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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 black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

OMB No 1545-0047

2010

Open to Public Inspection

A For the 2010 calendar year, or tax year beginning 01-01-2010 and ending 12-31-2010

B Check if applicable
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
FAITH REGIONAL HEALTH SERVICES

Doing Business As

Number and street (or P O box if mail is not delivered to street address) | Room/suite
1500 KOENIGSTEIN AVENUE PO BOX 869

City or town, state or country, and ZIP + 4
NORFOLK, NE 687020869

D Employer identification number
47-0796875

E Telephone number
(402) 371-4880

G Gross receipts $ 143,526,588

F Name and address of principal officer
JAMES J SINEK
1500 KOENIGSTEIN AVENUE PO BOX 869
NORFOLK, NE 687020869

H(a) Is this a group return for affiliates? ☐ Yes ☑ No

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW FRHS ORG

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶ | **L** Year of formation 1996 | **M** State of legal domicile NE

Part I Summary

1 Briefly describe the organization's mission or most significant activities
FAITH REGIONAL HEALTH SERVICES IS A HEALTHCARE ORGANIZATION PROVIDING ACUTE, SKILLED AND OUTPATIENT SERVICES TO INDIVIDUALS IN OUR SERVICE AREA

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

Activities & Governance

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	15
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 2010 (Part V, line 2a)	**5**	1,438
6	Total number of volunteers (estimate if necessary)	**6**	186
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	321,331
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	159,872

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	1,580,016	1,228,007
9	Program service revenue (Part VIII, line 2g)	142,225,769	140,448,769
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	639,670	387,599
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	176,528	221,862
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	144,621,983	142,286,237
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	315,802	491,544
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)	72,641,870	75,834,466
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶483,312		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)	62,898,742	61,532,461
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	135,856,414	137,858,471
19	Revenue less expenses Subtract line 18 from line 12	8,765,569	4,427,766

Revenue

Expenses

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	189,016,005	185,782,930
21	Total liabilities (Part X, line 26)	112,670,191	105,166,197
22	Net assets or fund balances Subtract line 21 from line 20	76,345,814	80,616,733

Net Assets or Fund Balances

Part II Signature Block

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

Sign Here

****** | 2011-11-09
Signature of officer | Date

DOUGLAS WISMER CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed ▶ ☐	PTIN
BARBARA J FAJEN	BARBARA J FAJEN			

Firm's name ▶ SEIM JOHNSON LLP — Firm's EIN ▶

Firm's address ▶ 18081 BURT STREET SUITE 200
OMAHA, NE 680224722 — Phone no ▶ (402) 330-2660

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 to any question in this Part III . . . . . ☑

1 Briefly describe the organization's mission

FAITH REGIONAL HEALTH SERVICES (FAITH REGIONAL), A NOT-FOR-PROFIT HEALTH CARE FACILITY LOCATED IN NORTHEAST NEBRASKA OPERATES FOR THE BENEFIT OF THE INDIVIDUALS IN ITS SERVICE AREA FAITH REGIONAL SERVES ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY AND DOES NOT LIMIT ITS SERVICES OR DISCRIMINATE AGAINST ANYONE ON THE BASIS OF RACE, COLOR, SEX, NATIONAL ORIGIN, SEXUAL ORIENTATION, RELIGION, AGE, DISABILITY, DISEASE, OR DIAGNOSIS

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

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

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

If "Yes," describe these changes on Schedule O

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a (Code) (Expenses $ 64,910,178 including grants of $) (Revenue $ 42,618,868)

FAITH REGIONAL PROVIDES HEALTHCARE TO ALL PEOPLE REGARDLESS OF THEIR ABILITY TO PAY OR THEIR INSURANCE PROVIDER DURING 2010 FAITH PROVIDED 12,456 PATIENT DAYS TO MEDICARE PATIENTS AND 2,273 PATIENT DAYS TO MEDICAID PATIENTS

4b (Code) (Expenses $ 18,863,784 including grants of $) (Revenue $ 13,154,795)

MANY SERVICES PROVIDED BY FAITH REGIONAL ARE DONE SO TO MEET SPECIFIC NEEDS OF THE COMMUNITY BECAUSE NO OTHER SERVICES ARE AVAILABLE AS A RESULT, THESE SERVICES ARE PROVIDED KNOWING THAT THEY WILL NOT BE FINANCIALLY VIABLE OR SELF-SUPPORTING THESE SERVICES INCLUDE ACUTE REHABILITATION, BEHAVIORAL HEALTH INPATIENT SERVICES, CARDIOPULMONARY REHABILTIATION SERVICES, DIALYSIS, HOME HEALTH CARE AND TRANSITIONAL CARE (LONG-TERM REHABILITIATION) SERVICES

4c (Code) (Expenses $ 5,777,593 including grants of $) (Revenue $)

A SUBSTANTIAL PORTION OF COMMUNITY BENEFITS PROVIDED BY FAITH REGIONAL IS THE PROVISION OF PATIENT CARE SERVICES THAT ARE NOT PAID FOR EITHER BY THE PATIENT OR A THIRD PARTY INSURANCE DURING 2010 FAITH REGIONAL PROVIDED PATIENTS OVER $5 MILLION IN ASSISTANCE WITH PAYING THEIR HOSPITAL BILLS

4d Other program services (Describe in Schedule O) **See also Additional Data for Description**

(Expenses $ 31,433,764 including grants of $ 491,544) (Revenue $ 84,048,724)

4e **Total program service expenses** ▶ $ 120,985,319

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instruction)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4		No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		
6	Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in term, permanent,or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10	Yes	
11	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, line10? *If "Yes," complete Schedule D, Part VI.*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII.*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII.*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX.*	11d		No
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X.*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X.*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered 'No' to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the United States? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the U S ? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the U S ? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000, of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I (see instructions)*	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach its audited financial statement to this return? **Note.** Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b		No

Part IV Checklist of Required Schedules *(continued)*

21	Did the organization report more than $5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	**21**	Yes	
22	Did the organization report more than $5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	**22**		No
23	Did the organization answer "Yes" to Part VII, Section A, questions 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b–24d and complete Schedule K. If "No," go to line 25*	**24a**	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		No
25a	**Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties? (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**	Yes	
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**	Yes	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	**34**	Yes	
35	Is any related organization a controlled entity within the meaning of section 512(b)(13)?	**35**	Yes	
a	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2* ☑ **Yes** ☐ **No**			
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response to any question in this Part V . . . . . ☐

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . .	**1a**	106		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	**1b**	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?			**1c** Yes	
2a	Enter the number of employees reported on Form W-3, *Transmittal of Wage and Tax Statements* filed for the calendar year ending with or within the year covered by this return	**2a**	1,438		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?			**2b** Yes	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?			**3a** Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*			**3b** Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?			**4a**	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible?			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.** Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the organization make any taxable distributions under section 4966?			**9a**	
b	Did the organization make a distribution to a donor, donor advisor, or related person?			**9b**	
10	**Section 501(c)(7) organizations.** Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	

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 to any question in this Part VI . . . . . ☑

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	15		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	9		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?		2	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? . .		3		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		4		No
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .		5		No
6	Does the organization have members or stockholders?		6	Yes	
7a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?		7a	Yes	
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons? . .		7b	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?		8a	Yes	
b	Each committee with authority to act on behalf of the governing body?		8b	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		9		No

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

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

Section C. Disclosure

17 List the States with which a copy of this Form 990 is required to be filed ▶

18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you make these available Check all that apply

☐ Own website ☐ Another's website ☑ Upon request

19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public See Additional Data Table

20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization ▶

DOUGLAS WISMER
1500 KOENIGSTEIN AVENUE PO BOX 869
NORFOLK, NE 687020869
(402) 644-7249

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

Check if Schedule O contains a response to any question 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, and **current** key employees 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, and 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 (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

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

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b **Sub-Total**										
c **Total from continuation sheets to Part VII, Section A**										
d **Total (add lines 1b and 1c)**								5,244,765	0	292,610

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 in reportable compensation from the organization ▶ 58

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
JE DUNN CONSTRUCTION CO 929 HOLMES KANSAS CITY, MO 641062682	CONSTRUCTION	6,965,407
HDR ARCHITECTURE 8404 INDIAN HILLS DR OMAHA, NE 68114	ARCHITECTURE FEES	1,062,443
QUAMMEN HEALTH CARE CONSULTANT PO BOX 560070 MONTVERDE, FL 34756	IT CONSULTING	913,300
NEBRASKA LAB LINC PO BOX 30244 MIDDLEBURG HEIGHTS, OH 44130	LAB SERVICES	445,622
MIDWEST HEME MANAGEMENT INC 8625 OAKMONT LINCOLN, NE 685269616	MEDICAL SERVICES	386,783

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 in compensation from the organization ▶ 10

Part VIII Statement of Revenue

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a Federated campaigns 1a	17,000				
	b Membership dues 1b					
	c Fundraising events 1c					
	d Related organizations 1d	878,272				
	e Government grants (contributions) 1e					
	f All other contributions, gifts, grants, and similar amounts not included above 1f	332,735				
	g Noncash contributions included in lines 1a-1f $					
	h **Total.** Add lines 1a-1f ▶		1,228,007			
Program Service Revenue		Business Code				
	2a NET PATIENT SERVICE RE	623000	93,300,592	93,300,592		
	b MEDICARE/MEDICAID	623000	42,618,868	42,618,868		
	c OTHER OPERATING REVENU	900099	2,475,808	1,849,426	147,149	479,233
	d PHYSICIAN CLINICS	621110	1,064,447	1,064,447		
	e LEASED MEDICAL EMPLOYE	900099	989,054	989,054		
	f All other program service revenue					
	g **Total.** Add lines 2a–2f ▶		140,448,769			
	3 Investment income (including dividends, interest and other similar amounts) ▶		504,241			504,241
	4 Income from investment of tax-exempt bond proceeds ▶					
	5 Royalties ▶					
		(i) Real / (ii) Personal				
	6a Gross Rents	1,171,389				
	b Less rental expenses	1,123,709				
	c Rental income or (loss)	47,680				
	d Net rental income or (loss) ▶		47,680			47,680
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory					
	b Less cost or other basis and sales expenses	116,642				
	c Gain or (loss)	-116,642				
	d Net gain or (loss) ▶		-116,642			-116,642
Other Revenue	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					
	b Less cost of goods sold b					
	c Net income or (loss) from sales of inventory ▶					
	Miscellaneous Revenue	Business Code				
	11a MHR HOME CARE LLC	446199	174,182		174,182	
	b					
	c					
	d All other revenue					
	e **Total.** Add lines 11a–11d ▶		174,182			
	12 **Total revenue.** See Instructions ▶		142,286,237	139,822,387	321,331	914,512

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and organizations in the U S See Part IV, line 21	491,544	491,544		
2	Grants and other assistance to individuals in the U S See Part IV, line 22				
3	Grants and other assistance to governments, organizations, and individuals outside the U S See Part IV, lines 15 and 16				
4	Benefits paid to or for members				
5	Compensation of current officers, directors, trustees, and key employees	2,099,144	1,441,870	481,251	176,023
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	267,881	267,881		
7	Other salaries and wages	58,114,185	51,400,743	6,647,927	65,515
8	Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	2,622,467	2,319,516	299,995	2,956
9	Other employee benefits	8,840,997	7,819,671	1,011,359	9,967
10	Payroll taxes	3,889,792	3,440,437	444,970	4,385
a	Fees for services (non-employees) Management	281,694		281,694	
b	Legal	237,594		237,594	
c	Accounting	148,788		148,788	
d	Lobbying				
e	Professional fundraising services *See Part IV, line 17*				
f	Investment management fees				
g	Other	9,132,982	6,063,986	2,908,694	160,302
12	Advertising and promotion	412,245	396,273	7,749	8,223
13	Office expenses	30,274,621	26,687,756	3,545,511	41,354
14	Information technology				
15	Royalties				
16	Occupancy	3,010,799	2,764,233	246,566	
17	Travel	23,022	22,631	391	
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings				
20	Interest	3,893,343	3,893,343		
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	9,223,629	9,223,629		
23	Insurance	796,918	796,918		
24	Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O)				
a	BAD DEBT	3,824,326	3,824,326		
b	DUES & SUBSCRIPTIONS	252,396	110,458	127,351	14,587
c	LICENSES	20,104	20,104		
d					
e					
f	All other expenses				
25	**Total functional expenses.** Add lines 1 through 24f	137,858,471	120,985,319	16,389,840	483,312
26	**Joint costs.** Check here ▶ ☐ if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X Balance Sheet

