Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/2007

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
CHARLESTON HOSPITAL, INC.
ST. FRANCIS HOSPITAL

333 LAIDLEY STREET
CHARLESTON, WV 25322

2b Employer Identification Number (EIN) 61-1272692

2c Sponsor's telephone number 304-347-6633

2d Business code (see instructions) 622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2010	RENEE A. CROSS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2010	RENEEE A. CROSS
	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

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

333 LAIDLEY STREET
CHARLESTON, WV 25322

3b Administrator's EIN
61-1272692

3c Administrator's telephone number
304-347-6633

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	819
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	646
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	140
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	786
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	786
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	686
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

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

A Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

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
JOHN HANCOCK LIFE INSURANCE COMPANY U.S.A.

(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
01-0233346	65838	58654	752	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
16380	3858

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

WELLS FARGO INSURANCE
SERVICE OF WV, INC.
ONE HILLCREST DRIVE EAST
CHARLESTON, WV 25311

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
16380			3

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

DUNBAR, BENDER & ZAPF, INC.
FRICK BUILDING, SUITE 1100
437 GRANT STREET
PITTSBURGH, PA 15219

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	3824	TPA COMPENSATION NOT PAID FROM CONTRACT; PAID BY JOHN HANCOCK TO TPA	5

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

DUNBAR, BENDER & ZAPF, INC.

FRICK BUILDING, SUITE 1100
437 GRANT STREET
PITTSBURGH, PA 15219

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	34	TPA FEE	5

(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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	8734917

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

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

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

A Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

JOHN HANCOCK LIFE INSURANCE COMPANY

01-0233346

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

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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)

JOHN HANCOCK, USA

P. O. BOX 600
BUFFALO, NY 14201-0600

01-0233346

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 28 59 60 62 63 67	RECORDKEEPER	0	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

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

A Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: JH LIFESTYLE CONSERVATIVE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	432798

a Name of MTIA, CCT, PSA, or 103-12 IE: JH LIFESTYLE MODERATE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	755801

a Name of MTIA, CCT, PSA, or 103-12 IE: JH LIFESTYLE BALANCED

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	4105901

a Name of MTIA, CCT, PSA, or 103-12 IE: JH LIFESTYLE GROWTH

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	2203810

a Name of MTIA, CCT, PSA, or 103-12 IE: JH LIFESTYLE AGGRESSIVE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	455342

a Name of MTIA, CCT, PSA, or 103-12 IE: JH JOHN HANCOCK STABLE VAL

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	374923

a Name of MTIA, CCT, PSA, or 103-12 IE: JH PIMCO TOTAL RETURN

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

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)
01-0233346-000	P	16337

a Name of MTIA, CCT, PSA, or 103-12 IE: JH DAVIS NEW YORK VENTURE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 37725

a Name of MTIA, CCT, PSA, or 103-12 IE: JH MUTUAL DISCOVERY

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 12448

a Name of MTIA, CCT, PSA, or 103-12 IE: THE GROWTH FUND OF AMERICA

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 51862

a Name of MTIA, CCT, PSA, or 103-12 IE: JH BLACKROCK LARGE VALUE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 50550

a Name of MTIA, CCT, PSA, or 103-12 IE: RIVERSOURCE MID CAP VALUE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 30472

a Name of MTIA, CCT, PSA, or 103-12 IE: JH OPPENHEIMER GLOBAL

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 27103

a Name of MTIA, CCT, PSA, or 103-12 IE: EUROPACIFIC GROWTH FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 88264

a Name of MTIA, CCT, PSA, or 103-12 IE: DFA INTERNATIONAL VALUE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 10363

a Name of MTIA, CCT, PSA, or 103-12 IE: JH FRANKLIN SMALL-MID GROWTH

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 18064

a Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP VALUE FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 23837

a Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP OPPORTUNITIES FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 4284

a Name of MTIA, CCT, PSA, or 103-12 IE: MID CAP INDEX FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 916

a Name of MTIA, CCT, PSA, or 103-12 IE: MID CAP STOCK FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 11977

a Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP GROWTH FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 22141

