

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 2010 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>11/01/2010</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan; or ☒ 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:	☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information
1a Name of plan <u>FREMONT MEDICAL CENTER, LTD. 401K PLAN</u>	1b Three-digit plan number (PN) ► <u>001</u> 1c Effective date of plan <u>06/01/1993</u>
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD.</u> <u>770 EAST WARM SPRINGS ROAD</u> <u>SUITE 250</u> <u>LAS VEGAS, NV 89119</u>	2b Employer Identification Number (EIN) <u>88-0213519</u> 2c Sponsor's telephone number <u>702-932-8543</u> 2d Business code (see instructions) <u>621111</u>

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	<u>Filed with authorized/valid electronic signature.</u>	<u>10/17/2011</u>	<u>ANGELA SCURRY</u>
	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.

Form 5500 (2010)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD. 770 EAST WARM SPRINGS ROAD SUITE 250 LAS VEGAS, NV 89119	3b Administrator's EIN 88-0213519 3c Administrator's telephone number 702-932-8543
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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 FREMONT MEDICAL CENTER, LTD.	4b EIN 88-0322143 4c PN 001
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5 Total number of participants at the beginning of the plan year	5	336
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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	0
b Retired or separated participants receiving benefits.....	6b	0
c Other retired or separated participants entitled to future benefits.....	6c	0
d Subtotal. Add lines 6a , 6b , and 6c	6d	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	0
f Total. Add lines 6d and 6e	6f	0
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	0
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	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 2E 2F 2G 2J 2K 2S 2T 3D 3H

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:
 4B

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
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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) ☒ **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) ☒ **H** (Financial Information)
 (2) ☐ **I** (Financial Information – Small Plan)
 (3) ☒ **A** (Insurance Information)
 (4) ☒ **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 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 11/01/2010		
A Name of plan FREMONT MEDICAL CENTER, LTD. 401K PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500. AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD.	D Employer Identification Number (EIN) 88-0213519	

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.
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1 Coverage Information:

(a) Name of insurance carrier
NEW YORK 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
13-5582869	66915	P55788	1	05/01/2010	04/30/2011

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
DAVID FUNK, CLU 5214 ANNIE OAKLEY DRIVE LAS VEGAS, NV 89120

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	0		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	

(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 ▶ AS STATED ON THE INDIVIDUAL POLICY		
b Premiums paid to carrier	6b	2826
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) ☒ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add b and c(6)).	7d	
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)	7e(4)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract e(5) from d)	7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE 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 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 11/01/2010		
A Name of plan FREMONT MEDICAL CENTER, LTD. 401K PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500. AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD.	D Employer Identification Number (EIN) 88-0213519	

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.
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1 Coverage Information:

(a) Name of insurance carrier
PHOENIX 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
06-0493340	67814	M52504	3	01/01/2010	12/31/2010

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
217	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

PHILLIP S. RICHARDS
PO BOX 8027
BOSTON, MA 02266-8027

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
217			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	

(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 ▶ AS STATED ON INDIVIDUAL POLICY		
b Premiums paid to carrier	6b	7241
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) ☒ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐		
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits	7c(2)	
(3) Interest credited during the year	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add b and c(6)).	7d	
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)	7e(4)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract e(5) from d)	7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2010
		This Form is Open to Public Inspection.
For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 11/01/2010		
A Name of plan FREMONT MEDICAL CENTER, LTD. 401K PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD.	D Employer Identification Number (EIN) 88-0213519	

Part I	Service Provider Information (see instructions)
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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
CHARLES SCHWAB INVESTMENT MGMT INC.
94-3106735

(b) Enter name and EIN or address of person who provided you disclosure 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)

NEWPORT RETIREMENT SERVICES, INC.

