Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2009** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

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

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] 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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES PENSION PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 10/01/1965

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
HOLZER HOSPITAL FOUNDATION
HOLZER MEDICAL CENTER

100 JACKSON PIKE
GALLIPOLIS, OH 45631-1560

2b Employer Identification Number (EIN) 31-4379491

2c Sponsor's telephone number 740-446-5105

2d Business code (see instructions) 622000

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.	09/30/2010	LISA HALLEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/30/2010	LISA HALLEY
	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.

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
HOLZER HOSPITAL FOUNDATION

100 JACKSON PIKE
GALLIPOLIS, OH 45631-1560

3b Administrator's EIN
31-4379491

3c Administrator's telephone number
740-446-5105

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

4c PN

5 Total number of participants at the beginning of the plan year	**5**	1441
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**	1063
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	345
d Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	1408
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f Total. Add lines **6d** and **6e**	**6f**	1408
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	1127
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
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:
2C 2F 2G 2K 2T

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)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] 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)** [X] **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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **A** (Insurance Information)
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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
HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500.
HOLZER HOSPITAL FOUNDATION

D Employer Identification Number (EIN)
31-4379491

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G62054	1127	01/01/2009	12/31/2009

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
47297	36476

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
SHAWN A BOGENRIEF/GAWES
5925 WILCOX PLACE
DUBLIN, OH 43016

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
47297	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GARDNER & WHITE
PO BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	36476	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	4	27106340
5	Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	26284326
c	Additions: (1) Contributions deposited during the year	7c(1)	1084835	
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)	1069450	
	(4) Transferred from separate account	7c(4)	1269894	
	(5) Other (specify below) ▶	7c(5)		
	(6) Total additions		7c(6)	3424179
d	Total of balance and additions (add **b** and **c(6)**).		7d	29708505
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	2399341	
	(2) Administration charge made by carrier	7e(2)	195	
	(3) Transferred to separate account	7e(3)	202629	
	(4) Other (specify below) ▶	7e(4)		
	(5) Total deductions		7e(5)	2602165
f	Balance at the end of the current year (subtract **e(5)** from **d**)		7f	27106340

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☐ Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((**1**) + (**2**) - (**3**))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (**1**) and (**2**))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

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

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

A Name of plan
HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
HOLZER HOSPITAL FOUNDATION

D Employer Identification Number (EIN)
31-4379491

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).. . . . . [X] 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

ALGER PORTFOLIOS

13-2510833

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

AM CENT INVESTMENT SERVICES INC

20-2036524

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

AMERICAN FUNDS SERVICE COMPANY

12711 NORTH MERIDIAN STREET
CARMEL, IN 46032-9181

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

CALVERT FUND & CALVERT WORLD VALUES

52-6228948

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

FIDELITY VARIABLE INS PRODUCTS FUND

04-2270522

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

JANUS ASPEN SERIES

75-3019319

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

PIONEER VARIABLE CONTRACTS TRUST

13-1961193

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

STATE STREET INSTITUTIONAL TRUST

04-2456637

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

T ROWE PRICE FUNDS

52-1184650

(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)

AMERICAN UNITED LIFE INSURANCE CO

35-0145825

(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?
37 50 52 59 60 63 66 67	SERVICE PROVIDER	570	Yes [X] No [ ]	Yes [ ] No [X]	40497	Yes [X] 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 ☐

(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
AMERICAN UNITED LIFE INSURANCE CO	66 67	40497

(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 UNITED LIFE INSURANCE CO 35-0145825	ASSET CHARGE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
ALGER PORTFOLIOS 13-2510833	REVENUE SHARING FORMULA SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
AM CENT INVESTMENT SERVICES INC 20-2036524	REVENUE SHARING FORMULA SEE ATTACHED

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
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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 SERVICE COMPANY 12711 NORTH MERIDIAN STREET CARMEL, IN 46032-9181	REVENUE SHARING FORMULA SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
CALVERT FUND & CALVERT WORLD VALUES 52-6228948	REVENUE SHARING FORMULA SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
FIDELITY VARIABLE INS PRODUCTS FUND 04-2270522	REVENUE SHARING FORMULA SEE ATTACHED

