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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
2015
Open to Public Inspection

A For the 2015 calendar year, or tax year beginning 01-01-2015, and ending 12-31-2015

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 Doing business as GOOD SAMARITAN REGIONAL MEDICAL CTR Number and street (or P.O. box if mail is not delivered to street address) Room/suite C/O SHS ACCOUNTING PO BOX 3000 City or town, state or province, country, and ZIP or foreign postal code CORVALLIS, OR 973393000 F Name and address of principal officer BECKY PAPE 3600 NW SAMARITAN DR CORVALLIS, OR 97330	D Employer identification number 93-0391573 E Telephone number (541) 768-4773 G Gross receipts \$ 396,725,598
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		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 ▶
J Website: ▶ WWW.SAMHEALTH.ORG		L Year of formation 1948 M State of legal domicile OR
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶		

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		
3	Number of voting members of the governing body (Part VI, line 1a)	3	11
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	9
5	Total number of individuals employed in calendar year 2015 (Part V, line 2a)	5	2,485
6	Total number of volunteers (estimate if necessary)	6	337
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	264,278
b	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)	1,054,619	6,731,496
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	325,920,895	370,433,780
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	973,496	1,018,014
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	3,464,197	4,303,874
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	334,474	316,084
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	177,147,666	194,098,591
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶ 271,684		
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	156,824,903	171,843,081
18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	334,307,043	366,257,756	
19 Revenue less expenses Subtract line 18 from line 12	-2,893,836	16,229,408	
Net Assets or Fund Balances		Beginning of Current Year	End of Year
	20 Total assets (Part X, line 16)	170,488,288	181,252,375
	21 Total liabilities (Part X, line 26)	93,703,835	88,077,021
22 Net assets or fund balances Subtract line 21 from line 20	76,784,453	93,175,354	

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	2016-11-09 Date			
	DANIEL 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 [X]

1 Briefly describe the organization's mission

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

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

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

4a (Code) (Expenses \$ 335,418,734 including grants of \$) (Revenue \$ 371,769,066)
GOOD SAMARITAN HOSPITAL CORVALLIS (GSH), THE LARGEST HOSPITAL IN LINN, BENTON AND LINCOLN COUNTIES, OFFERS MORE THAN 22 MEDICAL SPECIALTIES INCLUDING COMPREHENSIVE CANCER CARE, A FULL-SERVICE CARDIOLOGY AND VASCULAR SURGERY PROGRAM, A SLEEP LAB, NEUROSURGERY AND OTHER REGIONAL SERVICES GSH HAS MORE THAN 2,000 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 2015, GSH SERVED 9,451 INPATIENTS, HAD 27,678 EMERGENCY DEPARTMENT VISITS, PERFORMED 9,845 SURGERIES AND DELIVERED 1,068 BABIES IN ADDITION, GSH PERFORMED 85,300 IMAGING PROCEDURES, HAD 33,774 HOME HEALTH VISITS, AND HAD 217,268 PHYSICIAN CLINIC VISITS

4b (Code) (Expenses \$ 316,084 including grants of \$ 316,084) (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 ▶ 335,734,818

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)

Table with 3 columns: Question ID, Question Text, and Answer. Rows include questions 21 through 38 regarding organizational reporting, tax-exempt bond issues, and controlled entities.

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question ID, question text, sub-questions (1a-13c), Yes/No columns, and a checkbox for Schedule O. Includes questions 1a-13c regarding reporting requirements, backup withholding, employee counts, 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?		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
6	Did the organization have members or stockholders?	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	Yes	
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
8a	a The governing body?	Yes	
8b	b Each committee with authority to act on behalf of the governing body?	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		No

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

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?		No
10b	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	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	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	Yes	
12c	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	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 <input type="checkbox"/> OR <input type="checkbox"/>
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. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> Other (explain in Schedule O)
19	Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year
20	State the name, address, and telephone number of the person who possesses the organization's books and records ▶SAMARITAN HEALTH SERVICES PO BOX 3000 CORVALLIS, OR 973393000 (541) 768-4773

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) RICHARD CRONK MD BOARD CHAIR	1 00 2 00	X		X				0	0	0
(2) JUDY LIST BOARD VICE CHAIR	1 00 1 00	X		X				0	0	0
(3) REVEREND SIMON JUSTICE BOARD SECRETARY	1 00	X		X				0	0	0
(4) NANCY SEIFERT BOARD TREASURER	1 00	X		X				0	0	0
(5) CLIFFORD HALL MD BOARD MEMBER	1 00	X						0	900	0
(6) BISHOP MICHAEL HANLEY BOARD MEMBER	1 00	X						0	0	0
(7) TIM HENNESSY BOARD MEMBER	1 00	X						0	4,960	0
(8) SHIRLEY PETERSON BOARD MEMBER	1 00	X						0	0	0
(9) STEFAN SPANN MD BOARD MEMBER	1 00	X						0	1,650	0
(10) ERIC THOMPSON BOARD MEMBER	1 00	X						0	0	0
(11) STEVE UERLINGS BOARD MEMBER	1 00	X						0	0	0
(12) BECKY PAPE COO (JAN - NOV) / CEO (DEC)	30 00 10 00			X				0	340,865	53,257
(13) DANIEL SMITH VP FINANCE / CFO	2 00 38 00			X				0	436,557	88,384
(14) LARRY MULLINS DHA CEO (JAN - NOV) / CEO SHS	10 00 30 00			X				0	1,465,392	47,400

