

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 2009 This Form is Open to Public Inspection
---	--	---

Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning <u>01/01/2009</u> and ending <u>12/31/2009</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan; or ☒ a single-employer plan; ☐ a DFE (specify) ____
B This return/report is:	☐ the first return/report; ☐ the final return/report; ☒ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☐ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>003</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/2007</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>003</u>	1c Effective date of plan <u>01/01/2007</u>	
1b Three-digit plan number (PN) ▶	<u>003</u>				
1c Effective date of plan <u>01/01/2007</u>					
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>REYNOLDS MEMORIAL HOSPITAL, INC.</u> <u>C/O CPI-QPC, INC.</u> <u>P.O. BOX 1167</u> <u>GREAT BEND, KS 67530</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>55-0357045</u></td> </tr> <tr> <td>2c Sponsor's telephone number <u>620-793-8473</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>622000</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>55-0357045</u>	2c Sponsor's telephone number <u>620-793-8473</u>	2d Business code (see instructions) <u>622000</u>	
2b Employer Identification Number (EIN) <u>55-0357045</u>					
2c Sponsor's telephone number <u>620-793-8473</u>					
2d Business code (see instructions) <u>622000</u>					

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/30/2010	R. CRAIG MADDEN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/30/2010	JAY PRAGER
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2009)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") REYNOLDS MEMORIAL HOSPITAL, INC. C/O CPI-QPC, INC. P.O. BOX 1167 GREAT BEND, KS 67530	3b Administrator's EIN 55-0357045 <hr/> 3c Administrator's telephone number 620-793-8473
---	---

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN <hr/> 4c PN
---	-------------------------------------

5 Total number of participants at the beginning of the plan year	5	175
---	----------	-----

6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	175
b Retired or separated participants receiving benefits.....	6b	1
c Other retired or separated participants entitled to future benefits.....	6c	8
d Subtotal. Add lines 6a , 6b , and 6c	6d	184
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	0
f Total. Add lines 6d and 6e	6f	184
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	160
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	1
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 2F 2G 2M

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	(1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) ☒ **R** (Retirement Plan Information)
 (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
 (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- (1) ☒ **H** (Financial Information)
 (2) ☐ **I** (Financial Information – Small Plan)
 (3) ☐ 0 **A** (Insurance Information)
 (4) ☒ **C** (Service Provider Information)
 (5) ☐ **D** (DFE/Participating Plan Information)
 (6) ☐ **G** (Financial Transaction Schedules)

<div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>	OMB No. 1210-0110
		2009
		This Form is Open to Public Inspection.

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

<div>A</div> <div>Name of plan</div> <div>REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN</div>	<div>B</div> <div>Three-digit plan number (PN)</div> <div>▶</div> <div>003</div>
<div>C</div> <div>Plan sponsor's name as shown on line 2a of Form 5500</div> <div>REYNOLDS MEMORIAL HOSPITAL, INC.</div>	<div>D</div> <div>Employer Identification Number (EIN)</div> <div>55-0357045</div>

Part I

Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1

Information on Persons Receiving Only Eligible Indirect Compensation

a

Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).....

☒ Yes

☐ No

b

If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b)	Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
MSCS FINANCIAL SOLUTIONS	
20-1591048	

(b)	Enter name and EIN or address of person who provided you disclosure on eligible indirect compensation

(b)	Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b)	Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b)	Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CPI QUALIFIED PLAN CONSULTANTS, INC

1809 24TH STREET
P.O. BOX 1167
GREAT BEND, KS 67530

48-1205033

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 15 50 60 62 64		7908	Yes ☒ No ☐	Yes ☒ No ☐	2432	Yes ☐ No ☒

(a) Enter name and EIN or address (see instructions)

METLIFE SECURITIES, INC.