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)

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

a Plan name

b Name of plan sponsor	**c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

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

A Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		36210
(2) Participant contributions	1b(2)		49277
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	5059073	8734917
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	5059073	8820404
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	5059073	8820404

Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
a	**Contributions:**			
	(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	929359	
	(B) Participants	2a(1)(B)	1283166	
	(C) Others (including rollovers)	2a(1)(C)	5116	
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		2217641
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1905162
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		4122803
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	349396	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		349396
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	12076	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		12076
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		361472
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		3761331
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [ ] Unqualified (2) [ ] Qualified (3) [X] Disclaimer (4) [ ] Adverse

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

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

(1) Name: ARNETT & FOSTER, PLLC (2) EIN: 55-0486667

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		10000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

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

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

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

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

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

A Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Distributions

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1**

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 01-0233346

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year. **3**

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year **6a**

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

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c**

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☐ **Yes** ☐ **No** ☐ **N/A**

Part III Amendments

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

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

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ..... ☐ **Yes** ☐ **No**

11 a Does the ESOP hold any preferred stock? ..... ☐ **Yes** ☐ **No**

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ..... ☐ **Yes** ☐ **No**

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ..... ☐ **Yes** ☐ **No**

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):

---

a Name of contributing employer

b EIN **c** Dollar amount contributed by employer

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

e Contribution rate information *(If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

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

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

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

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

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

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

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

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

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

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

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

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

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

C.H.I. d/b/a ST. FRANCIS HOSPITAL
401(k) PLAN

Financial Report

December 31, 2009

ARNETT & FOSTER
Certified Public Accountants, P.L.L.C.

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ARNETT & FOSTER
Certified Public Accountants, P.L.L.C.

INDEPENDENT AUDITOR'S REPORT

To the Plan Trustees and Plan Administrator
C.H.I. d/b/a St. Francis Hospital 401(k) Plan
Charleston, West Virginia

We were engaged to audit the accompanying statements of net assets available for benefits for C.H.I. d/b/a St. Francis Hospital 401(k) Plan (the Plan) as of December 31, 2009 and 2008, and the related statements of changes in net assets available for benefits for the years then ended, and the supplemental 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 United States 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 investment information summarized in Note 6 to the financial statements, which was certified by John Hancock Life Insurance Company (USA), the custodian 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 the custodian holds the Plan's investment assets and executes investment transactions. As disclosed in Note 6, the plan administrator has obtained certifications from the custodian regarding the completeness and accuracy of the investment information provided to the plan administrator by the custodian as of and for the years ended December 31, 2009 and 2008.

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 custodian, 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 United States Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

ARNETT & FOSTER, P.L.L.C.

Arnett + Foster, P.L.L.C.

Charleston, West Virginia
October 11, 2010

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2009 and 2008

	2009	2008
ASSETS		
Investments at fair value	**$ 8,734,917**	$ 5,059,073
Contribution receivable:		
Employer contribution	**36,210**	-
Employee contribution	**49,277**	-
	85,487	-
Total assets	**8,820,404**	5,059,073
LIABILITIES	**-**	-
NET ASSETS AVAILABLE FOR BENEFITS	**$ 8,820,404**	$ 5,059,073

See Notes to Financial Statements

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years ended December 31, 2009 and 2008

	2009	2008
Additions to net assets attributed to:		
Net appreciation in fair value of investments	**$ 1,905,162**	$ -
Contributions:		
Employer	**929,359**	922,368
Participant	**1,283,166**	1,293,901
Rollovers from other qualified plans	**5,116**	91,515
	2,217,641	2,307,784
Total additions	**4,122,803**	2,307,784
Deductions from net assets attributed to:		
Net depreciation in fair value of investments	**-**	1,947,802
Benefits paid to participants	**349,396**	216,256
Administrative expenses	**12,076**	9,285
Total deductions	**361,472**	2,173,343
Net increase	**3,761,331**	134,441
Net assets available for benefits:		
Beginning of year	**5,059,073**	4,924,632
Ending of year	**$ 8,820,404**	$ 5,059,073

See Notes to Financial Statements

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS

Note 1. Description of Plan

Plan description: The following description of the C.H.I. d/b/a St. Francis Hospital 401(k) Plan (the Plan), provides only general information. Participants should refer to the Plan document for more complete information.