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			
(15) CAROLINE FISHER MD VP SMH MEDICAL DIRECTOR (MAR - DEC)	40 00				X			323,420	0	51,354
(16) RYAN COMBS VP PRIMARY CARE SPEC PRACTICES	40 00				X			205,331	0	38,748
(17) SCOTT WILSON VP ANCILLARY SUPPORT SVCS	40 00				X			182,619	0	41,034
(18) WILLIAM HOWDEN VP NURSING	40 00				X			181,247	0	35,153
(19) MICHAEL MAY MD VP SMH MEDICAL DIRECTOR (JAN - FEB)	39 00 1 00				X			151,752	1,200	19,795
(20) LUIS VELA DO PHYSICIAN	40 00					X		896,278	0	50,158
(21) DONALD PENNINGTON DO PHYSICIAN	40 00					X		711,038	0	53,130
(22) TOSHIO NAGAMOTO MD PHYSICIAN	40 00					X		682,799	0	50,582
(23) JEFF HSING MD PHYSICIAN	40 00					X		647,412	0	49,973
(24) DANA PENNER MD PHYSICIAN	40 00					X		623,186	0	52,446
(25) STEVEN JASPERSON FORMER CEO / VP SO CALIFORNIA OPS	0 00 40 00						X	0	476,259	46,642
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								4,605,082	2,727,783	678,056

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 ▶ 327

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

Section B. Independent Contractors

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

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

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

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns 1a					
	b	Membership dues 1b					
	c	Fundraising events 1c					
	d	Related organizations 1d	6,731,496				
	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 ▶	6,731,496				
Program Service Revenue	2a	NET PATIENT REVENUE	363,046,093	363,046,093			
	b	RETAIL PHARMACY	6,833,368	6,833,368			
	c	OTHER PATIENT REVENUE	554,319	554,319			
	d						
	e						
	f	All other program service revenue					
	g	Total. Add lines 2a-2f ▶	370,433,780				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) ▶	608,812			608,812	
	4	Income from investment of tax-exempt bond proceeds ▶					
	5	Royalties ▶					
	6a	Gross rents	(i) Real	1,040,642			
			(ii) Personal				
			b Less rental expenses	292,360			
			c Rental income or (loss)	748,282			
	d	Net rental income or (loss) ▶	748,282			748,282	
	7a	Gross amount from sales of assets other than inventory	(i) Securities	13,923,241	354,082		
			(ii) Other				
			b Less cost or other basis and sales expenses	13,422,362	445,759		
			c Gain or (loss)	500,879	-91,677		
	d	Net gain or (loss) ▶	409,202			409,202	
	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		342,231			
b Less cost of goods sold b			77,953				
c Net income or (loss) from sales of inventory ▶			264,278		264,278		
Miscellaneous Revenue		Business Code					
11a	CAFETERIA	722210	1,956,028			1,956,028	
b	MEDICAL DIRECTOR FEES	900099	318,263	318,263			
c	PSYCH PILOT PROGRAM	900099	200,816	200,816			
d	All other revenue		816,207	816,207			
e	Total. Add lines 11a-11d ▶		3,291,314				
12	Total revenue. See Instructions ▶		382,487,164	371,769,066	264,278	3,722,324	

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	269,633	269,633		
2	Grants and other assistance to domestic individuals See Part IV, line 22	46,451	46,451		
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	1,230,453	1,006,799	223,654	
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	146,800,169	143,298,532	3,420,325	81,312
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	11,090,558	10,828,213	256,253	6,092
9	Other employee benefits	24,437,307	23,859,247	564,637	13,423
10	Payroll taxes	10,540,104	10,290,779	243,535	5,790
11	Fees for services (non-employees)				
a	Management				
b	Legal	19,617		19,617	
c	Accounting	54,585	1,400	53,185	
d	Lobbying				
e	Professional fundraising services See Part IV, line 17				
f	Investment management fees	2,284	2,284		
g	Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	9,908,853	9,656,590	208,347	43,916
12	Advertising and promotion	56,946	13,847	31,134	11,965
13	Office expenses	12,610,749	12,155,084	385,579	70,086
14	Information technology	17,403,388	16,790,880	612,508	
15	Royalties				
16	Occupancy	5,429,742	5,307,203	122,539	
17	Travel	592,195	563,502	25,003	3,690
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings	784,558	781,174	3,384	
20	Interest	5,092,900	4,913,657	179,243	
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	9,770,010	9,566,210	203,184	616
23	Insurance	4,558,064	4,147,034	411,030	
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	51,594,603	51,594,603		
b	PURCHASED SERVICES	35,947,243	12,644,705	23,269,701	32,837
c	DUES, TAXES, & LICENSES	18,017,344	17,996,991	18,396	1,957
d					
e	All other expenses				
25	Total functional expenses. Add lines 1 through 24e	366,257,756	335,734,818	30,251,254	271,684
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	12,102	1	11,109
	2 Savings and temporary cash investments	1,071,389	2	823,575
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	42,347,735	4	48,289,711
	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	182,919	7	196,114
	8 Inventories for sale or use	6,556,040	8	7,468,394
	9 Prepaid expenses and deferred charges	1,899,245	9	1,676,419
	10a Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	10a 229,020,357		
	b Less accumulated depreciation	10b 129,051,701	96,074,746	10c 99,968,656
	11 Investments—publicly traded securities	16,845,632	11	16,486,395
	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	5,217,300	15	6,050,822
16 Total assets. Add lines 1 through 15 (must equal line 34)	170,488,288	16	181,252,375	
Liabilities	17 Accounts payable and accrued expenses	19,678,063	17	25,831,630
	18 Grants payable		18	
	19 Deferred revenue	1,192,186	19	1,257,377
	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	2,340,607	23	1,126,425
	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	66,784,979	25	56,153,589
	26 Total liabilities. Add lines 17 through 25	93,703,835	26	88,077,021
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	76,784,453	27	93,175,354
	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	76,784,453	33	93,175,354	
34 Total liabilities and net assets/fund balances	170,488,288	34	181,252,375	

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	382,487,164
2	Total expenses (must equal Part IX, column (A), line 25)	2	366,257,756
3	Revenue less expenses Subtract line 2 from line 1	3	16,229,408
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	76,784,453
5	Net unrealized gains (losses) on investments	5	-1,305,728
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	1,467,221
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	93,175,354

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990 Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
 If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
 If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

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

**SCHEDULE A
(Form 990 or
990EZ)**

Public Charity Status and Public Support

OMB No 1545-0047

2015

**Open to Public
Inspection**

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.

