Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2009** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

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

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

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [X] 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
COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 10/01/1974

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

1460 ORANGE ST
COSHOCTON, OH 43812-2229

2b Employer Identification Number (EIN) 31-4387577

2c Sponsor's telephone number 740-622-6411

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	RICHARD K. DAVIS
	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

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") OPOC.US 300 W. WILSON BRIDGE RD. WORTHINGTON, OH 43085	**3b** Administrator's EIN 34-0141161 **3c** Administrator's telephone number 614-318-2200

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:		**4b** EIN
a Sponsor's name		**4c** PN

5 Total number of participants at the beginning of the plan year	**5**	646
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**	423
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	241
d Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	664
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f Total. Add lines **6d** and **6e**	**6f**	664
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	664
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2C 2G 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)			**9b** Plan benefit arrangement (check all that apply)		
(1)	X	Insurance	**(1)**	X	Insurance
(2)		Code section 412(e)(3) insurance contracts	**(2)**		Code section 412(e)(3) insurance contracts
(3)	X	Trust	**(3)**	X	Trust
(4)		General assets of the sponsor	**(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			**b General Schedules**			
(1)	X	**R** (Retirement Plan Information)	**(1)**	X		**H** (Financial Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	**(2)**			**I** (Financial Information – Small Plan)
			(3)	X	1	**A** (Insurance Information)
			(4)			**C** (Service Provider Information)
(3)		**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	**(5)**			**D** (DFE/Participating Plan Information)
			(6)			**G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2009** **This Form is Open to Public Inspection**

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

A Name of plan
COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500.
COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.

D Employer Identification Number (EIN)
31-4387577

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
NATIONWIDE LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
31-4156830	66869	GAP-B2-HM60	664	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
25366	6342

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
INVEST FINANCIAL CORPORATION
5555 GRANDE MARKET DR.
APPLETON, WI 54913

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
13709		INVESTMENT	2

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
LINCOLN FINANCIAL ADVISORS
1300 SOUTH CLINTON ST., SUITE 150
FORT WAYNE, IN 46802

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
11657		INVESTMENT	2

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

EDWARD SOMMER
1491 ABBOTSFORD GREEN DR
POWELL, OH 43065

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	6342	INVESTMENT ADVISORY FEES	3

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

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

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

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

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

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

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

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

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 ▶

b	Balance at the end of the previous year		7b	5275991
c	Additions: (1) Contributions deposited during the year	7c(1)	190176	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	166226	
	(4) Transferred from separate account	7c(4)	235434	
	(5) Other (specify below)	7c(5)	157	
	▶ LOAN REPAYMENT - PRINCIPAL			
	(6)Total additions		7c(6)	591993
d	Total of balance and additions (add **b** and **c(6)**).		7d	5867984
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	411833	
	(2) Administration charge made by carrier	7e(2)	200	
	(3) Transferred to separate account	7e(3)	25001	
	(4) Other (specify below)	7e(4)	3036	
	▶ LOAN WITHDRAWAL			
	(5) Total deductions		7e(5)	440070
f	Balance at the end of the current year (subtract **e(5)** from **d**)		7f	5427914

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)	0
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)	0
(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)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

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

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

A Name of plan
COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.

D Employer Identification Number (EIN)
31-4387577

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?
15 64	RECORD KEEPER	158788	Yes [X] No [ ]	Yes [ ] No [X]	68158	Yes [ ] No [X]

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

LINCOLN FINANCIAL ADVISORS

1300 S. CLINTON ST.
SUITE 150
FT WAYNE, IN 46802

(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 64	RECORD KEEPER	0	Yes [X] No [ ]	Yes [ ] No [X]	45605	Yes [ ] No [X]

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

INVEST FINANCIAL CORPORATION

5555 GRANDE MARKET DR.
APPLETON, WI 54913

59-2195688

(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	INVESTMENT	0	Yes [X] No [ ]	Yes [ ] No [X]	38923	Yes [ ] No [X]

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

EDWARD DA SOMMER

300 W WILSON BRIDGE RD.
WORTHINGTON, OH 43085

59-2195688

(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 28	INVESTMENT	5159	Yes [X] No [ ]	Yes [ ] No [X]	32158	Yes [ ] No [X]

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

CLARKE LANZEN SKALLA

4020 SOUTH 147TH ST.
OMAHA, NE 68137

13-4109249

(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?
52	INVESTMENT	28760	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INVEST FIN CORY AGY INC.

