM THE FILING ORGANIZATION'S MEDICARE COST REPORT (CALCULATED BASED ON A COST-TO-CHARGE RATIO) CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED, AS THESE PATIENTS TYPICALLY HAVE LOW OR FIXED INCOMES AND GOVERNMENT REIMBURSEMENT IS NOT SUFFICIENT TO COVER THE COSTS OF PROVIDING CARE FOR THESE PATIENTS. MEDICARE PATIENTS ARE A GROWING SEGMENT OF THE LOCAL POPULATION, AND MANY ARE BECOMING INCREASINGLY DEPENDENT ON OUR HOSPITAL AND NON-PROFIT AFFILIATES TO PROVIDE FOR THEIR CARE, ESPECIALLY AS OTHER FOR-PROFIT HEALTHCARE PROVIDERS IN THE COMMUNITY DISCONTINUE ACCEPTING MEDICARE PATIENTS. THE AMOUNT OF MEDICARE SHORTFALL SHOWN ON LINE 7 OF PART III, SECTION B, IS UNDERSTATED. THIS IS PRIMARILY DUE TO THE FACT THAT THE MEDICARE COST REPORT INCLUDES ACTIVITY FOR MEDICARE FEE-FOR-SERVICE PATIENTS BUT NOT MEDICARE MANAGED CARE PATIENTS. MEDICARE MANAGED CARE ACCOUNTS FOR ROUGHLY HALF OF OUR MEDICARE ACTIVITY. IN ADDITION, CERTAIN COSTS OF PROVIDING HEALTHCARE SERVICES, SUCH AS PHYSICIAN COMPENSATION, ARE NOT ALLOWABLE ON THE MEDICARE COST REPORTS. THEREFORE, THE AMOUNT OF MEDICARE SHORTFALL SHOWN ON LINE 7 IS SMALLER THAN THE SHORTFALL CALCULATION USING REVENUE AND COST DATA FOR ALL MEDICARE PATIENT ACTIVITY, AS FOLLOWS:</p> <p>NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS) 91,243,926 MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO) 106,453,102 UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS (15,209,176)</p> |

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

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART VI, LINE 2 | GOOD SAMARITAN HOSPITAL (GSH) ACTIVELY PARTICIPATES IN ASSESSING THE HEALTH NEEDS OF THE COMMUNITY IN CONJUNCTION WITH THE UNITED WAY OF BENTON COUNTY, THE CITY OF CORVALLIS, BENTON COUNTY HEALTH DEPARTMENT, BENTON COUNTY FEDERALLY QUALIFIED HEALTH CENTER, OREGON STATE UNIVERSITY, WESTERN UNIVERSITY-COMP NORTHWEST, AND OTHER COMMUNITY PARTNERS, GSH EMPLOYEES AND OTHER SAMARITAN HEALTH SERVICES STAFF COMPLETED THE COMMUNITY HEALTH NEEDS ASSESSMENT FOR GSH THIS PROCESS INCLUDED EXAMINING PRIMARY DATA COLLECTED THROUGH FOCUS GROUPS, COMMUNITY FORUMS AND PERSONAL INTERVIEWS WITH SEVERAL COMMUNITY MEMBERS FROM THROUGHOUT BENTON COUNTY SECONDARY DATA WAS GATHERED FROM STATE AND LOCAL AGENCIES THAT ADDRESS HEALTH NEEDS OF CHILDREN, YOUTH AND FAMILIES GSH USES THE CHNA AS THE FOUNDATION FOR THE COMMUNITY BENEFIT PLAN THAT OUTLINES GOALS AND OBJECTIVES AND SERVICES THAT EXPAND ACROSS THE SAMARITAN HEALTH SERVICES SYSTEM RESPONDING TO COMMUNITY NEEDS |

| Form and Line Reference | Explanation |
|-------------------------|--|
| PART VI, LINE 3 | GSH IS COMMITTED TO PROVIDING THE HIGHEST QUALITY HEALTH CARE SERVICES TO ALL, REGARDLESS OF THEIR ABILITY TO PAY IF QUALIFICATIONS ARE MET, PATIENTS' CARE MAY BE PROVIDED FREE OR AT A REDUCED COST THE DETERMINATION IS BASED IN PART ON POVERTY INCOME GUIDELINES ISSUED BY THE U S DEPARTMENT OF HEALTH AND HUMAN SERVICES ONCE A COMPLETED FINANCIAL QUESTIONNAIRE HAS BEEN SUBMITTED, INDIVIDUALS/FAMILIES AT OR BELOW 300 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 REGARDING FINANCIAL ASSISTANCE THROUGH A VARIETY OF METHODS FLYERS ARE POSTED AT SPECIALTY CLINICS, THE MAIN ENTRANCE OF THE HOSPITAL AND IN THE EMERGENCY DEPARTMENT THE INFORMATION IS ALSO POSTED ON THE HOSPITAL'S WEBSITE AND PATIENTS ARE PROVIDED FACE-TO-FACE INFORMATION DURING THE REGISTRATION PROCESS THE FINANCIAL ASSISTANCE INFORMATION IS PROVIDED IN BOTH ENGLISH AND SPANISH |

| Form and Line Reference | Explanation |
|-------------------------|---|
| PART VI, LINE 4 | 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 85,579 (U S CENSUS 2010), 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 \$48,604, AND 22.5% OF THE RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL AS OF DECEMBER 2014, THE OREGON EMPLOYMENT DEPARTMENT REPORTED A 4.7% UNEMPLOYMENT RATE FOR BENTON COUNTY ACCORDING TO THE OREGON HEALTH AUTHORITY IMPACTS OF THE AFFORDABLE CARE ACT HEALTH INSURANCE IN OREGON REPORT, FEBRUARY 2015, 4.8% 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 |

