

|                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                               |
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| <div>Form 5500</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security<br/>Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Annual Return/Report of Employee Benefit Plan</div> <div>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).</div> <div>Complete all entries in accordance with the instructions to the Form 5500.</div> | <div>OMB Nos. 1210-0110<br/>1210-0089</div> <div>2009</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                            |                                                                                                                                                                                                                                                                                                                   |
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| 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: <div><div><input type="checkbox"/> a multiemployer plan;</div><div><input checked="" type="checkbox"/> a single-employer plan;</div><div><input type="checkbox"/> a multiple-employer plan; or</div><div><input type="checkbox"/> a DFE (specify) _____</div></div>                    |
| B                                                                                          | This return/report is: <div><div><input type="checkbox"/> the first return/report;</div><div><input type="checkbox"/> the final return/report;</div><div><input type="checkbox"/> an amended return/report;</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months).</div></div> |
| C                                                                                          | If the plan is a collectively-bargained plan, check here. .... <input type="checkbox"/>                                                                                                                                                                                                                           |
| D                                                                                          | Check box if filing under: <div><div><input checked="" type="checkbox"/> Form 5558;</div><div><input type="checkbox"/> automatic extension;</div><div><input type="checkbox"/> the DFVC program;</div><div><input type="checkbox"/> special extension (enter description)</div></div>                             |

|         |                                                                                                                                                                                                                          |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Basic Plan Information—enter all requested information                                                                                                                                                                   |
| 1a      | Name of plan<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC SAFE HARBOR 401K PROFIT-SHARING PLAN                                                                                                                        |
| 1b      | Three-digit plan number (PN) ▶ 001                                                                                                                                                                                       |
| 1c      | Effective date of plan<br>01/01/1999                                                                                                                                                                                     |
| 2a      | Plan sponsor's name and address (employer, if for a single-employer plan)<br>(Address should include room or suite no.)<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC<br><br>1100 E WILLOW ST<br>SIGNAL HILL, CA 90755 |
| 2b      | Employer Identification Number (EIN)<br>33-0819654                                                                                                                                                                       |
| 2c      | Sponsor's telephone number<br>562-981-9500                                                                                                                                                                               |
| 2d      | Business code (see instructions)<br>541600                                                                                                                                                                               |

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. | 10/08/2010 | LUPE RETAMOSA                                                |
|           | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| SIGN HERE | Filed with authorized/valid electronic signature. | 10/08/2010 | LUPE RETAMOSA                                                |
|           | 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                      |

|                                                                                                                                                                                          |                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address (if same as plan sponsor, enter "Same")<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC<br><br>1100 E WILLOW ST<br>SIGNAL HILL, CA 90755 | <b>3b</b> Administrator's EIN<br>33-0819654<br><br><b>3c</b> Administrator's telephone number<br>562-981-9500 |
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|                                                                                                                                                                                                                       |                                   |
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| <b>4</b> 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:<br><br><b>a</b> Sponsor's name | <b>4b</b> EIN<br><br><b>4c</b> PN |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|

  

|                                                                         |          |     |
|-------------------------------------------------------------------------|----------|-----|
| <b>5</b> Total number of participants at the beginning of the plan year | <b>5</b> | 171 |
|-------------------------------------------------------------------------|----------|-----|

  

|                                                                                                                                                        |           |     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|
| <b>6</b> Number of participants as of the end of the plan year (welfare plans complete only lines <b>6a</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). |           |     |
| <b>a</b> Active participants.....                                                                                                                      | <b>6a</b> | 128 |
| <b>b</b> Retired or separated participants receiving benefits.....                                                                                     | <b>6b</b> | 0   |
| <b>c</b> Other retired or separated participants entitled to future benefits.....                                                                      | <b>6c</b> | 19  |
| <b>d</b> Subtotal. Add lines <b>6a</b> , <b>6b</b> , and <b>6c</b> .....                                                                               | <b>6d</b> | 147 |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....                                              | <b>6e</b> | 0   |
| <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....                                                                                                | <b>6f</b> | 147 |
| <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....         | <b>6g</b> | 147 |
| <b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....             | <b>6h</b> | 0   |

  

|                                                                                                                                      |          |  |
|--------------------------------------------------------------------------------------------------------------------------------------|----------|--|
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ..... | <b>7</b> |  |
|--------------------------------------------------------------------------------------------------------------------------------------|----------|--|

  

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:  
 2E 2F 2G 2J 2K 3D 3H

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

|                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>9a</b> Plan funding arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor | <b>9b</b> Plan benefit arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input type="checkbox"/> Trust<br>(4) <input type="checkbox"/> 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)

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>a Pension Schedules</b><br>(1) <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information)<br>(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<br><br>(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | <b>b General Schedules</b><br>(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)<br>(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)<br>(3) <input checked="" type="checkbox"/> <u>1</u> <b>A</b> (Insurance Information)<br>(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)<br>(5) <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)<br>(6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance 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> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2009</div> <div>This Form is Open to Public Inspection</div> |
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|                                                                                                         |                                                      |     |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009              |                                                      |     |
| A Name of plan<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC SAFE HARBOR 401K PROFIT-SHARING PLAN     | B Three-digit plan number (PN) ▶                     | 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500.<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC | D Employer Identification Number (EIN)<br>33-0819654 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
MUTUAL OF AMERICA

| (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     |
| 13-1614399 | 88668         | 057717K                               | 147                                                                         | 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 |
| 0                                    | 0                             |

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

| (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 |                       |
|                                               |                                 |             |                       |

(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** 706527**5** Current value of plan's interest under this contract in separate accounts at year end ..... **5** 2495960**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶ N/A**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 ▶ N/A

**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 ▶**b** Balance at the end of the previous year ..... **7b** 0**c** Additions: (1) Contributions deposited during the year ..... **7c(1)** 282234(2) Dividends and credits ..... **7c(2)** 0(3) Interest credited during the year ..... **7c(3)** 16910(4) Transferred from separate account ..... **7c(4)** 398400(5) Other (specify below) ..... **7c(5)** 28416

▶ ROLLOVER; FORFEITURES APPLD; LOAN PRIN PAY; LOAN INT PAY;

(6) Total additions ..... **7c(6)** 725960**d** Total of balance and additions (add **b** and **c(6)**). .... **7d** 725960**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)** 3313(2) Administration charge made by carrier ..... **7e(2)** 441(3) Transferred to separate account ..... **7e(3)** 0(4) Other (specify below) ..... **7e(4)** 15679

▶ FINANCIAL ADJUSTMENT FORFEITURES INCURRED

(5) Total deductions ..... **7e(5)** 19433**f** Balance at the end of the current year (subtract **e(5)** from **d**) ..... **7f** 706527

