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
THOMPSON HEALTH 403B PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/1992

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
FF THOMPSON HEALTH SYSTEM INC

350 PARRISH STREET
CANANDAIGUA, NY 14424-1731

SAME
CANANDAIGUA, NY 14424-1731

2b Employer Identification Number (EIN)
16-0743024

2c Sponsor's telephone number
585-396-6681

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.	10/15/2010	MARK PRUNOSKE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	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")
FF THOMPSON HEALTH SYSTEM INC

350 PARRISH STREET
CANANDAIGUA, NY 14424-1731

3b Administrator's EIN
16-0743024

3c Administrator's telephone number
585-396-6681

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**	789
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**	658
b	Retired or separated participants receiving benefits	**6b**	1
c	Other retired or separated participants entitled to future benefits	**6c**	204
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	863
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	1
f	Total. Add lines **6d** and **6e**	**6f**	864
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	699
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:
2F 2G 2K 2L 2T 3D

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)	X	Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

SCHEDULE A (Form 5500)

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
THOMPSON HEALTH 403B PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500.
FF THOMPSON HEALTH SYSTEM INC

D Employer Identification Number (EIN)
16-0743024

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
LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

(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
22-0832760	60139	19403+030	103	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	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
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(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	748375
5	Current value of plan's interest under this contract in separate accounts at year end	5	716525

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶ ON FILE

b	Premiums paid to carrier	6b	0
c	Premiums due but unpaid at the end of the year	6c	0
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	0

Specify nature of costs ▶

e Type of contract: (1) [X] 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) [X] guaranteed investment (4) [ ] other ▶

b	Balance at the end of the previous year			7b	773109
c	Additions: (1) Contributions deposited during the year	7c(1)	0		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	32047		
	(4) Transferred from separate account	7c(4)	0		
	(5) Other (specify below)	7c(5)	28921		
	▶ LOAN PYMTS, FORFEITURES, TAKEOVERS, AND/OR ADJUSTMENTS				
	(6) Total additions			7c(6)	60968
d	Total of balance and additions (add **b** and **c(6)**)			7d	834077
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	23318		
	(2) Administration charge made by carrier	7e(2)	0		
	(3) Transferred to separate account	7e(3)	0		
	(4) Other (specify below)	7e(4)	62384		
	▶ LOANS ISSUED FORFEITURES, FEES, CORRECTIVES AND/OR ADJUSTMENTS				
	(5) Total deductions			7e(5)	85702
f	Balance at the end of the current year (subtract **e(5)** from **d**)			7f	748375

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
THOMPSON HEALTH 403B PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
FF THOMPSON HEALTH SYSTEM INC

D Employer Identification Number (EIN)
16-0743024

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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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)

NATIONWIDE

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

31-1592130

(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?
13 15 37 50 60 63 64	NONE	62669	Yes [X] No [ ]	Yes [ ] No [X]	31894	Yes [ ] No [X]

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

P & A RETIREMENT PLAN SERVICES INC

17 COURT STREET SUITE 500
BUFFALO, NY 14202-3204

16-1168903

(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?
13 15 37 50 64	NONE	17987	Yes [X] No [ ]	Yes [ ] No [X]	11125	Yes [ ] No [X]

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

COMMONWEALTH FINANCIAL NETWORK

29 SAWYER ROAD
ONE UNIVERSITY PARK
WALTHAM, MA 02453-3423

(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?
26 27	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	62252	Yes [ ] No [X]

(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
P & A RETIREMENT PLAN SERVICES INC	15 37 64	11125

(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.
NATIONWIDE ONE NATIONWIDE PLAZA COLUMBUS, OH 43215 31-1592130	ADMINISTRATIV SERVICES FEE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
COMMONWEALTH FINANCIAL NETWORK	26 27	62252

(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.
NATIONWIDE ONE NATIONWIDE PLAZA COLUMBUS, OH 43215 31-1592130	COMPENSATION

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	2149

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN CENTURY INVESTMENTS P O BOX 419200 KANSAS CITY, MO 64141-6200	MUTUAL FUND PAYMENTS