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 93-0391573

Name: GOOD SAMARITAN HOSPITAL CORVALLIS

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

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

| Form and Line Reference | Explanation |
|------------------------------------|---|
| GOOD SAMARITAN HOSPITAL, CORVALLIS | |
| GOOD SAMARITAN HOSPITAL, CORVALLIS | PART V, SECTION B, LINE 7D COPIES OF THE CHNA WERE EMAILED TO KEY COMMUNITY PARTNERS AND DISTRIBUTED DURING LOCAL COALITION MEETINGS |
| GOOD SAMARITAN HOSPITAL, CORVALLIS | PART V, SECTION B, LINE 11 GSH IS ADDRESSING THE SIGNIFICANT NEEDS IDENTIFIED IN THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENTS THROUGH MULTIPLE STRATEGIES FIRST, GSH PROVIDE S GRANT FUNDING TO LOCAL COMMUNITY AGENCIES THAT ADDRESS ONE OR MORE OF THE PRIORITIES IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT AND IS INCLUDED IN THE HOSPITAL'S COMMUNITY BENEFIT PLAN SECOND, THE HOSPITAL STAFF SERVES ON COMMUNITY ADVISORY BOARDS AND COALITIONS TO ADDRESS THE MOST PRESSING NEEDS IN THE COMMUNITY AND FINALLY, THE HOSPITAL IS PROVIDING WORKSHOPS, CLASSES AND SUPPORT GROUPS TO ADDRESS THE HIGHEST HEALTH CONCERNS IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT BECAUSE SEVERAL NEEDS TO IMPROVE HEALTH WERE IDENTIFIED IN THE COMMUNITY HEALTH NEEDS ASSESSMENT, GSH DOES NOT HAVE THE FINANCES OR RESOURCES TO ADDRESS ALL THE NEEDS |
| GOOD SAMARITAN HOSPITAL, CORVALLIS | PART V, SECTION B, LINE 15E REGISTRATION REFERS UNINSURED AND/OR LOW INCOME PATIENTS TO THE ONSITE PATIENT FINANCIAL ADVOCATE AND A THIRD PARTY VENDOR WHO CONTACTS THE PATIENTS TO ASSESS THEIR FINANCIAL STATUS AND NEEDS |
| GOOD SAMARITAN HOSPITAL, CORVALLIS | PART V, SECTION B, LINE 22D THE HOSPITAL USED THE AVERAGE AMOUNT ACCEPTED AS PAYMENT IN FULL FOR THE COMBINATION OF MEDICARE AND COMMERCIALLY INSURED PATIENTS |

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

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

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

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

| Name and address | Type of Facility (describe) |
|--|-----------------------------|
| SAMARITAN REGIONAL CANCER CENTER 501 N WELKS DR CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN ORTHOPEDICS CLINIC 3620 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN HEART & VASC - VASC SURGERY 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN SURGICAL SPECIALISTS 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN GYN & SURGICAL ASSOCIATES 400 NW WALNUT BLVD STE 300 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN INTERNAL MEDICINE 3521 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN NEUROSURGERY 3615 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN FAMILY MEDICINE 3517 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| MAMMOGRAPHY CLINIC 3615 NW SAMARITAN DR CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN KIDNEY SPECIALISTS 3615 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN PEDIATRICS 777 NW 9TH ST STE 320 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN URGENT CARE CENTER 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333 | RADIATION ONCOLOGY |
| SAMARITAN RHEUMATOLOGY 3620 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN ENDOSCOPY CENTER 3509 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| CORVALLIS MRI 3615 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |

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

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

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

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

| Name and address | Type of Facility (describe) |
|---|-----------------------------|
| SAMARITAN OBSTETRICS & GYN 3640 NW SAMARITAN DR STE 270 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN MENTAL HEALTH - CORVALLIS 3509 NW SAMARITAN DR CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN PLASTICRECON SURG - HAVARD 996 NW CIRCLE BLVD STE 103 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN HEMATOLOGY & ONCOLOGY 3640 NW SAMARITAN DR STE 161 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN ORTHOPEDICS - DR VELA 3620 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN MENTAL HEALTH - ALBANY 1052 SW 29TH ST ALBANY, OR 97321 | RADIATION ONCOLOGY |
| SAMARITAN INFECTIOUS DISEASE 3640 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN UROLOGY 990 NW CIRCLE BLVD STE 102 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN HAND THERAPY 3640 NW SAMARITAN DR CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| OUTPATIENT SURGERY 3620 NW SAMARITAN DR CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN WEIGHT MGMT & METABOLIC SURG 3517 NW SAMARITAN DR STE 100 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN FAMILY MEDICINE SOUTHWEST 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333 | RADIATION ONCOLOGY |
| SAMARITAN PHYSICAL REHAB - CORVALLIS 3580 NW SAMARITAN DRIVE CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN OCC MED - ALBANY 2615 WILLET TA ST SW STE C2 ALBANY, OR 97321 | RADIATION ONCOLOGY |
| SAMARITAN OCC MED - LEBANON 100 MULLINS DRIVE STE B2 LEBANON, OR 97355 | RADIATION ONCOLOGY |

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

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

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

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

| Name and address | Type of Facility (describe) |
|---|-----------------------------|
| SAMARITAM OCC MED - CORVALLIS 5234 SW PHILOMATH BLVD STE B CORVALLIS, OR 97333 | RADIATION ONCOLOGY |
| SAMARITAN OB & GYN RESIDENT CLINIC 3517 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN MENTAL HEALTH FAMILY CTR 3517 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330 | RADIATION ONCOLOGY |
| SAMARITAN ATHLETIC MEDICINE 845 SW 30TH ST CORVALLIS, OR 97330 | RADIATION ONCOLOGY |

**Schedule I
(Form 990)**

OMB No 1545-0047

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

2014

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

▶ Attach to Form 990.