**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:

|                                                                                                                                                   |                 |                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|--|
| <b>a</b> Premiums: (1) Amount received.....                                                                                                       | <b>9a(1)</b>    |                 |  |
| (2) Increase (decrease) in amount due but unpaid.....                                                                                             | <b>9a(2)</b>    |                 |  |
| (3) Increase (decrease) in unearned premium reserve.....                                                                                          | <b>9a(3)</b>    |                 |  |
| (4) Earned ((1) + (2) - (3)).....                                                                                                                 |                 | <b>9a(4)</b>    |  |
| <b>b</b> Benefit charges (1) Claims paid.....                                                                                                     | <b>9b(1)</b>    |                 |  |
| (2) Increase (decrease) in claim reserves.....                                                                                                    | <b>9b(2)</b>    |                 |  |
| (3) Incurred claims (add (1) and (2)).....                                                                                                        |                 | <b>9b(3)</b>    |  |
| (4) Claims charged.....                                                                                                                           |                 | <b>9b(4)</b>    |  |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                     |                 |                 |  |
| (A) Commissions.....                                                                                                                              | <b>9c(1)(A)</b> |                 |  |
| (B) Administrative service or other fees.....                                                                                                     | <b>9c(1)(B)</b> |                 |  |
| (C) Other specific acquisition costs.....                                                                                                         | <b>9c(1)(C)</b> |                 |  |
| (D) Other expenses.....                                                                                                                           | <b>9c(1)(D)</b> |                 |  |
| (E) Taxes.....                                                                                                                                    | <b>9c(1)(E)</b> |                 |  |
| (F) Charges for risks or other contingencies.....                                                                                                 | <b>9c(1)(F)</b> |                 |  |
| (G) Other retention charges.....                                                                                                                  | <b>9c(1)(G)</b> |                 |  |
| (H) Total retention.....                                                                                                                          |                 | <b>9c(1)(H)</b> |  |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)..... |                 | <b>9c(2)</b>    |  |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....                                |                 | <b>9d(1)</b>    |  |
| (2) Claim reserves.....                                                                                                                           |                 | <b>9d(2)</b>    |  |
| (3) Other reserves.....                                                                                                                           |                 | <b>9d(3)</b>    |  |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....                                                 |                 | <b>9e</b>       |  |

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                 |            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Total premiums or subscription charges paid to carrier.....                                                                                                                                                            | <b>10a</b> |  |
| <b>b</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. .... | <b>10b</b> |  |

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. ▶

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        |                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                                           |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>2009</b>                                                 |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>This Form is Open to Public Inspection.</b>              |
| For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009                                                                                                                                |                                                                                                                                                                                                                        |                                                             |
| <b>A</b> Name of plan<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC SAFE HARBOR 401K PROFIT-SHARING PLAN                                                                                                                |                                                                                                                                                                                                                        | <b>B</b> Three-digit plan number (PN) ▶ 001                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC                                                                                                             |                                                                                                                                                                                                                        | <b>D</b> Employer Identification Number (EIN)<br>33-0819654 |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <b>Part I</b> | <b>Service Provider Information (see instructions)</b> |
|---------------|--------------------------------------------------------|

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>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |                                          |
| FIDELITY MANAGEMENT & RESEARCH COMP                                                                               | 82 DEVONSHIRE STREET<br>BOSTON, MA 02109 |

|                                                                                                                  |                                       |
|------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosure on eligible indirect compensation |                                       |
| THE VANGUARD GROUP                                                                                               | PO BOX 2600<br>VALLEY FORGE, PA 18482 |

|                                                                                                                   |                                                     |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |                                                     |
| DEUTSCHE ASSET MANAGEMENT                                                                                         | 222 SOUTH RIVERSIDE PLAZA<br>CHICAGO, IL 60606-5808 |

|                                                                                                                   |                                      |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |                                      |
| OPPENHEIMER FUNDS, INC.                                                                                           | PO BOX 5270<br>DENVER, CO 80217-5270 |

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

AMERICAN CENTURY INVESTMENT MANAGEM      PO BOX 419786  
KANSAS CITY, MO 64141

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

CALVERT ASSET MANAGEMENT COMPANY, I      4550 MONTGOMERY AVENUE, SUITE 1000N  
BETHESDA, MD 20814

(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

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(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)

MUTUAL OF AMERICA LIFE INSURANCE CO

320 PARK AVENUE  
NEW YORK, NY 10022

| <b>(b)</b><br>Service<br>Code(s) | <b>(c)</b><br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | <b>(d)</b><br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | <b>(e)</b><br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | <b>(f)</b><br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | <b>(g)</b><br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | <b>(h)</b><br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| 12 15 37 65                      | INSURANCE<br>CARRIER                                                                                                 | 2169                                                                                   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                     | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                               | 0                                                                                                                                                                                                        | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                             |

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

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

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

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

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

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

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

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

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

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

**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<br>(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<br>(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<br>(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)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN;       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN;       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:



**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
code**e** Dollar value of interest in MTIA, CCT, PSA, or  
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
code**e** Dollar value of interest in MTIA, CCT, PSA, or  
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
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103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
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103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
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103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
code**e** Dollar value of interest in MTIA, CCT, PSA, or  
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
code**e** Dollar value of interest in MTIA, CCT, PSA, or  
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
code**e** Dollar value of interest in MTIA, CCT, PSA, or  
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity  
code**e** Dollar value of interest in MTIA, CCT, PSA, or  
103-12 IE at end of year (see instructions)

**Part II Information on Participating Plans (to be completed by DFEs)**

(Complete as many entries as needed to report all participating plans)

**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              |                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Financial Information</b><br><br>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).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110                             |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>2009</b>                                   |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                              | <b>This Form is Open to Public Inspection</b> |