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		619	1	73
	2	Savings and temporary cash investments		33,213,189	2	20,380,825
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		17,792,284	4	18,245,967
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	6	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) Schedule L			6	
	7	Notes and loans receivable, net		1,007,053	7	782,142
	8	Inventories for sale or use		3,551,580	8	4,083,846
	9	Prepaid expenses and deferred charges		609,230	9	1,139,734
	10a	Land, buildings, and equipment cost or other basis *Complete Part VI of Schedule D*	10a 190,995,534			
	b	Less accumulated depreciation	10b 68,849,448	118,927,406	10c	122,146,086
	11	Investments—publicly traded securities		8,836,148	11	13,126,141
	12	Investments—other securities See Part IV, line 11		22,385	12	25,302
	13	Investments—program-related See Part IV, line 11		1,741,235	13	2,028,769
	14	Intangible assets			14	
	15	Other assets See Part IV, line 11		3,314,876	15	3,824,045
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		189,016,005	16	185,782,930
Liabilities	17	Accounts payable and accrued expenses		19,442,300	17	13,599,377
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		78,062,054	20	75,508,998
	21	Escrow or custodial account liability *Complete Part IV of Schedule D*			21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons *Complete Part II of Schedule L*			22	
	23	Secured mortgages and notes payable to unrelated third parties		14,646,394	23	15,134,135
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities Complete Part X of Schedule D		519,443	25	923,687
	26	**Total liabilities.** Add lines 17 through 25		112,670,191	26	105,166,197
Net Assets or Fund Balances		**Organizations that follow SFAS 117, check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		76,317,737	27	80,588,488
	28	Temporarily restricted net assets		28,077	28	28,245
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117, check here ▶ ☐ 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		76,345,814	33	80,616,733
	34	Total liabilities and net assets/fund balances		189,016,005	34	185,782,930

Part XI Reconcilliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI . . . . . ☑

1	Total revenue (must equal Part VIII, column (A), line 12) . . .	1	142,286,237
2	Total expenses (must equal Part IX, column (A), line 25)	2	137,858,471
3	Revenue less expenses Subtract line 2 from line 1	3	4,427,766
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A)) . .	4	76,345,814
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-156,847
6	Net assets or fund balances at end of year Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	80,616,733

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII . . . . . ☑

			Yes	No
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? . .	2a		No
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
c	If "Yes," to 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	Yes	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both ☐ Separate basis ☑ Consolidated basis ☐ Both consolidated and separated basis			
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits . .	3b		

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

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

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

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

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

3 ☑ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**

4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state

_____

5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)

6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**

7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)** (Complete Part II)

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)

9 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

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

11 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h

a ☐ Type I **b** ☐ Type II **c** ☐ Type III - Functionally integrated **d** ☐ Type III - Other

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

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

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

	Yes	No
(i) a person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the the supported organization? **11g(i)**		
(ii) a family member of a person described in (i) above? **11g(ii)**		
(iii) a 35% controlled entity of a person described in (i) or (ii) above? **11g(iii)**		

h Provide the following information about the supported organization(s)

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document? Yes	(iv) No	(v) Did you notify the organization in col (i) of your support? Yes	(v) No	(vi) Is the organization in col (i) organized in the U S ? Yes	(vi) No	(vii) Amount of support
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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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 IV)						
11 **Total support** (Add lines 7 through 10)						

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

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

Section C. Computation of Public Support Percentage

14 Public Support Percentage for 2010 (line 6 column (f) divided by line 11 column (f)) **14**

15 Public Support Percentage for 2009 Schedule A, Part II, line 14 **15**

16a **33 1/3% support test—2010.** 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—2009.** If the organization did not check the box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

17a **10%-facts-and-circumstances test—2010.** If the organization did not check a box on line 13, 16a, or 16b and line 14 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization ▶☐

b **10%-facts-and-circumstances test—2009.** If the organization did not check a box on line 13, 16a, 16b, or 17a and line 15 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and **stop here.** Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization ▶☐

18 **Private Foundation** If the organization did not check a box on line 13, 16a, 16b, 17a or 17b, check this box and see instructions ▶☐

Part 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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(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) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
13 **Total support** (Add lines 9, 10c, 11 and 12)						

14 **First Five Years** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section501(c)(3) organization, check this box and **stop here** ▶☐

Section C. Computation of Public Support Percentage

15	Public Support Percentage for 2010 (line 8 column (f) divided by line 13 column (f))	15
16	Public support percentage from 2009 Schedule A, Part III, line 15	16

Section D. Computation of Investment Income Percentage

17	Investment income percentage for **2010** (line 10c column (f) divided by line 13 column (f))	17
18	Investment income percentage from **2009** Schedule A, Part III, line 17	18

19a **33 1/3% support tests—2010.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3% and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

b **33 1/3% support tests—2009.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶☐

20 **Private Foundation** If the organization did not check a box on line 14, 19a or 19b, check this box and see instructions ▶☐

Part IV **Supplemental Information.** Supplemental Information. Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Additional Data

Software ID:
Software Version:
EIN: 47-0796875
Name: FAITH REGIONAL HEALTH SERVICES

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

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JIM MILLER PRESIDENT	1 00	X		X				0	0	0
BERT LAMMLI VICE PRESIDENT	1 00	X		X				0	0	0
BERNIE AUTEN TREASURER	1 00	X		X				0	0	0
PAUL SANDALL SECRETARY	1 00	X		X				0	0	0
ANITA BRENNEMAN MEMBER	1 00	X						0	0	0
JOHN DINKEL MEMBER	1 00	X						0	0	0
JEFF EISENMENGER MEMBER	1 00	X						0	0	0
DR LEON GEBHARDT MEMBER	1 00	X						0	0	0
DONNA HERRICK MEMBER	1 00	X						0	0	0
DR STEF LACEY MEMBER	1 00	X						0	0	0
DAVID MAUCH MEMBER	1 00	X						0	0	0
SCOTT MILLER MEMBER	1 00	X						0	0	0
JEFF PAPE MEMBER	1 00	X						0	0	0
MARY KAY UHING MEMBER	1 00	X						0	0	0
DR PHIL ECKSTROM MEMBER	1 00	X						0	0	0
JAMES J SINEK CEO	39 00			X				463,192	0	18,059
DALE POHLMAN CFO (01/10 - 06/10)	39 00			X				141,181	0	11,808
DOUGLAS WISMER CFO (06/10 - PRESENT)	39 00			X				175,690	0	12,828
LINDA MILLER CNO	40 00			X				154,494	0	16,386
DR DEAN FRENCH VP MEDICAL AFFAIRS	40 00			X				369,366	0	17,379
H MICHAEL HAMMOND VP ALLIED HEALTH	40 00			X				179,052	0	18,460
JANET PINKELMAN VP HUMAN RESOURCES	40 00			X				139,419	0	7,873
PATRICK ROCHE COO - FRPS	40 00			X				179,302	0	18,633
BARRY SPEAR VP GROWTH AND DEVELOPMENT	24 00			X				165,076	0	10,947
JOSEPH MCCLAIN MD CARDIOVASCULAR SURGEON	40 00					X		838,773	0	40,935

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

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DOUGLAS WELSH MD CARDIOLOGIST	40 00					X		700,920	0	41,380
RIAD MEADA MD CARDIOVASCULAR SURGEON	40 00					X		612,360	0	30,519
MOHAMMAD IMRAN MD CARDIOLOGIST	40 00					X		570,698	0	29,859
JEFFREY YOSTEN MD DIRECTOR OF ER MEDICINE	40 00					X		555,242	0	17,544

Form 990, Part III - 4 Program Service Accomplishments (See the Instructions)

4d. Other program services

(Code) (Expenses $ 31,433,764 including grants of $ 491,544) (Revenue $ 84,048,724)

FAITH REGIONAL IS COMMITTED TO MAINTAINING AND ENHANCING THE QUALITY OF CARE THROUGH THE PROVISION OF EDUCATION TO EMPLOYEES AND MEDICAL STAFF AND THROUGH THE OFFERING OF BENEFITS THAT SUPPORT EDUCATION BENEFITS TO OUR EMPLOYEES INCLUDE EDUCATIONAL LOANS, TUITION REIMBURSEMENT AND WORKSHOP EXPENSE REIMBURSEMENT A TOTAL OF 16,000 HOURS OF EDUCATION HOURS WERE PROVIDED TO OUR 1100 EMPLOYEES AND MEDICAL STAFF MEMBERS THIS INCLUDED 550 PROGRAMS AND 3,700 HOURS OF CONTINUING EDUCATION FOR HEALTHCARE PROFESSIONALS AND PHYSICIANS FAITH REGIONAL ALSO PROMOTES HEALTHCARE CAREER BY PARTICIPATING AT HIGH SCHOOL CAREER FAIRS, OFFERING STUDENT SHADOWING AND HOSTING MEDICAL EXPLORERS

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

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

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

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

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply)
☐ Preservation of land for public use (e g , recreation or pleasure)
☐ Protection of natural habitat
☐ Preservation of open space
☐ Preservation of an historically importantly land area
☐ Preservation of a certified historic structure

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

			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	2d	

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

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

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

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

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

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

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

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

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

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

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

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

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

a Revenues included in Form 990, Part VIII, line 1 ▶ $ _____

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

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

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

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

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

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

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

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

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

		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? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIV

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

	(a) Current Year	(b) Prior Year	(c) Two Years Back	(d) Three Years Back	(e) Four Years Back
1a Beginning of year balance	5,188,508	4,493,972	5,706,317		
b Contributions	2,727	6,814	4,188		
c Investment earnings or losses	517,780	721,427	-1,146,496		
d Grants or scholarships	38,914	33,705	71,037		
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	5,670,101	5,188,508	4,492,972		

2 Provide the estimated percentage of the year end balance held as

- a Board designated or quasi-endowment ▶ 0 %
- b Permanent endowment ▶ 100 000 %
- c Term endowment ▶ 0 %

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

		Yes	No
(i) unrelated organizations	3a(i)		No
(ii) related organizations	3a(ii)	Yes	
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b	Yes	

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

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

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,006,212		1,006,212
b Buildings	7,149,316	85,558,275	32,204,007	60,503,584
c Leasehold improvements				
d Equipment	176,685	88,977,606	35,520,127	53,634,164
e Other		8,127,440	1,125,314	7,002,126
Total. Add lines 1a-1e *(Column (d) should equal Form 990, Part X, column (B), line 10(c).)* ▶				122,146,086

Part VII Investments—Other Securities. See Form 990, Part X, line 12.

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

Part VIII Investments—Program Related. See Form 990, Part X, line 13.

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

Part IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
Total. *(Column (b) should equal Form 990, Part X, col.(B) line 15.)* . . . . . ▶	

Part X Other Liabilities. See Form 990, Part X, line 25.