**Open to Public
Inspection**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

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

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

| | | |
|---|---|---|
| 2 | Enter total number of section 501(c)(3) and government organizations listed in the line 1 table | 7 |
| 3 | Enter total number of other organizations listed in the line 1 table | 2 |

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

Part III can be duplicated if additional space is needed.

| (a) Type of grant or assistance | (b) Number of recipients | (c) Amount of cash grant | (d) Amount of non-cash assistance | (e) Method of valuation (book, FMV, appraisal, other) | (f) Description of non-cash assistance |
|--|--------------------------|--------------------------|-----------------------------------|---|--|
| (1) TRANSPORTATION | 463 | 22,148 | | | |
| (2) MEDICAL ASSISTANCE | 2 | | 525 | BOOK | MEDICAL SUPPLIES |
| (3) SHELTER | 3 | 755 | | | |
| (4) MEALS FOR FAMILY MEMBERS OF PATIENTS | 1435 | | 14,331 | BOOK | MEALS |
| (5) ACCOMODATIONS - PASTEGA HOUSE | 1689 | | 41,816 | BOOK | TEMPORARY HOUSING FOR HEALTH CARE RECIPIENTS |

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

| Return Reference | Explanation |
|------------------|--|
| PART I, LINE 2 | AGENCIES IN THE COMMUNITY ARE INVITED TO SUBMIT GRANT PROPOSALS THROUGH AN APPLICATION PROCESS A COMMITTEE REVIEWS THE APPLICATIONS TO DETERMINE IF THE FUNDS REQUESTED WILL BE USED TO ADDRESS THE ORGANIZATION'S ESTABLISHED COMMUNITY HEALTH PRIORITIES, IDENTIFIED NEEDS, AND SUPPORTS THE ORGANIZATION'S MISSION ONCE APPROVED AND FUNDED, AGENCIES MUST SUBMIT A COMPLETE ANNUAL REPORT DESCRIBING HOW THE FUNDS WERE USED, THE NUMBER OF CLIENTS SERVED, AND HOW OUTCOMES WERE ACHIEVED |

Additional Data

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

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|--|----------------|---|---------------------------------|--|--|---|--|
| COMMUNITY OUTREACH 865 REIMAN AVENUE CORVALLIS, OR 97330 | 93-0602094 | 501(C)(3) | 116,779 | | | | MEDICAL, DENTAL, MENTAL HEALTH CLINICS |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|--|----------------|---|---------------------------------|--|--|---|--|
| OLD MILL CENTER 1650 SW 45TH PLACE CORVALLIS, OR 97333 | 93-0722603 | 501(C)(3) | 20,000 | | | | COUNSELING, MENTAL HEALTH, AND PARENT EDUCATION |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|---|----------------|---|---------------------------------|--|--|---|---|
| ALBANY HELPING HANDS PO BOX 2252 ALBANY, OR 97321 | 93-1244271 | 501(C)(3) | 13,000 | | | | SUPPORT FOR HOMELESS PEOPLE |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|--|----------------|---|---------------------------------|--|--|---|---|
| CENTER AGAINST RAPE & DOMESTIC VIOLENCEPO BOX 914 CORVALLIS,OR 97339 | 93-0792125 | 501(C)(3) | 14,500 | | | | TRANSITIONAL HOUSING SERVICES FOR DOMESTIC VIOLENCE SURVIVORS |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|--|----------------|---|---------------------------------|--|--|---|--|
| BENTON COUNTY HEALTH DEPARTMENT 530 NW 27TH ST CORVALLIS, OR 97330 | 93-6002285 | GOV'T | 30,620 | | | | ORAL HEALTH SUPPORT & SUPPORT TO DRUG COURT PARTICIPANTS |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|---|----------------|---|---------------------------------|--|--|---|---|
| STRENGTHENING RURAL FAMILIESPO BOX 1528 PHILOMATH, OR 97370 | 20-2934930 | 501(C)(3) | 6,400 | | | | ORAL HEALTH SUPPORT |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|---|----------------|---|---------------------------------|--|--|---|--|
| BENTON COUNTY COMMITTEE FOR THE PREVENTION OF CHILD ABUSE INC421 NW 4TH ST STE A CORVALLIS,OR 97330 | 93-0842537 | 501(C)(3) | 10,000 | | | | PARENT EDUCATION & SUPPORT TO LOW INCOME/HIGH-RISK FAMILIES IN BENTON CO |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|---|----------------|---|---------------------------------|--|--|---|--|
| COMMUNITY SERVICES CONSORTIUM545 SE 2ND ST STE A CORVALLIS,OR 97333 | 93-6118438 | GOV'T | 25,000 | | | | RENT ASSISTANCE TO LOW INCOME FAMILIES IN BENTON, LINN, & LINCOLN COUNTIES |

