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
FAYETTE REGIONAL HEALTH SYSTEM TAX SHELTERED ANNUITY PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/2001

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

500 WEST BERKLEY STREET
UNIONTOWN, PA 15401

500 WEST BERKLEY STREET
UNIONTOWN, PA 15401

2b Employer Identification Number (EIN)
25-1451183

2c Sponsor's telephone number
724-430-5000

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	JAMES PROUD
	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")
MANAGEMENT EXECUTIVE COMMITTEE

UNIONTOWN HOSPITAL
500 WEST BERKLEY STREET
UNIONTOWN, PA 15401

3b Administrator's EIN
51-0629244

3c Administrator's telephone number
724-430-5290

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**	1295
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**	1033
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	112
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	1145
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	1145
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	1145
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:
2G 2K 2L 2M

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

9a Plan funding arrangement (check all that apply)

(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)		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	2	**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
FAYETTE REGIONAL HEALTH SYSTEM TAX SHELTERED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
FAYETTE REGIONAL HEALTH SYSTEM

D Employer Identification Number (EIN)
25-1451183

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
ING LIFE INSURANCE AND ANNUITY COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
71-0294708	86509	6-3209B	0	01/01/2009	12/31/2009

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP PENSION FUNDING

b	Balance at the end of the previous year			7b	2410898
c	Additions: (1) Contributions deposited during the year	7c(1)	169233		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	55624		
	(4) Transferred from separate account	7c(4)	220966		
	(5) Other (specify below)	7c(5)	6403		
	▶				
	(6) Total additions			7c(6)	452226
d	Total of balance and additions (add **b** and **c(6)**)			7d	2863124
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	180613		
	(2) Administration charge made by carrier	7e(2)	113		
	(3) Transferred to separate account	7e(3)	30945		
	(4) Other (specify below)	7e(4)	2651453		
	▶				
	(5) Total deductions			7e(5)	2863124
f	Balance at the end of the current year (subtract **e(5)** from **d**)			7f	0

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 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
FAYETTE REGIONAL HEALTH SYSTEM TAX SHELTERED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
FAYETTE REGIONAL HEALTH SYSTEM

D Employer Identification Number (EIN)
25-1451183

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 NATIONAL LIFE INSURANCE CO.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0472300	65686	96-9658476	1	01/01/2009	12/31/2009

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	36488
5	Current value of plan's interest under this contract in separate accounts at year end	5	0

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP VAR ANNUITY WITH GUARANTEED FUND

b	Balance at the end of the previous year			7b	34479
c	Additions: (1) Contributions deposited during the year	7c(1)	975		
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)	1034		
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6) Total additions			7c(6)	2009
d	Total of balance and additions (add **b** and **c(6)**).			7d	36488
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	36488

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
FAYETTE REGIONAL HEALTH SYSTEM TAX SHELTERED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
FAYETTE REGIONAL HEALTH SYSTEM

D Employer Identification Number (EIN)
25-1451183

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

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

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

LPL FINANCIAL CORPORATION

ATTN CARMELA WILLIAMS
9785 TOWNE CENTRE DRIVE
SAN DIEGO, CA 92121

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	SERVICE PROVIDER	0	Yes [X] No [ ]	Yes [X] No [ ]	173439	Yes [ ] No [X]

(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?
15		47863	Yes [X] No [ ]	Yes [X] No [ ]	1187	Yes [ ] No [X]

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

CAPITAL RETIREMENT PLAN SERVICES

501 CORPORATE DRIVE
SUITE 215
CANONSBURG, PA 15317

25-1802421

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 37 49	THIRD PARTY ADMINISTRATOR	2690	Yes [X] No [ ]	Yes [X] No [ ]	12395	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
(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 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
FAYETTE REGIONAL HEALTH SYSTEM TAX SHELTERED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
FAYETTE REGIONAL HEALTH SYSTEM