1 (a) Description of Liability	(b) Amount
Federal Income Taxes	
ESTIMATED THIRD PARTY PAYOR SETTLEMENTS - MEDICARE & MEDICAID	500,564
DEFERRED COMP INVESTMENT	423,123
Total. *(Column (b) should equal Form 990, Part X, col (B) line 25)* ▶	923,687

2. Fin 48 (ASC 740) Footnote In Part XIV, 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 (ASC740)

Part XI Reconciliation of Change in Net Assets from Form 990 to Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	142,286,237
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	137,858,471
3	Excess or (deficit) for the year Subtract line 2 from line 1	3	4,427,766
4	Net unrealized gains (losses) on investments	4	-156,847
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV)	8	
9	Total adjustments (net) Add lines 4 - 8	9	-156,847
10	Excess or (deficit) for the year per financial statements Combine lines 3 and 9	10	4,270,919

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

1	Total revenue, gains, and other support per audited financial statements			1	143,253,099
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains on investments	2a	-156,847		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV)	2d	1,123,709		
e	Add lines **2a** through **2d**			2e	966,862
3	Subtract line **2e** from line **1**			3	142,286,237
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 XIV)	4b			
c	Add lines **4a** and **4b**			4c	0
5	Total Revenue Add lines **3** and **4c.** (This should equal Form 990, Part I, line 12)			5	142,286,237

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements			1	138,982,180
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 XIV)	2d	1,123,709		
e	Add lines **2a** through **2d**			2e	1,123,709
3	Subtract line **2e** from line **1**			3	137,858,471
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 XIV)	4b			
c	Add lines **4a** and **4b**			4c	0
5	Total expenses Add lines **3** and **4c.** (This should equal Form 990, Part I, line 18)			5	137,858,471

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b Also complete this part to provide any additional information

Identifier	Return Reference	Explanation
DESCRIPTION OF INTENDED USE OF ENDOWMENT FUNDS	PART V, LINE 4	CARSON CANCER CENTER ENDOWMENT FUNDS ARE PERMANENTLY SET ASIDE TO GENERATE INVESTMENT EARNINGS TO BE USED TO FUND CAPITAL EQUIPMENT PURCHASES AND/OR OPERATIONS OF THE CARSON REGIONAL CANCER CENTER INVESTMENT EARNINGS ON THESE FUNDS ARE TEMPORARILY RESTRICTED AS TO USE GENERAL ENDOWMENT FUNDS ARE PERMANENTLY SET ASIDE TO GENERATE INVESTMENT EARNINGS INVESTMENT EARNINGS ON THESE FUNDS ARE NOT RESTRICTED AS TO USE THE HOSPICE ENDOWMENT FUNDS ARE PERMANENTLY SET ASIDE TO GENERATE INVESTMENT EARNINGS TO BENEFIT THE HOSPICE PROGRAM AND ITS PATIENTS INVESTMENT INCOME ON THESE FUNDS ARE TEMPORARILY RESTRICTED AS TO USE THE CARDIAC SERVICES ENDOWMENT FUNDS ARE PERMANENTLY SET ASIDE TO GENERATE INVESTMENT EARNINGS TO FUND FAITH REGIONAL HEALTH SERVICE'S CARDIAC PROGRAM CAPITAL AND/OR OPERATIONAL EXPENSES THE EDUCATION ENDOWMENT FUNDS ARE PERMANENTLY SET ASIDE TO GENERATE INVESTMENT EARNINGS TO BENEFIT FAITH REGIONAL HEALTH SERVICE'S EDUCATION PROGRAMS AND ITS EFFORTS TO RECRUIT AND RETAIN EMPLOYEES INVESTMENT INCOME ON THESE FUNDS ARE TEMPORARILY RESTRICTED AS TO USE ST JOSEPH'S NURSING HOME/SKYVIEW VILLA ENDOWMENT FUNDS ARE PERMANENTLY SET ASIDE TO GENERATE INVESTMENT EARNINGS TO BE USED TO FUND CAPITAL EQUIPMENT PURCHASES AND/OR OPERATION OF ST JOSEPH'S NURSING HOME AND SKYVIEW VILLA INVESTMENT EARNINGS ON THESE FUNDS ARE TEMPORARILY RESTRICTED AS TO USE DONORS CAN SPECIFY CONTRIBUTIONS TO ANY OF THE ENDOWMENT FUNDS
DESCRIPTION OF UNCERTAIN TAX POSITIONS UNDER FIN 48	PART X	FAITH REGIONAL DID NOT REPORT ANY INCOME TAX EXPENSE OR BENEFIT, NOR HAVE ANY DEFERRED TAX ASSETS OR LIABILITIES IN 2010 THE FOLLOWING IS THE RELEVANT PORTION OF THE FINANCIAL STATEMENT FOOTNOTE ON INCOME TAXES INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF FAITH REGIONAL HEALTH SERVICES AND AFFILIATES "FAITH ADOPTED FASB ASC TOPIC 740 SUBTOPIC 10 SECTION 25, ACCOUNTING FOR UNCERTAINTY IN INCOME TAXES - AN INTERPRETATION OF FASB ASC 740 DURING 2007 SECTION 25 PROVIDES SPECIFIC GUIDANCE ON HOW TO ADDRESS UNCERTAINTY IN ACCOUNTING FOR INCOME TAX ASSETS AND LIABILITIES, PRESCRIBING RECOGNITION THRESHOLDS AND MEASUREMENT ATTRIBUTES THE ADOPTION OF SECTION 25 BY FAITH DID NOT HAVE A MATERIAL IMPACT ON FAITH' FINANCIAL POSITION, RESULTS OF OPERATIONS OR CASH FLOWS "
PART XII, LINE 2D - OTHER ADJUSTMENTS		RENTAL EXPENSES 1,123,709
PART XIII, LINE 2D - OTHER ADJUSTMENTS		RENTAL EXPENSES 1,123,709

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

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," is it a written policy?	1b	Yes	
2	If the organization has multiple hospitals, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year ☐ Applied uniformly to all hospitals ☐ Applied uniformly to most hospitals ☐ Generally tailored to individual hospitals			
3	Answer the following based on the the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing *free* care to low income individuals? If "Yes," indicate which of the following is the FPG family income limit for eligibility for free care ☐ 100% ☐ 150% ☐ 200% ☑ Other **400.000000000000 %**	3a	Yes	
b	Does the organization use FPG to determine eligibility for providing *discounted* care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care ☐ 200% ☐ 250% ☐ 300% ☑ 350% ☐ 400% ☐ Other _____ %	3b	Yes	
c	If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care			
4	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 eligibile for free or discounted care?	5c		No
6a	Does the organization prepare a community benefit report during the tax year?	6a	Yes	
6b	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 Worksheets 1 and 2)			2,455,477		2,455,477	1 830 %
b Unreimbursed Medicaid (from Worksheet 3, column a)			9,770,447	8,208,222	1,562,225	1 170 %
c Unreimbursed costs—other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			12,225,924	8,208,222	4,017,702	3 000 %
Other Benefits						
e Community health improvement services and community benefit operations (from (Worksheet 4)			777,429	61,523	715,906	0 530 %
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)			13,154,795	7,847,989	5,306,806	3 960 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)			411,713		411,713	0 310 %
j **Total** Other Benefits			14,343,937	7,909,512	6,434,425	4 800 %
k **Total.** Add lines 7d and 7j			26,569,861	16,117,734	10,452,127	7 800 %

Part II Community Building Activities during the tax year, and describe in Part VI how its community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

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

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15?	1	Yes		
2	Enter the amount of the organization's bad debt expense (at cost)	2	1,644,629		
3	Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's financial assistance policy	3	69,909		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit				

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	33,970,833
6	Enter Medicare allowable costs of care relating to payments on line 5	6	42,956,418
7	Subtract line 6 from line 5 This is the surplus or (shortfall)	7	-8,985,585
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		

☑ Cost accounting system ☐ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership%	(e) Physicians' profit % or stock ownership %
1	3 NORTHEAST NE IMAGING CENTER LLC	IMAGING SERVICES	25 000 %	0 %	75 000 %
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 2

	Name and address	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)
1	FAITH REGIONAL HEALTH SERVICES - EAST 1500 KOENIGSTEIN AVE NORFOLK, NE 68701	X	X							
2	FAITH REGIONAL HEALTH SERVICES - WEST 2700 NORFOLK AVENUE NORFOLK, NE 68701	X	X					X		

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: FAITH REGIONAL HEALTH SERVICES

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 1

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8		
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9		
If "Yes," indicate the FPG family income limit for eligibility for free care __%			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
If "Yes," indicate the FPG family income limit for eligibility for discounted care __%			
11 Explained the basis for calculating amounts charged to patients?	11		
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☐ Income level			
b ☐ Asset level			
c ☐ Medical indigency			
d ☐ Insurance status			
e ☐ Uninsured discount			
f ☐ Medicaid/Medicare			
g ☐ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12		
13 Included measures to publicize the policy within the community served by the hospital facility?	13		
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☐ The policy was available upon request			
g ☐ Other (describe in Part VI)			
Billing and Collections			
14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	16		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☐ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☐ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	**18**		
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices.

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

Name of Hospital Facility: FAITH REGIONAL HEALTH SERVICES

Line Number of Hospital Facility (from Schedule H, Part V, Section A): 2

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8	1		
If "Yes," indicate what the Needs Assessment describes (check all that apply)			
a ☐ A definition of the community served by the hospital facility			
b ☐ Demographics of the community			
c ☐ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☐ How data was obtained			
e ☐ The health needs of the community			
f ☐ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☐ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☐ The process for consulting with persons representing the community's interests			
i ☐ Information gaps that limit the hospital facility's ability to assess all of the community's health needs			
j ☐ Other (describe in Part VI)			
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 ___			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3		
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4		
5 Did the hospital facility make its Needs Assessment widely available to the public?	5		
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)			
a ☐ Hospital facility's website			
b ☐ Available upon request from the hospital facility			
c ☐ Other (describe in Part VI)			
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply)			
a ☐ Adoption of an implementation strategy to address the health needs of the hospital facility's community			
b ☐ Execution of the implementation strategy			
c ☐ Participation in the development of a community-wide community benefit plan			
d ☐ Participation in the execution of a community-wide community benefit plan			
e ☐ Inclusion of a community benefit section in operational plans			
f ☐ Adoption of a budget for provision of services that address the needs identified in the Needs Assessment			
g ☐ Prioritization of health needs in the community			
h ☐ Prioritization of services that the hospital facility will undertake to meet health needs in its community			
i ☐ Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7		
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8		
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care to low income individuals?	9		
If "Yes," indicate the FPG family income limit for eligibility for free care __%			

Part V Facility Information *(continued)*

		Yes	No
10 Used FPG to determine eligibility for providing *discounted* care to low income individuals?	10		
If "Yes," indicate the FPG family income limit for eligibility for discounted care __%			
11 Explained the basis for calculating amounts charged to patients?	11		
If "Yes," indicate the factors used in determining such amounts (check all that apply)			
a ☐ Income level			
b ☐ Asset level			
c ☐ Medical indigency			
d ☐ Insurance status			
e ☐ Uninsured discount			
f ☐ Medicaid/Medicare			
g ☐ State regulation			
h ☐ Other (describe in Part VI)			
12 Explained the method for applying for financial assistance?	12		
13 Included measures to publicize the policy within the community served by the hospital facility?	13		
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a ☐ The policy was posted at all times on the hospital facility's web site			
b ☐ The policy was attached to all billing invoices			
c ☐ The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d ☐ The policy was posted in the hospital facility's admissions offices			
e ☐ The policy was provided, in writing, to patients upon admission to the hospital facility			
f ☐ The policy was available upon request			
g ☐ Other (describe in Part VI)			
Billing and Collections			
14 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy that explained actions the hospital facility may take upon non-payment?	14		
15 Check all of the following collection actions against a patient that were permitted under the hospital facility's policies at any time during the tax year			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
16 Did the hospital facility engage in or authorize a third party to engage in any of the following collection actions during the tax year?	16		
If "Yes," check all collection actions in which the hospital facility or a third party engaged (check all that apply)			
a ☐ Reporting to credit agency			
b ☐ Lawsuits			
c ☐ Liens on residences			
d ☐ Body attachments			
e ☐ Other (describe in Part VI)			
17 Indicate which actions the hospital facility took before initiating any of the collection actions checked in question 16 (check all that apply)			
a ☐ Notified patients of the financial assistance policy upon admission			
b ☐ Notified patients of the financial assistance policy prior to discharge			
c ☐ Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills			
d ☐ Documented its determination of whether a patient who applied for financial assistance under the financial assistance policy qualified for financial assistance			
e ☐ Other (describe in Part VI)			