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

| (a) Name and address of organization or government | (b) EIN | (c) IRC 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 |
|--|----------------|---|---------------------------------|--|--|---|---|
| LOVE IN THE NAME OF CHRIST OF BENTON COUNTY PO BOX 270 CORVALLIS, OR 97339 | 93-1326307 | 501(C)(3) | 5,100 | | | | ORAL HEALTH SUPPORT |

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

2014

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, line 23.**

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

Part I Questions Regarding Compensation

| | Yes | No |
|--|-----|----|
| <p>1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.</p> <p> <input type="checkbox"/> First-class or charter travel <input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Travel for companions <input type="checkbox"/> Payments for business use of personal residence <input type="checkbox"/> Tax indemnification and gross-up payments <input checked="" type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Discretionary spending account <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) </p> | | |
| <p>b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain.</p> | Yes | |
| <p>2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p> | Yes | |
| <p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.</p> <p> <input type="checkbox"/> Compensation committee <input type="checkbox"/> Written employment contract <input type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Compensation survey or study <input type="checkbox"/> Form 990 of other organizations <input type="checkbox"/> Approval by the board or compensation committee </p> | | |
| <p>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:</p> | | |
| <p>a Receive a severance payment or change-of-control payment?</p> | | No |
| <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> | Yes | |
| <p>c Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p> | | No |
| <p>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</p> | | |
| <p>5 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:</p> | | |
| <p>a The organization?</p> | Yes | |
| <p>b Any related organization? If "Yes," to line 5a or 5b, describe in Part III.</p> | | No |
| <p>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:</p> | | |
| <p>a The organization?</p> | | No |
| <p>b Any related organization? If "Yes," to line 6a or 6b, describe in Part III.</p> | | No |
| <p>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.</p> | | No |
| <p>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 Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.</p> | | No |
| <p>9 If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p> | | |

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported 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) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual

| (A) Name and Title | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column(B) reported as deferred in prior Form 990 |
|---------------------------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|--|
| | (i) Base compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| See Additional Data Table | | | | | | | |

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II

Also complete this part for any additional information

| Return Reference | Explanation |
|------------------|--|
| PART I, LINE 1A | IN CONNECTION WITH ITS EMPLOYEE WELLNESS PROGRAM, THE ORGANIZATION HAS A GYM/FITNESS FACILITY BENEFIT THAT IS AVAILABLE TO ALL EMPLOYEES WHO WORK AT LEAST 32 HOURS PER MONTH IF AN EMPLOYEE PARTICIPATES AT A NON-SAMARITAN GYM, REIMBURSEMENT IS MADE FOR FEES REIMBURSEMENT DOES NOT EXCEED \$300 PER YEAR AND IS INCLUDED IN THE EMPLOYEE'S TAXABLE WAGES AND IS SUBJECT TO FEDERAL/STATE WITHHOLDING TAX ONE KEY EMPLOYEE RECEIVED THIS TAXABLE GYM BENEFIT IN 2014 IF AN EMPLOYEE PARTICIPATES AT A SAMARITAN FITNESS CENTER (SAMFIT), MEMBERSHIP IS FREE OF CHARGE (PROVIDED AS A NONTAXABLE FRINGE BENEFIT) NO PERSONS LISTED IN PART VII THAT ARE EMPLOYED BY THE FILING ORGANIZATION RECEIVED THE SAMFIT BENEFIT DURING 2014 |
| PART I, LINE 3 | THE CHIEF EXECUTIVE OFFICER IS EMPLOYED AND PAID BY A RELATED ORGANIZATION THE RELATED ORGANIZATION CONDUCTS A COMPENSATION ANALYSIS EACH YEAR TO COMPARE COMPENSATION OF ALL PAID POSITIONS TO MARKET SURVEYS OF COMPENSATION FOR SIMILAR POSITIONS IN OTHER ORGANIZATIONS PERIODICALLY, THE RELATED ORGANIZATION WILL ALSO USE WRITTEN EMPLOYMENT CONTRACTS, FORM 990 OF OTHER ORGANIZATIONS, AND INDEPENDENT COMPENSATION CONSULTANTS TO DETERMINE THE COMPENSATION OF THE CHIEF EXECUTIVE OFFICER |
| PART I, LINE 4B | 4 B THE ORGANIZATION MAINTAINS SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS UNDER THESE PLANS, LARRY A MULLINS, DHA AND DANIEL B SMITH, ACCRUED DEFERRED COMPENSATION BENEFITS DURING 2014 NO PAYMENTS WERE MADE FROM THESE PLANS IN 2014 |
| PART I, LINE 5 | VARIOUS PHYSICIAN COMPENSATION METHODOLOGIES ARE UTILIZED AND, DEPENDING ON SPECIALTY, RELATIVE VALUE UNITS (RVU'S) MAY BE USED IN DETERMINING A PORTION OF OR ALL OF THEIR COMPENSATION |