|                                                                                                                      |                                                                        |            |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------|
| For calendar plan year 2009 or fiscal plan year beginning <u>01/01/2009</u> and ending <u>12/31/2009</u>             |                                                                        |            |
| <b>A</b> Name of plan<br><u>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC SAFE HARBOR 401K PROFIT-SHARING PLAN</u>    | <b>B</b> Three-digit plan number (PN) <b>►</b>                         | <u>001</u> |
|                                                                                                                      |                                                                        |            |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC</u> | <b>D</b> Employer Identification Number (EIN)<br><br><u>33-0819654</u> |            |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**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 |
|---------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash .....                                                     | <b>1a</b>       |                       |                 |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                      |                 |                       |                 |
| <b>(1)</b> Employer contributions .....                                                           | <b>1b(1)</b>    |                       |                 |
| <b>(2)</b> Participant contributions .....                                                        | <b>1b(2)</b>    |                       |                 |
| <b>(3)</b> Other.....                                                                             | <b>1b(3)</b>    |                       |                 |
| <b>c</b> General investments:                                                                     |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....  | <b>1c(1)</b>    |                       |                 |
| <b>(2)</b> U.S. Government securities.....                                                        | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                           |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other.....                                                                         | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                     |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....                                                                           | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....                                              | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                  | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....                                               | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....                                                                | <b>1c(8)</b>    | <u>39491</u>          | <u>49821</u>    |
| <b>(9)</b> Value of interest in common/collective trusts.....                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts.....                                    | <b>1c(10)</b>   |                       |                 |
| <b>(11)</b> Value of interest in master trust investment accounts .....                           | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                 | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds).....        | <b>1c(13)</b>   | <u>1088712</u>        | <u>2495960</u>  |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts)..... | <b>1c(14)</b>   | <u>0</u>              | <u>706527</u>   |
| <b>(15)</b> Other .....                                                                           | <b>1c(15)</b>   |                       |                 |

| <b>1d</b> Employer-related investments:                              |              | (a) Beginning of Year | (b) End of Year |
|----------------------------------------------------------------------|--------------|-----------------------|-----------------|
| (1) Employer securities .....                                        | <b>1d(1)</b> |                       |                 |
| (2) Employer real property .....                                     | <b>1d(2)</b> |                       |                 |
| <b>e</b> Buildings and other property used in plan operation .....   | <b>1e</b>    |                       |                 |
| <b>f</b> Total assets (add all amounts in lines 1a through 1e) ..... | <b>1f</b>    | 1128203               | 3252308         |

**Liabilities**

|                                                                           |           |   |   |
|---------------------------------------------------------------------------|-----------|---|---|
| <b>g</b> Benefit claims payable .....                                     | <b>1g</b> |   |   |
| <b>h</b> Operating payables .....                                         | <b>1h</b> |   |   |
| <b>i</b> Acquisition indebtedness .....                                   | <b>1i</b> |   |   |
| <b>j</b> Other liabilities .....                                          | <b>1j</b> |   |   |
| <b>k</b> Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b> | 0 | 0 |

**Net Assets**

|                                                           |           |         |         |
|-----------------------------------------------------------|-----------|---------|---------|
| <b>l</b> Net assets (subtract line 1k from line 1f) ..... | <b>1l</b> | 1128203 | 3252308 |
|-----------------------------------------------------------|-----------|---------|---------|

**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 |
|------------------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| <b>a Contributions:</b>                                                                                    |                 |            |           |
| (1) Received or receivable in cash from: <b>(A)</b> Employers .....                                        | <b>2a(1)(A)</b> | 342525     |           |
| <b>(B)</b> Participants .....                                                                              | <b>2a(1)(B)</b> | 438607     |           |
| <b>(C)</b> Others (including rollovers) .....                                                              | <b>2a(1)(C)</b> | 1044486    |           |
| (2) Noncash contributions .....                                                                            | <b>2a(2)</b>    |            |           |
| (3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    |            | 1825618   |
| <b>b Earnings on investments:</b>                                                                          |                 |            |           |
| (1) Interest:                                                                                              |                 |            |           |
| <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....       | <b>2b(1)(A)</b> |            |           |
| <b>(B)</b> U.S. Government securities .....                                                                | <b>2b(1)(B)</b> |            |           |
| <b>(C)</b> Corporate debt instruments .....                                                                | <b>2b(1)(C)</b> |            |           |
| <b>(D)</b> Loans (other than to participants) .....                                                        | <b>2b(1)(D)</b> |            |           |
| <b>(E)</b> Participant loans .....                                                                         | <b>2b(1)(E)</b> | 3207       |           |
| <b>(F)</b> Other .....                                                                                     | <b>2b(1)(F)</b> | 16910      |           |
| <b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                              | <b>2b(1)(G)</b> |            | 20117     |
| (2) Dividends: <b>(A)</b> Preferred stock .....                                                            | <b>2b(2)(A)</b> |            |           |
| <b>(B)</b> Common stock .....                                                                              | <b>2b(2)(B)</b> |            |           |
| <b>(C)</b> Registered investment company shares (e.g. mutual funds) .....                                  | <b>2b(2)(C)</b> |            |           |
| <b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....                  | <b>2b(2)(D)</b> |            | 0         |
| (3) Rents .....                                                                                            | <b>2b(3)</b>    |            |           |
| (4) Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....                                 | <b>2b(4)(A)</b> |            |           |
| <b>(B)</b> Aggregate carrying amount (see instructions) .....                                              | <b>2b(4)(B)</b> |            |           |
| <b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....                  | <b>2b(4)(C)</b> |            | 0         |

|                                                                                                   |                 | (a) Amount | (b) Total |
|---------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| <b>2b</b> (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....              | <b>2b(5)(A)</b> |            |           |
| (B) Other .....                                                                                   | <b>2b(5)(B)</b> |            |           |
| (C) Total unrealized appreciation of assets.<br>Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....    | <b>2b(5)(C)</b> |            | 0         |
| (6) Net investment gain (loss) from common/collective trusts .....                                | <b>2b(6)</b>    |            |           |
| (7) Net investment gain (loss) from pooled separate accounts .....                                | <b>2b(7)</b>    |            | 308608    |
| (8) Net investment gain (loss) from master trust investment accounts .....                        | <b>2b(8)</b>    |            |           |
| (9) Net investment gain (loss) from 103-12 investment entities .....                              | <b>2b(9)</b>    |            |           |
| (10) Net investment gain (loss) from registered investment<br>companies (e.g., mutual funds)..... | <b>2b(10)</b>   |            |           |
| <b>c</b> Other income.....                                                                        | <b>2c</b>       |            | 14525     |
| <b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....           | <b>2d</b>       |            | 2168868   |

**Expenses**

|                                                                                            |              |       |       |
|--------------------------------------------------------------------------------------------|--------------|-------|-------|
| <b>e</b> Benefit payment and payments to provide benefits:                                 |              |       |       |
| (1) Directly to participants or beneficiaries, including direct rollovers .....            | <b>2e(1)</b> | 8935  |       |
| (2) To insurance carriers for the provision of benefits .....                              | <b>2e(2)</b> | 0     |       |
| (3) Other .....                                                                            | <b>2e(3)</b> |       |       |
| (4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....                | <b>2e(4)</b> |       | 8935  |
| <b>f</b> Corrective distributions (see instructions) .....                                 | <b>2f</b>    |       | 15992 |
| <b>g</b> Certain deemed distributions of participant loans (see instructions).....         | <b>2g</b>    |       | 0     |
| <b>h</b> Interest expense.....                                                             | <b>2h</b>    |       |       |
| <b>i</b> Administrative expenses: (1) Professional fees .....                              | <b>2i(1)</b> |       |       |
| (2) Contract administrator fees .....                                                      | <b>2i(2)</b> |       |       |
| (3) Investment advisory and management fees .....                                          | <b>2i(3)</b> |       |       |
| (4) Other .....                                                                            | <b>2i(4)</b> | 19836 |       |
| (5) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(4)</b> .....         | <b>2i(5)</b> |       | 19836 |
| <b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total..... | <b>2j</b>    |       | 44763 |