5555 GRANDE MARKET DR.
APPLETON, WI 54913

59-2195688

(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?
52	INVESTMENT	0	Yes [X] No [ ]	Yes [ ] No [X]	16813	Yes [ ] No [X]

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

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

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

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

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

A Name of plan
COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.

D Employer Identification Number (EIN)
31-4387577

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1730505	1313729
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	10443060	14310961
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	5283088	5427914
(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	17456653	21052604
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	17456653	21052604

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)	1193854	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		1193854
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	55	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		55
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0

		(a) Amount	(b) Total
2b **(5)** Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	148689	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		148689
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		3268386
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		4610984

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1014579	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		1014579
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		0
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		1014579

Net Income and Reconciliation

k Net income (loss). Subtract line **2j** from line **2d**	2k		3596405
l Transfers of assets:			
(1) To this plan	2l(1)		666
(2) From this plan	2l(2)		1120

Part III Accountant's Opinion

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

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

(1) ☐ Unqualified **(2)** ☐ Qualified **(3)** ☒ Disclaimer **(4)** ☐ Adverse

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

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

(1) Name: NORMAN, JONES, ENLOW & CO. **(2)** EIN: 31-1282719

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

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

Part IV Compliance Questions

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

During the plan year:

			Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

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

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

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

SCHEDULE R (Form 5500)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2009** **This Form is Open to Public Inspection.**

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

A Name of plan
COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.

D Employer Identification Number (EIN)
31-4387577

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 _____

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** 0

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** 1193854

b Enter the amount contributed by the employer to the plan for this plan year **6b** 1193854

c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c** 0

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. *Complete as many entries as needed to report all applicable employers.*

a Name of contributing employer

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

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

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

a Name of contributing employer

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

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

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

a Name of contributing employer

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

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

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

a Name of contributing employer

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

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

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

a Name of contributing employer

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

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

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

a Name of contributing employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COSHOCTON COUNTY MEMORIAL HOSPITAL
EMPLOYEES PENSION PLAN
FINANCIAL STATEMENTS
December 31, 2009 and 2008

Norman Jones Enlow & Co.

Certified Public Accountants
& Management Consultants

INDEPENDENT AUDITORS' REPORT

Board of Trustees
Coshocton County Memorial Hospital
Employees Pension Plan
1460 Orange Street
Coshocton, OH 43812

We were engaged to audit the accompanying statement of net assets available for plan benefits of Coshocton County Memorial Hospital Employees Pension Plan (the "Plan") as of December 31, 2009 and 2008, and the related statement of changes in net assets available for plan benefits, and the supplemental schedule, as of and for the year ended 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 (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA), the Plan Administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information in Note 3, which was certified by Nationwide Financial Services, Inc., the Trustee of the Plan, except for comparing such information with the related information included in the financial statements and supplemental schedule. The Plan Administrator has informed us that the Trustee holds the Plan's investment assets and executes investment transactions. The Plan Administrator has obtained a certification from the Trustee as of December 31, 2009 and 2008, and for the years then ended, that the information provided to the Plan Administrator by the Trustee is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and 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 Trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

Norman, Jones, Enlow & Co.

Columbus, Ohio
October 12, 2010

226 North Fifth Street, Suite 500, Columbus Ohio 43215
p 614.228.4000 f 614.228.4040 **www.NJE.com**

COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2009 and 2008

	2009	2008
ASSETS		
Cash	$ 1,329,410	$ 1,745,356
Guaranteed investment contract	5,332,925	5,084,537
Investments, at fair value	14,314,514	10,447,084
Receivables		
Employer contributions	149,655	46,020
NET ASSETS AVAILABLE FOR BENEFITS AT FAIR MARKET VALUE	21,126,504	17,322,997
ADJUSTMENT TO CONTRACT VALUE	94,989	191,453
NET ASSETS AVAILABLE FOR BENEFITS	$ 21,221,493	$ 17,514,450

See notes to financial statements.

COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Year Ended December 31, 2009

INVESTMENT ACTIVITY AND CONTRIBUTIONS		
Net appreciation in fair value of investments	$	3,436,390
Contributions		
Employer		1,301,318
Transfers		649
		1,301,967
TOTAL INVESTMENT ACTIVITY AND CONTRIBUTIONS		4,738,357
DEDUCTIONS		
Benefits paid to participants		1,031,314
INCREASE IN NET ASSETS AVAILABLE FOR BENEFITS		3,707,043
NET ASSETS AVAILABLE FOR BENEFITS AT BEGINNING OF YEAR		17,514,450
NET ASSETS AVAILABLE FOR BENEFITS AT END OF YEAR	$	21,221,493

See notes to financial statements.

COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN
NOTES TO FINANCIAL STATEMENTS

1. DESCRIPTION OF THE PLAN

Coshocton County Memorial Hospital Employees Pension Plan (the "Plan") provides for Hospital contributions equal to 7% of total compensation for non-union employees with a hire date prior to December 26, 2004. Registered Nurses covered by the ONA Collective Bargaining Agreement will receive an allocation of 7% of compensation. All non-union employees with a date of hire on or after December 26, 2004, will receive an allocation of 5% of their total compensation. The Plan has met the ERISA minimum funding requirements.

Participants of the Plan may direct their contributions into one or more mutual funds or the benefit-responsive guaranteed investment contract.

Vesting in the employer's contributions and earnings thereon is based on years of continuous service. For employer contributions made on or before December 31, 2006 a participant becomes 100% vested following five years of credited service. For employer contributions made after December 31, 2006, a participant becomes 100% vested following three years of credited service.

Upon termination of service, a participant may elect to receive either a lump-sum amount equal to the vested value of his or her account, or to have the Plan purchase a single premium annuity contract from Nationwide Financial Services, Inc. ("Nationwide"), the Trustee, with the vested value of his or her account. The Plan provides that the Trustee make a lump-sum distribution of terminated accounts with a vested balance below $5,000. During 2009, the Plan made total benefit payments of $1,031,314, all of which were lump sum payments.

2. SIGNIFICANT ACCOUNTING POLICIES

General

The Plan is a defined contribution plan covering all full-time employees of Coshocton County Memorial Hospital (the "Hospital") who have one year of service, are age 21 or older, and have completed 1,000 hours of services during the Plan year. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Basis of Presentation

The accounting records of the Plan are maintained on the accrual basis.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair value except for its benefit-responsive investment contract, which is valued at contract value. Quoted market prices are used to value investments.

As described in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 946-210, investment contracts held by a pension plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a pension plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the plan. As required by the Codification, the Statement of Net Assets Available for Benefits presents the fair value of the investment contracts as well as the adjustment of the fully benefit-responsive investment contracts from fair value to contract value. The Statement of Changes in Net Assets Available for Benefits is prepared on a contract value basis.

2. SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Administrative Expenses

Administrative expenses of the Plan are paid by the Hospital. In addition, the Hospital provides accounting and administrative services to the Plan.

Payment of Benefits

Benefits are recorded when paid. Single premium annuity contracts purchased to satisfy benefit payment obligations are excluded from the assets of the Plan.

Forfeited Accounts

Accounts forfeited by participants who terminate service prior to becoming fully vested are used to reduce future contributions made by the Hospital. The Plan had forfeitures of $18,585 at December 31, 2009. There were no forfeitures for December 31, 2008.

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 assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

FASB ASC 820-10-65

In September 2006, the Financial Accounting Standards Board issued FASB ASC 820-10-65, regarding fair value measurements. FASB ASC 820-10-65 establishes a framework for measuring fair value under generally accepted accounting principles, clarifies the definition of fair value within that framework, and expands financial statement disclosures about the use of fair value measurements. The financial statement presentation and disclosure provisions are effective for financial statements issued for annual periods beginning after November 15, 2007. The Plan adopted the provisions of FASB ASC 820-10-65 at January 1, 2008.