General: The Plan, which was established January 1, 2007 is a defined contribution 401(k) safe harbor plan covering all employees who have attained age 21 and who have 90 days of service. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Amendments: The Plan was amended January 3, 2007, effective January 1, 2007, to adopt the following provisions:

(1) To adopt the provisions of the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA).
(2) To adopt POST-EGTRRA amendments to allow catch-up contributions, revision of Section 402(g) as it relates to a hardship distribution and clarification on definition of compensation in regards to Section 125.
(3) To allow for Roth elective deferrals.

The Plan was restated effective January 1, 2010 to incorporate the above provisions and modify eligibility to those who have attained age 18 and who have 90 days of service.

Contributions: Participants may elect to defer a portion of their compensation, as defined in the Plan document, limited to the maximum allowed under the Internal Revenue Code for such Plan year. The employer's matching contribution is an Enhanced Safe Harbor Matching Contribution which is an amount equal to 100% of the participant's deferral contributions up to 4% of participant's compensation and an additional 50% of the participants' elective deferrals from 4% to 6% of participant's compensation.

The Plan allows rollovers from other qualified plans.

Participant investment options: Each Plan participant has the right to direct contributions and earnings of their account among alternative investment funds provided under the Plan. Participants should refer to the most recent annual report of each investment fund for information on risk factors, asset concentrations, use of derivative financial instruments and other financial data. Participants may transfer funds between investment options at any time.

Participant accounts: Each participant account is credited with the participant's elective deferrals, participant rollover contributions and any employer contributions. In addition, each participant's account is credited with their share of appreciation/depreciation in the value of investments and charged with an allocation of administrative expenses. The benefit to which a participant is entitled is the benefit that can be provided from the participant's account.

Vesting: Participants are immediately vested in deferral and employer contributions and actual earnings thereon which are credited to their respective account.

Payment of benefits: Upon retirement (normal retirement age is 65), death, disability or other termination of employment, as defined in the Plan document, participants or their spouses and/or beneficiaries receive their account as a lump sum cash payment. If the participant's account balance has never exceeded $1,000, the entire vested balance will be paid in a lump sum. Early retirement is permitted if the participant has attained age 60 and has completed five years of service. Further, upon termination of employment, the participant may elect to transfer his or her account balances to another qualified plan or individual retirement account. Minimum distributions for a participant must begin the later of April 1 of the calendar year after a participant attains age 70½ or when the participant actually retires.

The Plan allows for hardship withdrawals for certain participant needs as defined in the Plan document from participant elective contributions, Roth deferrals and related earnings. The employer has sole authority to authorize hardship withdrawals, pursuant to the Plan specifications.

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS

Note 2. Significant accounting policies

The accounting and reporting policies of the Plan conform to accounting principles generally accepted in the United States of America and to general practices within the employee benefit plan industry. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates. The principles and policies which significantly affect the determination of net assets and the changes in net assets are summarized below.

Basis of accounting: The financial statements of the Plan are prepared on the accrual basis of accounting.

Investment valuation and income recognition: Pursuant to provisions under the Plan's contract with John Hancock Life Insurance Company (USA), Plan assets are invested in various pooled separate accounts.

The value of a unit in a pooled separate account is the fair market value of investments in the account as of the valuation date, plus cash balances and accruals less accounts payable, expenses and taxes that are allocable to the account, divided by the number of outstanding participation units in the account. Securities held in the pooled separate accounts are valued based on quoted market prices. If there is no readily available market value for a particular security, the investment manager will determine the fair market value of such investment in accordance with accepted practices and applicable laws and regulations. As of any date, the value of the Plan's share of a separate account will equal the number of participation units held by the Plan multiplied by the participation unit value.

The Plan does not require collateral to secure investment instruments.