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 (Form 990 or 990-EZ))
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)
- 8 A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9 An 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 (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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						

12 Gross receipts from related activities, etc (see instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2015 (line 6, column (f) divided by line 11, column (f))	14
15 Public support percentage for 2014 Schedule A, Part II, line 14	15

16a 33 1/3% support test—2015. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

b 33 1/3% support test—2014. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

17a 10%-facts-and-circumstances test—2015. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization

b 10%-facts-and-circumstances test—2014. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization

18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions

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

(Complete only if you checked the box on line 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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(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)2011	(b)2012	(c)2013	(d)2014	(e)2015	(f)Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2015 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2014 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2015 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2014 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2015. 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 <input type="checkbox"/>		
b 33 1/3% support tests—2014. 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 <input type="checkbox"/>		
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions <input type="checkbox"/>		

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

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

Section A - Adjusted Net Income

- 1** Net short-term capital gain
- 2** Recoveries of prior-year distributions
- 3** Other gross income (see instructions)
- 4** Add lines 1 through 3
- 5** Depreciation and depletion
- 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)
- 7** Other expenses (see instructions)
- 8** **Adjusted Net Income** (subtract lines 5, 6 and 7 from line 4)

	(A) Prior Year	(B) Current Year (optional)
1		
2		
3		
4		
5		
6		
7		
8		

Section B - Minimum Asset Amount

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

	(A) Prior Year	(B) Current Year (optional)
1		
1a		
1b		
1c		
1d		
2		
3		
4		
5		
6		
7		
8		

Section C - Distributable Amount

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

		Current Year
1		
2		
3		
4		
5		
6		

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2015 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-2015	(iii) Distributable Amount for 2015
1 Distributable amount for 2015 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2015 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2015			
a			
b			
c			
d From 2013. _____			
e From 2014. _____			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2015 distributable amount			
i Carryover from 2010 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2015 from Section D, line 7 \$ _____			
a Applied to underdistributions of prior years			
b Applied to 2015 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2015, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2015 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2016. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b			
c Excess from 2013. _____			
d From 2014. _____			
e From 2015. _____			

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)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2015
Open to Public Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? Yes No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? Yes No

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

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

Preservation of land for public use (e.g., recreation or education) Preservation of an historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space

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

	Held at the End of the Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(continued)

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

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No

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

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

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

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

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

	(a)Current year	(b)Prior year	b (c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	6,118,410	6,035,183	5,430,883	4,758,581	4,975,845
b Contributions	136,267	61,783	269,432	316,843	106,549
c Net investment earnings, gains, and losses	-233,344	214,664	578,249	543,063	-131,912
d Grants or scholarships	289,157	193,220	243,381	187,604	191,901
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	5,732,176	6,118,410	6,035,183	5,430,883	4,758,581

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

a Board designated or quasi-endowment ▶ 19 880 %

b Permanent endowment ▶ 80 120 %

c Temporarily restricted endowment ▶

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

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

(i) unrelated organizations

(ii) related organizations

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

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

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.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	Accumulated (c) depreciation	(d) Book value
1a Land		2,051,610		2,051,610
b Buildings		149,196,616	71,284,400	77,912,216
c Leasehold improvements		3,070,929	803,148	2,267,781
d Equipment		65,084,029	52,216,112	12,867,917
e Other		9,617,173	4,748,041	4,869,132
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c) ▶				99,968,656

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

Table with 3 columns: (a) Description of security or category, (b) Book value, (c) Method of valuation. Rows include (1) Financial derivatives, (2) Closely-held equity interests, (3) Other, and a Total row.

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

Table with 3 columns: (a) Description of investment, (b) Book value, (c) Method of valuation. Includes a Total row at the bottom.

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

Table with 2 columns: (a) Description, (b) Book value. Includes a Total row at the bottom.

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

Table with 2 columns: (a) Description of liability, (b) Book value. Rows include Federal income taxes, PROFESSIONAL LIABILITY RESERVE, OTHER LIABILITIES, PAYABLE TO CONTRACTUAL AGENCIES, MINIMUM PENSION LIABILITY, ACCRUED INTEREST, ACCOUNTS PAYABLE-AFFILIATES, and a Total row.

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
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 XIII Supplemental Information *(continued)*

Return Reference	Explanation

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

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

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

OMB No 1545-0047

2015

Open to Public Inspection

Name of the organization
GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number
93-0391573

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for <i>free</i> care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other <u>22500 0000000000 %</u>	3a Yes	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	3b Yes	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	No
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	
Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.		

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)	16	12,976	4,342,632		4,342,632	1 190 %
b Medicaid (from Worksheet 3, column a)	11	82,217	73,586,447	55,716,342	17,870,105	4 880 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	27	95,193	77,929,079	55,716,342	22,212,737	6 070 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	11	16,843	521,536	2,484	519,052	0 140 %
f Health professions education (from Worksheet 5)	5	19,365	18,263,411	9,280,420	8,982,991	2 450 %
g Subsidized health services (from Worksheet 6)	13	54,448	22,411,907	12,669,373	9,742,534	2 660 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	11	22,853	720,166	183,493	536,673	0 150 %
j Total Other Benefits	40	113,509	41,917,020	22,135,770	19,781,250	5 400 %
k Total . Add lines 7d and 7j	67	208,702	119,846,099	77,852,112	41,993,987	11 470 %

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	2	1,385	24,363		24,363	0.010 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development	1	31	1,796		1,796	0 %
9 Other						
10 Total	3	1,416	26,159		26,159	0.010 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	61,317,903
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	63,889,337
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-2,571,434
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 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 %		21.500 %
2 2 HULL IMAGING LLC	IMAGING SERVICES	60.000 %		40.000 %
3 3 SAMARITAN ENDOSCOPY CENTER	MEDICAL SERVICES	66.670 %		33.330 %
4 4 CORVALLIS MRI 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)

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

Table with 3 columns: Question, Yes, No. Rows include Community Health Needs Assessment questions 1 through 12b.