Accounting for Uncertainty in Income Taxes

The Plan has adopted FASB ASC 740-10-65 (formerly *FIN* 48), regarding uncertainty in income taxes, as of January 1, 2009. The Plan evaluates all tax positions in conformity with FASB ASC 450 for contingencies, and as such would reserve for any tax positions deemed probable of not being sustained by the Internal Revenue Service (IRS). The Plan recognizes tax benefits only to the extent that the Plan believes it is "more likely than not" that its tax positions will be sustained upon IRS examination. The Plan does not have a provision for unpaid federal income taxes (liability for unrecognized tax benefits) related to uncertain tax positions in the balance sheet, as it believes all tax positions taken would "more likely than not" be sustained upon IRS examination.

3. SUMMARY OF INFORMATION CERTIFIED BY THE TRUSTEE (UNAUDITED)

The Plan Administrator has obtained certification from the Trustee that the information provided to the Plan Administrator by the Trustee is complete and accurate in accordance with 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. A summary of information included in the financial statements, which has been certified, is as follows:

3. SUMMARY OF INFORMATION CERTIFIED BY THE TRUSTEE (UNAUDITED) (CONTINUED)

	December 31	
	2009	2008
Investments, at fair value	$ 15,643,924	$ 12,192,440
Investments, at contract value	5,427,914	5,275,990
Year Ended December 31, 2009:		
Net appreciation in fair value of investments	$ 3,436,390	
Benefit payments	1,031,314	

4. INVESTMENTS

The fair market value of individual assets that represent 5% or more of the Plan's total assets, as of December 31, 2009 and 2008, are as follows:

	2009	2008
BOA - Fixed	$ 5,332,925	$ 5,084,537
Nationwide Money Market	1,329,410	1,745,356
Advisorone Amerigo FD	1,686,710	1,303,663
Van Kampen Equity & Inc A	1,390,055	1,194,322
Neu Ber Genesis FD TC	1,421,432	1,104,983
WFAF Gov Securities Inv Cl	1,057,402	-
Aim Basic Value Fd A	-	-
Aim Leisure Fund	-	-
Frank Msf Mutbea Fnd Cls A	-	-

5. FAIR VALUE

FASB ASC 820-10-65, *Fair Value Measurements,* establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unobservable inputs (Level 3 measurement). The three levels of the fair value hierarchy under FASB ASC 820-10-65 are described below:

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs to the valuation methodology include:
- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from, or corroborated by, observable market data by correlation or other means;

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

5. FAIR VALUE (CONTINUED)

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

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2009 and 2008.

Mutual funds: Valued at the net asset value (NAV) of shares held by the plan at year-end.

Guaranteed investment contracts: Valued at fair value by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the credit-worthiness of the issuer.

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

The following table sets forth, by level within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2009 and 2008:

	Fair Value Measurements Reporting Data Using Quoted Prices in Active Markets for Identical Assets (Level 1)	
Description	2009	2008
Mutual Funds	$ 14,314,514	$ 10,447,084
Cash and cash equivalents	1,329,410	1,745,356

	Fair Value Measurements Reporting Data Using Observable Inputs (Level 2)	
Description	2009	2008
Guaranteed investment contracts	$ 5,332,925	$ 5,084,537

Net appreciation in fair value of investments and earnings on the investments held by the Plan for the year ended December 31, 2009 was $3,436,390.

6. GUARANTEED INVESTMENT CONTRACT

The Plan entered into a benefit-responsive investment contract with Nationwide. Nationwide maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The contract is included in the financial statements at contract value as reported to the Plan by Nationwide. Contract value represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan.