Part V Facility Information *(continued)*

Policy Relating to Emergency Medical Care

		Yes	No
18 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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?	**18**		
If "No," indicate the reasons why (check all that apply)			
a ☐ The hospital facility did not provide care for any emergency medical conditions			
b ☐ The hospital facility did not have a policy relating to emergency medical care			
c ☐ The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)			
d ☐ Other (describe in Part VI)			

Charges for Medical Care

19 Indicate how the hospital facility determined the amounts billed to individuals who did not have insurance covering emergency or other medically necessary care (check all that apply)			
a ☐ The hospital facility used the lowest negotiated commercial insurance rate for those services at the hospital facility			
b ☐ The hospital facility used the average of the three lowest negotiated commercial insurance rates for those services at the hospital facility			
c ☐ The hospital facility used the Medicare rate for those services			
d ☐ Other (describe in Part VI)			
20 Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and 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?	**20**		
If "Yes," explain in Part VI			
21 Did the hospital facility charge any of its patients an amount equal to the gross charge for services provided to that patient?	**21**		
If "Yes," explain in Part VI			

Part V Facility Information *(continued)*

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, measured by total revenue per facility, from largest to smallest)

How many non-hospital facilities did the organization operate during the tax year? 3

	Name and address	Type of Facility (Describe)
1	ST JOSEPH REHABILITIATION & CARE CTR 401 N 18TH STREET NORFOLK, NE 68701	SKILLED NURSING FACILITY
2	ST JOSEPH REHABILITIATION & CARE CTR 401 N 18TH STREET NORFOLK, NE 68701	SKILLED NURSING FACILITY
3	ST JOSEPH REHABILITIATION & CARE CTR 401 N 18TH STREET NORFOLK, NE 68701	SKILLED NURSING FACILITY
4		
5		
6		
7		
8		
9		
10		

Part VI Supplemental Information

Complete this part to provide the following information

1. **Required descriptions.** Provide the description required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
2. **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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

