

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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 2010 This Form is Open to Public Inspection
---	--	---

Part I	Annual Report Identification Information
For calendar plan year 2010 or fiscal plan year beginning <u>01/01/2010</u> and ending <u>12/31/2010</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>UNITED REGIONAL MEDICAL CENTER 401(K) RETIREMENT PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>07/01/2003</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>07/01/2003</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>07/01/2003</u>					
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>COFFEE MEDICAL GROUP LLC DBA UNITED REGIONAL MEDICAL CENTER</u> <u>PO BOX 1079</u> <u>MANCHESTER, TN 37349</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>46-0485169</u></td> </tr> <tr> <td>2c Sponsor's telephone number <u>931-728-3586</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>622000</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>46-0485169</u>	2c Sponsor's telephone number <u>931-728-3586</u>	2d Business code (see instructions) <u>622000</u>	
2b Employer Identification Number (EIN) <u>46-0485169</u>					
2c Sponsor's telephone number <u>931-728-3586</u>					
2d Business code (see instructions) <u>622000</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	Filed with authorized/valid electronic signature.	06/30/2014	PHIL TISUE
	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") TAG RESOURCES, LLC 6322 DEANE HILL DRIVE, SUITE 201 KNOXVILLE, TN 37919	3b Administrator's EIN 62-1874769 3c Administrator's telephone number 865-670-1844
--	---

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	336
---	----------	-----

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	
--	----------	--

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 3D

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

9a Plan funding arrangement (check all that apply) (1) ☐ 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
---	---

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 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 12/31/2010		
A Name of plan UNITED REGIONAL MEDICAL CENTER 401(K) RETIREMENT PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 COFFEE MEDICAL GROUP LLC DBA UNITED REGIONAL MEDICAL CENTER	D Employer Identification Number (EIN) 46-0485169	

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

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

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

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

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

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

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

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

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

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

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

(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)

COMPASS ADVISORY PARTNERS, LLC

26-1224528

(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	NONE	8546	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 ☐

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III **Termination Information on Accountants and Enrolled Actuaries (see instructions)**
(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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 <u>01/01/2010</u> and ending <u>12/31/2010</u>		
A Name of plan <u>UNITED REGIONAL MEDICAL CENTER 401(K) RETIREMENT 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>COFFEE MEDICAL GROUP LLC DBA UNITED REGIONAL MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>46-0485169</u>	

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)	6287	0
(2) Participant contributions	1b(2)	20145	0
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(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)	699307	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	725739	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	725739	0
---	-----------	--------	---

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)	9101	
(B) Participants	2a(1)(B)	90595	
(C) Others (including rollovers)	2a(1)(C)	3711	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		103407

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

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	74739	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		74739

(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0

(3) Rents	2b(3)		
-----------------	--------------	--	--

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

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)		
(B) Other	2b(5)(B)		
(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)		
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		178146

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	103034	
(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)		103034
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)	3527	
(3) Investment advisory and management fees	2i(3)	8546	
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		12073
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		115107

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		63039
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		788778

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: MATHENEY, STEES, & ASSOCIATES P.C.

(2) EIN: 62-1404815

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		70000
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.			

- 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)
401(K) ADVANTAGE, LLC 401K PLAN	20-1826891	002

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 01/01/2010 and ending 12/31/2010

A Name of plan <u>UNITED REGIONAL MEDICAL CENTER 401(K) RETIREMENT 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>COFFEE MEDICAL GROUP LLC DBA UNITED REGIONAL MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>46-0485169</u>

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	<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): <u>57-1170423</u>		
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 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