Payment of benefits: Benefit payments are recorded upon distribution.

Significant New Accounting Pronouncements

The Financial Accounting Standards Board's (FASB) Accounting Standards Codification ("ASC") became effective on July 1, 2009. At that date, the ASC became the officially recognized source of authoritative accounting principles recognized by the FASB to be applied by non-governmental entities in the preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP). All guidance contained in the ASC carries an equal level of authority. All non-grandfathered, non-SEC accounting literature not included in the ASC is superseded and deemed non-authoritative. The switch to the ASC affects the way Plans refer to U.S. GAAP in financial statements and accounting policies. Citing particular content in the ASC involves specifying the unique numeric path to the content through the Topic, Subtopic, Section and Paragraph structure.

New authoritative accounting guidance under ASC Topic 855, *Subsequent Events,* establishes general standards of accounting for and disclosure of events occurring subsequent to the statement of net assets available for benefit date. It does not change the definition of a subsequent event (i.e. an event or transaction that occurs after the statement of net assets available for benefit date but before the financial statements are issued) but requires disclosure of the date through which subsequent events were evaluated when determining whether adjustment to or disclosure in the financial statements is required. The new authoritative guidance under ASC Topic 855 was effective in 2009 and did not affect the Plan's statement of net assets available for benefits or statement of changes in net assets available for benefits. The Plan has evaluated subsequent events through October 11, 2010, the date the financial statements were available to be issued.

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS

Note 3. Tax Status

The Plan has adopted the Dpb&z Inc., Prototype Non-Standardized Profit-Sharing Plan with CODA. Dpb&z has received a determination letter dated August 7, 2001 that the prototype plan and related amendments qualify under Internal Revenue Code Section 401(a). An employer who has adopted the prototype plan will also be considered to have a plan qualified under Section 401(a) provided all of the terms of the plan are followed, and the eligibility requirements and contribution or benefit provisions are not more favorable for highly compensated employees than other employees. The Plan has been restated since the date of the determination letter; however, the Plan Administrator believes that the C.H.I. d/b/a St. Francis Hospital 401(k) Plan is currently being operated in compliance with the aforementioned prototype plan and applicable provisions of the Internal Revenue Code.

Note 4. Plan Termination

The Plan Sponsor has the right under the Plan to terminate the Plan subject to the provisions of ERISA. In the event of plan termination, participant accounts will become fully vested and nonforfeitable.

Note 5. Parties-in-Interest and Related Party Transactions

Parties-in-interest are defined under United States Department of Labor Regulations as any fiduciary of the Plan, any party rendering service to the Plan, and certain others. The Plan Sponsor has contracted with John Hancock Life Insurance Company (USA) to administer the Plan assets. Administrative functions include participant account maintenance, and custodial services. During the years ended December 31, 2009 and 2008, fees for these services were $12,076 and $9,285, respectively. Certain other administrative expenses for legal, auditing, and other professional services are paid directly by the Plan Sponsor and certain administrative functions are performed by officers or employees of the Plan Sponsor at no cost to the Plan.

Note 6. Investment Information

Investment Information Certified by the Plan Custodian: For the years ended December 31, 2009 and 2008, John Hancock Life Insurance Company (USA) (John Hancock), custodian of the Plan, held the assets of Plan participants and executed transactions therein. Such investment assets were participant directed. Financial information relating to investment assets is included in the accompanying financial statements based on information certified by the custodian. That information, which has not been audited by independent auditors, is summarized as follows. Investments that represent 5% or more of the Plan's net assets are separately identified.