Additional Data

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

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

| (A) Name and Title | | (B) Breakdown of W-2 and/or 1099-MISC compensation | | | (C) Retirement and other deferred compensation | (D) Nontaxable benefits | (E) Total of columns (B)(i)-(D) | (F) Compensation in column (B) reported as deferred in prior Form 990 |
|---|------|--|-------------------------------------|-------------------------------------|--|-------------------------|---------------------------------|---|
| | | (i) Base Compensation | (ii) Bonus & incentive compensation | (iii) Other reportable compensation | | | | |
| 1 LARRY A MULLINS DHA, CEO/CEO SHS | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 604,468 | 205,160 | 100,208 | 21,320 | 24,697 | 955,853 | 0 |
| 1 DANIEL B SMITH, VP FINANCE/CFO | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 311,938 | 46,000 | 13,677 | 41,755 | 29,768 | 443,138 | 0 |
| 2 BECKY PAPE, COO/CEO MVH | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 293,518 | 31,000 | 4,280 | 21,320 | 30,290 | 380,408 | 0 |
| 3 MICHAEL A MAY MD, VP SMH MEDICAL DIRECTOR | (i) | 197,229 | 500 | 5,564 | 16,049 | 26,728 | 246,070 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4 WILLIAM HOWDEN, VP NURSING | (i) | 154,223 | 1,000 | 3,999 | 11,683 | 21,018 | 191,923 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5 RYAN COMBS, VP PRIMARY CARE SPEC PRACTICES | (i) | 34,146 | 1,000 | 72 | 3,562 | 3,334 | 42,114 | 0 |
| | (ii) | 126,681 | 20,000 | 9,686 | 11,128 | 13,831 | 181,326 | 0 |
| 6 SCOTT WILSON, VP ANCILLARY & SUPPORT SERVICES | (i) | 156,016 | 1,000 | 1,171 | 11,406 | 26,054 | 195,647 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7 JAMES RYAN MD, PHYSICIAN | (i) | 560,100 | 46,955 | 579 | 21,320 | 29,645 | 658,599 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 8 DONALD PENNINGTON DO, PHYSICIAN | (i) | 573,183 | 203,025 | 18,310 | 21,320 | 29,706 | 845,544 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 9 TOSHIO NAGAMOTO MD, PHYSICIAN | (i) | 466,434 | 281,820 | 18,690 | 21,320 | 27,877 | 816,141 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10 DANA PENNER MD, PHYSICIAN | (i) | 385,230 | 198,086 | 18,135 | 21,320 | 27,042 | 649,813 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 11 LUIS VELA DO, PHYSICIAN | (i) | 892,409 | 1,000 | 1,267 | 21,320 | 28,956 | 944,952 | 0 |
| | (ii) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 12 STEVEN JASPERSON, VP - S CALIFORNIA OPS | (i) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | (ii) | 387,017 | 0 | 77,530 | 21,320 | 23,484 | 509,351 | 0 |

Schedule L (Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

2014

Open to Public Inspection

Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b. Attach to Form 990 or Form 990-EZ.

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

Department of the Treasury Internal Revenue Service

Name of the organization GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

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

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

Table with 4 main columns: (a) Name of disqualified person, (b) Relationship between disqualified person and organization, (c) Description of transaction, (d) Corrected? (Yes/No)

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 \$

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization \$

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

Table with 9 main columns: (a) Name of interested person, (b) Relationship with organization, (c) Purpose of loan, (d) Loan to or from the organization (To/From), (e) Original principal amount, (f) Balance due, (g) In default? (Yes/No), (h) Approved by board or committee? (Yes/No), (i) Written agreement? (Yes/No)

Total \$

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

Table with 5 main columns: (a) Name of interested person, (b) Relationship between interested person and the organization, (c) Amount of assistance, (d) Type of assistance, (e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

| (a) Name of interested person | (b) Relationship between interested person and the organization | (c) Amount of transaction | (d) Description of transaction | (e) Sharing of organization's revenues? | |
|-------------------------------|---|---------------------------|--------------------------------|---|----|
| | | | | Yes | No |
| (1) TANIA MAY | FAM MBR, M MAY | 148,162 | EMP BY ORG | | No |

Part V Supplemental Information

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

| Return Reference | Explanation |
|------------------|-------------|
|------------------|-------------|

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

2014

Open to Public Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

| Return Reference | Explanation |
|--------------------------------------|---|
| FORM 990, PART VI, SECTION A, LINE 4 | ARTICLE III OF THE ORGANIZATION'S BYLAWS (BOARD OF DIRECTORS) WAS AMENDED AS FOLLOWS POSITION 3 AND 4 ON THE BOARD NO LONGER MUST BE NOMINATED BY THE DIOCESE OF OREGON OR BE A RESIDENT OF BENTON COUNTY SECTION 3 15 OF THE ORGANIZATION'S BYLAWS WAS DELETED IT READ AS FOLLOWS "SALE OR ENCUMBRANCE OF CORPORATE PROPERTY NO ACTION SHALL BE TAKEN BY THE BOARD WHEREBY THE PHYSICAL PROPERTY, REAL OR PERSONAL, OF THE CORPORATION SHALL BE SOLD, LEASED FOR A PERIOD IN EXCESS OF ONE YEAR, CONVEYED, MORTGAGED, OR OTHERWISE HYPOTHECATED, UNLESS AT LEAST THREE (3) OF THE DIRECTORS IN POSITIONS 1 THROUGH 4 SHALL BE PRESENT AT THE MEETING WHEREIN THE ACTION IS TAKEN, AND FOR THE ACTION TO BECOME EFFECTIVE THREE (3) OF THE FOUR (4) DIRECTORS MUST VOTE IN FAVOR OF THE ACTION TAKEN " SECTION 3 20 OF THE ORGANIZATION'S BYLAWS WAS DELETED IT READ AS FOLLOWS "3 20 EXECUTIVE SESSION THE BOARD MAY GO INTO EXECUTIVE SESSION BY A VOTE OF A MAJORITY OF THE DIRECTORS IN ATTENDANCE AT THE MEETING ONLY BOARD MEMBERS AND THOSE BY SPECIAL INVITATION OF THE BOARD SHALL BE IN ATTENDANCE DURING AN EXECUTIVE SESSION" ARTICLE IV OF THE ORGANIZATION'S BYLAWS (OFFICERS) WAS AMENDED AS FOLLOWS THE OFFICERS MAY HOLD OFFICE FOR TWO YEARS AND MAY BE ELECTED TO ADDITIONAL TERMS, BUT NOT MORE THAN THREE CONSECUTIVE TERMS (SIX TOTAL YEARS) ARTICLE VI OF THE ORGANIZATION'S BYLAWS (COMMITTEES) WAS AMENDED AS FOLLOWS THE PERSONNEL, QUALITY ASSURANCE & PUBLIC RELATIONS COMMITTEE AND THE AUDIT COMMITTEE WERE REMOVED AS COMMITTEES |