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
NATIONWIDE	60 63	1642

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN FUNDS GROUP P O BOX 2280 NORFOLK, VA 23501-2280	MUTUAL FUND PAYMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	2350

(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.
DAVIS FUNDS P O BOX 8406 BOSTON, MA 02266-8409	MUTUAL FUND PAYMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	1681

(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.
DWS INVESTMENTS P O BOX 219151 KANSAS CITY, MO 64121-9151	MUTUAL FUND PAYMENTS

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
NATIONWIDE	60 63	1513

(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.
EAGLE FAMILY OF FUNDS 880 CARILLON PARKWAY ST PETERSBURG, FL 33716	MUTUAL FUND PAYMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	2334

(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.
EATON VANCE FUNDS P O BOX 9653 PROVIDENCE, RI 02940-9653	MUTUAL FUND PAYMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	3397

(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.
LOOMIS SAYLES & COMPANY LP ONE FINANCIAL CENTER BOSTON, MA 02111	MUTUTAL FUND PAYMENTS

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
NATIONWIDE	60 63	7313

(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.
PIMCO FUNDS	840 NEWPORT CENTER DRIVE SUITE 100 NEWPORT BEACH, CA 92660	MUTUATL FUND PAYMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	3711

(d) Enter name and EIN (address) of source of indirect compensation		**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
T ROWE PRICE	100 EAST PRATT STREET BALTIMORE, MD 21202	MUTUTAL FUND PAYMENTS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NATIONWIDE	60 63	2439

(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.
WADDELL & REED INC	6300 LAMAR AVENUE P O BOX 29217 SHAWNEE MISSION, KS 66201-9217	MUTUTAL FUND PAYMENTS

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

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

A Name of plan
THOMPSON HEALTH 403B PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
FF THOMPSON HEALTH SYSTEM INC

D Employer Identification Number (EIN)
16-0743024

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	468613	500274
(2) Participant contributions	1b(2)	94955	93855
(3) Other	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	2075791	1924051
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	2143665	3114612
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	314629	349139
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	14344652	20183139
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	773109	748375
(15) Other	1c(15)	0	0

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	20215414	26913445
Liabilities			
g Benefit claims payable	1g	0	0
h Operating payables	1h	0	0
i Acquisition indebtedness	1i	0	0
j Other liabilities	1j	0	0
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	20215414	26913445

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)	500274	
(B) Participants	2a(1)(B)	2455609	
(C) Others (including rollovers)	2a(1)(C)	132107	
(2) Noncash contributions	2a(2)	0	
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		3087990
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	0	
(B) U.S. Government securities	2b(1)(B)	0	
(C) Corporate debt instruments	2b(1)(C)	0	
(D) Loans (other than to participants)	2b(1)(D)	0	
(E) Participant loans	2b(1)(E)	21565	
(F) Other	2b(1)(F)	0	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		21565
(2) Dividends: **(A)** Preferred stock	2b(2)(A)	0	
(B) Common stock	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	438816	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		438816
(3) Rents	2b(3)		0
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
(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)	0	
	(B) Other	2b(5)(B)	0	
	(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)		0
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)		32047
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)		0
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		0
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		4400114
c	Other income	2c		0
d	Total income. Add all **income** amounts in column (b) and enter total	2d		7980532
	Expenses			
e	Benefit payment and payments to provide benefits:			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1137931	
	(2) To insurance carriers for the provision of benefits	2e(2)	0	
	(3) Other	2e(3)	0	
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		1137931
f	Corrective distributions (see instructions)	2f		0
g	Certain deemed distributions of participant loans (see instructions)	2g		63914
h	Interest expense	2h		0
i	Administrative expenses: (1) Professional fees	2i(1)	0	
	(2) Contract administrator fees	2i(2)	80656	
	(3) Investment advisory and management fees	2i(3)	0	
	(4) Other	2i(4)	0	
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		80656
j	Total expenses. Add all **expense** amounts in column (b) and enter total	2j		1282501
	Net Income and Reconciliation			
k	Net income (loss). Subtract line 2j from line 2d	2k		6698031
l	Transfers of assets:			
	(1) To this plan	2l(1)		0
	(2) From this plan	2l(2)		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)** [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: EFP ROTENBERG LLP **(2)** EIN: 26-4298079