**Net Income and Reconciliation**

|                                                                               |              |  |         |
|-------------------------------------------------------------------------------|--------------|--|---------|
| <b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> ..... | <b>2k</b>    |  | 2124105 |
| <b>l</b> Transfers of assets:                                                 |              |  |         |
| (1) To this plan.....                                                         | <b>2l(1)</b> |  |         |
| (2) From this plan .....                                                      | <b>2l(2)</b> |  | 0       |

**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: KELLOGG & ANDELSON ACCOUNTANCY CORP

(2) EIN: 95-2793306

**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 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|
| <b>a</b> 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>b</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  |        |
| <b>c</b> 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  |        |
| <b>d</b> 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  |        |
| <b>e</b> Was this plan covered by a fidelity bond?.....                                                                                                                                                                                                                                                         | X   |    | 250000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                                                                                                         |     | X  |        |
| <b>g</b> 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  |        |
| <b>h</b> 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  |        |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....                                                                                                                                                   | X   |    |        |
| <b>j</b> 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  |        |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....                                                                                                                                              |     | X  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                                                                                                              |     | X  |        |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....                                                                                                                                                                                     | X   |    |        |
| <b>n</b> 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. ....                                                                                                                        | X   |    |        |

- 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)

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                            |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>SCHEDULE R</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Retirement Plan Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                              |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                            | <b>2009</b>                                    |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                            | <b>This Form is Open to Public Inspection.</b> |

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

|                                                                                                                      |                                                                    |
|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>A</b> Name of plan<br><u>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC SAFE HARBOR 401K PROFIT-SHARING PLAN</u>    | <b>B</b> Three-digit plan number (PN) ▶<br><u>001</u>              |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC</u> | <b>D</b> Employer Identification Number (EIN)<br><u>33-0819654</u> |

|               |                      |
|---------------|----------------------|
| <b>Part I</b> | <b>Distributions</b> |
|---------------|----------------------|

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

|                                                                                                                                                                                                                                                                    |          |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| <b>1</b> Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....                                                                                                                              | <b>1</b> | <u>0</u> |
| <b>2</b> 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):<br><br>EIN(s): <u>13-3590259</u> |          |          |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.                                                                                                                                                                                                   |          |          |
| <b>3</b> Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....                                                                                                                                    | <b>3</b> |          |

|                |                                                                                                                                                                              |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part II</b> | <b>Funding Information</b> (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) |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                         |                                                                                                                         |                             |                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------|
| <b>4</b> Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?.....                                                                                                                                     | <input type="checkbox"/> Yes                                                                                            | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8.                                                                                                                                                                                                    |                                                                                                                         |                             |                              |
| <b>5</b> 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. |                             |                              |
| <b>6 a</b> Enter the minimum required contribution for this plan year .....                                                                                                                                                                             | <b>6a</b>                                                                                                               |                             |                              |
| <b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                              | <b>6b</b>                                                                                                               |                             |                              |
| <b>c</b> 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).....                                                                                                         | <b>6c</b>                                                                                                               |                             |                              |
| If you completed line 6c, skip lines 8 and 9.                                                                                                                                                                                                           |                                                                                                                         |                             |                              |
| <b>7</b> Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                      | <input type="checkbox"/> Yes                                                                                            | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>8</b> 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?..... | <input type="checkbox"/> Yes                                                                                            | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|                 |                   |
|-----------------|-------------------|
| <b>Part III</b> | <b>Amendments</b> |
|-----------------|-------------------|

|                                                                                                                                                                                                                                |                                   |                                   |                               |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| <b>9</b> 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..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

|                |                                                                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part IV</b> | <b>ESOPs</b> (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. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                              |                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>10</b> Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?.....                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>11 a</b> Does the ESOP hold any preferred stock? .....                                                                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>b</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.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12</b> Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> 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:

|                                                                          |            |  |
|--------------------------------------------------------------------------|------------|--|
| <b>a</b> The current year .....                                          | <b>14a</b> |  |
| <b>b</b> The plan year immediately preceding the current plan year ..... | <b>14b</b> |  |
| <b>c</b> The second preceding plan year .....                            | <b>14c</b> |  |

- 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:

|                                                                                                       |            |  |
|-------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> The corresponding number for the plan year immediately preceding the current plan year ..... | <b>15a</b> |  |
| <b>b</b> The corresponding number for the second preceding plan year .....                            | <b>15b</b> |  |

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

|                                                                                                                                                                        |            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Enter the number of employers who withdrew during the preceding plan year .....                                                                               | <b>16a</b> |  |
| <b>b</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 ..... | <b>16b</b> |  |

- 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): \_\_\_\_\_

**MEMORIAL HEALTHCARE  
MANAGEMENT SERVICES, LLC's**

**SAFE HARBOR 401(k) PROFIT SHARING PLAN**

**FINANCIAL STATEMENTS**

**DECEMBER 31, 2009 AND 2008**

## **CONTENTS**

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To the Plan Administrator and Participants of the  
Memorial Healthcare Management Services, LLC's  
Safe Harbor 401(k) Profit-Sharing Plan  
Signal Hill, California

Independent Auditors' Report



We were engaged to audit the accompanying statements of net assets available for plan benefits of Memorial Healthcare Management Services, LLC's Safe Harbor 401(k) Profit-Sharing Plan (the "Plan") as of December 31, 2009 and 2008 and the related statement of changes in net assets available for plan benefits for the year ended December 31, 2009, and the supplemental Schedule H, line 4i – Schedule of Assets (Held at End of Year) as of December 31, 2009. 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 5, which was certified by Mutual of America Life Insurance Company and State Street Bank & Trust Co., the trustees of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedule. We have been informed by the plan administrator that Mutual of America Life Insurance Company held the Plan's investment assets and executed investment transactions from January 1, 2009 through December 31, 2009, and that State Street Bank & Trust Co. held the Plan's investment assets and executed investment transactions from January 1, 2008 through December 31, 2008. The plan administrator has obtained a certification from the trustees as of December 31, 2009 and 2008 and for the year ended December 31, 2009, that the information provided to the plan administrator by the trustees 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.