62-1868111

(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 15 37 60 64 50	NONE	19492	Yes ☒ No ☐	Yes ☐ No ☒	5847	Yes ☐ No ☒

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

THE INVESTMENT COUNSEL COMPANY

88-0228985

(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?
28 51	NONE	30932	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CHARLES SCHWAB TRUST COMPANY

42-1558009

(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 19 65 99	NONE	0	Yes ☒ No ☐	Yes ☒ No ☐	7162	Yes ☐ No ☒

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NEWPORT RETIREMENT SERVICES, INC.	12 15 37 60 64	5847
(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.	
CHARLES SCHWAB AND COMPANY, INC. 94-1737782	REVENUE SHARING USED TO OFFSET PLAN EXPENSES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CHARLES SCHWAB TRUST COMPANY	12 19 65 99	7162
(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.	
NEWPORT RETIREMENT SERVICES, INC. 62-1868111	TRUST TRADE PARTNER/CUSTODIAN FEES FOR PLAN YEAR	
(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)
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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:

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

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

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

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

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
		2010
		This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 11/01/2010		
A Name of plan FREMONT MEDICAL CENTER, LTD. 401K PLAN	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD.	D Employer Identification Number (EIN) 88-0213519	

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	
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)	177114	0
(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)	84365	0
(9) Value of interest in common/collective trusts	1c(9)	515699	0
(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)	6305204	0
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(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	7082382	0

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 through 1j)	1k	0	0

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	7082382	0
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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 Contributions:**

		(a) Amount	(b) Total
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	133044	
(B) Participants	2a(1)(B)	395345	
(C) Others (including rollovers)	2a(1)(C)	187239	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		715628

b Earnings on investments:**(1) Interest:**

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	19	
(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)	2344	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		2363

(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)	48875	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		48875

(3) Rents	2b(3)		
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(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0
(6) Net investment gain (loss) from common/collective trusts	2b(6)		7082
(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)		547305
c Other income.....	2c		597867
d Total income. Add all income amounts in column (b) and enter total.....	2d		1919120

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1231598	
(2) To insurance carriers for the provision of benefits	2e(2)	3176	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		1234774
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)	19492	
(3) Investment advisory and management fees	2i(3)	30932	
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		50424
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		1285198

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		633922
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		7716304

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: BRADSHAW, SMITH & CO., LLP

(2) EIN: 88-0213519

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.).....		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.).....		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.)		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.).....		X	
e Was this plan covered by a fidelity bond?.....	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?		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?		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?		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.).....	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.).....		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?.....	X		
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....	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.	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: 0

- 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)
HEALTHCARE PARTNERS OF NEVADA 401(K) PLAN	74-3177329	001

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
		2010
		This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>11/01/2010</u>		
A Name of plan <u>FREMONT MEDICAL CENTER, LTD. 401K PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>	
C Plan sponsor's name as shown on line 2a of Form 5500 <u>AMIR BACCHUS, M.D., FREMONT MEDICAL CENTER, LTD.</u>	D Employer Identification Number (EIN) <u>88-0213519</u>	

Part I	Distributions
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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	<u>0</u>
----------	----------

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): 42-1558009

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

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN
REPORT ON AUDIT OF FINANCIAL STATEMENTS
FOR THE YEAR ENDED DECEMBER 31, 2010

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

FOR THE YEAR ENDED DECEMBER 31, 2010

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Bradshaw, Smith & Co., LLP

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INDEPENDENT AUDITORS' REPORT

The Advisory Committee and Participants
Fremont Medical Center, Ltd. 401(k) Plan
Las Vegas, Nevada

We were engaged to audit the financial statements of Fremont Medical Center, Ltd. 401(k) Plan as of December 31, 2010 and 2009, and for the year ended December 31, 2010, as listed in the accompanying index. These financial statements are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by The Charles Schwab Trust Company, the custodian of the Plan, except for comparing the information with the related information included in the financial statements. We have been informed by the plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the custodian as of December 31, 2010 and 2009 and for the year ended December 31, 2010, 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 taken as a whole. The form and content of the information included in the financial statements, 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.

Bradshaw, Smith & Co., LLP

October 13, 2011

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

AS OF DECEMBER 31, 2010 AND 2009

	2010	2009
Assets:		
Investments, at fair value:		
Money market fund	\$ --	\$ 177,114
Collective investment trust fund	--	518,123
Mutual funds	--	6,305,204
	--	7,000,441
Cash	--	4,510
Employer contributions receivable	--	5,754
Participant contributions receivable	--	6,158
Notes receivable from participants	--	79,283
	--	95,705
Total assets	--	7,096,146
Liabilities:		
Other liabilities	--	35,189
Net assets reflecting all investments at fair value	--	7,060,957
Adjustment from fair value to contract value for fully benefit-responsive investment contracts	--	(2,424)
Net assets available for benefits	\$ --	\$ 7,058,533