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		3000000
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
THOMPSON HEALTH 403B PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
FF THOMPSON HEALTH SYSTEM INC

D Employer Identification Number (EIN)
16-0743024

Part I Distributions

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1** 0

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

EIN(s): 31-1592130 22-0832760

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** 46

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):

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):

THOMPSON HEALTH 403(b) PLAN

FINANCIAL STATEMENTS

DECEMBER 31, 2009

Certified Public Accountants | 280 Kenneth Drive, Suite 100 | Rochester, New York 14623 | 585.427.8900 | EFPRotenberg.com

EFP ROTENBERG
what counts

INDEPENDENT AUDITORS' REPORT

Thompson Health 403(b) Plan
Canandaigua, New York

We were engaged to audit the accompanying statements of net assets available for benefits of Thompson Health 403(b) Plan (the Plan) as of December 31, 2009 and 2008, the related statement of changes in net assets available for benefits for the year ended December 31, 2009, 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 Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by Nationwide Trust Company, FSB and Lincoln Life and Annuity Company of New York, the custodians 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 custodians hold the Plan's investment assets and execute investment transactions. The Plan administrator has obtained certifications from the custodians as of and for the years ended December 31, 2009 and 2008, that the information provided to the Plan administrator by the custodians 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 custodians, 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.

EFP Rotenberg, LLP

EFP Rotenberg, LLP
Rochester, New York
October 14, 2010

THOMPSON HEALTH 403(b) PLAN
Statements of Net Assets Available for Benefits
December 31, 2009 and 2008

	2009	2008
ASSETS		
Investments, at Fair Value		
Cash and cash equivalents	$ 1,924,051	$ 2,075,791
Group variable annuity	748,375	773,109
Pooled separate accounts	716,525	608,224
Mutual funds	22,581,226	15,880,093
Participant loans	349,139	314,629
Total investments, at fair value	26,319,316	19,651,846
Receivables		
Employer's contributions	500,274	468,613
Participants' contributions	93,855	94,955
Total receivables	594,129	563,568
Total Assets	26,913,445	20,215,414
Net Assets Available for Benefits	$ 26,913,445	$ 20,215,414

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

THOMPSON HEALTH 403(b) PLAN
Statement of Changes in Net Assets Available for Benefits
For the Year Ended December 31, 2009

	2009
Additions to Net Assets	
Investment income	
Net gain in fair value of investments	$ 4,432,161
Dividend income	438,816
Interest income	21,565
Net investment income	4,892,542
Contributions	
Participants'	2,455,609
Employer's	500,274
Rollovers	132,107
Total contributions	3,087,990
Total additions	7,980,532
Deductions from Net Assets	
Benefits paid to participants	1,201,845
Administrative expenses	80,656
Total deductions	1,282,501
Net Change in Net Assets	6,698,031
Net Assets Available for Benefits - Beginning	20,215,414
Net Assets Available for Benefits - Ending	$ 26,913,445

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

Note 1. **Description of Plan** - The following description of the Thompson Health 403(b) Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General - The Plan is a defined contribution plan covering all employees of Thompson Health (the Company). There is no minimum age or service requirements for participation in the Employee Elective Deferral Contributions of the Plan. Employees with one year and 1000 hours of service are eligible for the employer match. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions - Eligible participants may defer up to $16,500 of their pre-tax annual compensation, as defined in the Plan, as a qualified pre-tax contribution subject to maximum annual dollar contribution restrictions of PPA and the Internal Revenue Service. Participants may also contribute amounts representing distributions from other qualified defined benefit or contribution plans. Employer contributions are equal to a discretionary percentage, to be determined by the Company, of the participants' contributions. All employer contributions are invested in the same allocation as participant contributions. All contributions are participant directed.