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

GOOD SAMARITAN HOSPITAL CORVALLIS

Name of hospital facility or letter of facility reporting group _____

		Yes	No
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 a <input type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>225 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>300 000000000000</u> % b <input type="checkbox"/> Income level other than FPG (describe in Section C) c <input type="checkbox"/> Asset level d <input type="checkbox"/> Medical indigency e <input type="checkbox"/> Insurance status f <input type="checkbox"/> Underinsurance discount g <input type="checkbox"/> Residency h <input type="checkbox"/> Other (describe in Section C)	13 Yes	
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply) a <input type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application b <input type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application c <input type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications e <input type="checkbox"/> Other (describe in Section C)	15 Yes	
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a <input type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW SAMHEALTH ORG</u> b <input type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW SAMHEALTH ORG</u> c <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW SAMHEALTH ORG</u> d <input type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail) e <input 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 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 type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility h <input 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)	16 Yes	

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?	17 Yes	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Actions that require a legal or judicial process d <input type="checkbox"/> Other similar actions (describe in Section C) e <input 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 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 19 (check all that apply)		
a	<input type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b	<input type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c	<input type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d	<input 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 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

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? 33

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 CONSISTENT WITH THE LATEST SCHEDULE H INSTRUCTIONS, PHYSICIAN CLINIC ACTIVITY FOR 2015 HAS BEEN COMBINED WITH ASSOCIATED HOSPITAL SERVICES IN DETERMINING WHETHER THE SERVICES WERE PROVIDED AT A LOSS PRIOR TO 2015, HOSPITAL SERVICES ASSOCIATED WITH OUR PHYSICIAN CLINICS HAD NOT BEEN COMBINED FOR PURPOSES OF THIS CALCULATION THE EFFECT OF THIS CHANGE IS A REDUCTION IN OVERALL SUBSIDIZED HEALTH SERVICES REPORTED IN 2015 AS COMPARED TO PRIOR YEARS THE PORTION OF NET COMMUNITY BENEFIT EXPENSE RELATED TO PHYSICIAN CLINICS, COMBINED WITH ASSOCIATED HOSPITAL ACTIVITY, THAT IS BEING COUNTED AS SUBSIDIZED HEALTH SERVICES IN 2015 IS \$7,269,846

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	GSH PROVIDES SERVICES AND ACTIVITIES THAT ARE CLASSIFIED AS COMMUNITY BUILDING TO PROMOTE THE HEALTH OF BENTON COUNTY RECOGNIZING THAT THE HEALTH OF A COMMUNITY ENCOMPASSES MULTIPLE FACTORS, GSH LEADERSHIP AND STAFF ARE INVOLVED IN A VARIETY OF ACTIONS THAT WORK TO IMPROVE COMMUNITY OUTCOMES DURING 2015, GSH SERVED AS THE LEAD AGENCY TO CONDUCT DISASTER PREPAREDNESS DRILLS WITH LOCAL AGENCIES IN BENTON COUNTY THIS INCLUDED HOLDING REGULAR COMMUNITY MEETINGS TO REVIEW AND UPDATE THE COMMUNITY DISASTER PREPAREDNESS PLAN, IDENTIFY DISASTER DRILL DATES, ORGANIZE THE DISASTER PREPAREDNESS DRILL AND RECRUITING AND TRAINING COMMUNITY VOLUNTEERS TO SERVE AS VICTIMS DURING THE DRILL GSH BELIEVES THAT TRAINED AND COMPETENT STAFF IN ALL ASPECTS OF THE ORGANIZATION PROMOTES COMMUNITY HEALTH GSH ACTIVELY PARTICIPATES IN WORKFORCE DEVELOPMENT IN PARTNERSHIP WITH OREGON STATE UNIVERSITY, LINN-BENTON COMMUNITY COLLEGE AND WESTERN UNIVERSITY-COMP NW TO RECRUIT, TRAIN AND RETAIN HEALTHCARE WORKERS AT ALL LEVELS GSH ALSO HOSTS LOCAL EVENTS SUPPORTED BY THE HOSPITAL'S FOUNDATION AND OTHER DEPARTMENTS IN THE ORGANIZATION ANNUAL EVENTS SUCH AS SENIOR HEALTH FAIRS, FESTIVAL LATINO, CHILDREN'S HEALTH FAIRS, BENTON COUNTY FAIR AND PROJECT HOMELESS CONNECT ARE A FEW EXAMPLES OF HOW GSH PROMOTES THE HEALTH OF THE COMMUNITY GSH ALSO PROVIDES OPPORTUNITIES FOR COMMUNITY MEMBERS TO OBTAIN TRAINING ON CIVIC AND CULTURAL ISSUES THAT IMPACT HEALTH SOME OF THE TRAINING OPPORTUNITIES INCLUDE GRANT WRITING, ORGANIZATIONAL SUSTAINABILITY, AND BOARD DEVELOPMENT GSH STAFF SERVE ON MANY LOCAL COALITIONS AND BOARDS THAT PROMOTE THE HEALTH OF THE COMMUNITY BOARD AFFILIATIONS INCLUDE, BUT ARE NOT LIMITED TO, COMMUNITY OUTREACH INC , OREGON CASCADES WEST COUNCIL OF GOVERNMENTS, AND THE UNITED WAY OF BENTON AND LINCOLN COUNTIES ADDITIONALLY GSH STAFF SERVE ON THE OREGON HEALTH POLICY ADVISORY BOARD, THE OREGON HEALTH RESOURCES COMMISSION, THE MEDICAID ADVISORY COMMITTEE, THE OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS AND REGIONAL BOARDS THAT ADDRESS HEALTH CARE ISSUES

