Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2009

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [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:
- [ ] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
PEORIA HOSPITALS MOBILE MEDICAL SERVICES DBA ADVANCED MEDICAL TRANSPORT OF CENTRAL ILLINOIS 403(B) PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/1994

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
PEORIA HOSPITALS MOBILE MEDICAL SERVICES
ADVANCED MEDICAL TRANSPORT

P.O. BOX 1569
PEORIA, IL 61655-1569

1718 N. STERLING AVE.
PEORIA, IL 61655-1569

2b Employer Identification Number (EIN)
37-0999878

2c Sponsor's telephone number
309-494-6206

2d Business code (see instructions)
621900

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.	06/04/2012	JERRY KOLB
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	06/04/2012	JERRY KOLB
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

PEORIA HOSPITALS MOBILE MEDICAL SERVICES
ADVANCED MEDIAL TRANSPORT
1718 N. STERLING AVE.
PEORIA, IL 61655-1569

3b Administrator's EIN: 37-0999878

3c Administrator's telephone number: 309-494-6206

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**	180
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**	225
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	8
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	233
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	233
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	103
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

2E 2G 2K 2M

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

A Name of plan
PEORIA HOSPITALS MOBILE MEDICAL SERVICES DBA ADVANCED MEDICAL TRANSPORT OF CENTRAL ILLINOIS 403(B) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
PEORIA HOSPITALS MOBILE MEDICAL SERVICES

D Employer Identification Number (EIN)
37-0999878

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)

ALLIANCE BENEFIT GROUP OF ILLINOIS

456 FULTON STREET
SUITE 345
PEORIA, IL 61602

37-0899315

(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	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	2870	Yes [ ] No [X]

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

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

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

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

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

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

(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
ALLIANCE BENEFIT GROUP OF ILLINOIS	59	2870
(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.	
FIDELITY INVESTMENTS 04-3523567	SHAREHOLDER SERVICING FEES USED TO PAY TPA FEES	

(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

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

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

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

A Name of plan
PEORIA HOSPITALS MOBILE MEDICAL SERVICES DBA ADVANCED MEDICAL TRANSPORT OF CENTRAL ILLINOIS 403(B) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
PEORIA HOSPITALS MOBILE MEDICAL SERVICES

D Employer Identification Number (EIN)
37-0999878

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)	1663	7142
(2) Participant contributions	1b(2)	6652	14284
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	81331	138353
(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)	1033909	1521757
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	1123555	1681536
	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	1123555	1681536

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)	96044	
	(B) Participants	2a(1)(B)	192080	
	(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)		288124
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	604	
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		604
	(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)	19487	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		19487
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0

			(a) Amount	(b) Total
2b	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0
	(6) Net investment gain (loss) from common/collective trusts	2b(6)		
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		299155
c	Other income	2c		
d	Total income. Add all **income** amounts in column (b) and enter total	2d		607370
	Expenses			
e	Benefit payment and payments to provide benefits:			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	48265	
	(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)		48265
f	Corrective distributions (see instructions)	2f		1124
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		49389
	Net Income and Reconciliation			
k	Net income (loss). Subtract line 2j from line 2d	2k		557981
l	Transfers of assets:			
	(1) To this plan	2l(1)		
	(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] 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 [X] No

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

(1) Name: CLIFTONLARSONALLEN **(2)** EIN: 41-0746749

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		111287
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		100000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n		X	

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

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

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

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

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

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

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

A Name of plan
PEORIA HOSPITALS MOBILE MEDICAL SERVICES DBA ADVANCED MEDICAL TRANSPORT OF CENTRAL ILLINOIS 403(B) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
PEORIA HOSPITALS MOBILE MEDICAL SERVICES

D Employer Identification Number (EIN)
37-0999878

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): 37-0899315

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

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

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

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

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

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

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

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

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

---

a Name of contributing employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES DBA ADVANCED MEDICAL TRANSPORT SERVICES OF CENTRAL ILLINOIS 403(B) PLAN

Peoria, Illinois

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

December 31, 2009 and 2008

CliftonLarsonAllen

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES
DBA ADVANCED MEDICAL TRANSPORT SERVICES
OF CENTRAL ILLINOIS 403(B) PLAN

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CliftonLarsonAllen LLP
www.cliftonlarsonallen.com

Independent Auditor's Report

Plan Administrator
Peoria Hospital's Mobile Medical Services
DBA Advanced Medical Transport Services of Central Illinois
403(b) Plan
Peoria, Illinois