D Employer Identification Number (EIN)
25-1451183

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)		0
(2) Participant contributions	1b(2)		0
(3) Other	1b(3)		0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		66347
(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)	225438	226535
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	11085112	
(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)		18229548
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	2445377	36488
(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	13755927	18558918
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		0
j	Other liabilities	1j		0
k	Total liabilities (add all amounts in lines 1g through1j)	1k		0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	13755927	18558918

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)	345732	
	(B) Participants	2a(1)(B)	2174812	
	(C) Others (including rollovers)	2a(1)(C)	87892	
	(2) Noncash contributions	2a(2)	0	
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		2608436
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	-144	
	(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)	11473	
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		11329
	(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)		
	(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)		

		(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)		
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		1738542
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(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)		1240481
c Other income	2c		56658
d Total income. Add all **income** amounts in column (b) and enter total	2d		5655446
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	818386	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)	29350	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		847736
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)	0	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	4719	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		4719
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		852455
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		4802991
l Transfers of assets:			
(1) To this plan	2l(1)		0
(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: BKD, LLP (2) EIN: 44-0160260

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		1000000
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	X		

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

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

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

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
FAYETTE REGIONAL HEALTH SYSTEM TAX SHELTERED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
FAYETTE REGIONAL HEALTH SYSTEM

D Employer Identification Number (EIN)
25-1451183

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): 71-0294708 31-1592130

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):

Fayette Regional Health System Tax Sheltered Annuity Plan

EIN 25-1451183 PN 001

Accountants' Report and Financial Statements

December 31, 2009 (Audited) and 2008 (Compiled)

Fayette Regional Health System Tax Sheltered Annuity Plan

December 31, 2009 and 2008

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Independent Accountants' Report

Plan Administrator
Fayette Regional Health System Tax Sheltered Annuity Plan
Uniontown, Pennsylvania

We were engaged to audit the accompanying statement of net assets available for benefits of Fayette Regional Health System Tax Sheltered Annuity Plan as of December 31, 2009, and the related statement of changes in net assets available for benefits for the year then ended and the accompanying supplemental schedule. These financial statements and 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, auditing procedures with respect to the information summarized in *Note 3*, which was certified by The Nationwide Financial Services, Inc., the custodian of the Plan for the period June 24, 2009 through December 31, 2009, except for comparing such information with the related information included in the financial statements and supplemental schedule. We have been informed by the plan administrator that the custodian held the Plan's investment assets and executed investment transactions during the period June 24, 2009, through December 31, 2009. The plan administrator has obtained certifications from the custodian as of and for the period ended December 31, 2009, that the information provided to the plan administrator by the custodian is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and schedule taken as a whole. The form and content of the information included in the financial statements and schedule, other than that derived from the information certified by the 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 Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

We have compiled the accompanying statement of net assets available for benefits as of December 31, 2008, in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. A compilation is limited to presenting, in the form of financial statements, information that is the representation of the Plan's management. We have not audited or reviewed the statement of net assets available for benefits referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

BKD, LLP

Springfield, Missouri
October 14, 2010

Federal Employer Identification Number: 44-0160260

experience BKD

Praxity MEMBER GLOBAL ALLIANCE OF INDEPENDENT FIRMS

Fayette Regional Health System Tax Sheltered Annuity Plan

Statements of Net Assets Available for Benefits

December 31, 2009 and 2008

Assets

	2009	2008 (Compiled)
Investments, At Fair Value	$ 18,558,918	$ 13,755,926
Net Assets Available for Benefits	$ 18,558,918	$ 13,755,926

Fayette Regional Health System Tax Sheltered Annuity Plan

Statement of Changes in Net Assets Available for Benefits

Year Ended December 31, 2009

	2009
Investment Income	
Net appreciation in fair value of investments	$ 2,638,782
Interest and dividends	408,229
Net investment income	3,047,011
Contributions	
Employer	345,732
Participants	2,174,812
Rollovers	87,892
	2,608,436
Total additions	5,655,447
Deductions	
Benefits paid directly to participants	847,736
Administrative expenses	4,719
Total deductions	852,455
Net Increase	4,802,992
Net Assets Available for Benefits, Beginning of Year	13,755,926
Net Assets Available for Benefits, End of Year	$ 18,558,918