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 PAGE 12 OF THE 2015 SHS CONSOLIDATED FINANCIAL STATEMENTS

Form and Line Reference	Explanation						
PART III, LINE 8	<p>TOTAL MEDICARE ALLOWABLE COSTS REPORTED ON PART III, SECTION B, LINE 6 IS CALCULATED BY UTILIZING WORKSHEET A IN THE SCHEDULE H INSTRUCTIONS IN CONJUNCTION WITH AMOUNTS TAKEN DIRECTLY FROM THE FILING ORGANIZATION'S MEDICARE COST REPORT (CALCULATED BASED ON A COST-TO-CHARGE RATIO) CARING FOR MEDICARE PATIENTS FULFILLS A COMMUNITY NEED, AS THESE PATIENTS TYPICALLY HAVE LOW OR FIXED INCOMES AND GOVERNMENT REIMBURSEMENT IS NOT SUFFICIENT TO COVER THE COSTS OF PROVIDING CARE FOR THESE PATIENTS. MEDICARE PATIENTS ARE A GROWING SEGMENT OF THE LOCAL POPULATION, AND MANY ARE BECOMING INCREASINGLY DEPENDENT ON OUR HOSPITAL AND NON-PROFIT AFFILIATES TO PROVIDE FOR THEIR CARE, ESPECIALLY AS OTHER FOR-PROFIT HEALTHCARE PROVIDERS IN THE COMMUNITY DISCONTINUE ACCEPTING MEDICARE PATIENTS. THE AMOUNT OF MEDICARE SHORTFALL SHOWN ON LINE 7 OF PART III, SECTION B, IS UNDERSTATED. THIS IS PRIMARILY DUE TO THE FACT THAT THE MEDICARE COST REPORT INCLUDES ACTIVITY FOR MEDICARE FEE-FOR-SERVICE PATIENTS BUT NOT MEDICARE MANAGED CARE PATIENTS. MEDICARE MANAGED CARE ACCOUNTS FOR ROUGHLY HALF OF OUR MEDICARE ACTIVITY. IN ADDITION, CERTAIN COSTS OF PROVIDING HEALTHCARE SERVICES, SUCH AS PHYSICIAN COMPENSATION, ARE NOT ALLOWABLE ON THE MEDICARE COST REPORTS. THEREFORE, THE AMOUNT OF MEDICARE SHORTFALL SHOWN ON LINE 7 IS SMALLER THAN THE SHORTFALL CALCULATION USING REVENUE AND COST DATA FOR ALL MEDICARE PATIENT ACTIVITY, AS FOLLOWS:</p> <table><tr><td>NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS)</td><td>116,803,732</td></tr><tr><td>MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO)</td><td>134,619,341</td></tr><tr><td>UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS</td><td>-17,815,609</td></tr></table>	NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS)	116,803,732	MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO)	134,619,341	UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS	-17,815,609
NET REV RECEIVED FROM MEDICARE (ALL MEDICARE PATIENT PROGRAMS)	116,803,732						
MEDICARE COSTS (BASED ON A COST-TO-CHARGE RATIO)	134,619,341						
UNPAID COST OF PROVIDING SERVICES TO ALL MEDICARE PATIENTS	-17,815,609						

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

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

Form and Line Reference	Explanation
PART VI, LINE 4	<p>GSH PRIMARILY SERVE RESIDENTS OF BENTON COUNTY ESTABLISHED BY THE PROVISIONAL LEGISLATURE IN 1847, BENTON COUNTY OCCUPIES 679 SQUARE MILES OF THE CENTRAL WILLAMETTE VALLEY BENTON COUNTY IS BORDERED ON THE EAST BY THE WILLAMETTE RIVER AND LINN COUNTY, WITH LINCOLN COUNTY ON THE WEST, POLK COUNTY ON THE NORTH, AND BY LANE COUNTY ON THE SOUTH THE CITY OF CORVALLIS IS THE COUNTY SEAT FOR BENTON COUNTY AND IS HOME TO OREGON STATE UNIVERSITY ALTHOUGH THE MAJORITY OF RESIDENTS LIVE IN CORVALLIS OR OTHER INCORPORATED CITIES IN THE COUNTY, APPROXIMATELY 21% OF RESIDENTS LIVE IN RURAL BENTON COUNTY THESE RURAL COMMUNITIES INCLUDE ALSEA, KINGS VALLEY, WREN, BLODGETT, SUMMIT AND BELLFOUNTAIN PORTIONS OF BENTON COUNTY HAVE DESIGNATIONS OF MEDICALLY UNDERSERVED AREAS AND MEDICALLY UNDERSERVED POPULATIONS ACCORDING TO THE HEALTH RESOURCES AND SERVICES ADMINISTRATION, WITH GSH BEING THE ONLY HOSPITAL LOCATED IN BENTON COUNTY THE CHARTS BELOW DESCRIBE THE DEMOGRAPHICS OF BENTON COUNTY RACE/ETHNICITY</p> <p>POPULATION WHITE/CAUCASIAN 87.1% BLACK/AFRICAN AMERICAN 0.9% AMERICAN INDIAN/ALASKA NATIVE 0.7% ASIAN AND PACIFIC ISLANDER 5.4% HISPANIC 6.4% OTHER 2.7% REPORTING TWO OR MORE RACES 3.6% SOURCE U.S. CENSUS BUREAU, 2010 CENSUS, PUBLIC LAW 94-171 SUMMARY FILE HEALTH AND SOCIAL INDICATORS ARE USED TO GENERALIZE THE CONDITIONS OF BENTON COUNTY HEALTH AND SOCIAL INDICATORS</p> <p>TOTALS MEDIAN INCOME \$49,338 UNEMPLOYMENT 5.3% POVERTY 18.9% HOMELESSNESS (ADULTS) 306 * EARLY PRENATAL CARE 78.2% IMMUNIZATIONS 53.8% UNINSURED CHILDREN 5.3% CHILD CARE SLOTS 22/100 CHILD ABUSE 11.1/1000 EARLY CHILDHOOD OBESITY 20.6% CHILDREN ON FREE AND REDUCED LUNCH 38.3% CHILDREN ENROLLED WITH A DENTAL CARE ORGANIZATION 89.3% HOMELESS STUDENTS 261 TEEN PREGNANCY 8.1/1000 HIGH SCHOOL GRADUATION RATES 72% JUVENILE ARRESTS 11/1000 8TH GRADE ALCOHOL USE 13.7% 8TH GRADE DRUG USE 6.4% * THERE IS NO ACCURATE WAY TO COUNT THE NUMBER OF HOMELESS PEOPLE IN A COUNTY HOMELESS DATA IS BASED ON LOCAL AGENCIES SERVING BENTON COUNTY DURING 2015 THE INFORMATION LISTED ABOVE WAS OBTAINED FROM VARIOUS LOCAL, STATE AND FEDERAL DATABASES USING THE MOST RECENT AVAILABLE DATA BETWEEN THE YEARS 2012 - 2015</p>