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

FOR THE YEAR ENDED DECEMBER 31, 2010

Additions to net assets:

Investment income:

Net appreciation in fair value of investments	\$ 563,639
Interest	2,344
Dividends	48,896
Employer contributions	133,210
Participant contributions	383,805
Rollovers	785,106

Total additions	<u>1,917,000</u>
------------------------	------------------

Deductions from net assets:

Benefits paid to participants	1,204,326
Plan expenses	50,424
Transfer of plan assets due to merger	7,716,280
Other	4,503

Total deductions	<u>8,975,533</u>
-------------------------	------------------

Net decrease in net assets available for benefits	<u>(7,058,533)</u>
--	--------------------

Net assets available for benefits:

Beginning of year	<u>7,058,533</u>
End of year	<u>\$ --</u>

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS

FOR THE YEAR ENDED DECEMBER 31, 2010

1. History and description of the Plan:

The Fremont Medical Center, Ltd. 401(k) Plan (the "Plan") (formerly the J. Corey Brown M.D., Fremont Medical Center, LTD. 401(k) Plan and the Fremont Primary Care 401(k) Plan) was established with an effective date of July 1, 1993. The Plan and Trust agreement were written to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) and the provisions of the Tax Reform Act of 1986.

Plan participants should refer to the Plan document for a complete description of the Plan's provisions. A description of the major aspects of the Plan after being restated and amended is as follows:

Amendments:

Effective January 1, 2009 the Plan was amended to change the Plan name to the J. Corey Brown M.D., Fremont Medical Center, Ltd. 401(k) Plan. The Plan Sponsor was also changed to the J. Corey Brown M.D., Fremont Medical Center, Ltd.

On July 1, 2009 the plan sponsor was acquired by HealthCare Partners of Nevada. At acquisition, all non-physician participants were eligible to participate and rollover their accounts into an existing plan of HealthCare Partners of Nevada and could no longer contribute to this Plan. All physician participants remained eligible to participate in the Plan. At the time of the acquisition, there were a group of employees that were spun off into another entity and not included in the purchase. These employees were no longer eligible to participant in the Plan after the purchase however, these employees were allowed to make contributions after July 1, 2009 in error. Plan management corrected these contributions using voluntary plan correction procedures. Other liabilities at December 31, 2009 include \$33,189 relating to these contributions.

Effective in 2010 the Plan name was changed to the Fremont Medical Center, Ltd. 401(k) Plan and the Plan Sponsor name was also changed to the Amir Bacchus, M.D., Fremont Medical Center, Ltd.

Effective March 2010 the Plan was amended to recognize service with the employer Rainbow Medical Centers.

Merger:

Management of HealthCare Partners of Nevada, a controlling party of the Plan Sponsor, approved the merger of this Plan into the Healthcare Partners of Nevada 401(k) Plan (the "HCP Plan"). All assets of the Plan were transferred into the HCP Plan on November 1, 2010. A summary of the transferred assets follows:

Investments	\$ 7,630,341
Notes receivable from participants	85,939
	<hr/>
	\$ 7,716,280
	<hr/>

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

1. History and description of the Plan (continued):

Organization:

Amir Bacchus, M.D., Fremont Medical Center, Ltd. ("Employer") is the Plan Administrator. The Plan permits the Plan Administrator to appoint an Advisory Committee to oversee the operations of the Plan.

Eligibility:

All employees who met the following requirements were eligible under the Plan: (a) the employee has attained age twenty-one, (b) the employee's job description is not covered by a collective bargaining agreement, (c) the employee has completed three months of service, and (d) the employee is neither a leased employee nor a nonresident alien who does not receive any earned income from the Employer which constitutes U. S. source income.

Plan participant:

The participation of any employee eligible to become a participant commenced as of the first day of the month immediately following or coinciding with the completion of the eligibility requirements.