Fayette Regional Health System Tax Sheltered Annuity Plan

Notes to Financial Statements

December 31, 2009 and 2008

Note 1: Description of the Plan

The following description of Fayette Regional Health System Tax Sheltered Annuity Plan (Plan) provides only general information. Participants should refer to the *Plan Document and Summary Plan Description* for a more complete description of the Plan's provisions, which is available from the plan administrator.

General

The Plan is a defined contribution plan according to Code Section 403(b) sponsored by The Fayette Regional Health System (Health System) for the benefit of its employees. An employee is eligible to make a contribution on his first day of employment. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Management Executive Committee of the Uniontown Hospital serves as the administrator of the Plan. Metropolitan Life Insurance Company served as custodian for the Plan from January 1, 2008 to June 23, 2009. Effective June 24, 2009, The Nationwide Financial Services, Inc. serves as plan custodian.

Contributions

The Plan permits eligible employees through a salary deferral election to have the Health System make annual contributions of up to the maximum allowed by the Internal Revenue Code. Employee rollover contributions are also permitted. The Health System makes matching contributions for eligible employees who are not members of a collective bargaining unit of $0.25 on the dollar up to 5% of eligible wages limited to $1,250 per year. Contributions are subject to certain limitations.

Participant Investment Account Options

Investment account options available include various funds. Each participant has the option of directing the contributions to his account into any of the separate investment accounts and may change the allocation daily.

Participant Accounts

Each participant's account is credited with the participant's contribution, the Health System's contribution, and plan earnings and is charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

The plan document also includes an automatic deferral feature which is effective 90 days after the participant becomes eligible to participate in the Plan. A participant is treated as electing to defer 5% of eligible compensation, unless the participant made an affirmative election otherwise.

Vesting

Participants are immediately vested in their voluntary contributions and the Health System's contributions plus earnings thereon.

Payment of Benefits

Upon termination of service, a participant may elect to receive a lump-sum amount equal to the value of his account or have the balance rolled to an IRA or another plan.

Participant Loans

Participants may borrow from their accounts a minimum of $1,000 and up to a maximum of $50,000 or 50% of their vested account balance, whichever is less. All loans are secured by the balance in the participant's account and are repayable over a period not to exceed five years (except for loans for the purchase of a principal residence) through payroll withholdings unless the participant is paying the loan in full. Interest on the loans is based on the prime rate charged by the most prominent bank in the city where the Plan is administered.

Plan Termination

Although it has not expressed an intention to do so, the Health System has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA. In the event of plan termination, participants will become 100% vested in their accounts.

Note 2: Summary of Significant Accounting Policies

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of net assets and changes in net assets and disclosure of contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates.

Valuation of Investments and Income Recognition

Quoted market prices if available, are used to value investments. Mutual funds are valued at the net asset value (NAV) of shares held by the Plan at year end. Participant loans are valued at amortized cost, which approximates fair value.

The fair value of the fixed income account is calculated by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the creditworthiness of the issuer.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Plan Tax Status

The Plan has not requested or obtained a determination letter as the Internal Revenue Service does not currently provide that service for 403(b) plans. The plan administrator believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code and therefore not subject to tax. With a few exceptions, the Plan is no longer subject to U.S. federal, state and local income tax examinations by tax authorities for years before 2006.

Payment of Benefits

Benefit payments to participants are recorded upon distribution.

Administrative Expenses

Administrative expenses may be paid by the Health System or the Plan at the Health System's discretion.

Subsequent Events

Subsequent events have been evaluated through October 14, 2010, which is the date the financial statements were available to be issued.