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
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
JANUS ASPEN SERIES 75-3019319	REVENUE SHARING FORMULA SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
PIONEER VARIABLE CONTRACTS TRUST 13-1961193	REVENUE SHARING FORMULA SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
STATE STREET INSTITUTIONAL TRUST 04-2456637	REVENUE SHARING FORMULA SEE ATTACHED

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
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0

(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.
T ROWE PRICE FUNDS 52-1184650	REVENUE SHARING FORMULA SEE ATTACHED

(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)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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
HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
HOLZER HOSPITAL FOUNDATION

D Employer Identification Number (EIN)
31-4379491

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		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	17634241	23496750
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	26284326	27106340
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	43918567	50603090
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	43918567	50603090

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) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	3250762	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)	187796	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		3438558
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	1069450	
(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)		1069450
(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)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0

		(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)		5183551
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		9691559

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	3006466	
(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)		3006466
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)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	570	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		570
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		3007036

Net Income and Reconciliation

k Net income (loss). Subtract line **2j** from line **2d**	2k		6684523
l Transfers of assets:			
(1) To this plan	2l(1)		
(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: PLANTE & MORAN **(2)** EIN: 38-1357951

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.)	4a		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.)	4b		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.)	4c		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.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		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?	4g		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?	4h		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.)	4i	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.)	4j		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?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		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.	4n			

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)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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
HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
HOLZER HOSPITAL FOUNDATION

D Employer Identification Number (EIN)
31-4379491

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** 0

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): 35-0145825 _____

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** 85

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section of 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** 3317306

b Enter the amount contributed by the employer to the plan for this plan year **6b** 3317306

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** 0

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**

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):

Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan

Financial Report

December 31, 2009

Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan

Contents

Report Letter	1
Statement of Net Assets Available for Benefits	2
Statement of Changes in Net Assets Available for Benefits	3
Notes to Financial Statements	4-9
Schedule of Assets Held at End of Year	10

Plante & Moran, PLLC
Suite 600
65 E. State St.
Columbus, OH 43215
Tel: 614.849.3000
Fax: 614.221.3535
plantemoran.com

Independent Auditor's Report

To the Audit Committee and Board of Directors
Holzer Hospital Foundation d/b/a Holzer
Medical Center Employees' Pension Plan

We were engaged to audit the financial statements and supplemental schedule of Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan as of December 31, 2009 and 2008 and for the years then ended, as listed in the accompanying table of contents. These financial statements and supplemental schedule 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 3, which was certified by American United Life Insurance Company, the trustee of the Plan, except for comparing such information with the related information included in the financial statements and supplemental schedule. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained certifications from the trustee as of December 31, 2009 and 2008 and for the years then ended that the information provided to the plan administrator by the trustee 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 supplemental schedule taken as a whole. The form and content of the information included in the financial statements and supplemental 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.

As explained in Note 7, the financial statements include investments valued at approximately $27,100,000 (54 percent of net assets available for plan benefits) at December 31, 2009 and at $26,300,000 (60 percent of net assets available for plan benefits) at December 31, 2008 whose fair values have been estimated by management in the absence of readily determinable market values. Management's estimates are based on information provided by the Trustee.

Plante & Moran, PLLC

Columbus, Ohio
September 17, 2010

Praxity MEMBER
GLOBAL ALLIANCE OF INDEPENDENT FIRMS

Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan

Statement of Net Assets Available for Benefits

	December 31, 2009	December 31, 2008
Assets - Participant-directed investments		
Mutual funds	$ 23,496,750	$ 17,634,241
General insurance accounts	27,106,340	26,284,326
Net Assets Available for Benefits	**$ 50,603,090**	**$ 43,918,567**

See Notes to Financial Statements.

Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan

Statement of Changes in Net Assets Available for Benefits

	Year Ended	
	December 31, 2009	December 31, 2008
Additions to Net Assets		
Contributions:		
Employer	$ 3,250,762	$ 3,422,298
Rollovers	187,796	62,023
Total contributions	3,438,558	3,484,321
Investment income (loss):		
Interest income	1,069,450	1,005,722
Net appreciation (depreciation) in fair value of mutual funds	5,183,551	(9,977,565)
Total investment income (loss)	6,253,001	(8,971,843)
Total additions - Net	9,691,559	(5,487,522)
Deductions from Net Assets		
Benefits paid directly to participants or beneficiaries	3,006,466	8,983,089
Administrative expenses - Other	570	189
Total deductions	3,007,036	8,983,278
Net Increase (Decrease)	6,684,523	(14,470,800)
Net Assets Available for Benefits		
Beginning of year	43,918,567	58,389,367
End of year	**$ 50,603,090**	**$ 43,918,567**

See Notes to Financial Statements.

Note 1 - Plan Description

The following description of Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan (the "Plan") provides only general information. Participants should refer to the plan agreement for more complete information.

General - The Plan is a noncontributory defined contribution plan, which covers all Holzer Medical Center (the "Hospital") employees who meet certain requirements as to age and length of service and provides for retirement, death, and disability benefits. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Employees are eligible to participate in the Plan upon reaching 21 years of age and completing two years of credited service, as defined in the plan agreement.

Contributions - Contributions to the Plan are invested as directed by the participants in any one or more investment alternatives. For participants of the Plan employed prior to August 1, 2005, the Hospital contributes 8 percent of each participant's eligible compensation. The Hospital also makes a matching contribution under this Plan equal to 100 percent of the participant's salary reduction contributions made to the tax-deferred annuity plan up to a maximum matching contribution of 2 percent of the participant's compensation. For participants of the Plan employed after August 1, 2005, the Hospital contributes 3 percent of eligible compensation and upon the third anniversary of enrollment into the Plan, an additional employer match of up to 3 percent.

Participant Accounts - American United Life Insurance Company (AUL) maintains an individual self-directed account for each participant for the deposit of contributions and earnings thereon. Earnings on plan assets are allocated based upon each participant's pro rata share of total account balances.

Vesting - Each employee of the Hospital shall be eligible to become a participant in the Plan and is 100 percent vested in employer contributions and earnings thereon after attaining the age of 21 and the completion of two years of service.

Payment of Benefits - The Plan allows participants to select optional forms of payment upon early retirement or normal retirement as stipulated in the plan agreement. A participant could select a lump-sum payment or purchase an annuity that would provide a monthly retirement benefit for life (or other specified period of time), and this annuity payment may continue to a spouse or other beneficiary upon the employee's death. A terminated participant may leave the monies invested until a later time, receive a lump-sum payout, or roll over the monies into another qualified plan.

Note 2 - Summary of Significant Accounting Policies

Investment Valuation - The Plan's assets are held in mutual funds and general insurance accounts that are maintained by American United Life Insurance Company (AUL). The mutual funds are valued at fair value based on the fair value on quoted market prices.

The general insurance accounts are group annuity contracts issued by AUL that invest in the general assets of AUL. AUL considers these contracts to be benefit-responsive; however, since there are no specific securities in AUL's general insurance account related to this contract, contract value is equal to fair value. Contract value represents principal invested plus interest earned.

The methods described above may produce a fair value calculation that may not be indicative of the net realizable value or reflective of future fair values. Furthermore, while the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date. (see Note 7).

Benefit Payments - Benefits are recorded when paid.

Administrative Expenses - Certain administrative expenses of the Plan are paid by the Hospital. Additionally, the Hospital provides certain accounting and administrative services at no cost to the Plan.

Use of Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates that affect the amounts reported in the financial statements. Actual results could differ from those estimates.

Risks and Uncertainties - The Plan invests in various investment securities, which 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 the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

Subsequent Events - The financial statements and related disclosures include evaluation of events up through and including September 17, 2010, which is the date the financial statements were available to be issued.