Identifier	ReturnReference	Explanation
		PART I, LINE 3C FAITH REGIONAL USES THE FEDERAL POVERTY GUIDELINES TO DETERMINE ELIGIBILITY FOR DISCOUNTED CARE FINANCIALLY RESPONSIBLE PARTIES WHO SUBMIT A COMPLETE, VERIFIABLE APPLICATION FOR FINANCIAL ASSISTANCE WILL BE CONSIDERED FOR FREE OR REDUCED "CHARITY CARE" FINANCIAL ASSISTANCE ON THE BASIS OF THE FEDERAL POVERTY GUIDELINES (400% FPG LIMIT) ELIGIBILITY FOR THIS PROGRAM WILL BE DETERMINED BY FAMILY SIZE, GROSS INCOME BASED ON THE FEDERAL POVERY GUIDELINES AND AN ASSET TEST THE GROSS INCOME LEVELS ARE UPDATED EACH YEAR AS THE FEDERAL POVERTY GUIDELINES ARE UPDATED CHARITY CARE MAY BE GRANTED WITH RESPECT TO ANY DOLLARS OWED BY A FINANCIALLY RESPONSIBLE PARTY, INCLUDING, BUT NOT LIMITED TO, DEDUCTIBLE, COINSURANCE AND COPAYMENT AMOUNTS, CHARGES FOR NON-COVERED SERVICES AND MEDICAID COST OF SHARE AMOUNTS CHARITY CARE MAY BE AUTHORIZED FOR FINANCIALLY RESPONSIBLE PARTIES WITH INCOME LEVELS EXCEEDING 400% FPG IN THE CASE OF UNUSUAL, SPECIAL AND/OR EXTENUATING CIRCUMSTANCES THESE INSTANCES ARE GENERALLY DUE TO MEDICAL CATASTROPHE SITUATIONS
		PART I, LINE 7 FAITH REGIONAL USES A COST ACCOUNTING SYSTEM TO DETERMINE COSTS REPORTABLE ON PART I, LINE 7 (AND ELSEWHERE ON SCHEDULE H) THE FIRST STEP IN THE COST ACCOUNTING PROCESS IS TO ALLOCATE THE OVERHEAD EXPENSES (ADMINISTRATION AND GENERAL, PLANT, ETC) TO THE REVENUE PRODUCING DEPARTMENTS (OPERATING ROOM, IMAGING, ONCOLOGY, ETC) THIS IS DONE SIMILAR TO THE MEDICARE COST REPORT USING A SINGLE STEP DOWN METHOD TO ALLOCATE THE COSTS USING APPLICABLE STATISTICS FOR EXAMPLE PLANT EXPENSES ARE ALLOCATED DOWN TO THE OTHER DEPARTMENTS USING CURRENT SQUARE FOOTAGE SO DEPARTMENTS WITH MORE SQUARE FOOTAGE WILL BE ALLOCATED MORE PLANT EXPENSES, DIETARY EXPENSES ARE ALLOCATED BASED ON MEALS SERVED, EMPLOYEE BENEFITS ARE ALLOCATED BASED ON SALARIES, ADMINISTRATIVE AND GENERAL EXPENSES ARE ALLOCATED BASED ON ACCUMULATED COSTS, AND SO ON ONCE ALL THE OVERHEAD EXPENSES ARE ALLOCATED TO THE REVENUE PRODUCING DEPARTMENTS THE COSTS ARE FURTHER ALLOCATED DOWN TO THE CHARGE CODE LEVEL IN ORDER TO DO THIS WE USE TWO DIFFERENT METHODS DEPENDING ON THE DEPARTMENT FOR SPECIFIC DEPARTMENTS WE USE A RVU (RELATIVE VALUE UNIT) ALLOCATION WHERE EACH PROCEDURE IS WEIGHTED BY THE INTENSITY OF THE SERVICE AND IS THEN ALLOCATED COST BASED ON THAT LEVEL OF INTENSITY FOR EXAMPLE AN XRAY WITH SEDATION IS MORE COMPLICATED AND TIME INTENSIVE THAN A SIMPLE CHEST XRAY SO IT WOULD HAVE A HIGHER RVU VALUE AND, IN TURN, A HIGHER COST ALLOCATED TO IT THE DEPARTMENTS USING THIS ALLOCATION METHOD ARE IMAGING, CARDIAC CATH, CT, MRI, ULTRASOUND, NUCLEAR MEDICINE, RADIATION ONCOLOGY, AND REHAB (PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY) FOR THE OTHER DEPARTMENTS WE USE A RATIO OF COST TO CHARGE METHOD TO ALLOCATE THE COSTS DOWN TO THE CHARGE CODE LEVEL AFTER ALL THE COSTS HAVE BEEN ALLOCATED TO THE CHARGE CODES THE COSTING IS APPLIED TO ALL PATIENT ACCOUNTS BASED ON THEIR CHARGES TO DETERMINE THE COST OF THEIR ENCOUNTER AND THEN REPORTS CAN BE RUN TO DETERMINE THE PROFITABILITY OF CERTAIN PAYORS, SERVICE LINES OR DEPARTMENTS FOR SCHEDULE H PART III, LINE 2, A REPORT WAS RUN ON ALL PATIENTS THAT HAD ACCOUNTS WRITTEN OFF AS BAD DEBT DURING 2010 SHOWING THEIR CHARGES, PAYMENTS AND COSTS THE AMOUNT REPORTED ON LINE 2 REPRESENTS ALL COSTS LESS ANY PAYMENTS RECEIVED ON THOSE ACCOUNTS
		PART I, LINE 7G MANY SERVICES PROVIDED BY FAITH REGIONAL ARE DONE SO TO MEET SPECIFIC NEEDS OF THE COMMUNITY BECAUSE NO OTHER SERVICES ARE AVAILABLE AS A RESULT, THESE SERVICES ARE PROVIDED KNOWING THAT THEY WILL NOT BE FINANCIALLY VIABLE OR SELF-SUPPORTING FAITH REGIONAL DID NOT INCLUDE COSTS ATTRIBUTABLE TO PHYSICIAN CLINICS AS SUBSIDIZED SERVICES A SUBSIDIZED HEALTH SERVICE BENEFIT WAS CALCULATED FOR THE ACUTE REHABILITIATION, BEHAVIORAL HEALTH INPATIENT SERVICES, CARDIOPULMONARY REHABILITATION, DIALYSIS, HOME HEALTH CARE, TRANSITIONAL CARE (LONG-TERM REHABILITATION) AND SKILLED NURSING CARE DEPARTMENTS TO RECOGNIZE THAT THESE AREAS OPERATE AT A NEGATIVE MARGIN WHEN THE INDIRECT COSTS ARE CONSIDERED THE REPORTED SUBSIDIZED LOSS REPRESENTS THE DIFFERENCE IN NET REVENUE RECEIVED FROM ALL PAYORS IN ADDITION TO ANY MISCELLANEOUS OPERATING REVENUE REPORTED BY THE DEPARTMENT LESS TOTAL OPERATING EXPENSES (DIRECT + INDIRECT COSTS INCLUDED) APPLICABLE TO EACH DEPARTMENT
		PART I, L7 COL(F) FAITH REGIONAL ACCOUNTS FOR DISCOUNTS OR PAYMENTS ON PATIENT ACCOUNTS PREVIOUSLY DETERMINED AS BAD DEBT BY CREDITING THE BAD DEBT EXPENSE ACCOUNT
		PART II NONE
		PART III, LINE 4 THE AUDITED FINANCIAL STATEMENT FOOTNOTES FOR FAITH REGIONAL DO NOT CONTAIN A FOOTNOTE RELATED TO BAD DEBT EXPENSE BAD DEBT EXPENSE IS IDENTIFIED ON THE CONSOLIDATED STATEMENT OF OPERATIONS WHICH IS CONSISTENT WITH THE REPORTING PRACTICE OF OTHER HEALTH CARE ORGANIZATIONS DESCRIBE THE COSTING METHOD USED TO DETERMINE AMOUNTS REPORTED IN LINES 2 & 3 FAITH REGIONAL USES A COST ACCOUNTING SYSTEM TO DETERMINE COSTS REPORTABLE ON LINES 2 & 3 (AND ELSEWHERE ON SCHEDULE H) THE FIRST STEP IN THE COST ACCOUNTING PROCESS IS TO ALLOCATE THE OVERHEAD EXPENSES (ADMINISTRATION AND GENERAL, PLANT, ETC) TO THE REVENUE PRODUCING DEPARTMENTS (OPERATING ROOM, IMAGING, ONCOLOGY, ETC) THIS IS DONE SIMILAR TO THE MEDICARE COST REPORT USING A SINGLE STEP DOWN METHOD TO ALLOCATE THE COSTS USING APPLICABLE STATISTICS FOR EXAMPLE PLANT EXPENSES ARE ALLOCATED DOWN TO THE OTHER DEPARTMENTS USING CURRENT SQUARE FOOTAGE SO DEPARTMENTS WITH MORE SQUARE FOOTAGE WILL BE ALLOCATED MORE PLANT EXPENSES, DIETARY EXPENSES ARE ALLOCATED BASED ON MEALS SERVED, EMPLOYEE BENEFITS ARE ALLOCATED BASED ON SALARIES, ADMINISTRATIVE AND GENERAL EXPENSES ARE ALLOCATED BASED ON ACCUMULATED COSTS, AND SO ON ONCE ALL THE OVERHEAD EXPENSES ARE ALLOCATED TO THE REVENUE PRODUCING DEPARTMENTS THE COSTS ARE FURTHER ALLOCATED DOWN TO THE CHARGE CODE LEVEL IN ORDER TO DO THIS WE USE 2 DIFFERENT METHODS DEPENDING ON THE DEPARTMENT FOR SPECIFIC DEPARTMENTS WE USE A RVU (RELATIVE VALUE UNIT) ALLOCATION WHERE EACH PROCEDURE IS WEIGHTED BY THE INTENSITY OF THE SERVICE AND IS THEN ALLOCATED COST BASED ON THAT LEVEL OF INTENSITY FOR EXAMPLE, AN XRAY WITH SEDATION IS MORE COMPLICATED AND TIME INTENSIVE THAN A SIMPLE CHEST XRAY SO IT WOULD HAVE A HIGHER RVU VALUE AND IN-TURN A HIGHER COST ALLOCATED TO IT THE DEPARTMENTS USING THIS ALLOCATION METHOD ARE IMAGING, CARDIAC CATH, CT, MRI, ULTRASOUND, NUCLEAR MEDICINE, RADIATION ONCOLOGY, AND REHAB (PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY) FOR THE OTHER DEPARTMENTS WE USE A RATIO OF COST TO CHARGE METHOD TO ALLOCATE THE COSTS DOWN TO THE CHARGE CODE LEVEL AFTER ALL THE COSTS HAVE BEEN ALLOCATED TO THE CHARGE CODES, THE COSTING IS APPLIED TO ALL PATIENT ACCOUNTS BASED ON THEIR CHARGES TO DETERMINE THE COST OF THEIR ENCOUNTER AND THEN REPORTS CAN BE RUN TO DETERMINE THE PROFITABILITY OF CERTAIN PAYORS, SERVICE LINES OR DEPARTMENTS FOR SCHEDULE H PART III, LINE 2, BAD DEBT DURING 2010 WAS MULTIPLIED BY THE RATIO COST TO CHARGES TO DETERMINE THE AMOUNT TO REPORT ON LINE 3 (ESTIMATED BAD DEBTS THAT COULD BE ATTRIBUTED TO THE PATIENTS ELIGIBLE UNDER THE CHARITY CARE POLICY), WE DIVIDED TOTAL CHARITY CARE FOR 2010 BY TOTAL NET PATIENT REVENUE AND MULITPLIED THIS RESULTING PERCENTAGE (4 25%) BY BAD DEBT EXPENSE (AT COST) FAITH REGIONAL ACCOUNTS FOR DISCOUNTS OR PAYMENTS ON PATIENT ACCOUNTS PREVIOUSLY DETERMINED AS BAD DEBT BY CREDITING THE BAD DEBT EXPENSE ACCOUNT
		PART III, LINE 8 FAITH REGIONAL USES A COST ACCOUNTING SYSTEM TO DETERMINE COSTS TO BE REPORTED IN SCHEDULE H THE MEDICARE COSTS WERE DETERMINED BY RUNNING A REPORT SHOWING ALL MEDICARE ACCOUNTS DURING 2010 AND REPORTING ALL PAYMENTS RECEVIED ON LINE 5 AND THE TOTAL COSTS (DIRECT AND INDIRECT) ASSOCIATED WITH THOSE ACCOUNTS ON LINE 6
		PART III, LINE 9B THROUGHOUT THE COLLECTION PROCESS EACH ACCOUNT IS ALSO CONSIDERED FOR FINANCIAL ASSISTANCE FOR THOSE GUARANTORS THAT ARE FINANCIALLY UNABLE TO PAY OR EXPRESS INABILITY TO PAY ALL CORRESPONDENCE, INCLUDING STATEMENTS AND COLLECTION LETTERS INCLUDE A STATEMENT THAT "FINANCIAL ASSISTANCE MAY BE AVAILABLE " ACCOUNTS THAT ARE NOT SUCCESSFULLY RESOLVED ARE CONSIDERED FOR REFERRAL TO OUTSIDE COLLECTION AGENCIES THE PATIENT ACCOUNTS' STAFF MEMBER WILL REVIEW THE ACCOUNT TO INSURE ALL PROCESSES ARE COMPLETE, AND THEN FLAG THE ACCOUNT TO BE SENT TO OUTSIDE COLLECTION AGENCIES THE COLLECTION AGENCIES WE UTILIZE ALSO HAVE COPIES OF OUR FINANCIAL ASSISTANCE POLICY AND APPLICATION IF THE NEED ARISES
		PART I, LINE 6A FAITH REGIONAL'S COMMUNITY BENEFIT REPORT IS FILED WITH THE NEBRASKA HOSPITAL ASSOCIATION AND IS AVAILABLE TO THE PUBLIC ON OUR WEBSITE WWW FRHS ORG
		PART VI, LINE 2 FAITH REGIONAL DOES NOT COMPLETE A FORMAL NEEDS ASSESSMENT AT THIS TIME AS THE PUBLIC HEALTH DEPARTMENT HAS DONE SEVERAL IN THE PAST COUPLE OF YEARS AND FAITH HAS CHOSEN NOT TO DUPLICATE THE WORK AS THE HEALTH DEPARTMENT DOES A COMPLETE REPORT IN ADDITION TO THE PUBLIC HEALTH DEPARTMENT'S ASSESSMENT, FAITH REGIONAL IS INTIMATELY INVOLVED IN THE ELKHORN ECONOMIC DEVELOPMENT ASSOCIATION, BOTH ON THE BOARD AND THROUGH FINANCIAL SUPPORT THAT INVOLVMENT IS INTENDED TO FACILITATE COMMUNITY GROWTH, JOB DEVELOPMENT, INFRASTRUCTURE DEVELOPMENT AND BUSINESS EDUCATION/TRAINING FAITH REGIONAL IS ALSO A MEMBER OF THE NORFOLK CHAMBER OF COMMERCE WHICH IS INVOLVED IN BUSINESS RETAIL DEVELOPMENT AND SUPPORT AS WELL AS THE COMMUNITY IMPROVEMENT PROJECTS FAITH ALSO WORKS WITH ORGANIZATIONS LIKE THE ORPHAN GRAIN TRAIN IN PROVIDING MEDICINE AND MEDICAL EQUIPMENT/SUPPLIES TO OTHER NATIONS IN NEED