| Return Reference | Explanation |
|--------------------------------------|--|
| FORM 990, PART VI, SECTION A, LINE 5 | <p>IN 2014, GSH BECAME AWARE THAT AN EMPLOYEE OF A RELATED ORGANIZATION HAD BEEN STEALING HOSPITAL SURGICAL SUPPLIES AND SELLING THEM TO A THIRD PARTY IN COOPERATION WITH FEDERAL AND LOCAL LAW ENFORCEMENT, INVESTIGATION OF THE DIVERSION REVEALED THAT THE THEFT OCCURRED BETWEEN 2009 AND 2014, COSTING GSH AN ESTIMATED \$577,000 THE EMPLOYEE WAS TERMINATED IN JUNE 2014 AND SUBSEQUENTLY PROSECUTED AND CONVICTED TO DATE, \$293,000 HAS BEEN RECOVERED THROUGH INSURANCE AND RESTITUTION PAYMENTS GSH HAS TAKEN THE FOLLOWING STEPS TO STRENGTHEN SUPPLY CHAIN PROCESSES AND INTERNAL CONTROLS TO PREVENT FUTURE DIVERSIONS IMPLEMENTED PROCESSES TO COMPARE SYSTEM TRACKING OF PRODUCT USAGE WITH REPLENISHMENT QUANTITIES AS ITEMS ARE ORDERED, IMPROVED CONTROLS FOR PERIODIC CYCLE COUNTS, INSTALLED CAMERAS AND ELECTRONIC LOCKS TO MONITOR AND CONTROL ACCESS TO INVENTORY ITEMS, ENGAGED A SUPPLY CHAIN EXPERT CONSULTANT TO ASSESS CURRENT PROCESSES AND RECOMMEND IMPROVEMENTS TO INVENTORY CONTROL, AND HIRED A SUPPLY CHAIN ENGINEER TO MONITOR AND PROVIDE CONTINUOUS IMPROVEMENT TO SUPPLY CHAIN AND INVENTORY CONTROLS THE EMPLOYEE INVOLVED IN THIS DIVERSION OF ASSETS WAS NOT A "DISQUALIFIED PERSON" FOR PURPOSES OF REPORTING EXCESS BENEFIT TRANSACTIONS</p> |

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

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

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

| Return Reference | Explanation |
|---------------------------------------|--|
| FORM 990, PART VI, SECTION B, LINE 11 | 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. |

| Return Reference | Explanation |
|--|---|
| FORM 990, PART VI, SECTION B, LINE 12C | <p>BOARD MEMBER CONFLICTS OF INTEREST THE MEMBERS OF THE BOARD MUST ANNUALLY COMPLETE A CONFLICT OF INTEREST QUESTIONNAIRE, WHICH REQUIRES DISCLOSURE OF ANY CONFLICTS OR POTENTIAL CONFLICTS OF INTEREST THE COMPLETED QUESTIONNAIRES ARE REVIEWED BY THE CHIEF FINANCIAL OFFICER AND CORPORATE COMPLIANCE OFFICER IF A CONFLICT IS DISCLOSED THAT COULD PROHIBIT A MEMBER FROM SERVING ON THE BOARD, THIS IS EVALUATED BY THE AUDIT AND COMPLIANCE COMMITTEE OF THE SAMARITAN HEALTH SERVICES (SHS) BOARD OF DIRECTORS TO DETERMINE WHETHER THE MEMBER SHOULD CONTINUE TO SERVE ON THE BOARD IF A CONFLICT IS DISCLOSED THAT DOES NOT PROHIBIT A MEMBER FROM SERVING ON THE BOARD, THE CONFLICT IS MANAGED THROUGH A PROCESS SET FORTH IN THE ORGANIZATION'S BYLAWS THE BYLAWS PROHIBIT ANY BOARD MEMBER FROM VOTING ON AN ACTION WHERE AN INDIVIDUAL MEMBER HAS A CONFLICT OF INTEREST EMPLOYEE CONFLICTS OF INTEREST THE SHS CODE OF 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</p> |