Reclassification - Certain prior year amounts have been reclassified to conform to the current year presentation.

Note 2 - Summary of Significant Accounting Policies (Continued)

Restatement - During 2009, it was determined that investments previously classified as Level 2 investments should have been classified as Level 1 and Level 3 based on the fair value hierarchy. Accordingly, the 2008 fair value disclosure has been restated (see Note 7).

Note 3 - Unaudited Investment Information

American United Life Insurance Company (the "Trustee") holds the Plan's investments and executes all investment transactions. The investment balances and related investment results included in the accompanying financial statements and supplemental schedule of assets held at end of year are based solely on information provided by the Trustee. Additionally, the Plan invests in certain investments managed by the Trustee.

Significant investments of end of year net assets are as follows:

	2009	2008
Mutual funds:		
American Funds Capital World Growth & Income	$ 3,002,572	$ 2,239,360
State Street Equity 500 Index	3,170,987	2,521,777
General insurance accounts:		
AUL Fixed Fund	12,671,185	11,404,439
Alternate Fixed Account	14,435,155	14,879,887

Note 4 - Investment Contracts

The Plan invests in benefit-responsive investment contracts with AUL. AUL maintains the contributions in a general insurance account. The accounts are credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan.

Interest rates are established and declared for new contributions that will be received in a calendar quarter. The rate is based on the return AUL expects on new investments made by it and held with the AUL general insurance account. When establishing interest credit rates for these contracts, AUL considers past general account investments, adjusted for portfolio turnover and withdrawals for benefit payments. The crediting rate will always equal or exceed the contractually guaranteed rate of 4 percent for the AUL Fixed Fund.

Note 4 - Investment Contracts (Continued)

Liquidation of the entire contract may cause a one-time adjustment to the aggregate contract value, resulting in a fair value different from the contract value. This total liquidation is a contingent event, which cannot be initiated by the plan participants and can only be initiated by the Trustee upon termination of the Plan or complete termination of the contract.

	2009	2008
Average yield earned by the Plan	4.11%	4.00%
Average yield credited to participants	4.11%	4.00%

Note 5 - Tax Status

The Plan has received a determination letter from the Internal Revenue Service indicating that the Plan, as designed, is qualified for tax-exempt treatment under the applicable section of the Internal Revenue Code (IRC). Although the Plan has been amended since receiving the determination letter, management believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

Note 6 - Plan Termination

Although it has not expressed an intent to do so, the Hospital has the right under the Plan to discontinue contributions and terminate the Plan. In the event of a termination or partial termination of the Plan, each participant's account shall become fully vested and nonforfeitable.

Note 7 - Fair Value Measurements

Accounting standards require certain assets and liabilities be reported at fair value in the financial statements and provide a framework for establishing that fair value. The framework for determining fair value is based on a hierarchy that prioritizes the inputs and valuation techniques used to measure fair value.

The following tables present information about the Plan's assets measured at fair value on a recurring basis at December 31, 2009 and 2008, and the valuation techniques used by the Plan to determine those fair values.

Note 7 - Fair Value Measurements (Continued)

Level 1 - In general, fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the Plan has the ability to access.

Level 2 - Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets and liabilities in active markets, and other inputs such as interest rates and yield curves that are observable at commonly quoted intervals.

Level 3 - Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset. These Level 3 fair value measurements are based primarily on management's own estimates using pricing models, discounted cash flow methodologies, or similar techniques taking into account the characteristics of the asset. Significant Level 3 inputs for the general insurance accounts where contract value approximates fair value include: credit rating of the issuer, deposits made to the contract, earnings at guaranteed crediting rates, withdrawals, and fees.

In instances where inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The Plan's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset.