Note 3: Investments Held by the Nationwide Financial Services, Inc.

The Plan's investments were held by The Nationwide Financial Services, Inc. from June 24, 2009, to December 31, 2009. The Plan's investments (including investments bought, sold and held during the period) appreciated in fair value during the six-month period ended December 31, 2009, as follows:

	2009	
	Net Appreciation in Fair Value During the Six-Month Period	Fair Value at End of Year
Mutual funds	$ 875,375	$ 18,295,895
Participant loans	-	226,535
	$ 875,375	$ 18,522,430

The fair value of individual investments that represent 5% or more of the Plan's net assets available for benefits at December 31, 2009, were as follows:

	2009
Vanguard Target Retirement 2015	$ 1,838,204
Vanguard Target Retirement 2020	3,298,450
Vanguard Target Retirement 2025	3,979,822
Vanguard Target Retirement 2030	2,134,582
Vanguard Target Retirement 2035	1,536,948

Interest and dividends realized on the Plan's investments held by The Nationwide Financial Services Inc. for the six-month period ended December 31, 2009, were $368,086.

Note 4: Other Investments

The Plan also has an investment in a fixed account, which is held by Lincoln Financial Group and is not included in the investments certified by The Nationwide Financial Services Inc. Interest and dividends realized on the Plan's investments held by Lincoln Financial Group for the year ended December 31, 2009, were $704. The Plan's investments (including investments bought, sold and held during the year) appreciated in fair value as follows:

	2009	
	Net Appreciation in Fair Value During the Period	Fair Value at End of Year
Lincoln fixed account	$ 330	$ 36,488

Note 5: Investments Held by Metropolitan Life Insurance Company and Lincoln Financial Group

The Plan's investments were held by Metropolitan Life Insurance Company, from January 1, 2008, to June 23, 2009. During the six-month period from January 1, 2009, to June 23, 2009, the Plan's investments (including investments bought, sold, and held during the period) appreciated in value by $1,763,077. Interest and dividends realized on the Plan's investments held by Metropolitan Life Insurance Company for the six-month period ended June 23, 2009, were $39,439. The Plan's investments at December 31, 2008, held by Metropolitan Life Insurance Company and Lincoln Financial Group were as follows:

	2008 (Compiled) Fair Value at End of Year
Mutual funds	$ 5,392,638
Fixed account	2,410,898
Lincoln fixed account	34,479
Variable annuities	5,692,473
Participant loans	225,438
	$ 13,755,926

The fair value of investments that represented 5% or more of the Plan's net assets available for benefits as of December 31, 2008, were as follows:

	2008
Fixed Account	$ 2,410,898
Dreyfus S&P 500 Index	732,536
Legg Mason Aggressive Growth A	793,098
MetLife Moderate Allocation	2,434,603
MetLife Moderate to Aggressive Allocation	1,444,017

Note 6: Party-in-Interest Transactions

Party-in-interest transactions include those with fiduciaries or employees of the Plan, any person who provides services to the Plan, an employer whose employees are covered by the Plan, and an employee organization whose members are covered by the Plan, a person who owns 50 percent or more of such an employer or employee association, or relatives of such persons.

Prior to June 24, 2009, certain plan investments in mutual funds and variable annuities were managed by Metropolitan Life Insurance Company.

Certain legal and accounting fees and certain other administrative expenses relating to the Plan are paid by the Health System. In addition, the Health System provides certain administrative services at no cost to the Plan.

Note 7: Fair Value Measurements

ASC Topic 820, *Fair Value Measurements*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Topic 820 also specifies a fair value hierarchy which requires a plan 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 in active markets for identical assets or liabilities.

Level 2 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 for substantially the full term of the assets or liabilities.

Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

Following is a description of the valuation methodologies and inputs used for assets measured at fair value on a recurring basis and recognized in the accompanying statements of net assets available for benefits, as well as the general classification of such assets pursuant to the valuation hierarchy.