Participant Accounts - Each participant's account is credited with the participant's contribution and allocations of (a) the Company's contribution, (b) plan earnings, and (c) charged with an allocation of administrative expenses. Allocations are based on participant balances or number of participants in the plan, as defined, depending on the nature of the item. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting - Participants are immediately vested in their contributions and the contributions of the Company plus actual earnings thereon.

Payment of Benefits - On termination of service due to death, disability, or retirement, a participant may elect to receive either (a) an annuity option of qualified joint and 50%, 75% or 100% survivor annuity for married participants and a single life annuity for unmarried participants, (b) a lump-sum amount equal to the value of the participant's vested interest in his or her account, or (c) annual installments over a period not to exceed the joint life expectancy of the participant and spouse. For termination of service due to other reasons, a participant may receive the value of the vested interest in his or her account as a lump-sum distribution.

Administrative Expenses - Administrative expenses are paid for by the Plan.

Note 2. **Summary of Significant Accounting Policies**

Basis of Accounting - The financial statements of the Plan are prepared using the accrual method of accounting.

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

Investment Valuation and Income Recognition - The Plan's mutual funds are stated at fair market value using quoted market prices in an active market. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis.

Pooled separate accounts and group variable annuities are not traded in an active market, but instead are valued using the Net Asset Value provided by the administrator of the fund. The unit price is based on underlying investments which are traded in an active market.

Participant loans are valued at amortized cost, which approximates fair value.

Payments of Benefits - Benefit payments to participants are recorded when paid.

Subsequent Events - On May 28, 2009, the FASB issued ASC 855-10 (formerly: SFAS No. 165 "Subsequent Events"). ASC 855-10 provides guidance on management's assessment of subsequent events and requires additional disclosure about the timing of management's assessment of subsequent events. It does not significantly change the accounting requirements for the reporting of subsequent events. ASC 855-10 is effective for interim or annual financial reporting periods ending after June 15, 2009. The Plan adopted ASC 855-10 as of December 31, 2009 and accordingly assessed subsequent events in these annual financial statements from December 31, 2009 through October 14, 2010, the date these financial statements were available to be issued. The adoption of this standard did not materially impact the Plan's statement of net assets available for benefits, statement of changes in net assets available for benefits or disclosures in the financial statements.

Note 3. Information Prepared and Certified by the Custodians

The Plan administrator has obtained certifications from Nationwide Trust Company, FSB and Lincoln Life and Annuity Company of New York, Plan custodians, that the following information is complete and accurate at and as of December 31:

	2009	2008
Cash and cash equivalents	$ 1,924,051	$ 2,075,791
Group variable annuity	748,375	773,109
Pooled separate accounts	716,525	608,224
Mutual funds	22,581,226	15,880,093
Participant loans	349,139	314,629
Investment income (loss)	$ 4,892,542	$ (6,991,536)

Note 4. Investments

Investments that represent 5% or more of the Plan's net assets available for benefits are separately identified below. Investments consisted of the following:

	2009	2008
Nationwide Money Market Instl	$ 1,924,051	$ 2,075,791
American Funds Capital World G/I R5	$ 1,526,009	$ 1,068,184
American Funds Growth Fund of Amer R5	$ 1,371,723	$ 791,723
Nationwide Inv Destination Mod Svc	$ 4,166,174	$ 3,645,323
Nationwide Inv Destination Mod Aggressive Svc	$ 3,883,219	$ 2,689,616

Note 5. Related Party Transactions

Certain Plan investments are managed by Nationwide Trust Company, FSB and Lincoln Life and Annuity Company of New York. These are the custodians as defined by the Plan and, therefore, these transactions qualify as party-in-interest transactions. Participant loans also qualify as party-in-interest transactions. These transactions qualify as non-prohibited party-in-interest transactions.

Note 6. Net Asset Value (NAV) Per Share

In accordance with ASU No. 2009-12, the Plan expanded its disclosures to include the category, fair value, redemption frequency, and redemption notice period for those assets whose fair value is estimated using the net asset value per share or its equivalent for which the fair value is not readily determinable, as of December 31, 2009. For the Plan, such as assets include investments in pooled separate accounts and group variable annuities.