Assets Measured at Fair Value on a Recurring Basis at December 31, 2009

	Level 1	Level 2	Level 3	Balance at December 31, 2009
Mutual funds:				
Money market	$ 629,538	$ -	$ -	$ 629,538
Equity securities	16,732,694	-	-	16,732,694
Bonds	1,902,637	-	-	1,902,637
Balanced investments	4,231,881	-	-	4,231,881
General insurance accounts	-	-	27,106,340	27,106,340
Total	$ 23,496,750	$ -	$ 27,106,340	$ 50,603,090

Note 7 - Fair Value Measurements (Continued)

Assets Measured at Fair Value on a Recurring Basis at December 31, 2008

	Level 1	Level 2	Level 3	Balance at December 31, 2008
Mutual funds:				
Money market	$ 688,106	$ -	$ -	$ 688,106
Equity securities	10,434,302	-	-	10,434,302
Bonds	3,229,523	-	-	3,229,523
Balanced investments	3,282,310	-	-	3,282,310
General insurance accounts	-	-	26,284,326	26,284,326
Total	$ 17,634,241	$ -	$ 26,284,326	$ 43,918,567

Changes in Level 3 assets measured at fair value on a recurring basis for the years ended December 31, 2009 and 2008 are as follows:

	General Insurance Accounts
Balance at January 1, 2009	$ 26,284,326
Net purchases and issuances (sales and settlements)	822,014
Balance at December 31, 2009	$ 27,106,340

	General Insurance Accounts
Balance at January 1, 2008	$ 27,836,891
Net purchases and issuances (sales and settlements)	(1,552,565)
Balance at December 31, 2008	$ 26,284,326

Note 8 - Subsequent Events

Subsequent to year end, as of January 1, 2010, the plan sponsor froze all employer contributions, both matching and fixed, for all participants in the Plan. No further employees will be eligible to become participants under the Plan and no further contributions will be made to the Plan as of this date. In addition, participants will no longer be able to make rollover contributions into the Plan.

Holzer Hospital Foundation d/b/a Holzer Medical Center Employees' Pension Plan

Schedule of Assets Held at End of Year
Form 5500, Schedule H, Line 4i
EIN 31-4379491, Plan No. 002
December 31, 2009

(a)(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
	General insurance accounts:		
*American United Life Insurance Company	AUL Fixed Fund	**	$ 12,671,185
*American United Life Insurance Company	Alternate Fixed Account	**	14,435,155
	Mutal funds:		
OneAmerica	OneAmerica Inv Grade Bond	**	1,064,308
OneAmerica	OneAmerica Value	**	1,654,097
OneAmerica	OneAmerica Asset Director	**	1,355,279
OneAmerica	OneAmerica Money Market	**	629,538
Fidelity	Fidelity VIP Growth	**	1,464,103
Fidelity	Fidelity VIP Overseas	**	751,271
Fidelity	Fidelity VIP Contrafund	**	1,613,885
Alger	Alger American Growth	**	2,352,584
Vanguard	Vanguard Explorer	**	262,031
State Street	State Street Equity 500 Index	**	3,170,987
T. Rowe Price	T. Rowe Price Equity Incom	**	817,381
AmCent	American Century Strategic Allocation Moderate	**	2,140,147
AmCent	American Century Heritage	**	1,643,784
AmCent	American Century Strategic Allocation Aggressive	**	736,455
American Funds	American Funds Capital World Growth & Income	**	3,002,572
American Funds	American Funds Amer H/I R4	**	838,328
	Total investments		**$ 50,603,090**

* Indicates party-in-interest to the Plan

** Cost information not required

Schedule C Attachment for Line Item 3(e)

HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES PENSION PLAN
002
31-4379491
December 31, 2009

The investment options of the Plan include various portfolios within an AUL separate account. The separate account in turn invests in investment portfolios of certain open-end management investment companies. AUL receives indirect compensation from these investment companies for the services provided by AUL.

The compensation received by AUL is computed by each investment company by multiplying the daily account balance of the AUL separate account's interest in a particular portfolio by a predetermined percentage rate negotiated with the investment company. This indirect compensation is not charged to the plan or participants accounts but is paid directly by the investment company.

The investment company, the underlying investment portfolio, and the annual compensation percentages are shown below.