6. GUARANTEED INVESTMENT CONTRACT (CONTINUED)

As described in Note 2, because the guaranteed investment contract is fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to the guaranteed investment contract. Contract value, as reported to the Plan by Nationwide, represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

Certain events limit the ability of the Plan to transact at contract value with the issuer. Such events include the following: (1) amendments to the Plan documents (including complete or partial Plan termination or merger with another plan), (2) changes to the Plan's prohibition on competing investment options or deletion of equity wash provisions, (3) bankruptcy of the Plan Sponsor or other Plan Sponsor events (for example, divestitures or spin-offs of a subsidiary) that cause a significant withdrawal from the Plan, or (4) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The Plan Administrator does not believe that any events that would limit the Plan's ability to transact at contract value with participants are probable of occurring.

The guaranteed investment contract does not permit the insurance company to terminate the agreement prior to the scheduled maturity date.

	2009	2008
Average yields:		
Based on actual earnings	3.20%	3.45%
Based on interest rate credited to participants	3.20%	3.45%

7. PLAN TERMINATION

Although it has not expressed any intent to do so, the Hospital 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.

8. INCOME TAX STATUS

The IRS has ruled (March 31, 2008) the Plan qualified under Section 401(a) of the Internal Revenue Code (IRC) and is, therefore, not subject to tax under present income tax law. Once qualified, the Plan is required to operate in conformity with the IRC to maintain its qualification. The Hospital is not aware of any course of action or series of events that have occurred that might adversely affect the Plan's qualified status.

9. RISKS AND UNCERTAINTIES

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

10. PARTY IN INTEREST

Certain Plan investments are shares of mutual funds managed by Nationwide Financial Services, Inc. ("Nationwide"). Nationwide is the Plan Trustee and asset custodian and, therefore, related investment transactions qualify as party-in-interest transactions.

11. SUBSEQUENT EVENTS

In preparing these financial statements, the Company has evaluated events and transactions for potential recognition or disclosure through October 12, 2010, the date the financial statements were available to be issued. No events arose subsequent to year-end that did not already exist as of the statement of net assets available for benefits date.

12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of the net assets available for benefits per the financial statements to Form 5500 as of December 31, 2009:

Total net assets available for benefits per the financial statements	$ 21,221,493
Less: Investments not included on Form 5500	(19,234)
Less: 2009 contribution receivable not shown on Form 5500	(149,655)
Total net assets available for benefits per Form 5500	$ 21,052,604

The following is a reconciliation of the net assets available for benefits per the financial statements to Form 5500 as of December 31, 2008:

Total net assets available for benefits per the financial statements	$ 17,514,450
Plus: Contributions from another plan shown on Form 5500	7,098
Less: 2008 contribution receivable not shown on Form 5500	(46,020)
Less: Excess of 2007 contribution receivable over 2008 contribution receivable not shown as invested in Form 5500	(18,258)
Less: Miscellaneous difference	(617)
Total net assets available for benefits per Form 5500	$ 17,456,653

The following is a reconciliation of the total investment activity and contributions per the financial statements to Form 5500 as of December 31, 2009:

Total investment activity and contributions per the financial statements	$ 4,738,357
Less: Contributions not captured on Form 5500	(3,620)
Less: Receivable activity not shown on Form 5500	(103,635)
Less: Activity classified as other income on Form 5500	(157)
Less: Transfers from another plan shown on Form 5500	(649)
Less: Retainer investment activity not shown on Form 5500	(19,315)
Add: Miscellaneous difference	3
Total investment activity and contributions per Form 5500	$ 4,610,984

12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (CONYINUED)

The following is a reconciliation of the total deductions per the financial statements for Form 5500 as of December 31, 2009:

Total deductions per the financial statements	$ 1,031,314
Less: benefits paid not included on for 5500	(16,735)
Total net assets available for benefits per Form 5500	$ 1,014,579

Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	2009 This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 10/01/1974