| Return Reference | Explanation |
|---------------------------------------|---|
| FORM 990, PART VI, SECTION B, LINE 15 | THE COMPENSATION COMMITTEE OF SAMARITAN HEALTH SERVICES, INC ANNUALLY ENGAGES AN INDEPENDENT CONSULTANT TO ASSIST IT IN PROVIDING COMPARABLE MARKET DATA FOR THE CEO/CEO SHS THIS ANALYSIS INCLUDES REGIONAL AND NATIONAL DATA AS TO COMPARABLE COMPENSATION FOR SIMILARLY QUALIFIED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS THIS INFORMATION IS USED BY THE COMPENSATION COMMITTEE IN ITS DELIBERATIONS REGARDING THE CEO/CEO SHS' COMPENSATION WHICH IS DOCUMENTED IN THE COMMITTEE'S MINUTES SAMARITAN HEALTH SERVICES (SHS) USES PUBLICLY AVAILABLE INFORMATION TO DETERMINE THE COMPENSATION FOR THE CEO/VP SOUTHERN CALIFORNIA OPS SHS CONSULTS WITH AN INDEPENDENT CONSULTANT AS TO THE REASONABLENESS OF THIS DATA TO ENSURE THAT THE COMPENSATION IS REASONABLE AS COMPARED TO SIMILARLY QUALIFIED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS PHYSICIAN EMPLOYEE COMPENSATION, INCLUDING PHYSICIANS WHO ARE BOARD MEMBERS, IS REVIEWED AT LEAST ANNUALLY BY SENIOR MANAGEMENT THIS REVIEW INCLUDES COMPARISON WITH PUBLISHED PHYSICIAN COMPENSATION STUDIES FOR ALL OTHER EMPLOYEES, THE ORGANIZATION PERFORMS AN ANALYSIS EACH YEAR TO COMPARE COMPENSATION OF ALL PAID POSITIONS TO MARKET SURVEYS OF COMPENSATION FOR SIMILAR POSITIONS IN OTHER ORGANIZATIONS |

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

| Return Reference | Explanation |
|------------------------------|--|
| FORM 990, PART XI, LINE 9 | DISTRIBUTIONS TO MINORITY INTEREST CONSOLIDATED JVS -1,358,800 INCREASE IN MINIMUM PENSION LIABILITY - 19,071,804 OTHER CHANGES 106,416 |

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2014

**Open to Public
Inspection**

- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
- ▶ **Attach to Form 990.**
- ▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

Department of the Treasury
Internal Revenue Service

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

| (a) Name, address, and EIN (if applicable) of disregarded entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Total income | (e) End-of-year assets | (f) Direct controlling entity |
|---|-------------------------|--|---------------------|---------------------------|----------------------------------|
| | | | | | |

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c)(3)) | (f) Direct controlling entity | (g) Section 512(b)(13) controlled entity? | |
|---|-------------------------|--|----------------------------|---|----------------------------------|--|----|
| | | | | | | Yes | No |
| 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? | | (k) Percentage ownership |
|--|-------------------------|--|--|---|---------------------------------|--|---|----|--|---|----|--------------------------------|
| | | | | | | | 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 | (i) Section 512 (b)(13) controlled entity? | |
|--|--|---|-------------------------------------|--|---------------------------------|---|--------------------------------|--|----|
| | | | | | | | | Yes | No |
| (1) SAMARITAN HEALTH PLANS INC 3600 NW SAMARITAN DRIVE CORVALLIS, OR 97330 93-0860860 | HEALTH INSURANCE CARRIER FOR THE COMMUNITY | OR | N/A | C | | | | | No |
| (2) SAMARITAN ENTERPRISES LLC PO BOX 3000 CORVALLIS, OR 973393000 46-5293120 | EVENT CENTER & HOSPITALITY SVCS | OR | N/A | C | | | | | No |
| (3) SYNERGY SURGICALISTS INC 678 SIMMONS LANE BOZEMAN, MT 59715 45-4639673 | ORTHOPEDIC & GENERAL SURGERY CARE | MT | N/A | S | | | | | No |

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

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

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

- a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)

- f** Dividends from related organization(s)
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s)
- j** Lease of facilities, equipment, or other assets to related organization(s)

- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)

- p** Reimbursement paid to related organization(s) for expenses
- q** Reimbursement paid by related organization(s) for expenses

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

| | Yes | No |
|-----------|-----|----|
| | | |
| 1a | Yes | |
| 1b | Yes | |
| 1c | Yes | |
| 1d | | No |
| 1e | | No |
| 1f | | No |
| 1g | | No |
| 1h | | No |
| 1i | | No |
| 1j | Yes | |
| 1k | Yes | |
| 1l | Yes | |
| 1m | Yes | |
| 1n | Yes | |
| 1o | Yes | |
| 1p | Yes | |
| 1q | Yes | |
| 1r | | No |
| 1s | Yes | |

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

| (a) Name of related organization | (b) Transaction type (a-s) | (c) Amount involved | (d) Method of determining amount involved |
|-------------------------------------|-------------------------------|------------------------|--|
| See Additional Data Table | | | |

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

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

| (a) Name, address, and EIN of entity | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Predominant income (related, unrelated, excluded from tax under sections 512-514) | (e) Are all partners section 501(c)(3) organizations? | | (f) Share of total income | (g) Share of end-of-year assets | (h) Disproportionate allocations? | | (i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065) | (j) General or managing partner? | | (k) Percentage ownership |
|---|-------------------------|--|--|--|----|------------------------------|------------------------------------|--------------------------------------|----|--|-------------------------------------|----|-----------------------------|
| | | | | Yes | No | | | Yes | No | | Yes | No | |
| | | | | | | | | | | | | | |