485 BUILDING E ROUTE 1 SOUTH
ISELIN, NJ 08830

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50		6026	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CPI QUALIFIED PLAN CONSULTANTS, INC	12 15 50 60 62 64	2294

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN FUNDS 135 S. STATE COLLEGE BLVD BREA, CA 92821	SUB-TA TO OFFSET CUSTODIAL, TRADING AND ALLOCATION EXPENSES

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110
		2009
		This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009		
A Name of plan REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN	B Three-digit plan number (PN) ►	003
C Plan sponsor's name as shown on line 2a of Form 5500 REYNOLDS MEMORIAL HOSPITAL, INC.	D Employer Identification Number (EIN) 55-0357045	

Part I	Asset and Liability Statement
---------------	--------------------------------------

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		0
(2) Participant contributions	1b(2)		0
(3) Other.....	1b(3)		0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		0
(2) U.S. Government securities.....	1c(2)		0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		0
(B) All other.....	1c(3)(B)		0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		0
(B) Common	1c(4)(B)		0
(5) Partnership/joint venture interests	1c(5)		0
(6) Real estate (other than employer real property)	1c(6)		0
(7) Loans (other than to participants)	1c(7)		0
(8) Participant loans	1c(8)		0
(9) Value of interest in common/collective trusts.....	1c(9)		0
(10) Value of interest in pooled separate accounts.....	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		0
(12) Value of interest in 103-12 investment entities	1c(12)		0
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	594548	1492822
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other	1c(15)		0

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		0
(2) Employer real property	1d(2)		0
e Buildings and other property used in plan operation	1e		0
f Total assets (add all amounts in lines 1a through 1e)	1f	594548	1492822

Liabilities

g Benefit claims payable	1g		0
h Operating payables	1h		0
i Acquisition indebtedness	1i		0
j Other liabilities	1j	3500	12000
k Total liabilities (add all amounts in lines 1g through 1j)	1k	3500	12000

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	591048	1480822
---	----	--------	---------

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income**a Contributions:**

		(a) Amount	(b) Total
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	505737	
(C) Others (including rollovers)	2a(1)(C)	5530	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		511267

b Earnings on investments:**(1) Interest:**

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0

(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	26407	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		26407

(3) Rents	2b(3)		
-----------------	-------	--	--

(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	165940	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	146551	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		19389

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		185355
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		742418

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	13342	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		13342
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	7708	
(3) Investment advisory and management fees	2i(3)	1143	
(4) Other	2i(4)	8500	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		17351
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		30693

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		711725
l Transfers of assets:			
(1) To this plan.....	2l(1)		178049
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☐ Unqualified (2) ☐ Qualified (3) ☒ Disclaimer (4) ☐ Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? ☒ Yes ☐ No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: BODKIN, WILSON, & KOZICKI, PLLC

(2) EIN: 55-0526247

d The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

- 4** CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
e Was this plan covered by a fidelity bond?.....	X		2000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.).....		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

- 5a** Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?
If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No Amount:

- 5b** If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2009
		This Form is Open to Public Inspection.

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan <u>REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN</u>	B Three-digit plan number (PN) ▶ <u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>REYNOLDS MEMORIAL HOSPITAL, INC.</u>	D Employer Identification Number (EIN) <u>55-0357045</u>

Part I	Distributions
---------------	----------------------

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	<u>0</u>
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>55-0675873</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3	

Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)
----------------	--

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?.....	☐ Yes	☐ No	☐ N/A
If the plan is a defined benefit plan, go to line 8.			
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year	6a		
b Enter the amount contributed by the employer to the plan for this plan year	6b		
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c		
If you completed line 6c, skip lines 8 and 9.			
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?	☐ Yes	☐ No	☐ N/A
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?.....	☐ Yes	☐ No	☐ N/A

Part III	Amendments
-----------------	-------------------

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box.....	☐ Increase	☐ Decrease	☐ Both	☐ No
--	-----------------------------------	-----------------------------------	-------------------------------	-----------------------------

Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?.....	☐ Yes	☐ No
11 a Does the ESOP hold any preferred stock?	☐ Yes	☐ No
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)	☐ Yes	☐ No
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?	☐ Yes	☐ No

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule R (Form 5500) 2009
v.092308.1

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box ☐ and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

- 14** Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	14a	
b The plan year immediately preceding the current plan year	14b	
c The second preceding plan year	14c	

- 15** Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

- 16** Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	

- 17** If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

- 18** If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐

- 19** If the total number of participants is 1,000 or more, complete items (a) through (c)

a Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate item 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

Reynolds Memorial Hospital, Inc.