*Kellogg + Anderson*

October 5, 2010

21700 OXNARD STREET, SUITE 900  
WOODLAND HILLS, CALIFORNIA 91367

12400 WILSHIRE BOULEVARD, SUITE 1100  
LOS ANGELES, CALIFORNIA 90025

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**STATEMENTS OF NET ASSETS AVAILABLE FOR PLAN BENEFITS**

**DECEMBER 31, 2009 AND 2008**

|                                                  | <u>2009</u>                | <u>2008</u>                |
|--------------------------------------------------|----------------------------|----------------------------|
| <b>ASSETS:</b>                                   |                            |                            |
| Investments, participant-directed, at fair value | \$ 3,202,487               | \$ 1,088,712               |
| Receivables:                                     |                            |                            |
| Employee contributions                           | 12,882                     | -                          |
| Employer contributions                           | <u>8,820</u>               | <u>103,623</u>             |
| Total receivables                                | <u>21,702</u>              | <u>103,623</u>             |
| Participant loans                                | <u>49,821</u>              | <u>39,491</u>              |
| Total assets                                     | 3,274,010                  | 1,231,826                  |
| <b>LIABILITIES:</b>                              |                            |                            |
| Corrective distributions payable                 | <u>-</u>                   | <u>22,654</u>              |
| Total liabilities                                | <u>-</u>                   | <u>22,654</u>              |
| <b>NET ASSETS AVAILABLE FOR PLAN BENEFITS</b>    | <b>\$ <u>3,274,010</u></b> | <b>\$ <u>1,209,172</u></b> |

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

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR PLAN BENEFITS  
FOR THE YEAR ENDED DECEMBER 31, 2009**

**ADDITIONS TO NET ASSETS ATTRIBUTED TO:**

|                                        |                  |
|----------------------------------------|------------------|
| Investment income:                     |                  |
| Net change in fair value of investment | \$ 325,518       |
| Interest – participant loans           | <u>3,207</u>     |
| Total investment income                | <u>328,725</u>   |
| Contributions:                         |                  |
| Employer                               | 247,722          |
| Participants                           | 451,489          |
| Rollovers                              | <u>1,044,486</u> |
| Total contributions                    | <u>1,743,697</u> |
| Other income                           | <u>21,187</u>    |
| Total additions                        | <u>2,093,609</u> |

**DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:**

|                                    |               |
|------------------------------------|---------------|
| Plan benefits paid to participants | 8,935         |
| Administrative expenses            | <u>19,836</u> |
| Total deductions                   | <u>28,771</u> |
| Net change                         | 2,064,838     |

**NET ASSETS AVAILABLE FOR PLAN BENEFITS:**

|                   |                            |
|-------------------|----------------------------|
| Beginning of year | <u>1,209,172</u>           |
| End of year       | \$ <u><u>3,274,010</u></u> |

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

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 1 - DESCRIPTION OF PLAN**

The following brief description of the Memorial Healthcare Management Services, LLC 401(k) Plan (the "Plan") is provided for general information purposes only. Participants should refer to the Plan agreement for more complete information of the Plan's provisions.

**General**

The Plan is a defined contribution plan, qualifies as a 401(k) plan, and was established effective January 1, 1999. The Plan covers eligible employees of Memorial Healthcare Management Services, LLC, Memorial Healthcare IPA, and Willow Urgent Care (the "Company"). All employees who are at least 21 years of age are eligible to participate in the Plan after completing 1 year of service. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and the Internal Revenue Code (IRC).

The Plan was amended effective January 1, 2009, to provide safe harbor employer match. The Plan was also amended at various dates through December 31, 2009 to comply with applicable laws and regulations.

**Plan Administration**

Through December 31, 2008, all of the assets of the Plan were held in trust by State Street Bank & Trust Co. Effective January 1, 2009, a new trustee and recordkeeper, Mutual of America Life Insurance Company (MOA), was appointed. Due to the change in service providers, the Company instituted a blackout period from January 1, 2009 through January 16, 2009. During this period, no contributions and loan repayments were transferred to the Plan. Participants were not able to change their investment allocation and withdraw money from the Plan until the end of the blackout period. At the end of the blackout period, Plan assets were transferred to the new trustee and invested in investment options provided by the new trustee (default options or investment options requested by the participants).

**Contributions**

Participants of the Plan may elect to contribute up to 100% of their compensation to the Plan as a pre-tax deferral, subject to limitations under the IRC. Plan participants over age 50 may defer catch-up contributions, subject to IRC limitations.

During the year ended December 31, 2009, with the adoption of the safe harbor provisions, the Company matched 100% of a participant's contribution up to 4% of eligible compensation.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 1 - DESCRIPTION OF PLAN - CONTINUED**

**Investment Options**

Participants direct the investment of their contributions into various investment options offered by the Plan. The investment options under the Plan's group variable annuity contract with MOA include the General Account and Separate Account funds. Investments in the General Account, also referred to as the Interest Accumulation Account, are credited with a contractual rate of return and are guaranteed by MOA. Separate Account investments consist solely of investments in mutual funds registered with the Securities and Exchange Commission (SEC). Currently, Separate Account invests into thirty five underlying funds.

**Vesting**

Participants are fully vested in their elective contributions plus actual earnings thereon. With the adoption of the safe harbor match provision and plan amendment, participants are also fully vested in the Company's match.

**Forfeited Accounts**

Forfeitures are created when participants terminate employment before becoming entitled to their full benefits under the Plan. Forfeitures may be first used to reduce the Company's matching contributions that would otherwise be made to the Plan. Any excess forfeiture may be used to defray any expenses associated with the administration of the Plan. During the year ended December 31, 2009, forfeitures in the amount of \$4,731 were used to reduce the Company's matching contributions. There were no forfeitures available to reduce future Company contributions and Plan expenses as of December 31, 2009. As of December 31, 2008, forfeitures amounted to \$4,167.

**Participant Accounts**

Individual accounts are maintained for each of the Plan's participants to reflect the participant's contributions (including those rolled over from another qualifying plan or trust) and related employer matching contributions, as well as the participant's share of the Plan's income and related administrative expenses. Allocations are based on the proportion that each participant's account balance has to the total of all participants account balances.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 1 - DESCRIPTION OF PLAN – CONTINUED**

**Payment of Benefits**

Upon termination of services due to death, disability, or retirement, a participant (or participant's beneficiary in the event of death) may elect to receive either a lump-sum or annuity installment distributions in the amount equal to the value of the participant's vested interest in his or her account. For termination of services for other reasons, a participant may receive the value of the vested interest in his or her account as a lump-sum distribution. Payment of account balances in excess of \$5,000 can be deferred until Normal Retirement Age of 65. With approval of the Company, early withdrawals may be paid by the Plan to those participants experiencing a financial hardship, as defined in the Plan document.