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

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

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

Schedule H (Form 990) 2015

Additional Data

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

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

Section A. Hospital Facilities

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

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

1

Name, address, primary website address, and state license number

1

GOOD SAMARITAN HOSPITAL
CORVALLIS
3600 NW SAMARITAN DRIVE
CORVALLIS, OR 97330
WWW.SAMHEALTH.ORG
STATE LICENSE 14-1074

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

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

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

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

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

Name and address	Type of Facility (describe)
1 1 - SAMARITAN PASTEGA REGIONAL CANCER CTR 441 NW ELKS DR CORVALLIS, OR 97330	RADIATION ONCOLOGY
1 2 - SAMARITAN ORTHOPEDICS CLINIC 3620 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
2 3 - SAMARITAN HEART & VASC - VASC SURGERY 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 4 - SAMARITAN SURGICAL SPECIALISTS 3615 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
4 5 - SAMARITAN GYN & SURGICAL ASSOCIATES 400 NW WALNUT BLVD STE 300 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
5 6 - SAMARITAN INTERNAL MEDICINE 3521 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
6 7 - SAMARITAN NEUROSURGERY 3615 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 8 - SAMARITAN FAMILY MEDICINE 3517 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 9 - MAMMOGRAPHY CLINIC 3615 NW SAMARITAN DR CORVALLIS, OR 97330	MAMMOGRAPHY CLINIC
9 10 - SAMARITAN KIDNEY SPECIALISTS 3615 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 11 - SAMARITAN PEDIATRICS 777 NW 9TH ST STE 320 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
11 12 - SAMARITAN URGENT CARE CENTER 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
12 13 - SAMARITAN RHEUMATOLOGY 3620 NW SAMARITAN DR STE 203 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
13 14 - SAMARITAN ENDOSCOPY CENTER 3509 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	ENDOSCOPY CENTER
14 15 - CORVALLIS MRI 3615 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330	IMAGING SERVICES

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

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

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

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

Name and address	Type of Facility (describe)
16 16 - SAMARITAN OBSTETRICS & GYN 3640 NW SAMARITAN DR STE 270 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
1 17 - SAMARITAN MENTAL HEALTH - CORVALLIS 3509 NW SAMARITAN DR CORVALLIS, OR 97330	MENTAL HEALTH SERVICES
2 18 - SAMARITAN PLASTICRECON SURG - HAVARD 996 NW CIRCLE BLVD STE 103 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
3 19 - SAMARITAN HEMATOLOGY & ONCOLOGY 501 NW ELKS DR CORVALLIS, OR 97330	RADIATION ONCOLOGY
4 20 - SAMARITAN ORTHOPEDICS - DR VELA 3620 NW SAMARITAN DR STE 201 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
5 21 - SAMARITAN MENTAL HEALTH - ALBANY 1052 SW 29TH ST ALBANY, OR 97321	MENTAL HEALTH SERVICES
6 22 - SAMARITAN INFECTIOUS DISEASE 3640 NW SAMARITAN DR STE 210 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
7 23 - SAMARITAN UROLOGY 990 NW CIRCLE BLVD STE 102 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
8 25 - OUTPATIENT SURGERY 3620 NW SAMARITAN DR CORVALLIS, OR 97330	AMBULATORY SURGERY
9 26 - SAMARITAN WEIGHT MGMT & METABOLIC SURG 3517 NW SAMARITAN DR STE 100 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
10 27 - SAMARITAN FAMILY MEDICINE SOUTHWEST 5234 SW PHILOMATH BLVD CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT
11 28 - SAMARITAN PHYSICAL REHAB - CORVALLIS 3580 NW SAMARITAN DRIVE CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
12 29 - SAMARITAN OCC MED - ALBANY 2615 WILLETТА ST SW STE C2 ALBANY, OR 97321	MEDICAL CLINIC - OUTPATIENT
13 30 - SAMARITAN OCC MED - LEBANON 100 MULLINS DRIVE STE B2 LEBANON, OR 97355	MEDICAL CLINIC - OUTPATIENT
14 31 - SAMARITAN OCC MED - CORVALLIS 5234 SW PHILOMATH BLVD STE B CORVALLIS, OR 97333	MEDICAL CLINIC - OUTPATIENT

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

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

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

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

Name and address	Type of Facility (describe)
31 32 - SAMARITAN OB & GYN RESIDENT CLINIC 3517 NW SAMARITAN DR STE 202 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
1 33 - SAMARITAN MENTAL HEALTH FAMILY CTR 3517 NW SAMARITAN DR STE 101 CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT
2 34 - SAMARITAN ATHLETIC MEDICINE 845 SW 30TH ST CORVALLIS, OR 97330	MEDICAL CLINIC - OUTPATIENT

Schedule I (Form 990)

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

OMB No 1545-0047

2015

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Attach to Form 990.