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

Schedule R (Form 5500) 2010
v.092308.1

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): _____

**UNITED REGIONAL MEDICAL CENTER
401(k) RETIREMENT PLAN**

2010

**UNITED REGIONAL MEDICAL CENTER
401(k) RETIREMENT PLAN**

Financial Statements

**For the Years Ended
December 31, 2010 and 2009**

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Financial Statements

For the Years Ended December 31, 2010 and 2009

Table of Contents

	<u>Page</u>
INDEPENDENT AUDITORS' REPORT	1
FINANCIAL STATEMENTS:	
Statements of Net Assets Available for Benefits	2
Statements of Change in Net Assets Available for Benefits	3
NOTES TO FINANCIAL STATEMENTS	4
SUPPLEMENTARY INFORMATION:	
Schedule 1 — Form 5500 Schedule H, Line 4i —Schedule of Assets (Held at End of Year)	8

INDEPENDENT AUDITORS' REPORT

Pam Jernigan, Sponsor's Agent
United Regional Medical Center 401(k) Retirement Plan

We were engaged to audit the accompanying statements of net assets available for benefits of the United Regional Medical Center 401(k) Retirement Plan ("the Plan") as of December 31, 2010 and 2009, and the related statements of change in net assets available for benefits for the years then ended, and the supplemental Schedule H, line 4i – Schedule of Assets (Held at End of Year), as of and for the year ended December 31, 2010. These financial statements and the supplemental schedule are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the investment information summarized in Note 4, which was certified by Employee Fiduciary Corporation and TAG Resources, LLC, the custodians of the Plan, except for comparing the information with the related information included in the financial statements and the supplemental schedule. We have been informed by the plan administrator that TAG Resources, LLC, held the Plan's investment assets and executed investment transactions from December 16, 2010, to December 31, 2010, and that Employee Fiduciary Corporation held the Plan's investment assets as of December 31, 2009, and for the period January 1, 2010, to December 31, 2010 and executed investment transactions as of December 31, 2009 and for the period January 1, 2010, to December 15, 2010. The plan administrator has obtained certifications from the custodians as of and for the periods ended December 31, 2010 and 2009, that the information provided to the plan administrator by the custodians is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and supplemental schedule taken as a whole. The form and content of the information included in the financial statements and supplemental schedule, other than that derived from the information certified by the trustee, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

August 2, 2011



UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Statements of Net Assets Available for Benefits

December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
ASSETS		
Contributions receivable – employer	\$ —	\$ 6,287
Contributions receivable – participants	5,944	20,145
Investments, at fair value	<u>782,834</u>	<u>699,307</u>
Total assets	788,778	725,739
LIABILITIES	<u>—</u>	<u>—</u>
Net assets available for benefits	<u>\$ 788,778</u>	<u>\$ 725,739</u>

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

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Statements of Change in Net Assets Available for Benefits

Years Ended December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
Additions to net assets attributed to:		
Investment income and net appreciation in fair value of investments	<u>\$ 74,739</u>	<u>\$ 149,108</u>
Contributions:		
Participants	90,595	152,087
Employer	<u>9,101</u>	<u>47,657</u>
Total contributions	<u>99,696</u>	<u>199,744</u>
Rollovers	<u>3,711</u>	<u>1,694</u>
Total additions	<u>178,146</u>	<u>350,546</u>
Deductions from net assets attributed to:		
Investment expense	12,073	11,206
Benefits paid to participants	<u>103,034</u>	<u>191,886</u>
Total deductions	<u>115,107</u>	<u>203,092</u>
Net additions	63,039	147,454
Net assets available for benefits:		
Beginning of year	<u>725,739</u>	<u>578,285</u>
End of year	<u>\$ 788,778</u>	<u>\$ 725,739</u>

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

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Notes to Financial Statements

December 31, 2010 and 2009

NOTE 1 DESCRIPTION OF PLAN

The following description of the United Regional Medical Center (hereafter “URMC”) 401(k) Retirement Plan (the “Plan”) is provided for general information purposes only. Participants should refer to the Plan agreement for a more complete description of the Plan’s provisions.