Contributions:

An eligible employee could make elective salary reduction contributions, limited to the maximum dollar limitation in effect for the calendar year which was \$16,500 in 2010. In addition, participants who attained age 50 or older by the end of the Plan year could elect to defer additional amounts called "catch-up contributions". The maximum catch-up contribution for 2010 was \$5,500. Contributions were made by payroll deductions from gross pay to the Plan. Participants directed the investment of their contributions into various investment options offered by the Plan. The Plan automatically deferred 3% of base compensation when an employee became eligible to participate in the Plan unless an enrollment form was completed.

The Employer made matching contributions equal to fifty percent (50%) of the first 6% of base compensation that a participant contributed to the Plan. In addition, the Employer was allowed to make discretionary non-elective contributions that would be allocated to non-highly compensated employees only. The Employer did not have to have net profits to make its contributions under this Plan.

Vesting:

Upon attaining the normal retirement age, or in the event of termination of a participant's employment by reason of his death or disability, the full value of the employee's account as of the day the Trustee of the Plan is notified of such an occurrence, became fully vested. A participant's voluntary account was fully vested at all times.

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

1. History and description of the Plan (continued):

Vesting (continued):

In the event of termination for any other reason, the percentage of vesting was determined by the years of service in accordance with the following schedule:

<u>Number of years of service</u>	<u>Percentage of balance of account vested</u>
Less than 2 years	0%
2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 or more years	100%

Forfeitures:

Upon termination, the remainder of the terminating participant's account, which was not vested in accordance with the foregoing vesting schedule, was to be applied first to reduce administrative expenses and then to reduce future matching contributions. If the participant was re-employed before incurring a forfeiture break in service, his unvested portion was returned to his account and he continued to earn vesting in the account. A forfeiture break in service is a period of five consecutive vesting service periods in which an employee did not work more than five hundred hours in each vesting service period comprising the five year period.

At December 31, 2010 and 2009 there were \$0 and \$42,860, respectively, in forfeited nonvested accounts. During the year ended December 31, 2010, there were \$25,651 in forfeitures from non-vested accounts. On November 1, 2010, \$44,113 of forfeiture accounts were transferred to the HCP Plan as part of the merger.

Notes receivable from participants:

Plan participants could apply for a loan ranging from \$1,000 to \$50,000, up to fifty percent (50%) of a participant's vested account balance. The \$50,000 maximum loan amount was to be reduced by the participant's highest outstanding loan balance in the previous twelve months, even if the amounts have been repaid. Interest rates were calculated at the beginning of the loan term at 1% above the prime rate published by the Wall Street Journal. Repayments of loan balances were made through payroll deductions. A participant could pay off the outstanding loan balance at any time. The Plan Administrator declared a loan in default when any payment was not received by the end of the calendar quarter following its original due date.

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

1. History and description of the Plan (continued):

Administrative expenses:

As more fully described in Note 7, some administrative expenses were paid by the Employer. Participant's accounts were subject to a .25% annual recordkeeping fee. Participants were subject to a \$75 processing fee on applying for a loan from the Plan. In addition, a \$25 annual loan maintenance fee was deducted from participant's accounts.

Payment of benefits:

Upon termination of service due to death, disability or retirement, a participant with a vested balance of at least \$5,000 could elect to leave the account in the Plan or could elect to receive a lump sum distribution. If the participant's balance is at least \$1,000 but less than \$5,000, the vested balance was to be directly rolled over to an individual retirement plan designated by the administration, unless the participant specified otherwise. If the vested balance did not exceed \$1,000, a lump sum distribution was automatically made. Benefits were recorded when paid.

Allocated insurance contracts:

Effective September 29, 2003, the Plan was amended to credit as service under the Plan the predecessor employer of Children's Clinic, Dushman, Dorway, Naiman & Globel, Ltd. ("Children's Clinic"). During 2004, allocated life insurance contracts were rolled into the Plan from the participants with service under the Children's Clinic. These insurance contracts were individual ordinary life insurance policies with Phoenix Life Insurance Company and New York Life Insurance Company and were fully guaranteed by the insurance companies, which had a legal obligation to make the benefit payments to the participants covered by the policies. The allocated insurance contracts totaled \$464,368 at December 31, 2009, and were excluded from Plan assets. In 2010, all of the insurance policies were surrendered and the cash value of the policies totaling \$597,867 was rolled into the Plan. The Plan has no policy to purchase allocated insurance contracts.