The following table for December 31, 2009, sets forth a summary of the Plan's investments with a reported NAV.

	Fair Value Estimated Using Net Asset Value per Share December 31, 2009	
	Fair Value*	Unfunded Commitment
Investment		
Equity funds - domestic[(a)]	$ 557,484	$ -
Equity funds - international[(b)]	35,288	-
Equity index funds[(c)]	123,753	-
Stable value fund[(d)]	748,375	-
Total	$ 1,464,900	$ -

* The fair values of the investments have been estimated using the net asset value of the investment.

(a) Equity funds - domestic strategies seek to invest in a diversified portfolio of common stocks.

(b) Equity funds - international strategies seek long-term growth of capital primarily through investments in foreign securities.

(c) Equity index fund strategies seek to track the performance of the S&P 500 Index.

(d) Strategies seek to invest in a variety of investment contracts such as group deferred annuity contracts (GVAs) issued by insurance companies and other financial institutions and other investment products with similar characteristics.

There are no redemption restrictions on the investments.

Note 7. Fair Value of Financial Instruments

ASC 820 (formerly: Statement of Financial Accounting Standards No. 157, "Fair Value Measurements") establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect a reporting entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

The following is a description of the valuation methodologies used for assets measured at fair value:

Money market and mutual funds - Valued at the net asset value of shares held by the plan at year end (Level 1).

Group variable annuity - Valued at the net asset value of shares held by the plan at year end (Level 2).

Pooled separate accounts - Valued at net asset value of shares held by the plan at year end (Level 2).

Participant loans - Valued at amortized cost, which approximates fair value (Level 3).

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.

Assets measured at fair value are summarized below:

	Assets at Fair Value			
	Level 1	Level 2	Level 3	Total
December 31, 2009				
Money market	$ 1,924,051	$ -	$ -	$ 1,924,051
Group variable annuity	-	748,375	-	748,375
Pooled separate accounts	-	716,525	-	716,525
Mutual funds	22,581,226	-	-	22,581,226
Participant loans	-	-	349,139	349,139
Total assets at fair value	$24,505,277	$ 1,464,900	$ 349,139	$26,319,316
December 31, 2008				
Money market	$ 2,075,791	$ -	$ -	$ 2,075,791
Group variable annuity	-	773,109	-	773,109
Pooled separate accounts	-	608,224	-	608,224
Mutual funds	15,880,093	-	-	15,880,093
Participant loans	-	-	314,629	314,629
Total assets at fair value	$17,955,884	$ 1,381,333	$ 314,629	$19,651,846

The following table is a summary of changes in the fair value of the Plan's Level 3 assets for the year ended December 31, 2009:

	Participant Loans
	2009
Beginning Balance	$ 314,629
Net purchases, sales, issuances and settlements	34,510
Ending Balance	$ 349,139

Note 8. Plan Termination

Although it has not expressed any intent to do so, the Company has the right under the Plan to terminate the Plan subject to the provisions of ERISA and the Plan.

Note 9. Tax Status

The cycle for applying for an Internal Revenue Service determination letter ends January 31, 2014. The Plan has not applied for a letter as of the report date. The Plan administrator believes that the Plan is currently designed and is being operated in compliance with the applicable requirements of the Internal Revenue Code.

THOMPSON HEALTH 403(b) PLAN
EIN: 16-0743024 Plan Number: 002
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)
Supplemental Schedule at December 31, 2009

(a)	(b) Identity of Issue	(c) Description	(e) Current Value
*	Nationwide Money Market	Cash and cash equivalents	$ 1,924,051