403(b) Plan

Financial Statements
Together with Auditor's Report
as of December 31, 2009

BODKIN WILSON & KOZICKI_{PLLC}
CERTIFIED PUBLIC ACCOUNTANTS

REYNOLDS MEMORIAL HOSPITAL, INC. 403(b) PLAN
INDEX OF FINANCIAL STATEMENTS AND SCHEDULES

	<u>Page</u>
Independent Auditor's Report	2
Financial Statements:	
Statements of Net Assets Available for Benefits - December 31, 2009 and 2008	3
Statement of Changes in Net Assets Available for Benefits - for the Year Ended December 31, 2009	4
Notes to Financial Statements	5-9
Supplemental Information:	
Schedule of Assets Held at End of Year As of December 31, 2009	10

BODKIN WILSON & KOZICKI PLLC
CERTIFIED PUBLIC ACCOUNTANTS

John S. Bodkin, Jr., CPA
Dan E. Wilson, CPA, MBA
Dennis A. Kozicki, CPA

The Maxwell Centre
32 Twentieth Street, Suite 300
Wheeling, West Virginia 26003

Weirton Office
3600 West Street, Suite 4
Weirton, West Virginia 26062

Michael N. Deemer, CPA
Nancy J. Gwynn, CPA
Brendan T. Welsh, CPA, MSA
Doreen M. DeMeter, CPA

304 232-2280
Fax 304 232-2322
www.bwkepas.com

304 748-5550
Fax 304 748-5551

INDEPENDENT AUDITOR'S REPORT

To Mr. Craig Madden, Administrator of the Reynolds Memorial Hospital, Inc. 403(b) Plan:

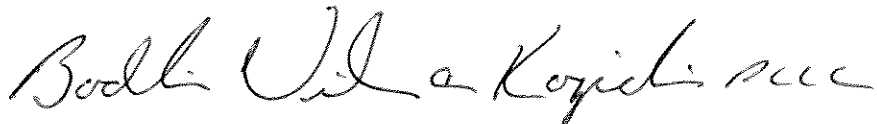
We were engaged to audit the financial statements of the Reynolds Memorial Hospital, Inc. 403(b) Plan as December 31, 2009 as listed in the accompanying index. These financial statements and schedules are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 9, which was certified by MG Trust Company LLC, the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the custodian as of and for the years ended December 31, 2009, that the information provided to the plan administrator by the custodian is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and schedule taken as a whole. The form and content of the information included in the financial statements and schedule, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

We have also compiled the accompanying Statement of Net Assets Available for Benefits of the Reynolds Memorial Hospital, Inc. 403(b) Plan as of December 31, 2008 in accordance with the Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form of financial statements information that is the representation of management. We have not audited or reviewed the accompanying statement of net assets available for benefits and, accordingly, do not express an opinion or any other form of assurance on it.



Weirton, West Virginia,
July 13, 2010.

REYNOLDS MEMORIAL HOSPITAL 403(b) PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2009 AND 2008

	<u>2009</u>	<u>(Compiled) 2008</u>
ASSETS		
Investments	<u>\$ 1,492,822</u>	<u>\$ 594,548</u>
Total assets	1,492,822	594,548
LIABILITIES		
Accrued liabilities	<u>12,000</u>	<u>3,500</u>
Total liabilities	<u>12,000</u>	<u>3,500</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u>\$ 1,480,822</u>	<u>\$ 591,048</u>

The accompanying notes are an integral part of these financial statements.