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

Name of the organization GOOD SAMARITAN HOSPITAL CORVALLIS

Employer identification number

93-0391573

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance?
2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

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

Table with 8 columns: (a) Name and address of organization or government, (b) EIN, (c) IRC section if applicable, (d) Amount of cash grant, (e) Amount of non-cash assistance, (f) Method of valuation, (g) Description of non-cash assistance, (h) Purpose of grant or assistance. Row 1 contains 'See Additional Data Table'.

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

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22
Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
(1) TRANSPORTATION	230	14,527			
(2) MEDICAL ASSISTANCE	1		75	BOOK	MEDICAL SUPPLIES
(3) SHELTER	1	95			
(4) MEALS FOR FAMILY MEMBERS OF PATIENTS	286		2,881	BOOK	MEALS
(5) ACCOMODATIONS - PASTEGA HOUSE	6403		28,873	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 section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
COMMUNITY OUTREACH 865 REIMAN AVENUE CORVALLIS, OR 97330	93-0602094	501(C)(3)	107,796				MEDICAL, DENTAL, MENTAL HEALTH CLINICS
OLD MILL CENTER 1650 SW 45TH PLACE CORVALLIS, OR 97333	93-0722603	501(C)(3)	15,000				COUNSELING, MENTAL HEALTH, AND PARENT EDUCATION
ALBANY HELPING HANDS PO BOX 2252 ALBANY, OR 97321	93-1244271	501(C)(3)	5,600				SUPPORT FOR HOMELESS PEOPLE

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CENTER AGAINST RAPE & DOMESTIC VIOLENCE PO BOX 914 CORVALLIS,OR 97339	93-0792125	501(C)(3)	20,500				TRANSITIONAL HOUSING SERVICES FOR DOMESTIC VIOLENCE SURVIVORS
BENTON COUNTY HEALTH DEPARTMENT 530 NW 27TH ST CORVALLIS,OR 97330	93-6002285	GOV'T	22,050				EMER DENTAL SERVICES TO UNINSURED AND UNDERINSURED ADULTS THROUGH A VOUCHER PROG
STRENGTHENING RURAL FAMILIES PO BOX 1528 PHILOMATH,OR 97370	20-2934930	501(C)(3)	8,500				ORGANIZING DENTAL VAN SERVICES IN RURAL COMMUNITIES

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LOVE IN THE NAME OF CHRIST OF BENTON COUNTY PO BOX 270 CORVALLIS, OR 97339	93-1326307	501(C)(3)	5,950				PROVIDING TRANSPORTATION AND MEDICAL CO-PAYS FOR UNINSURED AND HOMELESS ADULTS
BOYS AND GIRLS CLUB OF CORVALLIS INC 1112 NW CIRCLE BLVD CORVALLIS, OR 97330	23-7153987	501(C)(3)	50,000				YOUTH DEVELOPMENT FOR SCHOOL-AGED CHILDREN
JACKSON STREET YOUTH SHELTER INC PO BOX 285 CORVALLIS, OR 97339	93-1269503	501(C)(3)	10,000				OFFERING SHELTER AND CASE MANAGEMENT FOR HOMELESS YOUTH

**Schedule J
(Form 990)**

Compensation Information

OMB No 1545-0047

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

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

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

2015

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 Questions Regarding Compensation

- 1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.
- | | |
|--|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax 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) |
- 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
- 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?
- 3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.
- | | |
|--|--|
| <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input type="checkbox"/> Approval by the board or compensation committee |
- 4** During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization:
- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- 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.
- Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**
- 5** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:
- a** The organization?
- b** Any related organization?
If "Yes," on line 5a or 5b, describe in Part III.
- 6** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:
- a** The organization?
- b** Any related organization?
If "Yes," on line 6a or 6b, describe in Part III.
- 7** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.
- 8** Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.
- 9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1b	Yes	
2	Yes	
4a	Yes	
4b	Yes	
4c		No
5a	Yes	
5b		No
6a		No
6b		No
7		No
8		No
9		

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

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

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

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

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	IN CONNECTION WITH ITS EMPLOYEE WELLNESS PROGRAM, THE ORGANIZATION HAS A GYM/FITNESS FACILITY BENEFIT THAT IS AVAILABLE TO ALL EMPLOYEES WHO WORK AT LEAST 32 HOURS PER MONTH. IF AN EMPLOYEE PARTICIPATES AT A NON-SAMARITAN GYM, REIMBURSEMENT IS MADE FOR FEES. REIMBURSEMENT DOES NOT EXCEED \$300 PER YEAR AND IS INCLUDED IN THE EMPLOYEE'S TAXABLE WAGES AND IS SUBJECT TO FEDERAL/STATE WITHHOLDING TAX. NO PERSONS LISTED ON PART VII RECEIVED THIS TAXABLE GYM BENEFIT IN 2015. IF AN EMPLOYEE PARTICIPATES AT A SAMARITAN FITNESS CENTER (SAMFIT), MEMBERSHIP IS FREE OF CHARGE (PROVIDED AS A NONTAXABLE FRINGE BENEFIT). TWO KEY EMPLOYEES RECEIVED THE SAMFIT BENEFIT DURING 2015.
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, LINES 4A-B	4 A MICHAEL MAY, MD, A KEY EMPLOYEE, RECEIVED \$34,108 IN TAXABLE COMPENSATION, AND \$4,721 IN NON-TAXABLE BENEFITS PURSUANT TO HIS SEPARATION FROM THE FILING ORGANIZATION. 4 B THE ORGANIZATION MAINTAINS A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN. UNDER THIS PLAN, LARRY MULLINS, DHA AND DANIEL SMITH ACCRUED DEFERRED COMPENSATION BENEFITS DURING 2015. LARRY MULLINS, DHA RECEIVED A PAYMENT IN 2015 FROM THIS PLAN, WHICH IS INCLUDED IN HIS 2015 COMPENSATION ON SCHEDULE J AND FORM 990. \$225,675 OF THIS PAYMENT WAS ACCRUED IN PRIOR YEARS AND WAS ALSO INCLUDED IN COMPENSATION DISCLOSED IN PRIOR YEARS AS REQUIRED ON SCHEDULE J AND FORM 990. DANIEL SMITH RECEIVED NO PAYMENTS FROM HIS PLAN IN 2015.
PART I, LINE 5	VARIOUS PHYSICIAN COMPENSATION METHODOLOGIES ARE UTILIZED AND, DEPENDING ON SPECIALTY, RELATIVE VALUE UNITS (RVU'S) MAY BE USED IN DETERMINING A PORTION OF OR ALL OF THEIR COMPENSATION.