We have audited the accompanying statement of net assets available for benefits of Peoria Hospital's Mobile Medical Services DBA Advanced Medical Transport Services of Central Illinois 403(b) Plan as of December 31, 2009, and the related statement of changes in net assets available for benefits for the year then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits of Peoria Hospital's Mobile Medical Services DBA Advanced Medical Transport Services of Central Illinois 403(b) Plan, as of December 31, 2009, and the changes in its net assets available for benefits for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplementary schedules are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulation for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the 2009 financial statements. The information has been subjected to the auditing procedures applied in the audit of the 2009 financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the 2009 financial statements or to the 2009 financial statements themselves, and other procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the 2009 financial statements as a whole.

We have compiled the accompanying statement of net assets available for benefits of Peoria Hospital's Mobile Medical Services DBA Advanced Medical Transport Services of Central Illinois 403(b) Plan as of December 31, 2008 in accordance with Statements on Standards for Accounting and Review Services issued by the American Institute of Certified Public Accountants. A compilation is limited to presenting in the form of financial statements information that is the representation of management. We have not audited or reviewed the accompanying December 31, 2008 financial statement and, accordingly, do not express an opinion or any other form of assurance on it.

CliftonLarsonAllen LLP

Peoria, Illinois
May 11, 2012

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES
DBA ADVANCED MEDICAL TRANSPORT SERVICES
OF CENTRAL ILLINOIS 403(B) PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2009 and 2008

ASSETS

	2009	2008 (Unaudited)
PARTICIPANT - DIRECTED INVESTMENTS	$ 1,660,110	$ 1,115,240
RECEIVABLES		
Company contributions	7,142	1,663
Participant contributions	14,284	6,652
Total receivables	21,426	8,315
NET ASSETS AVAILABLE FOR BENEFITS	$ 1,681,536	$ 1,123,555

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

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES
DBA ADVANCED MEDICAL TRANSPORT SERVICES
OF CENTRAL ILLINOIS 403(B) PLAN
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Year Ended December 31, 2009

ADDITIONS	
Investment income:	
Net appreciation in fair value of investments	$ 299,158
Interest and dividends	20,088
Total investment income	319,246
Contributions:	
Employer's	96,044
Participants'	192,080
Total contributions	288,124
Total additions	607,370
DEDUCTIONS	
Benefits paid to participants	49,389
NET INCREASE	557,981
NET ASSETS AVAILABLE FOR BENEFITS, BEGINNING OF YEAR	1,123,555
NET ASSETS AVAILABLE FOR BENEFITS, END OF YEAR	$ 1,681,536

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

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES
DBA ADVANCED MEDICAL TRANSPORT SERVICES
OF CENTRAL ILLINOIS 403(B) PLAN
NOTES TO FINANCIAL STATEMENTS
December 31, 2009 and 2008

NOTE 1 - DESCRIPTION OF PLAN

The following description of Peoria Hospital's Mobile Medical Services DBA Advanced Medical Transport Services of Central Illinois (Organization) 403(b) Plan (Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

(a) General

The Plan is a defined contribution plan covering all eligible employees of the Organization. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

(b) Contributions

Participants may voluntarily contribute up to 100 percent of their pretax annual compensation, as defined in the Plan. In addition, any participant may request the Plan to accept a rollover contribution or Plan transfer received by such participant from a qualified plan. Additional amounts will be contributed by the Organization according to provisions of the Plan. For the year ended December 31, 2009, the Organization matched 50 percent of the amount contributed by the participant up to a total match of 20 percent of eligible wages. Participants direct the investment of their contributions and amounts contributed by the Organization into various investment options offered by the Plan. Contributions are subject to certain limitations.

(c) Participant Accounts

Each participant's account is credited with the participant's contribution, the Organization's matching contributions, and allocations of Plan earnings. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

(d) Vesting

Participants are immediately vested in their contributions and Organization contributions plus actual earnings thereon.

NOTE 1 - DESCRIPTION OF PLAN (CONTINUED)

(e) Payment of Benefits

On termination of service due to death, disability, or retirement, a participant with an account balance greater than $5,000 may elect to receive his or her account balance in either a lump-sum amount or in installments over a period of not more than the participant's assumed life expectancy or the assumed life expectancy of the participant and the beneficiary. If the participant's balance does not exceed $5,000, then the benefit must be distributed in a single lump-sum payment. Any distribution to a participant who has a benefit which exceeds $5,000 shall require such participant's consent. In-service distributions are also available for participants due to reaching the age of 59 ½, hardship, or disability.