Investments

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. Level 1 securities include mutual funds and money market mutual funds. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics or discounted cash flows. Securities classified as Level 2 include a fixed income account. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy. Participant loans

have been classified as Level 3 investments. See *Note 2* for definition of inputs utilized to determine fair value.

The following table presents the fair value measurements of assets recognized in the accompanying statements of net assets available for benefits measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at December 31, 2009 and 2008:

	2009 Fair Value Measurements Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds				
Foreign large blend	$ 257,105	$ 257,105	$ -	$ -
Foreign large growth	207,660	207,660	-	-
Intermediate government	386,135	386,135	-	-
Intermediate-term bond	435,767	435,767	-	-
Large blend	240,852	240,852	-	-
Large growth	351,309	351,309	-	-
Large value	23,845	23,845	-	-
Mid-Cap blend	78,511	78,511	-	-
Mid-Cap growth	56,964	56,964	-	-
Mid-Cap value	261,923	261,923	-	-
Moderate allocation	295,741	295,741	-	-
Money market	66,347	66,347	-	-
Retirement income	56,235	56,235	-	-
Small blend	60,322	60,322	-	-
Small growth	141,322	141,322	-	-
Small value	61,372	61,372	-	-
Target date	15,167,867	15,167,867	-	-
World stock	105,919	105,919	-	-
Other	40,699	40,699	-	-
Lincoln fixed account	36,488	-	36,488	-
Participant loans	226,535	-	-	226,535
	$ 18,558,918	$ 18,295,895	$ 36,488	$ 226,535

Fayette Regional Health System Tax Sheltered Annuity Plan

Notes to Financial Statements

December 31, 2009 and 2008

	2008 (Compiled) Fair Value Measurements Using			
	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds				
Foreign large growth	$ 363,696	$ 363,696	$ -	$ -
High yield bond	142,427	142,427	-	-
Intermediate-term bond	394,662	394,662	-	-
Large blend	1,372,133	1,372,133	-	-
Large growth	999,186	999,186	-	-
Large value	425,980	425,980	-	-
Mid-Cap growth	454,301	454,301	-	-
Money market	160,227	160,227	-	-
Small blend	398,722	398,722	-	-
Target date	104,505	104,505	-	-
Technology	65,924	65,924	-	-
World bond	52,699	52,699	-	-
World stock	458,176	458,176	-	-
Fixed account	2,410,898	-	2,410,898	-
Lincoln fixed account	34,479	-	34,479	-
Variable annuities	5,692,473	-	5,692,473	-
Participant loans	225,438	-	-	225,438
	$ 13,755,926	$ 5,392,638	$ 8,137,850	$ 225,438

The following is a reconciliation of the beginning and ending balances of recurring fair value measurements recognized in the accompanying statement of net assets available for benefits using significant unobservable (Level 3) inputs for 2009:

	Participant Loans
Balance, January 1, 2009	$ 225,438
Issuances	104,704
Payments	(103,607)
Balance, December 31, 2009	$ 226,535

Fayette Regional Health System Tax Sheltered Annuity Plan

Notes to Financial Statements

December 31, 2009 and 2008

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. The Plan's exposure to these risks has been heightened because of the current economic environment. 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 adversely affect the participants' account balances and the amounts reported in the statements of net assets available for benefits. The financial statements have been prepared using values and information currently available to the Plan.