(a)	(b) Identity of Issue	(c) Description	(e) Current Value
*	Lincoln Group Variable Annuity	Group variable annuity	$ 748,375
	American Century VP Balanced	Pooled separate accounts	$ 16,421
	American Funds Growth	Pooled separate accounts	1,059
	American Funds Growth-Income	Pooled separate accounts	1,927
	Delaware VIP REIT	Pooled separate accounts	1,037
	Delaware VIP Small Cap Value	Pooled separate accounts	574
	Dreyfus Stock Index	Pooled separate accounts	123,753
	Dreyfus VIF Opp Small Cap Portfolio	Pooled separate accounts	58,286
	Fidelity Equity-Income	Pooled separate accounts	64,157
	Fidelity VIP Asset Manager	Pooled separate accounts	134,061
	Fidelity VIP ContraFund	Pooled separate accounts	2,111
	Fidelity VIP Growth Portfolio	Pooled separate accounts	217,966
	Janus Aspen Worldwide Portfolio	Pooled separate accounts	3,681
*	LVIP Baron Growth Opportunities	Pooled separate accounts	4,084
*	LVIP Delaware Foundation Conservative Allocation	Pooled separate accounts	786
*	LVIP Delaware Growth and Income	Pooled separate accounts	86
*	LVIP Delaware Social Awareness	Pooled separate accounts	1,468
*	LVIP T. Rowe Price Structured Mid-Cap Growth	Pooled separate accounts	43,360
*	LVIPWilshire 2040 Profile	Pooled separate accounts	849
*	LVIPWilshire Aggressive Profile	Pooled separate accounts	851
	Neuberger Berman AMT Mid-Cap Growth	Pooled separate accounts	838
	Neuberger Berman AMT Partners	Pooled separate accounts	7,563
	T. Rowe Price International Stock	Pooled separate accounts	31,607
	Total pooled separate accounts		$ 716,525

* Denotes party-in-interest

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

THOMPSON HEALTH 403(b) PLAN
EIN: 16-0743024 Plan Number: 002
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)
Supplemental Schedule at December 31, 2009

(a)	(b) Identity of Issue/ (c) Description	Number of Shares	(e) Current Value
	Mutual Funds		
	American Century Small Cap Value A	71,933	$ 525,113
	American Funds Capital World G/I R5	44,777	1,526,009
	American Funds EuroPacific Gr R5	25,988	994,819
	American Funds Growth Fund of Amer R5	50,283	1,371,723
	American Funds Interm Bd Fd of Amer R5	22,066	289,942
	BlackRock Health Sciences Ops Inv A	7,411	205,202
	Calvert Social Investment Equity A	4,298	131,218
	DWS RREEF Real Estate Securities A	29,297	408,993
	Eagle Series Trust Mid Cap Growth A	13,848	333,190
	Eaton Vance Large-Cap Value A	41,930	701,916
	Davis New York Venture Adv	22,341	692,111
	Ivy Global Natural Resources Y	32,697	610,459
	Ivy Science & Technology Y	5,806	173,934
	Loomis Sayles Bond Admin	55,513	736,107
*	Nationwide Inv Dest Cnsrv Svc	37,710	370,692
*	Nationwide Inv Dest Mod Cnsrv Svc	102,248	964,197
*	Nationwide Inv Dest Mod Svc	482,755	4,166,174
*	Nationwide Inv Destination Mod Agrsv Svc	472,411	3,883,219
*	Nationwide Inv Destinations Agrsv Svc	171,420	1,299,363
*	Nationwide Inv Destinations Mod Agrsv I	12,719	104,674
	PIMCO Real Return A	78,912	851,464
	PIMCO Total Return A	88,207	952,635
	Principal High Yield A	36,522	283,772
	T. Rowe Price Mid-Cap Value R	36,473	746,232
	T. Rowe Price New Income R	75	692
	Turner Small Cap Growth	9,790	257,376
	Total mutual funds		$ 22,581,226
*	Participant loans - 5.25% to 10.25%		$ 349,139
	Total Assets Held at End of Year		$ 26,319,316

* Denotes party-in-interest

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

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

Plan Name THOMPSON HEALTH 403B PLAN **EIN:** 16-0743024
Plan Sponsor's Name FF THOMPSON HEALTH SYSTEM INC **PN:** 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	NATIONWIDE TRUST COMPANY	MUTUAL FUNDS	0	24,505,277