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

1460 ORANGE ST

COSHOCTON OH 43812-2229

2b Employer Identification Number (EIN) 31-4387577

2c Sponsor's telephone number 740-622-6411

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	R.K. Davis	10/14/2010	RICHARD K. DAVIS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	R.K. Davis	10/14/2010	RICHARD K. DAVIS
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") OPOC.us 300 W. Wilson Bridge Rd. Worthington OH 43085	**3b** Administrator's EIN 34-0141161 **3c** Administrator's telephone number 614-318-2200	
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**	646
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**	423
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	241
d Subtotal. Add lines **6a, 6b,** and **6c**	**6d**	664
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f Total. Add lines **6d** and **6e**	**6f**	664
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	664
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2C 2G 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)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	(2) [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	(3) [X] Trust
(4) [ ] General assets of the sponsor	(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	**b General Schedules**
(1) [X] **R** (Retirement Plan Information)	(1) [X] **H** (Financial Information)
(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) [ ] **I** (Financial Information – Small Plan)
	(3) [X] 1 **A** (Insurance Information)
	(4) [ ] **C** (Service Provider Information)
(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) [ ] **D** (DFE/Participating Plan Information)
	(6) [ ] **G** (Financial Transaction Schedules)

COSHOCTON COUNTY MEMORIAL HOSPITAL EMPLOYEES PENSION PLAN
FORM 5500 PLAN 001 EIN: 31-4387577
December 31, 2009

Schedule H, Part IV, Line 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

(a)	(b) Identity of Issue	(c) Description of Investment	(d) Current value
MONEY MARKET FUNDS			
*	NATIONWIDE FINANCIAL SERVICES, INC.	NATIONWIDE MONEY MKT FUND IC	$ 1,329,410
MUTUAL FUNDS			
	BANK OF AMERICA	BOA - FIXED	5,332,925
*	NATIONWIDE FINANCIAL SERVICES, INC.	ADVISORONE AMERIGO FD N	1,686,710
*	NATIONWIDE FINANCIAL SERVICES, INC.	NEU BER GENESIS FD TC	1,421,432
*	NATIONWIDE FINANCIAL SERVICES, INC.	VAN KAMPEN EQUITY AND INC A	1,390,055
*	NATIONWIDE FINANCIAL SERVICES, INC.	WFAF GOV SECURITIES INV CL	1,057,402
*	NATIONWIDE FINANCIAL SERVICES, INC.	CALVERT INCOME FD A	843,544
*	NATIONWIDE FINANCIAL SERVICES, INC.	JANUS TWENTY FND	624,606
*	NATIONWIDE FINANCIAL SERVICES, INC.	AIM BASIC VALUE FD A	613,677
*	NATIONWIDE FINANCIAL SERVICES, INC.	HARBOR INTERNATL FD INV CL	602,458
*	NATIONWIDE FINANCIAL SERVICES, INC.	AIM LEISURE FUND IC	598,670
*	NATIONWIDE FINANCIAL SERVICES, INC.	ADVONE DESCARTES	582,541
*	NATIONWIDE FINANCIAL SERVICES, INC.	OPPNHMR DEVL MARKETS FD A	567,365
*	NATIONWIDE FINANCIAL SERVICES, INC.	FRANK MSF METBEA FND CLS A	453,120