General

The Plan is a defined contribution plan covering all full-time employees of URMC who have completed six (6) months of service and are age 18 or older. Actual participation takes place on the first day of the seventh month or on the first day of the Plan year after both requirements are met. The Plan is subject to the provisions of the Employment Retirement Income Security Act of 1974 (“ERISA”).

Participant Accounts

Participant contributions to the Plan are made through pre-tax salary reduction agreements with URMC. Participants may choose to contribute up to the maximum allowed by law.

Participants’ compensation is calculated as total compensation subject to income tax. Each participant’s account is credited with the participant’s and employer’s contributions and allocations of (a) Plan earnings, and (b) forfeited employer contributions and 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.

Contributions

Each pay period, URMC contributed, on behalf of each participant, an amount equal to a uniform percentage of each participant’s salary deferrals. This employer match was suspended March 27, 2010. Participants may contribute amounts representing distributions from other qualified defined benefit or contribution plans.

Payment of Benefits

Retirement benefits are paid in lump-sum distributions or under certain conditions in installments as defined in the Plan. Hardship distributions are paid based on the participant’s situation, in accordance with the Plan’s provisions.

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Notes to Financial Statements

(Continued)

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Vesting

Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in URMCM's matching and discretionary contribution portion of their accounts plus actual earnings thereon is based on years of continuous service. The Plan provides for vesting based on the following schedule:

<u>Completed Years of Service</u>	<u>Vesting Percentage</u>
1	20%
2	50%
3	100%

Forfeiture Account

During the years ended December 31, 2010 and 2009, the Plan did not have any forfeited nonvested accounts. This amount can be used to reduce employer contributions and reduce administrative expenses paid by the Plan sponsor.

Administrative Expenses

All administrative expenses incurred by the plan are paid by URMCM, the sponsor of the plan.

Asset Valuation

The Plan's investments are stated at fair value established by the custodian. All investments of the Plan are reflected in the financial statements at aggregate fair value as determined by quoted market price.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

General

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

Investments

Investments in bonds traded on national securities exchanges or over-the-counter markets are valued either on closing prices or, when closing prices are not available, bid prices obtained from a broker-dealer regularly making a market in the security. Investments in common stocks traded on national securities exchanges are valued based on closing prices. Investments in common stocks traded on the over-the-counter markets are valued at the mean of closing bid and ask prices. Investments in short-term securities are valued at amortized cost, which approximates market value. All investments are comprised of contributions deposited therein, plus earnings credited to each fund and transfers from other separate funds, less withdrawals, investment fees and transfers to other separate funds.

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Notes to Financial Statements

(Continued)

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Income Taxes

On July 1, 2003, UPMC adopted the Taylor/Webster, Inc. prototype non-standardized profit sharing plan and trust, as amended. According to the opinion letter, "an employer that adopts this plan may rely on...the qualification of its plan under Code section 401(a)." On December 16, 2010, UPMC adopted TAG Resources' multiple employer plan, sponsored by 401(k) Advantage, LLC. According to the determination letter dated July 15, 2009, the IRS "made a favorable determination on the plan."

Benefits

Benefits are recorded when paid.

NOTE 3 PLAN TERMINATION

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

NOTE 4 INFORMATION PREPARED AND CERTIFIED BY CUSTODIANS

The following information included in the accompanying financial statements and supplemental schedules was obtained from data that has been prepared and certified to as complete and accurate by the custodians.

	<u>2010</u>	<u>2009</u>
Investments, at fair value:		
Investments in mutual funds	<u>\$ 782,834</u>	<u>\$ 699,307</u>
Investment income and net appreciation in fair value of investments	<u>\$ 74,739</u>	<u>\$ 149,108</u>

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Notes to Financial Statements

(Continued)

NOTE 5 INVESTMENTS

Investments that exceed 5% of the Plan's net assets at December 31, 2010 and 2009, are as follows:

	<u>2010</u>	<u>2009</u>
Investments held by :		
Growth Fund of America Class R4	\$ 50,479	\$ 54,134
American New Perspective Class R4	\$ 41,208	\$ 45,616
Invesco Van Kampen Mid Cap Growth Class A	\$ 42,854	\$ 36,303
Compass EMP Conservative to Mod	\$ 310,297	\$ 268,971
Compass EMP Long-Term Growth	\$ 194,657	\$ 167,606

NOTE 6 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

At December 31, 2010 and 2009, net assets available for benefits per the financial statements agree to the Form 5500 except for insignificant classification differences. The Form 5500 is prepared on the accrual basis.