NOTE 2 - SUMMARY OF ACCOUNTING POLICIES

(a) Basis of Accounting

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

(b) Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles 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.

(c) Investment Valuation and Income Recognition

The Plan's investments are stated at fair value, based on quoted market prices. See Note 4 for discussion of fair value measurements.

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

(d) Payment of Benefits

Benefits are recorded when paid.

NOTE 2 - SUMMARY OF ACCOUNTING POLICIES (CONTINUED)

(e) Expenses

Administrative expenses are paid by the Organization.

(f) Subsequent Events

Management evaluated subsequent events through May 11, 2012, the date the financial statements were available to be issued.

NOTE 3 - INVESTMENTS

The following presents the fair value of individual investments that represent 5 percent or more of the Plan's net assets available for benefits as of December 31, 2009 and 2008:

	2009	2008
Janus Worldwide Fund	$ 297,778	$ 197,181
Dreyfus Short Intermediate Government	208,089	173,821
Janus Orion Fund	170,258	101,752
Fidelity Money Market	138,099	81,104
Neuberger Berman Guardian Trust	137,106	92,662
Columbia Total Return Bond Fund	118,583	91,582
T Rowe Price Equity Income	96,594	62,969
First American Mid Cap Value	85,943	*

* Investment did not represent 5 percent or more of the Plan's net assets available for benefits.

NOTE 4 - FAIR VALUE MEASUREMENTS

In determining fair value, the Plan uses various valuation approaches within the required fair value measurement framework. Fair value measurements are determined based upon the assumptions that market participants would use in pricing an asset or liability.

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

Generally Accepted Accounting Principles ("GAAP") establishes a hierarchy for inputs in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Defined levels within the hierarchy based on the reliability of inputs as follows:

- Level 1 - Valuations based on unadjusted quoted prices for identical assets or liabilities in active markets;
- Level 2 - Valuations based on quoted prices for similar assets or liabilities or identical assets or liabilities in less active markets, such as dealer or broker markets; and
- Level 3 - Valuations derived from valuation techniques in which one or more significant inputs or significant value drivers are unobservable, such as pricing models, discounted cash flow models and similar techniques not based on market, exchange, dealer or broker-traded transactions.

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

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

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

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

NOTE 4 - FAIR VALUE MEASUREMENTS (CONTINUED)

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

	2009			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds:				
Domestic equities	$ 665,246	$ -	$ -	$ 665,246
International equities	529,838	-	-	529,838
Bond funds	326,672	-	-	326,672
Money market funds	138,354	-	-	138,354
Total assets at fair value	$ 1,660,110	$ -	$ -	$ 1,660,110

	2008			
	Level 1	**Level 2**	**Level 3**	**Total**
Mutual funds:				
Domestic equities	$ 431,416	$ -	$ -	$ 431,416
International equities	337,090	-	-	337,090
Bond funds	265,403	-	-	265,403
Money market funds	81,331	-	-	81,331
Total assets at fair value	$ 1,115,240	$ -	$ -	$ 1,115,240

NOTE 5 - PLAN TERMINATION

Although it has not expressed any intent to do so, the Organization has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

NOTE 6 - TAX STATUS

The Organization has adopted a standardized form of a prototype plan sponsored by Alliance Benefit Group, the trustee of the Plan. The prototype plan has not received an opinion letter from the Internal Revenue Service, however, the Plan administrator believes that the Plan is designed and is being operated in compliance with the applicable provisions of the Internal Revenue Service.

NOTE 7 - 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 statements of net assets available for benefits.

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES
DBA ADVANCED MEDICAL TRANSPORT SERVICES
OF CENTRAL ILLINOIS 403(B) PLAN
EIN: 37-0999878
PLAN: 001
SCHEDULE H, LINE 4(i) - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
December 31, 2009