**Loans to Participants**

Participants may borrow from their fund accounts a minimum of \$500 up to a maximum equal to the lesser of \$50,000 or 50% of their vested account balance. Loans must be fully repaid through payroll deductions within 5 years, unless the loan is used for the purchase of the primary residence. Loans used to purchase participant's primary residence may be repaid within a period of no more than 30 years. Loans are secured by the participant's account balance and bear a reasonable rate of interest.

**Administrative Expenses**

The Company pays certain expenses associated with the administration of the Plan, including audit fees and costs of communication with the participants.

**NOTE 2 - SUMMARY OF ACCOUNTING POLICIES**

**Basis of Accounting**

The accompanying financial statements of the Plan have been prepared on the accrual basis in conformity with accounting principles generally accepted in the United States of America.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 2 - SUMMARY OF ACCOUNTING POLICIES - CONTINUED**

**Accounting Standards Codification**

In June 2009, the Financial Accounting Standards Board (FASB) issued Accounting Standards Codification (ASC) 105, *Generally Accepted Accounting Principles*, which became the single official source of authoritative, nongovernmental U.S. generally accepted accounting principles (GAAP), other than guidance issued by the SEC. FASB ASC 105 was adopted by the Plan as of December 31, 2009. As FASB ASC 105 did not create any new GAAP standards but incorporated existing accounting and reporting standards into a new topical structure, the adoption of FASB ASC 105 only changed referencing convention of GAAP in the notes to the financial statements.

**Valuation of Investments**

All assets of the Plan are stated at fair value as follows:

- Separate Account investments in mutual funds are carried at net asset value at which the mutual fund shares are actively traded.
- General Account, or Interest Accumulation Account, is credited with a contractual rate of return (3% at December 31, 2009) and is comparable to cash equivalent. As such, investments in General Account are not subject to leveling provisions of FASB ASC 820, *Fair Value Measurements and Disclosure*. General Account investments are reported at amortized cost, or contract value, which approximates fair value.
- Participant loans are stated at outstanding balances, which approximate fair value.

The relevant accounting standard for defined contribution plans defines the circumstances in which an investment contract is considered fully benefit-responsive and provides certain reporting and disclosure requirements for fully benefit-responsive investment contracts in defined contribution plans. The Plan did not invest in such contracts as of December 31, 2009 and 2008.

**Net Change in Fair Value of Investments**

Net change in fair value of investments includes realized and unrealized gains and losses on investments sold or held during the year.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 2 - SUMMARY OF ACCOUNTING POLICIES – CONTINUED**

**Recognition of Income**

Sales and purchases are accounted for on a trade date basis, and interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

**Benefits**

Benefit payments to participants are recorded when paid.

**Use of 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 the reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Accordingly, actual results may differ from those estimates.

**Risks and Uncertainties**

The Plan utilizes various investment instruments. Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the statements of net assets available for plan benefits.

**Subsequent Events**

During the year ended December 31, 2009, the Plan adopted FASB ASC 855, *Subsequent Events*, which establishes general standards of accounting for and disclosures of events that occur after the financial statement date but before the financial statements are issued or are available to be issued.

In preparing the accompanying financial statements, events occurring between December 31, 2009 and October 5, 2010 (the date the financial statements were available to be issued) were evaluated, and no material subsequent events that required recognition in these financial statements were noted.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 2 - SUMMARY OF ACCOUNTING POLICIES – CONTINUED**

**New Accounting Pronouncements**

In September 2009, the FASB issued Accounting Standard Update (ASU) 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or Its equivalent)*. FASB ASU 2009-12 amended FASB ASC 820 to allow entities to use net asset value (NAV) per share (or its equivalent), as a practical expedient, to measure fair value when the investment does not have a readily determinable fair value, and net asset value is calculated in a manner consistent with investment company accounting.

The Plan adopted the guidance of FASB ASU 2009-12 for the reporting period ended December 31, 2009 and has utilized the practical expedient to measure the fair value of investments within the scope of this guidance based on the investment's NAV. The impact of adoption of this standard was not material to the Plan's net assets available for benefits.

In January 2010, the FASB ASU 2010-06, *Improving Disclosures about Fair Value Measurements*, to amend the disclosure requirements related to recurring and nonrecurring fair value measurements. The guidance requires new disclosures on the transfers of assets and liabilities between Level 1 (quoted prices in active market for identical assets or liabilities) and Level 2 (significant other observable inputs) of the fair value measurement hierarchy, including the reasons and the timing of the transfers.

Additionally, the guidance requires a roll forward of activities on purchases, sales, issuance, and settlements of the assets and liabilities measured using significant unobservable inputs (Level 3 fair value measurements). The guidance will become effective for fiscal years beginning after December 15, 2009, except for the disclosure on the roll forward activities for Level 3 fair value measurements, which will become effective for fiscal years beginning after December 15, 2010. The adoption of this new guidance is not expected to have a material impact on the Plan's financial statements.

On September 16, 2010, FASB approved for issuance the FASB ASU on *Reporting Loans to Participants by Defined Contribution Plans*, which is effective for plan years ending after December 15, 2010. The new standard will now require that participant loans be classified as notes receivable for GAAP purposes and measured at unpaid principal balance plus accrued but unpaid interest. Currently, these participant loans are classified as plan investments and are subject to fair value measurement and disclosure requirements of FASB ASC 820. Adopting this new standard will eliminate the need to calculate fair values and present disclosures for these loans in accordance with FASB ASC 820. The adoption of this new guidance is not expected to have a material impact on the Plan's financial statements.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 3 - PLAN TERMINATION AND AMENDMENT**

Although it has not expressed any intent to do so, the Company has the right under the Plan document to discontinue its contributions at any time and to amend or terminate the Plan, subject to the provisions of ERISA. In the event of Plan termination, participants will become fully vested in their account balances.

**NOTE 4 - TAX STATUS**

The Company has filed for a determination letter from the Internal Revenue Service (IRS) regarding the Plan's qualification under IRC Section 401(a). The plan administrator believes that the Plan is currently designed and is being operated in compliance with the applicable requirements of the IRC. The plan administrator will make any changes deemed necessary to ensure that the Plan is granted tax-exempt status.