NOTE 7 SUBSEQUENT EVENTS

Management has evaluated subsequent events for the Plan through August 2, 2011, the date the financial statements were available to be issued. In March 2011, all funds that were in the custody of Employee Fiduciary Corporation, the former custodian, were transferred to TAG Resources, LLC, the new custodian.

SUPPLEMENTARY INFORMATION

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Schedule 1—Form 5500 Schedule H, line 4i—Schedule of Assets (Held at End of Year)

December 31, 2010 and 2009

EIN: 46-0485169

Plan: 001

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost**	(e) Current Value
	American Beacon	Short-Term Bond Plan		\$ 21,454
	Wasatch	1 st Source Income Equity		17,516
	American	Target Date 2020		6,326
	Europacific Growth	Europacific Growth		7,051
	American Funds	Growth Fund of America R4		50,479
	American	New Perspective R4		41,208
	Invesco Van Kampen	Mid Cap Growth A		42,854
	Vanguard	Prime Money Market		7,154
	Columbia	Small Cap Value I A		7,882
	Compass EMP	Conservative to Mod		310,297
	Perkins	Mid Cap Value		3,571
	Compass EMP	Long-Term Growth		194,657
	Invesco Van Kampen	American Value A		12,934
	BlackRock	Small Cap Growth Equity Instl		2,550
	PIMCO	Total Return		28,048
	American	Fundamental Inv R4		15,809
	American	Target Date 2010		6,734
	American	Target Date 2035		20
	American	Target Date 2045		39
	American	Target Date 2050		39
	JP Morgan	Small Cap Equity		21
	Franklin	Small Cap Value		3
	Vanguard	Target Retirement 2010		10
	BlackRock	Equity Dividend		14
	Invesco	Mid Cap Core Equity		5
	JP Morgan	US Equity		3
	Neuberger Berman	Genesis		4
	Compass EMP	Moderate Portfolio		5,850
	Compass EMP	Aggressive Portfolio		302

* Indicates an allowable party-in-interest in column (a)

** Cost information omitted due to participant directed individual account plan

See independent auditors' report.

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	American Beacon	Short Term Bond Plan		21,454
	American	New Perspective R4		41,208
	American	Target Date 2020		6,326
	American	Fundamental Inv		15,809
	Black Rock	Small Cap Grth Equity Instl		2,550
	Europacific Growth	Europacific Growth		7,051
	American Funds	Growth Fund of America		50,479

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	Columbia	Small Cap Value I A		7,882
	Compass EMP	Cnsrv to Mod		310,297
	Compass EMP	Long-Term Growth		194,657
	Invesco Van Kampen	American Value A		12,934
	Invesco Van Kampen	Mid Cap Growth A		42,854
	Vanguard	Prime Money Market		7,154
	Wasatch	1st Source Income Equity		17,516

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	PIMCO	Total Return		28,048
	Perkins	Mid Cap Value		3,571
	American	Target Date 2010		6,734
	American	Target Date 2035		20
	American	Target Date 2045		39
	American	Target Date 2050		39
	JP Morgan	Small Cap Equity		21

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	Franklin	Small Cap Value		3
	Vanfuard	Target Retirement 2010		10
	BlackRock	Equity Dividend		14
	Invesco	Mid Cap Core Equity		5
	JP Morgan	US Equity		3
	Neuberger Berman	Genesis		4
	Compass EMP	Moderate Portfolio		5,850