(a) Party-in-Interest Identification	(b) Identity of Issue, Borrower, Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(d) Cost**	(e) Current Value
	Janus Worldwide Fund	Mutual Fund		$ 297,778
	Dreyfus Short Intermediate Government	Mutual Fund		208,089
	Janus Orion Fund	Mutual Fund		170,258
*	Fidelity Money Market	Money Market Account		138,099
	Neuberger Berman Guardian Trust	Mutual Fund		137,106
	Columbia Total Return Bond Fund	Mutual Fund		118,583
	T Rowe Price Equity Income	Mutual Fund		96,594
	First American Mid Cap Value	Mutual Fund		85,943
	Columbia Acorn	Mutual Fund		83,773
	Keeley Small Cap Value	Mutual Fund		80,609
	Evergreen Diversified Capital Builder	Mutual Fund		62,520
	Artisan International	Mutual Fund		61,802
	Aston/Montag & Caldwell Growth	Mutual Fund		46,793
	Dreyfus Appreciation Fund	Mutual Fund		40,216
	Alger Mid Cap Growth	Mutual Fund		17,211
*	Fidelity Spartan 500 Index	Mutual Fund		14,481
*	Fidelity Cash Reserves	Money Market Account		255
				$ 1,660,110

* A party-in-interest as defined by ERISA
** Not applicable - participant directed investments

PEORIA HOSPITAL'S MOBILE MEDICAL SERVICES
DBA ADVANCED MEDICAL TRANSPORT SERVICES
OF CENTRAL ILLINOIS 403(B) PLAN
SCHEDULE H LINE 4(a) - SCHEDULE OF
DELINQUENT PARTICIPANT CONTRIBUTIONS
Year Ended December 31, 2009

Name of Plan Sponsor: Peoria Hospital's Mobile Medical Services
DBA Advanced Medical Transport Services of Central Illinois
Employer Identification Number: 37-0999878
Three Digit Plan Number: 001

	Total That Constitutes Nonexempt Prohibited Transactions			
Participant Contributions Transferred Late to the Plan	Contributions Not Corrected	Contributions Corrected Outside of VFCP	Contributions Pending Correction in VFCP	Total Fully Corrected Under VFCP and PTE 2002-51
$111,287	$ -	$111,287	$ -	$ -

Sponsor's Name: PEORIA HOSPITALS MOBILE MEDICAL SERVICES DBA ADVANCE MEDICAL TRANSPORT OF CENTRAL ILLINOIS
EIN: 37-0999878
Name of Plan: PEORIA HOSPITALS MOBILE MEDICAL SERVICES DBA ADVANCE MEDICAL TRANSPORT OF CENTRAL ILLINOIS 403(B) PLAN
Plan Number: 001

Schedule H, Part IV, Line 4i

Schedule of Assets Held for Investment Purposes at End of Year 12/31/2009

(a)	(b) Identity of Issue, Borrower Lessor or Similar Party	(c) Description of Investment, including Maturity Date Rate of Interest, Collateral Par or Maturity date	(d) Cost	(e) Market
	Columbia	**Columbia Acorn**	**	83,773
	Alger	**Alger Mid Cap Growth**	**	17,211
	Artisan	**Artisan International**	**	61,802
	Dreyfus	**Dreyfus Appreciation**	**	40,216
	Dreyfus	**Dreyfus Short Intrm Gov't**	**	208,089
	Evergreen	**Evergreen Diversif Cap Builder**	**	62,520
	First American	**First American Mid Cap Value**	**	85,943
*	Fidelity	**Fidelity Cash Reserves**	**	255
*	Fidelity	**Fidelity Spartan 500 Index Inv**	**	14,481
*	Fidelity	**Fidelity Spartan Money Market**	**	138,099
	Janus	**Janus Worldwide**	**	297,778
	Janus	**Janus Orion**	**	170,258
	Keeley	**Keeley Small Cap Value**	**	80,609
	Ashton Montag & Caldwell	**Ashton/Montag & Caldwell Growth**	**	46,793
	Neuberger & Berman	**Neuberger & Berman Guardian TR**	**	137,106
	Columbia	**Columbia Total Return Bond Z**	**	118,583
	T Rowe Price	**T Rowe Price Equity Income**	**	96,594
	Total Assets			1,660,110

* Party in interest
** Participant directed - cost not required

Attachment to 2009 Form 5500
Schedule H, line 4a - Schedule of Delinquent Participant Contributions

Plan Name Peoria Hospitals Mobile Medical Services DBA Advanced Medical **EIN:** 37-0999878
Plan Sponsor's Name Peoria Hospitals Mobile Medical Services **PN:** 001

	Total that Constitute Nonexempt Prohibitied Transactions			
Participant Contributions Transferred Late to Plan	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	Total Fully Corrected Under VFCP and PTE 2002-51
Check here if Late Participant Loan Repayments are included: ☐	0	111,287	0	0