Investment Company	Investment Portfolio	Annual Percentage
ALGER	ALGER LRGCAP GRWTH PORTFOLIO	0.20
AMERICAN CENTURY	AMCENT HERITAGE	0.60
AMERICAN CENTURY	AMCENT STRATEGIC ALLOC AGGRES	0.35
AMERICAN CENTURY	AMCENT STRATEGIC ALLOC MOD	0.35
AMERICAN FUNDS	AMER FDS AMERI HIGH INC TRST	0.35
AMERICAN FUNDS	AMER FDS AMERI HIGH INC TRST	0.60
AMERICAN FUNDS	AMER FDS CAPITAL WORLD GRO&INC	0.35
AMERICAN FUNDS	AMER FDS CAPITAL WORLD GRO&INC	0.60
CALVERT	CALVERT SOC MID-CAP GROWTH	0.10
FIDELITY	FIDELITY VIP ASSET MANAGER	0.15
FIDELITY	FIDELITY VIP CONTRAFUND	0.15
FIDELITY	FIDELITY VIP GROWTH	0.15
FIDELITY	FIDELITY VIP HIGH INCOME	0.15
FIDELITY	FIDELITY VIP OVERSEAS	0.15
JANUS	JANUS ASPEN SERIES WW GROWTH	0.15
PIONEER	PIONEER FUND VCT	0.25
STATE STREET	STATE STREET EQUITY 500 INDEX	0.15
T. ROWE PRICE	T ROWE PRICE EQUITY-INCOME	0.25

Attachment to 2009 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES **EIN:** 31-4379491
Plan Sponsor's Name HOLZER HOSPITAL FOUNDATION **PN:** 002

(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
	AMERICAN UNITED LIFE INS CO	AUL FIXED ACCOUNT		12,671,186
	AMERICAN UNITED LIFE INS CO	ALTERNATE FIXED ACCOUNT		14,435,154
	AMERICAN UNITED LIFE INS CO	AMER FUNDS AMER H/I R4		838,329
	AMERICAN UNITED LIFE INS CO	AMER FDS CAPITAL WORLD GRO&INC		3,002,572
	AMERICAN UNITED LIFE INS CO	ONEAMERICA INVESTMENT GRD BOND		1,064,308
	AMERICAN UNITED LIFE INS CO	ONEAMERICA VALUE		1,654,097
	AMERICAN UNITED LIFE INS CO	ONEAMERICA ASSET DIRECTOR		1,355,279

Attachment to 2009 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES **EIN:** 31-4379491
Plan Sponsor's Name HOLZER HOSPITAL FOUNDATION **PN:** 002

(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
	AMERICAN UNITED LIFE INS CO	ONEAMERICA MONEY MARKET		629,538
	AMERICAN UNITED LIFE INS CO	FIDELITY VIP GROWTH		1,464,103
	AMERICAN UNITED LIFE INS CO	FIDELITY VIP OVERSEAS		751,271
	AMERICAN UNITED LIFE INS CO	FIDELITY VIP CONTRAFUND		1,613,885
	AMERICAN UNITED LIFE INS CO	AMCENT STRATEGIC ALLOC AGGRES		736,455
	AMERICAN UNITED LIFE INS CO	AMCENT STRATEGIC ALLOC MOD		2,140,147
	AMERICAN UNITED LIFE INS CO	AMCENT HERITAGE		1,643,784

Attachment to 2009 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name HOLZER HOSPITAL FOUNDATION DBA HOLZER MEDICAL CENTER EMPLOYEES **EIN:** 31-4379491
Plan Sponsor's Name HOLZER HOSPITAL FOUNDATION **PN:** 002

(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
	AMERICAN UNITED LIFE INS CO	ALGER LARGE CAP GROWTH PORTFOL		2,352,584
	AMERICAN UNITED LIFE INS CO	T ROWE PRICE EQUITY-INCOME		817,381
	AMERICAN UNITED LIFE INS CO	VANGUARD EXPLORER		262,031
	AMERICAN UNITED LIFE INS CO	STATE STREET EQUITY 500 INDEX		3,170,986