REYNOLDS MEMORIAL HOSPITAL 403(b) PLAN
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEAR ENDED DECEMBER 31, 2009

ADDITIONS TO NET ASSETS

Investment income:

Dividends	\$ 26,407
Net realized and unrealized appreciation of investments	<u>204,744</u>
	231,151
Less: investment expenses	<u>(1,143)</u>
Net investment income	<u>230,008</u>

Contributions:

Employee	505,737
Participant rollovers and transfers	<u>183,579</u>
Total contributions	689,316
	<u>919,324</u>
Total additions	<u>919,324</u>

DEDUCTIONS FROM NET ASSETS

Benefits paid to participants	13,341
Professional fees	8,500
Administrative fees	<u>7,708</u>
Total deductions	<u>29,549</u>
Net increase	889,774

NET ASSETS AVAILABLE FOR BENEFITS

Beginning of year	<u>591,048</u>
End of year	<u>\$ 1,480,822</u>

The accompanying notes are an integral part of these financial statements.

REYNOLDS MEMORIAL HOSPITAL, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

1. Description of Plan

The following description of the Reynolds Memorial Hospital, Inc. 403(b) Plan (the "Plan") provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions. The Plan is sponsored by Reynolds Memorial Hospital, Inc. (the "Hospital").

General – The Plan, which was established January 1, 2008, is a defined contribution plan which allows participation of all Hospital employees. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

The plan entered into a recordkeeping agreement with a third party administrator, CPI Qualified Plan Consultants, Inc. ("CPI"). CPI provides administration of the participant-level information. CPI has subcontracted the plan level reporting and custodial responsibilities to MG Trust Company, LLC ("MG Trust"). In addition, the Plan employs an independent registered investment advisor to provide assistance to plan participants.

Employee Contributions – The contributions to the plan include participant salary deferrals. Each participant may elect to contribute a prescribed percentage or flat dollar amount of his or her compensation to the Plan, subject to certain IRC limitations, up to a maximum of \$16,500 for the 2009 Plan year. Participants that are 50 years of age or older may contribute a catch-up contribution of up to \$5,500 for 2009. Participants direct the investment of their contributions into various investment options offered by the plan. The plan currently offers various mutual funds as investment options to participants.

Employer Contributions - No employer contributions are permitted.

Rollover Contributions and Transfers - Participants may also rollover amounts that represent distributions from other qualified plans or transfer amounts directly from other qualified plans.

Funding Policy – The contributions are to be funded to the Plan as soon as they can be reasonably segregated.

Participant accounts – Each participant's account is credited with the participant's contributions. The earnings (losses) allocation is based on the number of shares held by the participant. Expenses are allocated in the same proportion that each participant's account bears to the total of all participants' accounts as of the point in time when the expense is paid by the Plan, which is generally quarterly.

Vesting – Participants are fully vested immediately upon participation in the Plan.

Participant Loans – Participant loans are not permitted by the Plan.

REYNOLDS MEMORIAL HOSPITAL, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

1. Description of Plan (Continued)

Hardship Withdrawals – A withdrawal from a participant's account may be permitted if the participant has a financial hardship for certain specific reasons as defined in the Plan document. The amount of hardship distributions included in Benefits paid to participants in the Statement of Changes in Net Assets Available for Benefits is \$0 for 2009.

Payment of benefits – On termination of service due to death, disability, or retirement, a participant may elect to receive either a lump-sum amount equal to the value of the participant's vested interest in his or her account, or purchase an annuity which will pay annual installments over a term of years. For termination of service for other reasons, a participant may receive the value of the vested interest in his or her account as a lump sum distribution.

2. Summary of Significant Accounting Policies

Basis of Accounting - The accompanying financial statements are prepared on the accrual basis of accounting. Contributions are recorded by the Plan in the period the wages are earned. Benefits are recorded when paid.

Investments – The Plan's investments are stated at fair value. Purchases and sales of shares are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date.

Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

Subsequent Events - Management has evaluated subsequent events through the date that the financial statements were issued, July 13, 2010, and determined that no events occurred that require disclosure. No subsequent events occurring after this date have been evaluated for inclusion in financial statements.

3. Investments

All investments are participant directed. The Plan offers various mutual funds as investment options for participants. Participants may direct contributions of designated increments in any combination of the Plan's offered mutual funds.

REYNOLDS MEMORIAL HOSPITAL, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

3. Investments (Continued)

The following presents investments which individually represent 5% or more of the Plan's net assets. Items marked with an asterisk (*) represent less than 5% of net assets for the year indicated.

Description	December 31	
	2009	2008 (Compiled)
American Intermediate Bond Fund	\$ 93,621	\$ 43,532
American Funds Cash Management Trust	\$ *	\$ 32,368
American Funds US Government Securities Fund	\$ *	\$ 42,770
American 2015 Target Date Fund	\$ 245,873	\$ 112,471
American 2020 Target Date Fund	\$ 300,306	\$ 102,226
American 2025 Target Date Fund	\$ 143,374	\$ 36,490
American 2030 Target Date Fund	\$ 98,556	\$ 57,351
American Funds Money Market	\$ 100,564	\$ *

4. Fair Value

FASB Accounting Standards Codification ("ASC") 820 defines fair value, establishes a framework for measuring fair value, and establishes a fair value hierarchy which prioritizes the inputs to valuation techniques. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value measurement assumes that the transaction to sell the asset or transfer the liability occurs in the principal market for the asset or liability or, in the absence of a principal market, the most advantageous market. Valuation techniques that are consistent with the market, income or cost approach, as specified by ASC 820 are used to measure fair value.

The fair value hierarchy prioritizes the inputs to valuation techniques used to measure fair value into three broad levels:

- Level 1 inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities the Plan has the ability to access.
- Level 2 inputs are inputs (other than quoted prices included with level 1) that are observable for the assets or liability, either directly or indirectly. The valuation technique used by the Plan for Level 2 investments is the market approach. The American Funds Money Market Fund is a money market fund that is not publically traded. The value of this investment is based on other observable inputs such as maturities or yields for similar types of investments, in that market.
- Level 3 are unobservable inputs for the assets or liability and rely on management's own assumptions that market participants would use in pricing the asset or liability.

REYNOLDS MEMORIAL HOSPITAL, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

4. Fair Value (Continued)

The following presents the fair value hierarchy of the Plan's investments measured at fair value on a recurring basis as of December 31, 2009:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Cash and cash equivalents	\$ -	\$ 100,564	\$ -	\$ 100,564
Mutual funds	1,392,258	-	-	1,392,258
Totals	<u>\$ 1,392,258</u>	<u>\$ 100,564</u>	<u>\$ -</u>	<u>\$ 1,492,822</u>

The following presents the fair value hierarchy of the Plan's investments measured at fair value on a recurring basis as of December 31, 2008 (Compiled).

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Cash and cash equivalents	\$ -	\$ 36,492	\$ -	\$ 36,492
Mutual funds	558,056	-	-	558,056
Totals	<u>\$ 558,056</u>	<u>\$ 36,492</u>	<u>\$ -</u>	<u>\$ 594,548</u>

5. Plan Termination

The Hospital may terminate the Plan at any time by delivering to the Plan Administrator written notice of such termination. However, to the extent that the Plan holds participant accounts, Plan termination is only permitted if the Hospital does not make contributions to any 403(b) plan that is not part of the Plan during the period beginning on the date of Plan termination and ending 12 months after the distribution of all assets from the terminated Plan.

6. Tax Status

The Internal Revenue Service has no program for 403(b) plan sponsors to apply for a determination of tax exempt status. Management and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income tax has been included in the Plan's financial statements.

7. Investment Risk and Market Activity Subsequent to Year End

Investments of the Plan are not insured by the FDIC; are not deposits or other obligations of, or guaranteed by any bank or affiliates; and are subject to investment risks, including possible loss of the principal amount invested.