		PART VI, LINE 3 PATIENTS RECEIVING CARE ARE GIVEN INFORMATION REGARDING FAITH REGIONAL'S FINANCIAL ASSISTANCE PROGRAM THROUGH THE USE OF BROCHURES HANDED OUT BY REGISTRATION, HOSPITAL SOCIAL SERVICES, M A S H (MEDICAL ADVOCACY SERVICES FOR HEALTHCARE) PERSONNEL, AND BY PATIENT ACCOUNTS STAFF ANY PATIENT OR FAMILY MEMBER THAT EXPRESSES CONCERN REGARDING ABILITY TO PAY FOR SERVICES WILL BE DIRECTED TO A SOCIAL WORKER, REGISTRATION CLERK, CASHIER, OR FINANCIAL SERVICES REPRESENTATIVE WHO WILL THEN GIVE THEM AN APPLICATION FOR PATIENT FINANCIAL ASSISTANCE ALONG WITH A BROCHURE EXPLAINING HOW TO COMPLETE THE APPLICATION THE APPLICATION WILL NEED TO BE SUBMITTED ALONG WITH PROOF OF THEIR GROSS INCOME FOR THE PRECEDING THREE MONTHS THIS CAN BE ACCOMPLISHED BY PROVIDING CHECK STUBS FOR THE PRECEDING THREE MONTHS, PROVIDING THE MOST RECENTLY FILED TAX RETURN OR BY PRESENTING A STATEMENT FROM THEIR EMPLOYER (ON COMPANY LETTERHEAD) INDICATING GROSS INCOME FOR EACH OF THE PREVIOUS THREE MONTHS MEDICARE PATIENTS MAY SHOW THEIR ORIGINAL DETERMINATION AMOUNT, A PHOTOCOPY OF A MONTHLY CHECK, OR A COPY OF THEIR BANK STATEMENT THE FINANCIAL SERVICES REPRESENTATIVE WILL THEN MULTIPLY THE GROSS INCOME FOR THE THREE MONTHS BY FOUR TO GET AN ANNUAL GROSS INCOME THE FINANCIAL SERVICE REPRESENTATIVE WILL ALSO REVIEW THE PATIENT'S ASSETS TO SEE IF THERE IS SUFFICIENT EQUITY TO HELP PAY FOR HEALTH SERVICES THE EQUITY OF ASSETS WILL BE DETERMINED AS FOLLOWS REAL ESTATE - WE WILL EXCLUDE THE PRIMARY RESIDENCE ALONG WITH UP TO 1 ACRE OF LAND THAT THE RESIDENCE IS ON, WE WILL INCLUDE RENTAL PROPERTIES, ALL HOMES OR REAL PROPERTY ABOVE AND BEYOND THE PRIMARY RESIDENCE, CABINS, RECREATIONAL PROPERTY, ETC , AS WELL AS REAL ESTATE OWNED FOR BUSINESS PURPOSES PERSONAL PROPERTY - WE WILL EXCLUDE ONE VEHICLE PER WAGE EARNER (OR SOCIAL SECURITY OR DISABILITY RECIPIENT), WE WILL CONSIDER THE EQUITY IN MOTOR VEHICLES (MOTORCYCLES, MOTOR HOMES, BOATS, BOAT TRAILERS, AND ATVS) OTHER PERSONAL PROPERTY WILL INCLUDE STOCKS, BONDS, CDS, FUTURES, ANTIQUE COLLECTIBLES, AND ANY OTHER COLLECTIONS OF VALUE THE HOUSEHOLD SIZE WILL BE DETERMINED USING THE FEDERAL HOUSEHOLD DEFINITIONS IF THERE IS AN OMISSION OF INFORMATION ON THE APPLICATIONS OR INFORMATION PROVIDED APPEARS TO BE INCORRECT, A LETTER WILL BE SENT TO THE PATIENT REQUESTING THE MISSING INFORMATION OR REQUESTING CLARIFICATION OF THE INFORMATION THE DATE THAT THE LETTER IS SENT WILL BE DOCUMENTED ON A LOG OF PENDING APPLICATIONS IF THE REQUESTED DOCUMENTATION IS NOT RETURNED IN NINE WORKING DAYS, THE APPLICATION WILL BE DENIED THE TEAM LEADER FOR THE PATIENT FINANCIAL SERVICES REPRESENTATIVES WILL REVIEW THE APPLICATION AND ASSETS AND MAKE A DETERMINIATION WITHIN 3 DAYS OF THE RECEIPT OF A COMPLETE APPLICATION THE TEAM LEADER WILL THENNOTIFY (BY LETTER) THE PATIENT INDICATING THAT THE APPLCIATION HAS BEEN APPROVED OR DENIED IF THE APPLICATION IS DENIED THE PATIENT MAY APPLY AGAIN IF THEIR FINANCIAL CIRCUMSTANCES CHANGE
		PART VI, LINE 4 FAITH REGIONAL'S PRIMARY SERVICE AREA CONSISTS OF ANTELOPE, HOLT, KNOX, MADISON, PIERCE, PLATTE, STANTON AND WAYNE COUNTIES IN NEBRASKA REPRESENTING A POPULATION OF APPROXIMATELY 116,000 PEOPLE THE HOSPITAL'S SECONDARY SERVICE AREA CONSISTS OF BOONE, CEDAR, COLFAX, CUMING AND DIXON COUNTIES IN NEBRASKA REPRESENTING APPROXIMATELY 40,000 PEOPLE FAITH REGIONAL ALSO HAS A TERTIARY SERVICE AREA OF CHERRY, BROWN, KEYA PAHA, ROCK, BOYD, GARFIELD, WHEELER, GREELEY, NANCE, DAKOTA, THURSTON AND BURT COUNTIES IN NEBRASKA WITH APPROXIMATELY A POPULATION OF 57,400 FOR THE YEAR ENDED DECEMBER 31, 2010, 91% OF FAITH REGIONAL'S DISCHARGES WERE FROM PATIENTS RESIDING IN THE PRIMARY SERVICE AREA , 5% FROM THE SECONDARY, AND 1% FROM THE TERTIARY SERVICE AREAS THE REMAINING 3% OF DISCHARGES WERE FROM PATIENTS RESIDING OUTSIDE OF THE DEFINED SERVICE AREA DEMOGRAPHIC SURVEY (SOURCE US CENSUS BUREAU 2010 CENSUS)MADISON COUNTY TOTAL POPULATION 34,876AVERAGE INCOME $42,911"PERCENT OF INDIVIDUALS BELOW POVERTY LEVEL" 12%BREAKOUT OF POPULATION BY AGE AGE POPULATION % OF TOTALLESS THAN 19 9,911 28 4%20 - 24 2,458 7 1%25 - 44 8,037 23 0%45 - 64 9,346 26 8%65+ 5,124 14 7%TOTAL 34,876 100 0%BREAKOUT OF POPULATION BY RACE RACE POPULATION % OF TOTALWHITE 30,752 88 2%BLACK/AFRICAN AMERICAN 444 1 3%AMERICAN INDIAN 401 1 1%ASIAN/PACIFIC ISLANDER 183 0 5%OTHER 3,096 8 9%TOTAL 34,876 100 0%
		PART VI, LINE 6 FAITH REGIONAL, A NOT-FOR-PROFIT HEALTH CARE FACILITY, LOCATED IN NORTHEAST NEBRASKA, OPERATES FOR THE BENEFIT OF THE INDIVIDUALS IN THE SERVICE AREA FAITH REGIONAL SERVES ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY AND DOES NOT LIMIT ITS SERVICES OR DISCRIMINATE AGAINST ANYONE ON THE BASIS OF RACE, COLOR, SEX, NATIONAL ORIGIN, SEXUAL ORIENTATION, RELIGION, AGE, DISABILITY, DISEASE, OR DIAGNOSIS FAITH REGIONAL ALSO PROVIDES COMMUNICATIONS SERVICES (E G BILINGUAL STAFF AND INTERPRETERS, SIGN LANGUAGE INTERPRETERS, TDD SERVICES, ETC) FOR SENSORY IMPAIRED INDIVIDUALS FAITH REGIONAL EVALUATES ITSELF ON ITS EFFECTIVENESS ANNUALLY BY EXAMINING ITS ABILITY TO FULFILL ITS MISSION, ACCOMPLISH ITS VISION, PROVIDE SERVICE, AND MAINTAIN ITS VALUES FAITH REGIONAL'S MISSION, VISION, SERVICE, AND VALUESARE THE MISSION THE MISSION IS TO SERVE CHRIST BY PROVIDING ALL PEOPLE WITH EXEMPLARY MEDICAL SERVICES IN AN ENVIRONMENT OF LOVE AND CARE THE VISION THE VISION OF FAITH REGIONAL HEALTH SERVICES IS TO BECOME A REGIONAL REFERRAL CENTER BY PROVIDING THE MOST COMPREHENSIVE, HIGH QUALITY HEALTH SERVICES TO THE RESIDENTS OF NORTHEAST NEBRASKA THE VALUES SPIRITUALITYEXCELLENCEINTEGRITYCOMPASSIONRESPECTSTEWARDSHIPFAITH REGIONAL'S PROGRAM SERVICE ACCOMPLISHMENTS ARE BASED ON THE COMMUNITY ACCOUNTABILITY STANDARDS DEVELOPED BY THE VOLUNTARY HOSPITALS OF AMERICA (VHA) THESE FOUR STANDARDS ARE 1) DEMONSTRATE LEADERSHIP AS A CHARITABLE INSTITUTION "ORGANIZATIONS SHOULD ACTIVELY PURSUE AN UNDERSTANDING OF THEIR COMMUNITIES' NEEDS AND FULFILL THEM TO THE BEST OF THEIR ABILITY THIS INCLUDES REACHING OUT WITH PREVENTATIVE AND OTHER HEALTHCARE, PARTICIPATING IN MEDICARE, MEDICAID AND OTHER REIMBURSEMENT PROGRAMS FOR THE NEEDY, AND SOLICITING AND DONATING FUNDS TO HELP THOSE IN NEED "2) PROVIDING ESSENTIAL HEALTH CARE SERVICES - "ORGANIZATIONS SHOULD ASSESS THEIR COMMUNITIES' HEALTH NEEDS AND WORK TO MEET THEM AS NECESSARY, INCLUDING COOPERATING WITH OTHER COMMUNITY HEALTH CARE PROVIDERS TO PROVIDE THE BEST CARE POSSIBLE AND OFFERING 24-HOUR EMERGENCY SERVICES "3) BEING ACCOUNTABLE TO THE COMMUNITY "ORGANIZATIONS SHOULD WORK WITH A VOLUNTEER GOVERNING BOARD THAT IS REPRESENTATIVE OF THE COMMUNITY ORGANIZATIONS ARE ALSO ENCOURAGED TO VOLUNTARILY DISCLOSE INFORMATION ABOUT FINANCIAL STATUS, COMMUNITIY BENEFIT ACTIVITIES, SERVICES AND CHARITY CARE, AND TO ADVOCATE HEALTH CARE COST CONTAINMENT AND OTHER ISSUES AS APPROPRIATE "4) MAINTAING EVIDENCE OF COMMITMENT TO COMMUNITY BENEFIT "ORGANIZATIONS SHOULD EMBRACE A MISSION STATEMENT AND BYLAWS REFLECTING A COMMITMENT TO THE GOOD OF THE COMMUNITY AND SHOULD ACT AS LEADERS IN ORGANIZING COMMUNITY BENEFIT ACTIVITIES, BASED ON COMMUNITY NEEDS, SHOULD BE PART OF A STRATEGIC PLAN, AND EMPLOYEES AND MEDICAL STAFF SHOULD BE EDUCATED AND INVOLVED IN THESE ACTIVITIES "FAITH REGIONAL REGOGNIZES ITS OBLIGATION TO DEMONSTRATE LEADERSHIP AS A CHARITABLE ORGANIZATION BY PROVIDING A FULL RANGE OF HEALTH CARE, HEALTH EDUCATION AND WELLNESS RELATED SERVICES TO THE COMMUNITY, AND PARTICIPATING IN FEDERAL, STATE AND LOCAL PROGRAMS TO PROVIDE HEALTH BENEFITS TO THOSE IN NEED DURING 2010, FAITH REGIONAL PARTICIPATED IN A VARIETY OF PROGRAMS INTENDED TO BENEFIT THE ELDERLY AND NEEDY POPULATIONS WITHIN, AND THOSE INDIVIDUALS ENTERING, ITS SERVICE AREA THESE INCLUDE MEDICARE, MEDICAID, CHAMPUS, WORKERS COMPENSATION, AND OTHER DISCOUNTED HEALTH INSURANCE PROGRAMS FAITH IS ALSO A PARTICIPATING PROVIDER WITH SEVERAL COMMERCIAL INSURANCE COMPANIES PROVIDING MANAGED CARE TO EMPLOYERS IN OUR COMMUNITIES THIS PARTICIPATION PROVIDES INDIVIDUALS WITH ACCESS TO A LOCAL HEALTH CARE PROVIDER IN ADDITION, FAITH PROVIDES CHARITY CARE FOR THOSE INDIVIDUALS, WHEN IDENTIFIED, WHO ARE FOUND TO BE UNABLE TO PAY FOR SERVICES RENDERED BECAUSE OF ITS PARTICIPATATION IN VARIOUS HEALTH INSURANCE AND CHARITY PROGRAMS, FAITH REGIONAL ACCEPTS CONTRACTUALLY DISCOUNTED PAYMENTS AS PAYMENT IN FULL THIS DISCOUNTED PAYMENT VARIES WITH THE TYPE OF THIRD PARTY PAYOR THESE AMOUNTS, CONTRACTUAL ADJUSTMENTS, ARE DISCOUNTED FROM NORMAL CHARGES IN ADDITION TO PROVIDING UNCOMPENSATED MEDICAL CARE, DURING 2010 FAITH REGIONAL ALSO PROVIDED CASH AND IN-KIND CONTRIBUTIONS TO VARIOUS COMMUNITY ORGANIZATIONS TO FURTHER THE MISSION OF THOSE ORGANIZATIONS AND IMPROVE OVERALL AWARENESS OF HEALTHCARE RELATED ISSUES IN OUR COMMUNITIES ORGANIZATIONS RECEIVING CASH OR IN-KIND CONTRIBUTIONS FROM FAITH INCLUDE THE AMERICAN RED CROSS, AMERICAN HEART ASSOCIATION, CITY OF NORFOLK, BIRTHRIGHT OF NORFOLK, PLANNED APPROACH TO COMMUNITY HEALTH (PATCH), AND NORFOLK AREA CHAMBER OF COMMERCE ALSO DURING 2010 FAITH CONTRIBUTED FINANCIAL SUPPORT FOR A NEW 4-YEAR NURSING SCHOOL IN NORFOLK, NE THROUGH COLLABORATION BETWEEN NORTHEAST COMMUNITY COLLEGE AND THE UNIVERSITY OF NEBRASKA FAITH REGIONAL ALSO FINANCIALLY SUPPORTS THE NORFOLK COMMUNITY "FREE CLINIC" THROUGH PHYSICIAN RECRUITMENT AND CLINIC SPACE DONATION FAITH REGIONAL PROVIDES TRANSPORTATION SERVICES PRIMARILY TO RADIATION ONCOLOGY AND RENAL DIALYSIS PATIENTS AT NO CHARGE FAITH REGIONAL REMAINS ACCOUNTABLE TO THE COMMUNITY BY WORKING WITH A VOLUNTEER GOVERNING BOARD THAT IS REPRESENTATIVE OF THE COMMUNITY IT SERVES COOPERATION WITH COMMUNITY BASED HEALTH ORGANIZATIONS IDENTIFY PERTINENT ISSUES RELATED TO ESSENTIAL SERVICES, CHARITY CARE, HEALTH CARE COST CONTAINMENT, COMMUNITY BENEFIT ACTIVITIES AND OTHERS AS APPROPRIATE FAITH REGIONAL CONTINUES TO OPERATE UNDER A VOLUNTEER GOVERNING BOARD AND REMAINS ACTIVELY INVOLVED IN ADVOCATING PUBLIC AWARENESS OF HEALTH CARE AND HEALTH CARE POLICY ISSUES DISCLOSURES OF FINANCIAL INFORMATION, COMMUNITY BENEFIT INFORMATION AND ADVOCACY ISSUES IS PROVIDED THROUGH A VARIETY OF MEDIA INCLUDING AN ANNUAL REPORT TO THE COMMUNITY, MEDIA RELEASES, AND ITS INTERNET WEBSITE WWW FRHS ORGFAITH REGIONAL'S CONTRIBUTION TO THE COMMUNITY NOT ONLY INCLUDES COMPENSATED AND DONATED TIME BUT ALSO EQUIPMENT, MATERIALS AND SPACE MEETING ROOMS ARE PROVIDED AS NEEDED AND EQUIPMENT AND MATERIALS (E G COMPUTERS, COPIER,FAXES, TELEPHONES, CHILDBIRTH PROPS, PROJECTORS, MANNEQUINS, HEARING BOOTH, AUDIOMETERS, BEDS, MONITORS, WARMING UNITS, MINOR INSTRUMENTS, ETC) ARE PROVIDED AT NO CHARGE A MAJOR CONCERN IN HEALTH CARE THAT CAN SOMETIMES BE "HIDDEN" IS THAT OF SEXUAL ABUSE AND NEGLECT IN CHILDREN THE NORTHEAST NEBRASKA CHILD ADVOCACY PROGRAM AT FAITH REGIONAL PROVIDES A SAFE, NON THREATENING ENVIRONMENT WHERE CHILDREN (AGES INFANT TO 18) WHO ARE VICTIMS OF ABUSE RECEIVE IMMEDIATE MEDICAL CARE AND FORENSIC INTERVIEWS FROM VARIOUS AGENCIES WORKING TOGETHER ALL OF THESE SERVICES ARE AVAILABLE FREE TO FAMILIES WITHIN A 24-COUNTY AREA
		PART VI, LINE 7 N/A