**NOTE 5 - INFORMATION CERTIFIED BY THE PLAN'S TRUSTEES**

The plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, the trustees of the Plan have certified to the completeness and accuracy of all investments reflected in the accompanying statements of net assets available for Plan benefits as of December 31, 2009 and 2008, and the supplemental Schedule H, line 4i – Schedule of assets (Held at End of Year) as of December 31, 2009, and the related investment activity reflected in the accompanying statement of changes in net assets available for Plan benefits for the year ended December 31, 2009.

**NOTE 6 - FAIR VALUE MEASUREMENTS**

Authoritative accounting literature establishes a fair value hierarchy that prioritizes the inputs used to measure fair value based on observable and unobservable data. The hierarchy categorizes the inputs into three levels, with the highest priority given to unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest priority given to unobservable inputs (Level 3), as follows:

- Level 1 - Unadjusted quoted prices in active markets for identical assets or liabilities. An active market for the asset is defined as a market in which transactions for the asset or liability occur with sufficient frequency and volume to provide pricing information on an ongoing basis.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 6 - FAIR VALUE MEASUREMENTS**

- Level 2 - Inputs other than quoted prices included in Level 1 that are either directly or indirectly observable for the asset as of the reporting date. These inputs are derived principally from, or corroborated by, observable market data.
- Level 3 - Unobservable inputs that are supported by little, if any, market activity and are significant to the fair value of the assets as of the measurement date.

While the plan administrator believes that the valuation methods used 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.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2009 and 2008. As required by GAAP, assets are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

| Fair Value Measurement at December 31, 2009 |                         |                |                |              |
|---------------------------------------------|-------------------------|----------------|----------------|--------------|
|                                             | <u>Using Input Type</u> |                |                |              |
|                                             | <u>Level 1</u>          | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u> |
| Separate Account                            | \$ 2,495,960            | \$ -           | \$ -           | \$ 2,495,960 |
| Loans to participants                       | -                       | -              | 49,821         | 49,821       |
| Total investments                           | \$ 2,495,960            | \$ -           | \$ 49,821      | \$ 2,545,781 |

| Fair Value Measurement at December 31, 2008 |                         |                |                |              |
|---------------------------------------------|-------------------------|----------------|----------------|--------------|
|                                             | <u>Using Input Type</u> |                |                |              |
|                                             | <u>Level 1</u>          | <u>Level 2</u> | <u>Level 3</u> | <u>Total</u> |
| Mutual Funds                                | \$ 1,088,712            | \$ -           | \$ -           | \$ 1,088,712 |
| Loans to participants                       | -                       | -              | 39,491         | 39,491       |
| Total investments                           | \$ 1,088,712            | \$ -           | \$ 39,491      | \$ 1,128,203 |

For loans to participants measured at fair value on a recurring basis using significant unobservable inputs (Level 3) during 2009, the reconciliation of beginning and ending balances is as follows:

|                                                   |                  |
|---------------------------------------------------|------------------|
| Fair value at January 1, 2009                     | \$ 39,491        |
| Purchases, sales, issuances, and settlements, net | <u>10,330</u>    |
| Fair value at December 31, 2009                   | \$ <u>49,821</u> |

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 7 - INVESTMENTS**

The fair values of individual investments that represent 5% or more of the Plan's net assets are as follows:

|                                | <u>December 31</u> |             |
|--------------------------------|--------------------|-------------|
|                                | <u>2009</u>        | <u>2008</u> |
| MOA Interest Accumulation      | \$ 706,527         | \$ -*       |
| MOA Bond Fund                  | 576,920            | -*          |
| MOA Mid-Term Bond Fund         | 551,203            | -*          |
| Davis NY Venture Fund - R      | -*                 | 76,478      |
| Goldman Commodity Strat - A    | -*                 | 81,781      |
| Goldman Sachs Ret Strat 2010   | -*                 | 165,178     |
| Goldman Sachs Ret Strat 2040   | -*                 | 65,982      |
| Goldman Small/Mid Cap Gro - A  | -*                 | 66,239      |
| GS Core Fixed Income Fund - A  | -*                 | 115,147     |
| GS ILA Prima Obligations - Ser | -*                 | 152,926     |

\* For comparison purposes

During 2009, the Plan's investments (including interest, dividends, and gains and losses on investment bought and sold, as well as held during the year) appreciated in value by \$325,518.

**NOTE 8 - PARTY-IN-INTEREST TRANSACTIONS**

Certain Plan investments are managed by MOA, the trustee, as defined by the Plan. Therefore, these transactions qualify as party-in-interest and are denoted as such on the Supplemental Schedule H, line 4i – Schedule Assets (Held at End of Year). However, these party-in-interest transactions are exempt pursuant to ERISA regulations.

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 9 - RECONCILIATION OF THE FINANCIAL STATEMENTS TO THE FORM 5500**

The following is a reconciliation of net assets available for plan benefits reflected on the financial statements to the Form 5500 as of December 31:

|                                                                     | <u>2009</u>         | <u>2008</u>         |
|---------------------------------------------------------------------|---------------------|---------------------|
| Net assets available for plan benefits per the financial statements | \$ 3,274,010        | \$ 1,209,172        |
| Less: Receivables – employee contributions                          | (12,882)            | -                   |
| Less: Receivables – employer contributions                          | (8,820)             | (103,623)           |
| Add: Corrective distributions payable                               | <u>-</u>            | <u>22,654</u>       |
| Net assets available for plan benefits per the Form 5500            | \$ <u>3,252,308</u> | \$ <u>1,128,203</u> |

The following is a reconciliation of changes in net assets available for plan benefits reflected on the financial statements to the Form 5500 for the year ended December 31, 2009:

|                                                                                   |                     |
|-----------------------------------------------------------------------------------|---------------------|
| Net change in net assets available for plan benefits per the financial statements | \$ 2,064,838        |
| Add: Receivables – employer contributions at December 31, 2008                    | 103,623             |
| Less: Corrective distributions payable at December 31, 2008                       | (22,654)            |
| Less: Receivable – employee contributions at December 31, 2009                    | (12,882)            |
| Less: Receivables – employer contributions at December 31, 2009                   | <u>(8,820)</u>      |
| Net change in net assets available for plan benefits per the Form 5500            | \$ <u>2,124,105</u> |