Plan Name	United Regional Med Center 401(k) Ret Plan	EIN:	46-0485169
Plan Sponsor's Name	Coffee Medical Group LLC dba United Regional Medical Center	Plan ID	000

[illegible]

UNITED REGIONAL MEDICAL CENTER 401(k) RETIREMENT PLAN

Schedule 1—Form 5500 Schedule H, line 4i—Schedule of Assets (Held at End of Year)

December 31, 2010 and 2009

EIN: 46-0485169

Plan: 001

(a)	(b) Identity of Issuer	(c) Description of Investment	(d) Cost**	(e) Current Value
	American Beacon	Short-Term Bond Plan		\$ 21,454
	Wasatch	1 st Source Income Equity		17,516
	American	Target Date 2020		6,326
	Europacific Growth	Europacific Growth		7,051
	American Funds	Growth Fund of America R4		50,479
	American	New Perspective R4		41,208
	Invesco Van Kampen	Mid Cap Growth A		42,854
	Vanguard	Prime Money Market		7,154
	Columbia	Small Cap Value I A		7,882
	Compass EMP	Conservative to Mod		310,297
	Perkins	Mid Cap Value		3,571
	Compass EMP	Long-Term Growth		194,657
	Invesco Van Kampen	American Value A		12,934
	BlackRock	Small Cap Growth Equity Instl		2,550
	PIMCO	Total Return		28,048
	American	Fundamental Inv R4		15,809
	American	Target Date 2010		6,734
	American	Target Date 2035		20
	American	Target Date 2045		39
	American	Target Date 2050		39
	JP Morgan	Small Cap Equity		21
	Franklin	Small Cap Value		3
	Vanguard	Target Retirement 2010		10
	BlackRock	Equity Dividend		14
	Invesco	Mid Cap Core Equity		5
	JP Morgan	US Equity		3
	Neuberger Berman	Genesis		4
	Compass EMP	Moderate Portfolio		5,850
	Compass EMP	Aggressive Portfolio		302

* Indicates an allowable party-in-interest in column (a)

** Cost information omitted due to participant directed individual account plan

See independent auditors' report.

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	American Beacon	Short Term Bond Plan		21,454
	American	New Perspective R4		41,208
	American	Target Date 2020		6,326
	American	Fundamental Inv		15,809
	Black Rock	Small Cap Grth Equity Instl		2,550
	Europacific Growth	Europacific Growth		7,051
	American Funds	Growth Fund of America		50,479

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	Columbia	Small Cap Value I A		7,882
	Compass EMP	Cnsrv to Mod		310,297
	Compass EMP	Long-Term Growth		194,657
	Invesco Van Kampen	American Value A		12,934
	Invesco Van Kampen	Mid Cap Growth A		42,854
	Vanguard	Prime Money Market		7,154
	Wasatch	1st Source Income Equity		17,516

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	PIMCO	Total Return		28,048
	Perkins	Mid Cap Value		3,571
	American	Target Date 2010		6,734
	American	Target Date 2035		20
	American	Target Date 2045		39
	American	Target Date 2050		39
	JP Morgan	Small Cap Equity		21

Attachment to 2010 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name United Regional Med Center 401(k) Ret Plan **EIN:** 46-0485169
Plan Sponsor's Name Coffee Medical Group LLC dba United Regional Medical Center

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	Franklin	Small Cap Value		3
	Vanfuard	Target Retirement 2010		10
	BlackRock	Equity Dividend		14
	Invesco	Mid Cap Core Equity		5
	JP Morgan	US Equity		3
	Neuberger Berman	Genesis		4
	Compass EMP	Moderate Portfolio		5,850

Plan Name	United Regional Med Center 401(k) Ret Plan	EIN:	46-0485169
Plan Sponsor's Name	Coffee Medical Group LLC dba United Regional Medical Center	Plan ID:	000

[illegible]