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . ☑ Yes ☐ No

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

Part II Grants and Other Assistance to Governments and Organizations in the United States.

Complete if the organization answered "Yes" to Form 990, Part IV, line 21 for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Part II can be duplicated if additional space is needed. . . . ▶ ☐

1 (a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) THE AMERICAN RED CROSS3838 DEWEY AVENUE OMAHA,NE 68105	53-0196605	501(C)(3)		27,185	FMV	IN-KIND RENT	DEFRAY OPERATING COSTS
(2) NORTHEAST NEBRASKA AREA HEALTH EDUCATION CENTER (AHEC)110 NORTH 16TH STREET SUITE 2 NORFOLK,NE 68701	22-3867376	501(C)(3)		25,912	FMV	IN-KIND RENT	DEFRAY OPERATING COSTS
(3) NORFOLK COMMUNITY HEALTHCARE CLINIC INC 110 NORTH 16TH STREET SUITE 16 NORFOLK,NE 68701	47-0833378	501(C)(3)		45,771	FMV	IN-KIND RENT	DEFRAY OPERATING COSTS
(4) ORPHAN GRAIN TRAIN PO BOX 1466 NORFOLK,NE 68702	31-1614650	501(C)(3)		6,300	FMV	DONATION OF DISHES	SUPPORT MISSION OF ORPHAN GRAIN TRAIN
(5) UNIVERSITY OF NE - UNMC COLLEGE OF NURSING3838 HOLDREGE STREET LINCOLN,NE 68503	47-0049123	501(C)(3)	250,000				HELP FUND NEW NURSING COLLEGE LOCATION IN NORFOLK, NE
(6) BLOOMFIELD COMMUNITY CLINIC105 SOUTH BROADWAY BLOOMFIELD,NE 68718	26-1507298		15,000				ASSIST IN DEVELOPMENT OF COMMUNITY MEDICAL CLINIC
(7) MAKE-A-WISH FOUNDATION11926 ARBOR STREET SUITE 102 OMAHA,NE 68144	47-0671096	501(C)(3)		5,585	FMV	DONATION OF JACKETS	GOLF TOURNAMENT FOR BENEFIT OF MAKE-A-WISH FOUNDATION
(8) AMERICAN HEART ASSOCIATION460 N LINDBERGH BLVD ST LOUIS,MO 63141	13-5613797	501(C)(3)	10,500				GO RED FOR WOMEN EVENT
(9) FAITH REGIONAL HEALTH SERVICES FOUNDATION2700 WEST NORFOLK AVENUE SUITE 200 NORFOLK,NE 68701	91-1772474	501(C)(3)	14,115				GENERAL OPERATIONS

2 Enter total number of section 501(c)(3) and government organizations . . . ▶ 8

3 Enter total number of other organizations . . . ▶ 1

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 22. Use Schedule I-1 (Form 990) 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

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

Identifier	Return Reference	Explanation
PROCEDURE FOR MONITORING GRANTS IN THE U S	PART I, LINE 2	SCHEDULE I, PART I, LINE 2 IN-KIND DONATIONS OF RENT ARE MADE TO 501(C)(3) ORGANIZATIONS THESE DONATIONS HELP THE DONEE ORGANIZATIONS MINIMIZE CASH NEEDED FOR OPERATING COSTS AND ALLOW THE ORGANIZATIONS TO USE THEIR AVAILABLE FUNDS IN FURTHERANCE OF THEIR MISSIONS CASH DONATIONS ARE ALSO MADE TO 501(C)(3) ORGANIZATIONS, MANY OF WHICH HAVE HEALTH CARE OR SOCIAL SERVICES MISSIONS THESE DONATIONS ARE SOMETIME RESTRICTED FOR A SPECIFIC USE OR ACTIVITY 501 (C)(3) ORGANIZATIONS ARE BOUND BY THEIR ARTICLES OF ORGANIZATION AND STATED MISSIONS TO CONDUCTING ACTIVITIES STRICTLY FOR CHARITABLE PURPOSES FAITH REGIONAL DOES NOT REQUEST GRANT REPORTS FROM DONEE CHARITABLE ORGANIZATIONS
OTHER INFORMATION	PART IV	SCHEDULE I, PART II, LINE 1(A) IN 2010 FAITH REGIONAL MADE A $15,000 CONTRIBUTION TO THE BLOOMFIELD COMMUNITY CLINIC, NOW CALLED THE BLOOMFIELD MEDICAL CLINIC, FOR DEVELOPMENT OF THEIR NEW CLINIC FAITH REGIONAL RECEIVED NOTICE FROM THE BLOOMFIELD COMMUNITY CLINIC, AFTER REQUESTING THEIR EIN, THAT THEY ARE NOT A 501(C)(3) ORGANIZATION AND ARE A FOR-PROFIT ORGANIZATION FAITH REGIONAL CONSIDERS THIS PAYMENT WITHIN THEIR CHARITABLE MISSION OF PROMOTING HEALTH CARE IN THE COMMUNITY OF NORFOLK, NE

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Schedule J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 23.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☑ Travel for companions	☐ Payments for business use of personal residence		
	☑ Tax idemnification and gross-up payments	☑ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ 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 orprovision of all the expenses described above? If "No," complete Part III to explain	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply			
	☐ Compensation committee	☑ Written employment contract		
	☑ Independent compensation consultant	☑ Compensation survey or study		
	☑ Form 990 of other organizations	☑ Approval by the board or compensation committee		
4	During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment from the organization or a related organization?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		No
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.			
5	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," to line 5a or 5b, describe in Part III			
6	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," to line 6a or 6b, describe in Part III			
7	For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**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 in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions on row (ii) Do not list any individuals that are not listed on Form 990, Part VII

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

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) JAMES J SINEK	(i)	445,133	0	18,059	7,350	10,709	481,251	0
	(ii)	0	0	0	0	0	0	0
(2) DALE POHLMAN	(i)	129,373	0	11,808	6,611	5,197	152,989	0
	(ii)	0	0	0	0	0	0	0
(3) DOUGLAS WISMER	(i)	162,862	0	12,828	6,547	6,281	188,518	0
	(ii)	0	0	0	0	0	0	0
(4) LINDA MILLER	(i)	138,109	0	16,385	7,245	9,141	170,880	0
	(ii)	0	0	0	0	0	0	0
(5) DR DEAN FRENCH	(i)	351,987	0	17,379	7,350	10,029	386,745	0
	(ii)	0	0	0	0	0	0	0
(6) H MICHAEL HAMMOND	(i)	160,592	0	18,460	8,302	10,158	197,512	0
	(ii)	0	0	0	0	0	0	0
(7) PATRICK ROCHE	(i)	160,669	0	18,633	8,250	10,383	197,935	0
	(ii)	0	0	0	0	0	0	0
(8) BARRY SPEAR	(i)	154,129	0	10,947	4,663	6,284	176,023	0
	(ii)	0	0	0	0	0	0	0
(9) JOSEPH MCCLAIN MD	(i)	797,838	0	40,935	7,350	33,585	879,708	0
	(ii)	0	0	0	0	0	0	0
(10) DOUGLAS WELSH MD	(i)	659,540	0	41,380	9,800	31,580	742,300	0
	(ii)	0	0	0	0	0	0	0
(11) RIAD MEADA MD	(i)	581,841	0	30,519	7,350	23,169	642,879	0
	(ii)	0	0	0	0	0	0	0
(12) MOHAMMAD IMRAN MD	(i)	540,839	0	29,859	0	29,859	600,557	0
	(ii)	0	0	0	0	0	0	0
(13) JEFFREY YOSTEN MD	(i)	537,698	0	17,544	7,350	10,194	572,786	0
	(ii)	0	0	0	0	0	0	0
(14)								
(15)								
(16)								

Part III Supplemental Information

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

Identifier	Return Reference	Explanation
	PART I, LINE 1A	JAMES J SINEK'S YMCA MEMBERSHIP AND COUNTRY CLUB DUES ARE PAID BY FAITH REGIONAL HEALTH SERVICES THE AMOUNTS PAID FOR THESE ITEMS ARE ADDED TO MR SINEK'S W-2 AS WAGES BARRY SPEAR'S COUNTRY CLUB DUES ARE PAID BY FAITH REGIONAL HEALTH SERVICES THE AMOUNT PAID FOR THIS ITEM IS ADDED TO MR SPEAR'S W-2 AS WAGES

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Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Schedule O (Form 990).
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

Part I Bond Issues

	(a) Issuer Name	(b) Issuer EIN	(c) CUSIP #	(d) Date Issued	(e) Issue Price	(f) Description of Purpose	(g) Defeased		(h) On Behalf of Issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	HOSPITAL AUTHORITY #1 OF MADISON COUNTY NEBRASKA	52-1357975	557463DR9	07-10-2008	65,501,382	FUND NEW BED TOWER AND REIMBURSE PRIOR CAPITAL, REFUND PRIOR ISSUES		X		X		X
B	HOSPITAL AUTHORITY #1 OF MADISON COUNTY NEBRASKA	52-1357975	557352EF4	11-20-2008	15,000,000	CONSTRUCTION OF TOWER		X		X		X

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	5,130,000			
2	Amount of bonds legally defeased				
3	Total proceeds of issue	65,984,915	15,039,468		
4	Gross proceeds in reserve funds	5,822,866			
5	Capitalized interest from proceeds	113,793			
6	Proceeds in refunding escrow	12,532,261			
7	Issuance costs from proceeds				
8	Credit enhancement from proceeds	22,833	22,833		
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	38,580,806	15,016,635		
11	Other spent proceeds	8,935,189			
12	Other unspent proceeds				
13	Year of substantial completion	2010	2010		

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?	X			X				
15	Were the bonds issued as part of an advance refunding issue?	X			X				
16	Has the final allocation of proceeds been made?	X		X					
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X				

Part III Private Business Use *(Continued)*

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use?	X		X					
b	Are there any research agreements that may result in private business use of bond-financed property?		X		X				
c	Does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts or research agreements relating to the financed property?	X		X					
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	0 %		0 %					
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	0 %		0 %					
6	Total of lines 4 and 5	0 %		0 %					
7	Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X					