	2009	2008
John Hancock Life Insurance Company (USA) – JH Lifestyle Moderate Fund	**$ 755,801**	$ 482,139
John Hancock Life Insurance Company (USA) – JH Lifestyle Balanced Fund	**4,105,901**	2,373,085
John Hancock Life Insurance Company (USA) – JH Lifestyle Growth Fund	**2,203,810**	1,254,508
John Hancock Life Insurance Company (USA) – JH Lifestyle Aggressive Fund	**455,342**	**
John Hancock Life Insurance Company (USA) – JH Lifestyle Conservative Fund	**	264,501
John Hancock Life Insurance Company (USA) – JH Stable Value Fund	**	260,992
Others, none in excess of 5% of net assets	**1,214,063**	423,848
Total investments	**$ 8,734,917**	$ 5,059,073

** Investment was not in excess of 5% of net assets at year end.

Other Investment Information Certified by Custodian: During the years ended December 31, 2009 and 2008, the Plan's investments with John Hancock appreciated (depreciated) in value by $1,905,162 and $(1,947,802), respectively.

Note 7. Fair Value Measurement

ASC Topic 820 *"Fair Value Measurements and Disclosure"* (ASC 820), establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under ASC 820 are described below:

Level 1:	Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.
Level 2:	Inputs to the valuation methodology include: • Quoted prices for similar assets or liabilities in active markets; • Quoted prices for identical or similar assets or liabilities in inactive markets; • Inputs other than quoted prices that are observable for the asset or liability; • Inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.
Level 3:	Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value.

Pooled separate accounts, valued at the net asset value of units held by the Plan at year end.

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

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:

	Assets at Fair Value as of December 31, 2009			
	Level 1	**Level 2**	**Level 3**	**Total**
Small Cap Equities	**$ -**	**$ 50,262**	**$ -**	**$ 50,262**
Mid Cap Equities	**-**	**61,428**	**-**	**61,428**
Large Cap Equities	**-**	**2,799,289**	**-**	**2,799,289**
Conservative	**-**	**1,563,522**	**-**	**1,563,522**
Moderate	**-**	**4,105,901**	**-**	**4,105,901**
Bonds	**-**	**16,337**	**-**	**16,337**
World	**-**	**39,551**	**-**	**39,551**
Foreign	**-**	**98,627**	**-**	**98,627**
Total assets at fair value	**$ -**	**$ 8,734,917**	**$ -**	**$ 8,734,917**

	Assets at Fair Value as of December 31, 2008			
	Level 1	Level 2	Level 3	Total
Small Cap Equities	$ -	$ 20,010	$ -	$ 20,010
Mid Cap Equities	-	27,206	-	27,206
Large Cap Equities	-	1,555,816	-	1,555,816
Conservative	-	1,007,632	-	1,007,632
Moderate	-	2,373,085	-	2,373,085
Bonds	-	9,179	-	9,179
World	-	18,687	-	18,687
Foreign	-	47,458	-	47,458
Total assets at fair value	$ -	$ 5,059,073	$ -	$ 5,059,073

Note 8. Risks and Uncertainties

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

Note 9. Subsequent Events

The Plan was amended effective August 25, 2010, to modify the definition of compensation to exclude bonuses, as well as cash-ins and contributions for compensated absences.

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN
EIN: 61-1272692

SUPPLEMENTARY INFORMATION
SCHEDULE H, Line 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
December 31, 2009