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**SUPPLEMENTAL SCHEDULE**

**SCHEDULE H, LINE 4i –  
SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
AS OF DECEMBER 31, 2009**

| <u>(a)</u><br>Party-<br>in-<br>Interest | <u>(b)</u><br>Identity of Issuer,<br>Borrower, Lessor<br>or Similar Party | <u>(c)</u><br>Description of Investment, including<br>Maturity Date, Rate of Interest<br>Collateral, Par and Maturity Value | <u>(d)</u><br>Cost | <u>(e)</u><br>Current<br>Value |
|-----------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------------------|
| *                                       | General Account - Interest Accumulation                                   | Annual yield of interest is 3.00%                                                                                           | **                 | \$ 706,527                     |
| *                                       | Separate Account No. 1:                                                   |                                                                                                                             |                    |                                |
|                                         | American Century VP Capital Appre                                         | Mutual Fund - 2,281 shares                                                                                                  | **                 | 47,247                         |
|                                         | Calvert Social Balanced F                                                 | Mutual Fund - 518 shares                                                                                                    | **                 | 1,683                          |
|                                         | DWS Capital Growth                                                        | Mutual Fund - 869 shares                                                                                                    | **                 | 31,650                         |
|                                         | DWS International                                                         | Mutual Fund - 369 shares                                                                                                    | **                 | 6,862                          |
|                                         | Fidelity Investments VIP Contrafund                                       | Mutual Fund - 1,801 shares                                                                                                  | **                 | 70,442                         |
|                                         | Fidelity Investments VIP Eqty-Income                                      | Mutual Fund - 1,081 shares                                                                                                  | **                 | 38,517                         |
|                                         | Fidelity Investments VIP Mid Cap                                          | Mutual Fund - 2,505 shares                                                                                                  | **                 | 93,775                         |
|                                         | MOA 2010 Ret Fund                                                         | Mutual Fund - 19,339 shares                                                                                                 | **                 | 18,397                         |
|                                         | MOA 2015 Ret Fund                                                         | Mutual Fund - 99,657 shares                                                                                                 | **                 | 90,850                         |
|                                         | MOA 2020 Ret Fund                                                         | Mutual Fund - 64,166 shares                                                                                                 | **                 | 55,920                         |
|                                         | MOA 2025 Ret Fund                                                         | Mutual Fund - 23,785 shares                                                                                                 | **                 | 20,230                         |
|                                         | MOA 2030 Ret Fund                                                         | Mutual Fund - 46,598 shares                                                                                                 | **                 | 39,228                         |
|                                         | MOA 2035 Ret Fund                                                         | Mutual Fund - 86,857 shares                                                                                                 | **                 | 71,171                         |
|                                         | MOA 2040 Ret Fund                                                         | Mutual Fund - 142,811 shares                                                                                                | **                 | 116,001                        |
|                                         | MOA 2045 Ret Fund                                                         | Mutual Fund - 162,117 shares                                                                                                | **                 | 130,665                        |
|                                         | MOA Aggr Allocation                                                       | Mutual Fund - 46,537 shares                                                                                                 | **                 | 64,717                         |
|                                         | MOA All America Fund                                                      | Mutual Fund - 1,126 shares                                                                                                  | **                 | 23,905                         |
|                                         | MOA Bond Fund                                                             | Mutual Fund - 164,623 shares                                                                                                | **                 | 576,920                        |
|                                         | MOA Equity Index Fund                                                     | Mutual Fund - 35,371 shares                                                                                                 | **                 | 98,528                         |
|                                         | Mutual of America International Fund                                      | Mutual Fund - 1,257 shares                                                                                                  | **                 | 898                            |
|                                         | MOA Mid Cap Value Fund                                                    | Mutual Fund - 31,658 shares                                                                                                 | **                 | 32,061                         |
|                                         | MOA Mid Cap Equity Index                                                  | Mutual Fund - 32,460 shares                                                                                                 | **                 | 58,684                         |
|                                         | MOA Mid Term Bond Fund                                                    | Mutual Fund - 267,407 shares                                                                                                | **                 | 551,203                        |
|                                         | MOA Money Market Fund                                                     | Mutual Fund - 9,802 shares                                                                                                  | **                 | 19,536                         |
|                                         | MOA Ret Income Fund                                                       | Mutual Fund - 1,076 shares                                                                                                  | **                 | 1,110                          |
|                                         | MOA Small Cap Growth Fund                                                 | Mutual Fund - 65,494 shares                                                                                                 | **                 | 67,019                         |
|                                         | MOA Small Cap Value Fund                                                  | Mutual Fund - 61,178 shares                                                                                                 | **                 | 66,718                         |
|                                         | Oppenheimer Main Street VA                                                | Mutual Fund - 278 shares                                                                                                    | **                 | 5,519                          |
|                                         | Vanguard VIF Diversified Value                                            | Mutual Fund - 1,631 shares                                                                                                  | **                 | 22,530                         |
|                                         | Vanguard VIF International                                                | Mutual Fund - 3,789 shares                                                                                                  | **                 | 73,974                         |
|                                         |                                                                           |                                                                                                                             |                    | <u>2,495,960</u>               |

See independent auditors' report

**MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC's  
SAFE HARBOR 401(k) PROFIT-SHARING PLAN**

**SUPPLEMENTAL SCHEDULE - CONTINUED**

**SCHEDULE H, LINE 4i –  
SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
AS OF DECEMBER 31, 2009 - CONTINUED**

|    |                                                                        |                                                                        |   |                     |
|----|------------------------------------------------------------------------|------------------------------------------------------------------------|---|---------------------|
| *  | Participant loans                                                      | Interest ranging from 3.25% to<br>10.00%, maturing through May<br>2018 | - | <u>49,821</u>       |
| *  | Party-in-interest as defined by ERISA.                                 |                                                                        |   |                     |
| ** | Cost information has been omitted for participant-directed investments |                                                                        |   |                     |
|    |                                                                        |                                                                        |   | \$ <u>3,252,308</u> |

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

**Plan Name** MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC SAFE HARBOR 401K 33-0819654  
**Plan Sponsor's Name** MEMORIAL HEALTHCARE MANAGEMENT SERVICES, LLC **PN:** 001

| (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 |
|-----|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------|
| *   | Mutual of America                                         | GROUP ANNUITY CONTRACT<br>GENERAL ACCOUNT<br>Cost represents contrib.<br>remitted during<br>the current plan year                          | 282,234  | 706,527           |
| *   | Mutual of America                                         | GROUP ANNUITY CONTRACT<br>SEPARATE ACCOUNT<br>Cost represents contrib.<br>remitted during<br>the current plan year                         | 498,897  | 2,495,960         |
| *   | PARTICIPANT LOANS                                         | Represents outstanding<br>Participant Loan Balance<br>Current & Prior plan Yrs.<br>Highest Int. Charged 4.00%<br>Lowest Int. Charged 3.25% | 0        | 49,821            |
|     |                                                           |                                                                                                                                            |          |                   |
|     |                                                           |                                                                                                                                            |          |                   |
|     |                                                           |                                                                                                                                            |          |                   |
|     |                                                           |                                                                                                                                            |          |                   |
|     |                                                           |                                                                                                                                            |          |                   |