Part VII **Supplemental Information**

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

Return Reference**Explanation**

Additional Data

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

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

| (a) Name, address, and EIN of related organization | (b) Primary activity | (c) Legal domicile (state or foreign country) | (d) Exempt Code section | (e) Public charity status (if section 501(c) (3)) | (f) Direct controlling entity | (g) Section 512 (b)(13) controlled entity? | |
|---|---|---|-------------------------------|---|-------------------------------------|--|----|
| | | | | | | Yes | No |
| (1) ALBANY GENERAL HOSPITAL PO BOX 3000 CORVALLIS, OR 973393000 93-0110095 | HOSPITAL SERVICES FOR THE COMMUNITY | OR | 501(C)(3) | 3 | SAMARITAN HEALTH SERVICES | | No |
| (1) ALBANY GENERAL HOSPITAL FOUNDATION 1046 SIXTH AVENUE SW ALBANY, OR 97321 93-0712890 | TO SUPPORT ALBANY GENERAL HOSPITAL | OR | 501(C)(3) | 7 | ALBANY GENERAL HOSPITAL | | No |
| (2) FIRSTCARE HEALTH FOUNDATION PO BOX 3000 CORVALLIS, OR 973393000 93-0900124 | TO SUPPORT AFFILIATED EXEMPT ENTITIES | OR | 501(C)(3) | 11B, II | SAMARITAN HEALTH SERVICES | | No |
| (3) FIRSTCARE MEDICAL FOUNDATION PO BOX 3000 CORVALLIS, OR 973393000 93-0932697 | FUTURE CHARITABLE HEALTHCARE INITIATIVES (NO CURRENT YEAR ACTIVITY) | OR | 501(C)(3) | 9 | SAMARITAN HEALTH SERVICES | | No |
| (4) GOOD SAMARITAN HOSPITAL AUXILIARY 3600 NW SAMARITAN DRIVE CORVALLIS, OR 973393000 93-6024034 | TO SUPPORT GOOD SAMARITAN HOSPITAL | OR | 501(C)(3) | 9 | N/A | | No |
| (5) GOOD SAMARITAN HOSPITAL FOUNDATION PO BOX 1068 CORVALLIS, OR 97339 23-7252406 | TO SUPPORT GOOD SAMARITAN HOSPITAL | OR | 501(C)(3) | 7 | GOOD SAMARITAN HOSPITAL | Yes | |
| (6) INTERCOMMUNITY HEALTH PLANS INC PO BOX 3000 CORVALLIS, OR 973393000 93-1124326 | SERVE OREGON HEALTH PLAN FOR MEDICAID | OR | 501(C)(4) | N/A | SAMARITAN HEALTH SERVICES | | No |
| (7) LEBANON COMMUNITY HOSPITAL FOUNDATION PO BOX 739 LEBANON, OR 97355 93-1260080 | TO SUPPORT LEBANON COMMUNITY HOSPITAL | OR | 501(C)(3) | 7 | MID-VALLEY HEALTHCARE INC | | No |
| (8) MID-VALLEY HEALTHCARE INC PO BOX 3000 CORVALLIS, OR 973393000 93-0396847 | HOSPITAL SERVICES FOR THE COMMUNITY | OR | 501(C)(3) | 3 | SAMARITAN HEALTH SERVICES | | No |
| (9) PARADIGM INDEMNITY CORPORATION PO BOX 3000 CORVALLIS, OR 973393000 73-1668317 | PURE NON-PROFIT CAPTIVE INSURANCE COMPANY | HI | 501(C)(3) | 11A, I | SAMARITAN HEALTH SERVICES | | No |
| (10) SAMARITAN HEALTH SERVICES INC PO BOX 3000 CORVALLIS, OR 973393000 93-0951989 | PROVIDE HEALTHCARE SUPPORT SERVICES | OR | 501(C)(3) | 11C, III-FI | N/A | | No |
| (11) SAMARITAN NORTH LINCOLN HOSPITAL 3043 NE 28TH STREET LINCOLN CITY, OR 97367 93-1305493 | HOSPITAL SERVICES FOR THE COMMUNITY | OR | 501(C)(3) | 3 | SAMARITAN HEALTH SERVICES | | No |
| (12) SAMARITAN PACIFIC HEALTH SERVICES 930 SW ABBEY STREET NEWPORT, OR 97365 93-1329784 | HOSPITAL SERVICES FOR THE COMMUNITY | OR | 501(C)(3) | 3 | SAMARITAN HEALTH SERVICES | | No |
| (13) SAMARITAN SENIOR CARE INC PO BOX 3000 CORVALLIS, OR 973393000 93-1245534 | FUTURE CHARITABLE HEALTHCARE INITIATIVES (NO CURRENT YEAR ACTIVITY) | OR | 501(C)(3) | 9 | SAMARITAN HEALTH SERVICES | | No |

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

| (a) Name of related organization | (b) Transaction type(a-s) | (c) Amount Involved | (d) Method of determining amount involved |
|--|--|-------------------------------|--|
| INTERCOMMUNITY HEALTH PLANS INC | L | 19,928,684 | COST |
| SAMARITAN ENDOSCOPY CENTER LLC | A | 345,306 | COST |
| SAMARITAN ENDOSCOPY CENTER LLC | O | 93,775 | COST |
| SAMARITAN ENDOSCOPY CENTER LLC | P | 93,775 | COST |
| SAMARITAN ENDOSCOPY CENTER LLC | S | 440,000 | COST |
| CORVALLIS MEDICAL BUILDINGS LLC | A | 51,340 | COST |
| CORVALLIS MEDICAL BUILDINGS LLC | S | 196,200 | COST |
| CORVALLIS MEDICAL BUILDINGS LLC | K | 494,493 | COST |
| HULL IMAGING LLC | A | 79,780 | COST |
| HULL IMAGING LLC | O | 636,851 | COST |
| HULL IMAGING LLC | S | 915,000 | COST |