	(a)	(b) Identity of Issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or market value	(d) Cost	(e) Current Value
		Pooled separate accounts with John Hancock Life Insurance Company (U.S.A.):			
*		John Hancock Life Insurance Company (USA)	JH Lifestyle Conservative Fund	**	432,798
*		John Hancock Life Insurance Company (USA)	JH Lifestyle Moderate Fund	**	755,801
*		John Hancock Life Insurance Company (USA)	JH Lifestyle Balanced Fund	**	4,105,901
*		John Hancock Life Insurance Company (USA)	JH Lifestyle Growth Fund	**	2,203,810
*		John Hancock Life Insurance Company (USA)	JH Lifestyle Aggressive Fund	**	455,342
*		John Hancock Life Insurance Company (USA)	JH Stable Value Fund	**	374,923
*		John Hancock Life Insurance Company (USA)	JH RiverSource Mid Cap Value	**	30,471
*		John Hancock Life Insurance Company (USA)	JH American Funds Growth	**	51,862
*		John Hancock Life Insurance Company (USA)	JH PIMCO Total Return Fund	**	16,337
*		John Hancock Life Insurance Company (USA)	JH Davis New York Venture Fund	**	37,725
*		John Hancock Life Insurance Company (USA)	JH Franklin Small Mid Growth Fund	**	18,064
*		John Hancock Life Insurance Company (USA)	JH Mutual Discovery Fund	**	12,448
*		John Hancock Life Insurance Company (USA)	JH Blackrock Large Value Fund	**	50,550
*		John Hancock Life Insurance Company (USA)	JH Oppenheimer Global Fund	**	27,103
*		John Hancock Life Insurance Company (USA)	JH American Funds EuroPacific Fund	**	88,264
*		John Hancock Life Insurance Company (USA)	JH Small Cap Fund	**	22,141
*		John Hancock Life Insurance Company (USA)	Small Cap Value Fund	**	23,837
*		John Hancock Life Insurance Company (USA)	Small Cap Opportunities Fund	**	4,284
*		John Hancock Life Insurance Company (USA)	Mid Cap Index Fund	**	916
*		John Hancock Life Insurance Company (USA)	DFA International Value	**	10,363
*		John Hancock Life Insurance Company (USA)	Mid Cap Stock Fund	**	11,977
		Total pooled separate accounts with John Hancock Life Insurance Company (U.S.A.)			8,734,917
		Total investments			$ 8,734,917

* Denotes issuer or sponsor considered to be a party-in-interest to the Plan.

** Historical cost information is not required to be presented for participant directed investments.

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

Plan Name C.H.I. d/b/a St. Francis Hospital 401 (k) Plan **EIN:** 61-1272692
Plan Sponsor's Name Charleston Hospital, Inc. **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
*	JOHN HANCOCK USA	JH LIFESTYLE CONSRRVATIVE		432,798
*	JOHN HANCOCK USA	JH LIFESTYLE MODERATE		755,801
*	JOHN HANCOCK USA	JH LIFESTYLE BALANCED		4,105,901
*	JOHN HANCOCK USA	JH LIFESTYLE GROWTH		2,203,810
*	JOHN HANCOCK USA	JH LIFESTYLE AGGRESSIVE		455,342
*	JOHN HANCOCK USA	JH JOHN HANCOCK STABLE VAL		374,923
*	JOHN HANCOCK USA	JH PIMCO TOTAL RETURN		16,337

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

Plan Name C.H.I. d/b/a St. Francis Hospital 401 (k) Plan **EIN:** 61-1272692
Plan Sponsor's Name Charleston Hospital, Inc. **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
*	JOHN HANCOCK USA	JH DAVIS NEW YORK VENTURE		37,725
*	JOHN HANCOCK USA	JH MUTUAL GLOBAL DISCOVERY		12,448
*	JOHN HANCOCK USA	JH RIVERSOURCE MID CAP VALUE		30,471
*	JOHN HANCOCK USA	JH BLACKROCK LARGE VALUE		50,550
*	JOHN HANCOCK USA	JH AMERICAN FUNDS GROWTH FUND		51,862
*	JOHN HANCOCK USA	JH OPPENHEIMER GLOBAL		27,103
*	JOHN HANCOCK USA	JH AMERICAN FUNDS EUROPACIFIC		88,264

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

Plan Name C.H.I. d/b/a St. Francis Hospital 401 (k) Plan **EIN:** 61-1272692
Plan Sponsor's Name Charleston Hospital, Inc. **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
*	JOHN HANCOCK USA	DFA INTERNATIONAL VALUE		10,363
*	JOHN HANCOCK USA	JH FRANKLIN SMALL-MID GROWTH		18,064
*	JOHN HANCOCK USA	SMALL CAP VALUE FUND		23,837
*	JOHN HANCOCK USA	SMALL CAP OPPORTUNITIES FUND		4,284
*	JOHN HANCOCK USA	MID CAP INDEX FUND		916
*	JOHN HANCOCK USA	MID CAP STOCK FUND		11,977
*	JOHN HANCOCK USA	SMALL CAP GROWTH FUND		22,141