2. Summary of accounting policies:

Basis of accounting:

The financial statements of the Plan have been prepared on the accrual basis of accounting.

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

2. Summary of accounting policies (continued):

Valuation:

Plan assets are stated at fair value, except the collective investment trust fund as stated below, as reported to the Plan by The Charles Schwab Trust Company ("Custodian"). The investments in mutual funds are valued at quoted market prices which represent the net asset value of shares held by the Plan at year end. The investment in the money market fund is valued at amortized cost, which approximates market value. Unrealized gains and losses resulting from the valuation of the investments and realized gains and losses from the sale of investments, determined by average cost, are recognized in the statement of changes in net assets available for benefits. Security transactions are accounted for on the date the securities are purchased or sold. Interest income is recorded when received and dividend income and distributions are recorded at the ex-dividend date. All Plan assets were transferred to the HCP Plan on November 1, 2010.

At December 31, 2009, the Plan had invested in the Union Bond & Trust Company Stable Value Fund ("Fund"), which is a collective investment trust designed for retirement trusts. The Fund invests in conventional, synthetic and separate account investment contracts issued by life insurance companies, banks and other financial institutions which are fully benefit-responsive. Investment contracts held by a defined-contribution 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 defined contribution 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. 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 contract from fair value to contract value. The Statement of Changes in Net Assets Available for Benefits is prepared on a contract value basis. The fair value to contract value ratio was 100.47% for the year ended December 31, 2009. The blended net crediting rate for the Fund was 2.524% for the year ended December 31, 2009, and is calculated based on the weighted average crediting rate of all investment contracts and short term income at year end. Market yield for the Fund was 2.254% for the year ended December 31, 2009, and is calculated based on the weighted average yield to maturity of all underlying investments at year end.

Income taxes:

The Plan obtained its latest determination letter on March 8, 1996 in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has also obtained an opinion letter from the Internal Revenue Service dated June 3, 2004 with respect to a Plan amendment. The Plan has been amended since receiving the determination letter and opinion letter. However, the Plan Administrator believes that the Plan was designed and operated in compliance with applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Plan's financial statements.

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

2. Summary of accounting policies (continued):

Use of estimates:

The preparation of financial statements in conformity with generally accepted accounting principles requires the Plan Administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from these estimates.

Participant accounts:

Each participant's account was credited with the participants' contributions and allocations of (a) the Company's contributions, and (b) Plan earnings (including net realized and unrealized investment gains and losses), and charged with an allocation of administrative expenses. Allocations were based on participant account balances. The benefit to which a participant was entitled was the benefit that could be provided from the participant's vested account. All participant account balances were transferred to the HCP Plan on November 1, 2010.

Recent accounting pronouncements:

In September 2010, new accounting standards were issued to clarify the classification and measurement of participant loans of a defined contribution plan. Effective for fiscal years ending after December 15, 2010, and applicable retrospectively to all prior periods presented, participant loans are now classified as notes receivable from participants and are measured at their unpaid principal balance plus any accrued but unpaid interest. Notes receivable from participants are not subject to fair value measurements and disclosures. The Plan adopted the new accounting pronouncement as of December 31, 2010.

Reclassifications:

Certain amounts in the December 31, 2009 financial statements have been reclassified to conform to the December 31, 2010 presentation.

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

3. Information prepared and certified by custodian:

The following information included in the accompanying financial statements was obtained from data that has been prepared and certified to as complete and accurate by the custodian, The Charles Schwab Trust Company.

	<u>2010</u>	<u>2009</u>
Investments:		
Mutual funds, at fair value	\$ --	\$ 6,305,204
Collective investment trust fund, at contract value	--	515,699
Money market fund, at fair value	--	177,114
Cash	--	4,510
Net appreciation in fair value of investments	563,639	
Dividends	48,896	

4. Investments, at fair value:

The Plan's investments consisted primarily of participant-directed mutual funds held in a trust account at The Charles Schwab Trust Company. All investments were transferred to the HCP Plan on November 1, 2010.

