

U.S. SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 11-K

ANNUAL REPORT PURSUANT TO SECTION 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2003

OR

TRANSITION REPORT PURSUANT TO SECTION 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to

Commission File Number: 0-25328

A. Full title of the Plan:

First Keystone Federal Savings Bank Employees' 401(k) Profit Sharing Plan

B. Name of issuer of the securities held pursuant to the Plan and the address of its principal executive office:

First Keystone Financial, Inc.
22 West State Street
Media, Pennsylvania 19063

PROCESSED
JUN 28 2004
THOMSON FINANCIAL

As filed on June 30, 2004

FIRST KEYSTONE FINANCIAL, INC.

Contents

(a) Financial Statements:

The following Annual Return/Report of Employer Benefit Plan on Form 5500 and related schedules are filed as part of the annual report for First Keystone Federal Savings Bank Employees' 401(k) Profit Sharing Plan and appear immediately after the signature page.

Annual Return/Report of Employer Benefit Plan on Form 5500

Supplemental Schedules:

Schedule A - Insurance Information

Schedule D - DFE/Participating Plan Information

Schedule I - Financial Information-Small Plan

Schedule P- Annual Return of Fiduciary of Employee Benefit
Trust

Schedule R - Retirement Plan Information

Schedule SSA - Annual Registration Statement Identifying
Separated Participants With Deferred Vested Benefits

Schedule T - Qualified Pension Plan Coverage Information

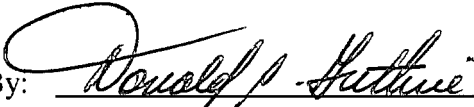
SIGNATURES

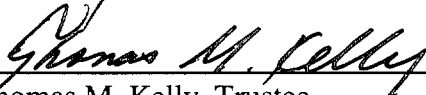
Pursuant to the requirements of the Securities Exchange Act of 1934, the trustees have duly caused this annual report to be signed by the undersigned hereunto duly authorized.

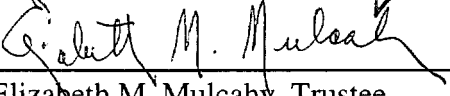
**FIRST KEYSTONE FEDERAL SAVINGS BANK
EMPLOYEES' 401(K) PROFIT SHARING PLAN**

TRUSTEES

Date: June 30, 2004

By: 
Donald S. Guthrie, Trustee

By: 
Thomas M. Kelly, Trustee

By: 
Elizabeth M. Mulcahy, Trustee

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 under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

Official Use Only
OMB Nos. 1210-0110
1210-0089

2003

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2003 or fiscal plan year beginning and ending

- A This return/report is for: (1) a multiemployer plan; (2) a single-employer plan (other than a multiple-employer plan); (3) a multiple-employer plan; or (4) a DFE (specify)
B This return/report is: (1) the first return/report filed for the plan; (2) an amended return/report; (3) the final return/report filed for the plan; (4) a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here
D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions)

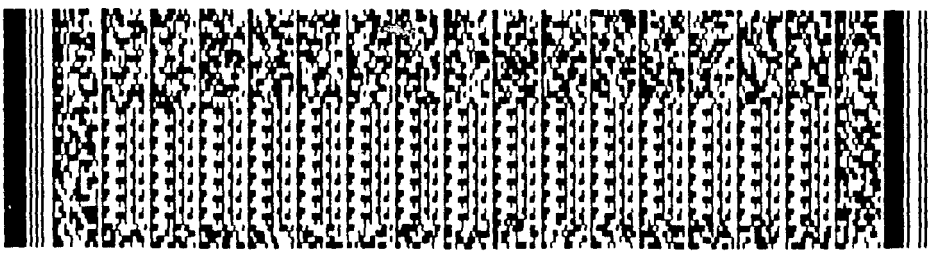
Part II Basic Plan Information - enter all requested information.