Supplemental Schedule

Fayette Regional Health System Tax Sheltered Annuity Plan

EIN 25-1451183 PN 001

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

Year Ended December 31, 2009

Identity of Issuer	Description of Investment	Current Value
Mutual Funds		
Invesco AIM	AIM Mid Cap Core Equity Institutional	$ 6,078
American Funds	American Funds American Mutual R6	478
American Funds	American Funds Capital World Growth Income R5	105,919
American Funds	American Funds Europacific Growth R5	253,291
American Funds	American Funds Fundamental Investors R5	125,143
American Funds	American Funds Growth Fund of America R5	351,309
American Funds	American Funds New World R6	654
BlackRock	BlackRock Basic Value Institutional	644
BlackRock	BlackRock Small Cap Growth Equity Institutional	115,801
DWS Investments	DWS RREEF Real Estate Securities Institutional	2,774
Dodge & Cox	Dodge & Cox International Stock	22,598
Dodge & Cox	Dodge & Cox Stock	22,723
Dreyfus	Dreyfus Institutional Preferred Money Market Fund	66,347
Flex-funds	Flex-funds Aggressive Growth	4,098
Flex-funds	Flex-funds Defensive Balanced	20,333
Flex-funds	Flex-funds Dynamic Growth	29,806
Flex-funds	Flex-funds Muirfield	32,670
Flex-funds	Flex-funds Strategic Growth	25,714
Goldman Sachs	Goldman Sachs Commodity Strategy Institutional	2,687
Goldman Sachs	Goldman Sachs Short Duration Government Institutional	264
Harbor	Harbor International Institutional	3,814
JPMorgan	JPMorgan Treasury & Agency Select	176
Janus	Janus Overseas I	207,660
Janus	Perkins Mid Cap Value I	221,158
MFS	MFS Massachusetts Investors Trust R4	5,622
Oppenheimer Funds	Oppenheimer Global Allocation Y	11,546
Pioneer Investments	Pioneer Growth Opportunities Y	25,521
Principal Funds	Principal MidCap Blend Institutional	624
Principal Funds	Principal SmallCap Value Institutional	61,372
	Total forward	1,726,824

Fayette Regional Health System Tax Sheltered Annuity Plan

EIN 25-1451183 PN 001

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

Year Ended December 31, 2009

Identity of Issuer	Description of Investment	Current Value
	Total forward	$ 1,726,824
Mutual Funds		
Principal Funds	Principal MidCap S&P 400 Index Institutional	71,809
Principal Funds	Principal SmallCap S&P 600 Index Institutional	60,322
Prudential	Prudential Total Return Bond Z	3,441
RidgeWorth	RidgeWorth Total Return Bond I	432,326
State Street Global Advisors	SSgA S&P 500 Index	12,354
Vanguard	Vanguard Growth & Income Fund	5,445
Vanguard	Vanguard GNMA Fund	739
Vanguard	Vanguard Intermediate Term Treasury	385,396
Vanguard	Vanguard Target Retirement Income	56,235
Vanguard	Vanguard Wellington	275,408
Vanguard	Vanguard Mid Cap Growth	56,964
Vanguard	Vanguard Selected Value	40,765
Vanguard	Vanguard Target Retirement 2005	128,681
Vanguard	Vanguard Target Retirement 2010	687,795
Vanguard	Vanguard Target Retirement 2015	1,838,204
Vanguard	Vanguard Target Retirement 2020	3,298,450
Vanguard	Vanguard Target Retirement 2025	3,979,822
Vanguard	Vanguard Target Retirement 2030	2,134,582
Vanguard	Vanguard Target Retirement 2035	1,536,948
Vanguard	Vanguard Target Retirement 2040	596,461
Vanguard	Vanguard Target Retirement 2045	734,572
Vanguard	Vanguard Target Retirement 2050	232,352
Fixed Account		
Lincoln Financial Group	Fixed Account	36,488
Participant Loans		
*Plan Participants	Participant loans, with interest rates from 3.25% to 10.25%	226,535
		$ 18,558,918

* Party-in-interest as defined by ERISA.