Investments that represent 5% or more of the Plan's net assets available for benefits as of December 31, 2009 are as follows:

Vanguard Life Strategy Star Conservative Growth Portfolio	\$ 1,297,160
Vanguard Life Strategy Growth Fund	662,966
Union Bond & Trust Company Stable Value Fund	518,123
Rainier Large Cap Equity Portfolio	462,772
WHG Large Cap Value Inst I	433,258
Artio International Equity Fund I	404,601
Dodge & Cox Income Fund	404,288
Oppenheimer Global Fund	396,863
Artisan Small-Cap Value Fund	359,633
Total investments that represent 5% or more of Plan's net assets	4,939,664
Other	2,060,777
Total investments	<u>\$ 7,000,441</u>

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

5. Fair value measurements:

Financial Accounting Standards Board ("FASB"), Accounting Standards Codification ("ASC"), *Fair Value Measurement and Disclosures*, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. If no Level 1 inputs were available to the Plan, then Level 2 inputs were used. The following is a description of the valuation methodologies used for assets measured at fair value.

Level 1 fair value measurements:

The fair value of mutual funds is based on quoted net asset values of the shares held by the Plan at year-end.

Level 2 fair value measurements:

The fair value of guaranteed investment contracts is based on the present value of future cash flows using the current discount rate. The fair value of the money market fund is based on amortized cost.

The following table sets forth by level, with the fair value hierarchy, the Plan's fair value measurement information for certain financial instruments as of December 31, 2009.

	Assets at fair value			
	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Total
Money market fund	\$ --	\$ 177,114	\$ --	\$ 177,114
Mutual funds	6,305,204	--	--	6,305,204
Collective investment trust fund	--	518,123	--	518,123
	<u>\$ 6,305,204</u>	<u>\$ 695,237</u>	<u>\$ --</u>	<u>\$ 7,000,441</u>

During the year ended December 31, 2010, \$155,583 of investments measured using Level 1 inputs was transferred to investments measured using Level 2 inputs at the direction of participants. Transfers are reported at their net amounts as of the end of the reporting period.

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

6. Nondiscrimination testing:

The Plan's nondiscrimination test for 401(k) elective deferrals (the ADP Test) and employer matching contributions (the ACP test) for 2010 and 2009 had not been completed as of the report date. If the Plan fails the tests, contributions may have to be distributed to participants and applicable excise taxes paid. The Plan's management does not believe the results of the nondiscrimination testing will have a material adverse effect on the Plan.

7. Related party transactions:

Administrative expenses:

The Plan sponsor has paid significant Plan administration costs for the year ended December 31, 2010.

The Plan provided administration through The Newport Group and investment management through the Investment Counsel, parties-in-interest. Fees for these services amounted to \$50,424 for the year ended December 31, 2010.

8. Plan expenses:

Fees paid by the Plan during the year ended December 31, 2010 consisted of the following:

Commissions and fees	\$ 19,492
Consulting fees	30,932
	<u>\$ 50,424</u>

9. Net appreciation in fair value of investments:

Net appreciation in fair value of investments for the year ended December 31, 2010 consisted of realized gains on investments as follows:

Collective investment trust fund	\$ 9,491
Mutual funds	554,148
	<u>\$ 563,639</u>

FREMONT MEDICAL CENTER, LTD. 401(K) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

FOR THE YEAR ENDED DECEMBER 31, 2010

10. Reconciliation of financial statements to Form 5500:

The following is a reconciliation of the net decrease in net assets available for benefits per the financial statements for the year ended December 31, 2010 to Schedule H of Form 5500:

Net decrease in net assets per financial statements	\$ (7,058,533)
Plus contributions receivable at December 31, 2009	11,912
Plus prior year cash adjustment	4,510
Plus transfers of assets per Schedule H of Form 5500	7,716,304
Less payable at December 31, 2009	(35,189)
Less defaulted loans distributed per financial statements in prior year	<u>(5,082)</u>
Net income per Schedule H of Form 5500	<u>\$ 633,922</u>

The Form 5500 is prepared on a cash basis and, accordingly, recognizes contributions and other receivables when received and contributions payable and other liabilities when paid. Additionally, the Form 5500 does not report cash balances until they are traded and posted to the recordkeeping system.

11. Risks and uncertainties:

The Plan provided for investments in various securities which, in general, were exposed to various risks, such as interest rate, credit, and overall market volatility risks.

12. Subsequent events:

Management has evaluated subsequent events through October 13, 2011, the date the financial statements were available to be issued.