REYNOLDS MEMORIAL HOSPITAL, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2009 AND 2008

7. Investment Risk and Market Activity Subsequent to Year End (Continued)

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in values of investment securities will occur in the near term and such changes could affect participants' account balances and the amounts reported in the Statement of Net Assets Available for Benefits.

8. Parties in Interest Transactions

Parties-in-interest is defined by IRS Section 4785(e)(2) and ERISA Section 3(14)(c) to include, among others, any entity that provides services to the Plan. Therefore, all the plan expenses included in the accompanying financial statements are considered parties-in-interest transactions.

9. Information Certified by the Plan's Custodian

The plan administrator has elected the method of annual reporting compliance permitted by 29 CFR 2520.103-8 of the Department of Labor Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, the custodian has certified that the following data included in the accompanying financial statements and supplemental schedule is complete and accurate:

- Investments, as shown in the Statements of Net Assets Available for Plan Benefits as of December 31, 2009 and 2008,
- Investment activity, as shown in the Statement of Changes in Net Assets Available for Plan Benefits for the years ended December 31, 2009, and,
- The Schedule of Assets Held at End of Year, as shown in the Supplemental Schedules, as of December 31, 2009.

The Plan's independent certified public accountants did not perform auditing procedures with respect to this information, except for comparing such information to the related information included in the financial statements and supplemental schedule.

SUPPLEMENTAL SCHEDULE

REYNOLDS MEMORIAL HOSPITAL 403(b) PLAN
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2009

<u>FACE/ SHARES</u>	<u>DESCRIPTION</u>	<u>FAIR VALUE</u>
<u>CASH AND CASH EQUIVALENTS</u>		
100,564	American Funds Money Market Fund	\$ 100,564
	Total Cash and Cash Equivalents	\$ 100,564
<u>MUTUAL FUNDS</u>		
7	American Funds AmCap Fund	\$ 120
572	American Funds American Balanced Fund	9,227
7,934	American Funds Bond Fund of America	93,621
1,295	American Funds Capital World Growth/Income	43,719
249	American Funds Capital Income Builder	11,916
1,040	American Funds Europacific Growth	38,860
148	American Funds Fundamental Investors	4,830
1,710	American Funds Growth Fund of American	45,679
958	American Funds High-Income Trust	10,160
733	American Funds Income Fund of America	11,270
43	American Funds Interim Bond Fund of America	635
694	American Funds New Economy Fund	15,245
412	American Funds New Perspective Fund	10,334
575	American Funds New World Fund	26,506
709	American Funds Smallcap World Fund	21,548
4,708	American Funds US Government Securities Fund	65,817
1,199	American Funds Washington Mutual Investors	29,288
1,652	American 2010 Target Date Retirement Fund	14,156
28,724	American 2015 Target Date Retirement Fund	245,873
35,792	American 2020 Target Date Retirement Fund	300,306
17,274	American 2025 Target Date Retirement Fund	143,374
11,719	American 2030 Target Date Retirement Fund	98,556
4,201	American 2035 Target Date Retirement Fund	35,332
2,317	American 2040 Target Date Retirement Fund	19,555
687	American 2045 Target Date Retirement Fund	5,818
95	American 2050 Target Date Retirement Fund	791
984	Federated Kaufmann Fund	4,586
2	Federated Kaufmann SmallCap Fund	35
22,523	Franklin Income Fund	46,233
286	Invesco Real Estate Fund	5,084
448	Oppenheimer Equity Fund	3,479
2,822	Oppenheimer Main St Opportunity Fund	30,305
	Total Mutual Funds	\$ 1,392,258
	Total Investments	\$ 1,492,822

Schedule H, Line 4i
Schedule of Assets (Held At End of Year)

Name of Plan:

► Reynolds Memorial Hospital, Inc. 403(b) Plan

Employer Identification Number: ► 55-0357045

For plan year (beginning/ending): ► 01/01/2009 to 12/31/2009

Plan number: ► 003

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current value
	AIM REAL ESTATE R	VALUE OF INT IN REGIST INVEST CO	N/A	5,084
	AMERICAN FUNDS AMCAP FUND R2	VALUE OF INT IN REGIST INVEST CO	N/A	120
	AMERICAN FUNDS AMER BALNCED R2	VALUE OF INT IN REGIST INVEST CO	N/A	9,227
	AMERICAN FUNDS BOND FUND AM R2	VALUE OF INT IN REGIST INVEST CO	N/A	93,621
	AMERICAN FUNDS CAP INC BLDR R2	VALUE OF INT IN REGIST INVEST CO	N/A	11,916
	AMERICAN FUNDS CAP WLD G&I R2	VALUE OF INT IN REGIST INVEST CO	N/A	43,719
	AMERICAN FUNDS EUROPACIFIC R2	VALUE OF INT IN REGIST INVEST CO	N/A	38,860
	AMERICAN FUNDS FUNDMNTL INV R2	VALUE OF INT IN REGIST INVEST CO	N/A	4,830
	AMERICAN FUNDS GROWTH FUND R2	VALUE OF INT IN REGIST INVEST CO	N/A	45,679
	AMERICAN FUNDS HIGH INC TR R2	VALUE OF INT IN REGIST INVEST CO	N/A	10,160
	AMERICAN FUNDS INCOME FUND R2	VALUE OF INT IN REGIST INVEST CO	N/A	11,270
	AMERICAN FUNDS INTER BND FD R2	VALUE OF INT IN REGIST INVEST CO	N/A	635
	AMERICAN FUNDS MONEY MKT R2	VALUE OF INT IN REGIST INVEST CO	N/A	100,564
	AMERICAN FUNDS NEW ECONOMY R2	VALUE OF INT IN REGIST INVEST CO	N/A	15,245
	AMERICAN FUNDS NEW PRSPECTV R2	VALUE OF INT IN REGIST INVEST CO	N/A	10,334
	AMERICAN FUNDS NEW WORLD FD R2	VALUE OF INT IN REGIST INVEST CO	N/A	26,506
	AMERICAN FUNDS SMALLCAP WLD R2	VALUE OF INT IN REGIST INVEST CO	N/A	21,548
	AMERICAN FUNDS US GOVT SEC R2	VALUE OF INT IN REGIST INVEST CO	N/A	65,817
	AMERICAN FUNDS WASH MUTUAL R2	VALUE OF INT IN REGIST INVEST CO	N/A	29,288
	AMERICAN FUNDS 2010 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	14,156
	AMERICAN FUNDS 2015 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	245,873
	AMERICAN FUNDS 2020 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	300,306
	AMERICAN FUNDS 2025 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	143,374
	AMERICAN FUNDS 2030 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	98,556
	AMERICAN FUNDS 2035 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	35,332
	AMERICAN FUNDS 2040 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	19,555
	AMERICAN FUNDS 2045 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	5,818
	AMERICAN FUNDS 2050 TDATE R2	VALUE OF INT IN REGIST INVEST CO	N/A	790
	FEDERATED KAUFMAN SMALL CAP K	VALUE OF INT IN REGIST INVEST CO	N/A	35
	FED KAUFMANN K	VALUE OF INT IN REGIST INVEST CO	N/A	4,586
	FRANKLIN INCOME R	VALUE OF INT IN REGIST INVEST CO	N/A	46,233

Schedule H, Line 4i
Schedule of Assets (Held At End of Year)

Name of Plan:

► Reynolds Memorial Hospital, Inc. 403(b) Plan

Employer Identification Number: ► 55-0357045

For plan year (beginning/ending): ► 01/01/2009 to 12/31/2009

Plan number: ► 003

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current value
	OPPENHEIMER EQUITY N	VALUE OF INT IN REGIST INVEST CO	N/A	3,479
	OPP MAIN STREET OPPORTUNITY N	VALUE OF INT IN REGIST INVEST CO	N/A	30,305