*	NATIONWIDE FINANCIAL SERVICES, INC.	FID ADV LEVERAGED CO STK A	399,224
*	NATIONWIDE FINANCIAL SERVICES, INC.	ADVONE BEROLINA	350,477
*	NATIONWIDE FINANCIAL SERVICES, INC.	JENSN 20/20 FOCUS FD A	247,090
*	NATIONWIDE FINANCIAL SERVICES, INC.	WFAF OPPOR FUND	219,010
*	NATIONWIDE FINANCIAL SERVICES, INC.	ADVISORONE CLERMONT FD N	209,837
*	NATIONWIDE FINANCIAL SERVICES, INC.	MFS VALUE FD A	205,584
*	NATIONWIDE FINANCIAL SERVICES, INC.	OPP GLOBAL FND CLS A	196,954
*	NATIONWIDE FINANCIAL SERVICES, INC.	AMFDS GR FD AM	185,769
*	NATIONWIDE FINANCIAL SERVICES, INC.	AIM MIDCAP COR EQUITY FD A	160,183
*	NATIONWIDE FINANCIAL SERVICES, INC.	DWS DRMN HI RTN EQ A	144,851
*	NATIONWIDE FINANCIAL SERVICES, INC.	OPP CAP APP FND CLS A	125,818
*	NATIONWIDE FINANCIAL SERVICES, INC.	NEU BER REGENCY FD TRUST	109,355
*	NATIONWIDE FINANCIAL SERVICES, INC.	BLKRK INTL OPP PORT INV A	106,040
*	NATIONWIDE FINANCIAL SERVICES, INC.	GROWTH FUND OF AMERICA R5	96,912
*	NATIONWIDE FINANCIAL SERVICES, INC.	ALLEGIANT SM CAP VALUE FD A	95,972
*	NATIONWIDE FINANCIAL SERVICES, INC.	ADVONE LIAHONA	92,406
*	NATIONWIDE FINANCIAL SERVICES, INC.	BUF SMCAP FD	92,044
*	NATIONWIDE FINANCIAL SERVICES, INC.	VAN KAMPEN MIDCAP GROWTH A	68,778
*	NATIONWIDE FINANCIAL SERVICES, INC.	AMFDS NEW WLD	67,240
*	NATIONWIDE FINANCIAL SERVICES, INC.	OPPNHMR INTL BOND FD A	62,856
*	NATIONWIDE FINANCIAL SERVICES, INC.	IVY SCIENCE AND TECH FUND Y	62,768
*	NATIONWIDE FINANCIAL SERVICES, INC.	PIONEER STRATEGIC INCOME A	60,802
*	NATIONWIDE FINANCIAL SERVICES, INC.	AIM REAL EST A	49,819
*	NATIONWIDE FINANCIAL SERVICES, INC.	BLKRK HLTH SCNC OPP INV A	46,754
*	NATIONWIDE FINANCIAL SERVICES, INC.	JENISN MDCAP GR A	42,229
*	NATIONWIDE FINANCIAL SERVICES, INC.	AMFDS HI INC TR	41,480
*	NATIONWIDE FINANCIAL SERVICES, INC.	FEDERATED CAP APPR FD A	38,014
*	NATIONWIDE FINANCIAL SERVICES, INC.	FID ADV SMALL CAP FD A	35,234
*	NATIONWIDE FINANCIAL SERVICES, INC.	RS PTNRS A	33,341
*	NATIONWIDE FINANCIAL SERVICES, INC.	IVY ASSET STRATEGY FD CL Y	30,125
*	NATIONWIDE FINANCIAL SERVICES, INC.	DWS HI INC INST	28,802
*	NATIONWIDE FINANCIAL SERVICES, INC.	AMCENT VAL A	27,393
*	NATIONWIDE FINANCIAL SERVICES, INC.	RYDEX SER NOVA FD AC	27,001
*	NATIONWIDE FINANCIAL SERVICES, INC.	TEMP FOREIGN FND CLS A	26,369
*	NATIONWIDE FINANCIAL SERVICES, INC.	EV WW HEALTH SCIENCES FD A	24,912
*	NATIONWIDE FINANCIAL SERVICES, INC.	AIM GLBL HLTH CARE INV CLS	16,127
*	NATIONWIDE FINANCIAL SERVICES, INC.	PRNCPL INV MDCAP BLND A	13,529
*	NATIONWIDE FINANCIAL SERVICES, INC.	PIMCO LOW DUR A	9,506
*	NATIONWIDE FINANCIAL SERVICES, INC.	HEARTLAND VALUE	9,190
*	NATIONWIDE FINANCIAL SERVICES, INC.	DREYFUS TECH GR A	4,884
*	NATIONWIDE FINANCIAL SERVICES, INC.	OPPHMR LTD TERM GOVT FD A	2,726
*	NATIONWIDE FINANCIAL SERVICES, INC.	BARON GR	1,983
*	NATIONWIDE FINANCIAL SERVICES, INC.	AM HIGH INCM TRUST CLS R5	1,936
*	NATIONWIDE FINANCIAL SERVICES, INC.	GROWTH FUND OF AMERICA	1,579
*	NATIONWIDE FINANCIAL SERVICES, INC.	NEW WORLD FUND CLASS R5	31
			19,647,439
			$ 20,976,849

* Party in interest

See independent auditors' report.