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

For the plan year beginning 01/01/2009 and ending 12/31/2009

Name of plan

Fayette Regional Health System Tax Sheltered Annuity Plan

Employer Identification Number

25-1451183

Three-digit plan number ▶ 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
*	Nationwide Financial	American Funds Fundamental		125,143
*	Nationwide Financial	American Funds Grwth Fd Amer		351,309
*	Nationwide Financial	American Funds EuroPacific		253,291
*	Nationwide Financial	American Funds Cap Wrld G&I		105,919
*	Nationwide Financial	BlackRock SmCap Gr Equity		115,801
*	Nationwide Financial	Dodge & Cox Intl Stock		22,598
*	Nationwide Financial	Dreyfus Inst Pref Money Mkt		66,347
*	Nationwide Financial	Dodge & Cox Stock		22,723
*	Nationwide Financial	Prudential Total Return Bond		3,442
*	Nationwide Financial	Flex Defn Bal		20,333
*	Nationwide Financial	Flex Strat Gr		25,714
*	Nationwide Financial	Flex Aggr Gr		4,098
*	Nationwide Financial	Flex Dynmc Gr		29,806
*	Nationwide Financial	Flex Mrfld		32,669
*	Nationwide Financial	Goldman Sachs Commodity Strat		2,687
*	Nationwide Financial	Invesco MidCap Cor Eq		6,078
*	Nationwide Financial	Goldman Sachs Short Dur Govt		264
*	Nationwide Financial	Harbor International		3,814
*	Nationwide Financial	JPM Treasury Agency Select		176
*	Nationwide Financial	BlackRock Basic Value		644
*	Nationwide Financial	MFS Mass Inv Tr		5,622
*	Nationwide Financial	Oppenheimer Global		11,546
*	Nationwide Financial	Principal Inv MdCap Blnd		624
*	Nationwide Financial	Pioneer Gr Opp		25,521
*	Nationwide Financial	Principal InvMdCap S&P 400 Ind		71,809
*	Nationwide Financial	DWS RREEF Real Estate Sec		2,774
*	Nationwide Financial	Principal Inv SmCap Value		61,372
*	Nationwide Financial	Principal InvSmCap S&P 600 Ind		60,322
*	Nationwide Financial	American Funds Am Mut		478
*	Nationwide Financial	American Funds New World		654
*	Nationwide Financial	RdgWrth Total Return Bond		432,326
*	Nationwide Financial	SSGA S&P 500 Index Fund		12,354
*	Nationwide Financial	Vanguard Target Rtrmt 2050		232,352
*	Nationwide Financial	Vanguard GNMA Fund		739
*	Nationwide Financial	Vanguard Target Rtrmt 2040		596,461
*	Nationwide Financial	Vanguard Inter Term US Treas		385,396
*	Nationwide Financial	Vanguard Mid Cap Growth		56,964
*	Nationwide Financial	Vanguard Target Rtrmt 2035		1,536,948
*	Nationwide Financial	Invesco VK Gr Inc		5,445

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

For the plan year beginning 01/01/2009 and ending 12/31/2009

Name of plan

Fayette Regional Health System Tax Sheltered Annuity Plan

Employer Identification Number

25-1451183

Three-digit plan number ▶ 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
*	Nationwide Financial	Vanguard Select Value		40,765
*	Nationwide Financial	Vanguard Target Rtrmt 2010		687,795
*	Nationwide Financial	Vanguard Target Rtrmt 2030		2,134,582
*	Nationwide Financial	Vanguard Target Rtrmt 2045		734,572
*	Nationwide Financial	Vanguard Target Rtrmt Income		56,235
*	Nationwide Financial	Vanguard Target Rtrmt 2005		128,681
*	Nationwide Financial	Vanguard Target Rtrmt 2025		3,979,822
*	Nationwide Financial	Vanguard Target Rtrmt 2020		3,298,450
*	Nationwide Financial	Vanguard Target Rtrmt 2015		1,838,204
*	Nationwide Financial	Vanguard Wellington Fund		275,408
*	Nationwide Financial	Janus Overseas		207,660
*	Nationwide Financial	Jns Prkns MdCap Value		221,158
	Participant Loans	IR 3.25%-10.25%;Mat to 6/21/19		226,535