Part IV Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X		X				
2	Is the bond issue a variable rate issue?		X	X					
3a	Has the organization or the governmental issuer entered into a hedge with respect to the bond issue?		X		X				
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was a hedge terminated?								
4a	Were gross proceeds invested in a GIC?		X		X				
b	Name of provider								
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
5	Were any gross proceeds invested beyond an available temporary period?		X		X				
6	Did the bond issue qualify for an exception to rebate?	X		X					

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule K (see instructions)

Identifier	Return Reference	Explanation
SCHEDULE K SUPPLENTAL INFORMATION		SCHEDULE K, PART II, LINE 3 THE TOTAL PROCEEDS DO NOT AGREE TO THE ISSUE PRICE IN PART I, COLUMN (E) DUE TO INVESTMENT EARNINGS

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ **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 lines 38a or 40b.**

▶ **Attach to Form 990 or Form 990-EZ.** ▶ **See separate instructions.**

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2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

Part I Excess Benefit Transactions (section 501(c)(3) and section 501 (c)(4) 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

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected? Yes	(c) Corrected? No

2 Enter the amount of tax imposed on the 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, Part IV, line 26, or Form 990-EZ, Part V, line 38a

(a) Name of interested person and purpose	(b) Loan to or from the organization? To	(b) Loan to or from the organization? From	(c) Original principal amount	(d) Balance due	(e) In default? Yes	(e) In default? No	(f) Approved by board or committee? Yes	(f) Approved by board or committee? No	(g) Written agreement? Yes	(g) Written agreement? No
Total . . . . . ▶ $										

Part III Grants or Assistance Benefitting Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of grant or type 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) JUDITH MILLER	JUDITH'S SPOUSE IS JAMES MILLER, BOARD MEMBER	23,953	JUDITH IS AN EMPLOYEE OF FAITH REGIONAL HEALTH SERVICES		No
(2) PAMELA PILE	PAMELA'S BROTHER-IN-LAW IS JOHN DINKEL, BOARD MEMBER	44,942	PAMELA IS AN EMPLOYEE OF FAITH REGIONAL HEALTH SERVICES		No
(3) LORI KNAPP	LORI'S BROTHER-IN-LAW IS SCOTT MILLER, A BOARD MEMBER	39,673	LORI IS AN EMPLOYEE OF FAITH REGIONAL HEALTH SERVICES		No
(4) DANIELLE FREUDENBURG	DANIELLE'S BROTHER-IN-LAW IS SCOTT MILLER, A BOARD MEMBER	38,846	DANIELLE IS AN EMPLOYEE OF FAITH REGIONAL HEALTH SERVICES		No
(5) PATHOLOGY MEDICAL SERVICES PC	DR LACY SERVES AS A DIRECTOR, AND HE IS A SHAREHOLDER OF THE COMPANY	120,467	PATHOLOGY MEDICAL SERVICES PC PROVIDES SERVICES TO FAITH REGIONAL HEALTH SERVICES		No

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

Identifier	Return Reference	Explanation

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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 to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

Identifier	Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2		JOHN DINKEL AND MARY KAY UHING HAVE A FAMILY RELATIONSHIP

Identifier	Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6		FAITH REGIONAL HAS ONE NONPROFIT 501(C)(3) CORPORATE MEMBER, LUTHERAN COMMUNITY HOSPITAL ASSOCIATION

Identifier	Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A		PURSUANT TO FAITH REGIONAL'S 2008 RESTATED BYLAWS, THE SOLE CORPORATE MEMBER, LUTHERAN COMMUNITY HOSPITAL ASSOCIATION, APPOINTS 14 OF THE 15 VOTING MEMBERS OF THE BOARD OF DIRECTORS OF FAITH REGIONAL HEALTH SERVICES

Identifier	Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B		FAITH REGIONAL'S RESTATED BYLAWS RESERVE CERTAIN POWERS TO ITS SOLE MEMBER, LUTHERAN COMMUNITY HOSPITAL ASSOCIATION THERE ARE 13 RESERVED POWERS, INCLUDING APPOINTMENT AND REMOVAL OF DIRECTORS, OTHER THAN CHIEF OF STAFF, AMENDMENT OF THE ARTICLES OF INCORPORATION AND BYLAWS, AMENDMENT OF THE MISSION, VISION AND VALUE STATEMENTS, AMONG OTHERS

Identifier	Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11		THE FORM 990 AND ALL APPLICABLE SCHEDULES WERE PREPARED BY SEIM JOHNSON, LLP IN OMAHA, NE POST-AUDIT REVIEW, FORM 990 AND SCHEDULES ARE MAILED TO EACH BOARD MEMBER FORM 990 IS REVIEWED AND DISCUSSED AT THE SCHEDULED BOARD MEETING PRIOR TO SUBMISSION TO IRS

Identifier	Return Reference	Explanation
	FORM 990, PART VI, SECTION B, LINE 12C	FAITH REGIONAL'S BOARD MEMBERS ARE REQUIRED TO SIGN A NEW CONFLICT OF INTEREST STATEMENT AND DISCLOSURE ANNUALLY ANY CONFLICTS ARE REVIEWED BY THE BOARD A MEMBER WITH A CONFLICT IS EXCUSED FROM THE BOARD DELIBERATIONS AND ACTION

Identifier	Return Reference	Explanation
	FORM 990, PART VI, SECTION B, LINE 15	DETERMINATION OF COMPENSATION FOR THE CEO AND OTHER OFFICERS AND KEY EMPLOYEES IS MADE BY GATHERING DATA FROM EXTERNAL SURVEYS AND THE FORM 990 DATA PROVIDED BY COMPARABLE FACILITIES FACILITIES USED ARE DETERMINED BY SIMILAR BED SIZE, NET REVENUES AND NUMBER OF FTES WAGES ARE GATHERED AND COMPARED BY TITLE, RESPONSIBILITIES, AND YEARS OF EXPERIENCE THE SALARY RECOMMENDATIONS ARE MADE BY THE HUMAN RESOURCE DEPARTMENT THE GOVERNING BOARD APPROVES THE SALARY RECOMMENDATIONS FOR THE CEO, THE CEO APPROVES THE RECOMMENDATIONS FOR THE OTHER OFFICERS AND VICE-PRESIDENTS, AND THE VICE-PRESIDENTS APPROVE THE RECOMMENDATIONS FOR THE "DIRECTORS" OF VARIOUS HOSPITAL DEPARTMENTS

Identifier	Return Reference	Explanation
	FORM 990, PART VI, SECTION C, LINE 19	FAITH REGIONAL DOES NOT MAKE ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY OR FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC

Identifier	Return Reference	Explanation
	FORM 990, PART VII, SECTION A, LINE 1A	JAMES SINEK, CEO, DEVOTES AN AVERAGE OF 1 00 HOURS PER WEEK TO FAITH REGIONAL HEALTH SERVICES FOUNDATION, A RELATED ORGANIZATION DOUGLAS WISMER, CFO, DEVOTES AN AVERAGE OF 1 00 HOURS PER WEEK TO FAITH REGIONAL HEALTH SERVICES FOUNDATION, A RELATED ORGANIZATION DALE POHLMAN, CFO , DEVOTED AN AVERAGE OF 1 00 HOURS PER WEEK TO FAITH REGIONAL HEALTH SERVICES FOUNDATION, A RELATED ORGANIZATION BARRY SPEAR, VP GROWTH & DEVELOPMENT, DEVOTED AN AVERAGE OF 16 00 HOUR PER WEEK TO FAITH REGIONAL HEALTH SERVICES FOUNDATION, A RELATED ORGANIZATION

Identifier	Return Reference	Explanation
CHANGES IN NET ASSETS OR FUND BALANCES	FORM 990, PART XI, LINE 5	NET UNREALIZED LOSSES ON INVESTMENTS -156,847

Identifier	Return Reference	Explanation
	FORM 990, PART XII, LINE 2C	THE FINANCE/AUDIT COMMITTEE MEETS MONTHLY TO REVIEW OUR UNAUDITED FINANCIAL STATEMENTS IN NOVEMBER OF EACH YEAR THEY MEET TO APPROVE OUR ANNUAL BUDGET AND FIVE-YEAR STRATEGIC FINANCIAL PLAN IN DECEMBER THEY WILL REVIEW AND APPROVE THE ENGAGEMENT LETTER PREPARED BY OUR EXTERNAL AUDITORS, SEIM JOHNSON, LLP, WHICH OUTLINES THE SCOPE OF THEIR AUDIT AND THEIR FEES AND EXPENSES IN JANUARY OF THE SUCCEEDING YEAR THEY WILL MEET IN EXECUTIVE SESSION WITH SEIM JOHNSON, LLP REPRESENTATIVES TO DISCUSS ANY CONCERNS OR ISSUES THEY MAY HAVE AT THE CLOSE OF THE AUDIT THEY MEET WITH THE FAITH REGIONAL EXECUTIVE TEAM AND SEIM JOHNSON, LLP REPRESENTATIVES TO DISCUSS ANY AUDIT ISSUES IN MID TO LATE MARCH THEY THEN MEET AGAIN WITH SEIM JOHNSON, LLP REPRESENTATIVES TO DISCUSS THE DRAFT AND FINAL AUDITED FINANCIAL STATEMENTS INCLUDING THEIR OPINION REGARDING THE SELECTION OF AN EXTERNAL AUDITOR, THE COMMITTEE HAS IN THE PAST SELECTED UP TO THREE REGIONAL CPA FIRMS SPECIALIZING IN HEALTHCARE AUDITS TO SEND RFPS TO AND THEN REVIEW THE RFPS AT A LATER DATE THE LAST TIME THIS WAS DONE THEY REAFFIRMED THE RETENTION OF SEIM JOHNSON, LLP AS THE EXTERNAL AUDITOR EACH FIVE YEARS, ALTHOUGH NOT REQUIRED BY THE SARBANES-OXLEY LEGISLATION, SEIM JOHNSON, LLP ROTATES ONE OF THEIR PARTNERS TO THE FAITH REGIONAL ENGAGEMENT

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2010

Open to Public Inspection

Name of the organization
FAITH REGIONAL HEALTH SERVICES

Employer identification number
47-0796875

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

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) FAITH REGIONAL PHYSICIAN SERVICES LLC 2700 WEST NORFOLK AVENUE NORFOLK, NE 68701 42-1629846	PHYSICIAN SERVICES	NE	11,350,683	3,631,411	

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 organization	
						Yes	No
(1) LUTHERAN COMMUNITY HOSPITAL ASSOCIATION 2700 W NORFOLK AVE NORFOLK, NE 68701 47-0396139	SUPPORT FAITH REGIONAL HEALTH SERVICES	NE	501(C)(3)	3			No
(2) FAITH REGIONAL HEALTH SERVICES FOUNDATION 1500 KOENIGSTEIN AVE NORFOLK, NE 68701 91-1772474	SUPPORT FAITH REGIONAL HEALTH SERVICES	NE	501(C)(3)	11A		Yes	

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? Yes	(h) No	(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership
(1) NORTHEAST NEBRASKA SURGERY CENTER 301 N 27TH STREET NORFOLK, NE68701 47-0819088	OUTPATIENT SURGERY	NE		RELATED	541,779	2,029,644		No			No	94 195 %

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

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

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

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

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

(a) Name of other organization	(b) Transaction type(a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) FAITH REGIONAL HEALTH SERVICES FOUNDATION	C	878,272	FAIR MARKET VALUE
(2) NORTHEAST NEBRASKA SURGERY CENTER	N	989,054	FAIR MARKET VALUE
(3) NORTHEAST NEBRASKA SURGERY CENTER	A	265,416	FAIR MARKET VALUE
(4) NORTHEAST NEBRASKA SURGERY CENTER	R	87,460	FAIR MARKET VALUE
(5)			
(6)			

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

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

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

Part VII Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions)

Identifier	Return Reference	Explanation