Additional Data

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 BECKY PAPE COO (JAN - NOV) / CEO (DEC)	(i)	0	0	0	0	0	0	0
	(ii)	300,950	37,000	2,915	21,760	31,497	394,122	0
1 DANIEL SMITH VP FINANCE / CFO	(i)	0	0	0	0	0	0	0
	(ii)	350,633	77,000	8,924	56,843	31,541	524,941	0
2 LARRY MULLINS DHA CEO (JAN - NOV) / CEO SHS	(i)	0	0	0	0	0	0	0
	(ii)	679,857	242,000	543,535	21,760	25,640	1,512,792	225,675
3 CAROLINE FISHER MD VP SMH MEDICAL DIRECTOR (MAR - DEC)	(i)	320,596	2,000	824	21,760	29,594	374,774	0
	(ii)	0	0	0	0	0	0	0
4 RYAN COMBS VP PRIMARY CARE SPEC PRACTICES	(i)	176,879	21,000	7,452	16,433	22,315	244,079	0
	(ii)	0	0	0	0	0	0	0
5 SCOTT WILSON VP ANCILLARY SUPPORT SVCS	(i)	163,807	4,500	14,312	13,789	27,245	223,653	0
	(ii)	0	0	0	0	0	0	0
6 WILLIAM HOWDEN VP NURSING	(i)	173,399	7,000	848	13,635	21,518	216,400	0
	(ii)	0	0	0	0	0	0	0
7 MICHAEL MAY MD VP SMH MEDICAL DIRECTOR (JAN - FEB)	(i)	40,265	0	111,487	10,533	9,262	171,547	0
	(ii)	1,200	0	0	0	0	1,200	0
8 LUIS VELA DOPHYSICIAN	(i)	894,036	1,000	1,242	19,356	30,802	946,436	0
	(ii)	0	0	0	0	0	0	0
9 DONALD PENNINGTON DO PHYSICIAN	(i)	586,513	111,582	12,943	21,760	31,370	764,168	0
	(ii)	0	0	0	0	0	0	0
10 TOSHIO NAGAMOTO MD PHYSICIAN	(i)	487,790	175,740	19,269	21,760	28,822	733,381	0
	(ii)	0	0	0	0	0	0	0
11 JEFF HSING MDPHYSICIAN	(i)	535,602	111,270	540	21,760	28,213	697,385	0
	(ii)	0	0	0	0	0	0	0
12 DANA PENNER MD PHYSICIAN	(i)	380,678	223,856	18,652	21,760	30,686	675,632	0
	(ii)	0	0	0	0	0	0	0
13 STEVEN JASPERSON FORMER CEO / VP SO CALIFORNIA OPS	(i)	0	0	0	0	0	0	0
	(ii)	386,534	0	89,725	21,760	24,882	522,901	0

Schedule L (Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

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.

2015 Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

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 5 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 10 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	146,152	EMP BY ORG		No
(2) JACOB SMITH	FAM MBR, D SMITH	13,132	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.

OMB No 1545-0047

2015**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 1TWO NON-EMPLOYEE BOARD MEMBERS OF THE FILING ORGANIZATION ARE NOT INDEPENDENT DUE TO
BUSINESS TRANSACTIONS WITH A RELATED ORGANIZATION

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	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

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 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 -1,148,000 INCREASE IN MINIMUM PENSION LIABILITY 2,492,500 OTHER CHANGES 122,721

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2015

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	Yes	
1s	Yes	

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

(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
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Additional Data

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
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
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
FIRSTCARE HEALTH FOUNDATION PO BOX 3000 CORVALLIS, OR 973393000 93-0900124	HEALTH SERVICES FOR LOW-INCOME PATIENTS	OR	501(C)(3)	7	SAMARITAN HEALTH SERVICES		No
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
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
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	
INTERCOMMUNITY HEALTH PLANS INC PO BOX 3000 CORVALLIS, OR 973393000 93-1124326	CCO PROVIDING MGMT OF INTEGRATED HEALTH SVCS FOR MEDICAID/OHP ENROLLEES	OR	501(C)(4)	N/A	SAMARITAN HEALTH SERVICES		No
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
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
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
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
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
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
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
(1) INTERCOMMUNITY HEALTH PLANS INC	L	28,996,143	COST
(1) SAMARITAN ENDOSCOPY CENTER LLC	A	382,654	COST
(2) SAMARITAN ENDOSCOPY CENTER LLC	S	500,000	COST
(3) CORVALLIS MEDICAL BUILDINGS LLC	A	51,761	COST
(4) CORVALLIS MEDICAL BUILDINGS LLC	S	218,000	COST
(5) CORVALLIS MEDICAL BUILDINGS LLC	K	544,338	COST
(6) HULL IMAGING LLC	A	45,600	COST
(7) HULL IMAGING LLC	O	636,432	COST
(8) HULL IMAGING LLC	S	561,000	COST
(9) HULL IMAGING LLC	L	420,840	COST
(10) GOOD SAMARITAN HOSPITAL FOUNDATION	C	6,707,480	COST
(11) GOOD SAMARITAN HOSPITAL FOUNDATION	O	249,250	COST
(12) GOOD SAMARITAN HOSPITAL FOUNDATION	R	164,358	COST