1a Name of plan: FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT SHARING PLAN
1b Three-digit plan number (PN): 002
1c Effective date of plan (mo., day, yr.): 01/01/1993
2a Plan sponsor's name and address (employer, if for a single-employer plan): FIRST KEYSTONE FEDERAL SAVINGS BANK, 22 WEST STATE STREET, MEDIA, PA 19063
2b Employer Identification Number (EIN): 23-0469351
2c Sponsor's telephone number: 610-565-6210
2d Business code (see instructions): 522110

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 if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

SIGN HERE: Kathy A. Williams, 6/23/04, KATHY A. WILLIAMS, Signature of plan administrator, Date, Type or print name of individual signing as plan administrator
SIGN HERE: Thomas M. Kelly, 6/23/04, THOMAS M. KELLY, Signature of employer/plan sponsor/DFE, Date, Type or print name of individual signing as employer, plan sponsor or DFE



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

3b Administrator's EIN

3c Administrator's telephone number

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 below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

b EIN

Telephone number

6 Total number of participants at the beginning of the plan year	6	91
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	84
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	21
d Subtotal. Add lines 7a, 7b, and 7c	7d	105
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	105
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	97
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	3

8 Benefits provided under the plan (complete 8a and 8b as applicable)

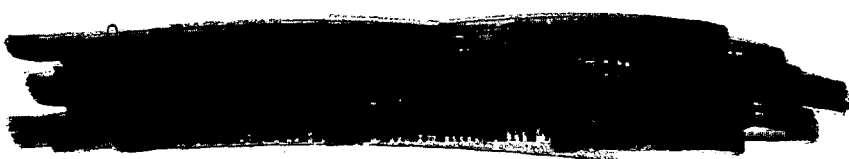
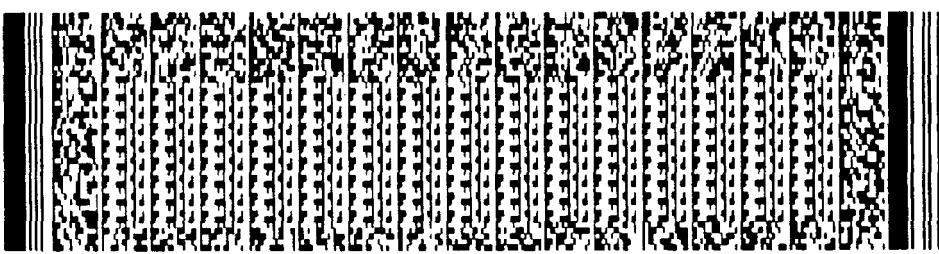
- a** Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2E 2G 2J 2K [] [] [] [] [] []
- b** Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions): [] [] [] [] [] [] [] [] [] []

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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



10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

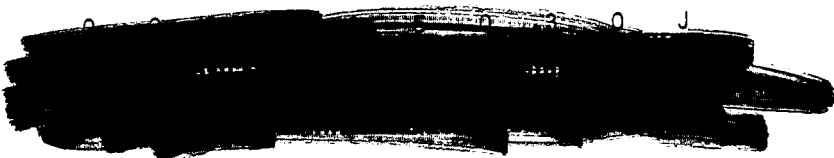
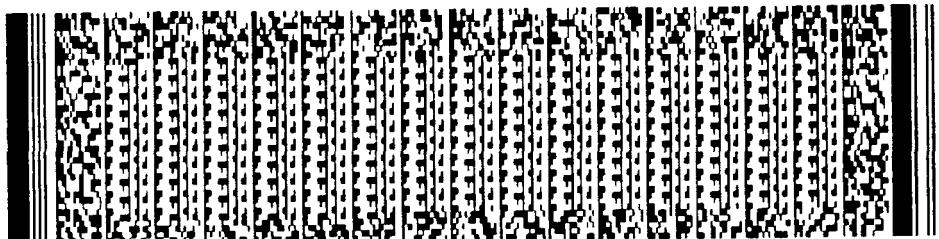
a Pension Benefit Schedules

- (1) R (Retirement Plan Information)
- (2) 1 T (Qualified Pension Plan Coverage Information)
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶ _____
- (3) B (Actuarial Information)
- (4) E (ESOP Annual Information)
- (5) SSA (Separated Vested Participant Information)

b Financial Schedules

- (1) H (Financial Information)
- (2) I (Financial Information - Small Plan)
- (3) 1 A (Insurance Information)
- (4) C (Service Provider Information)
- (5) D (DFE/Participating Plan Information)
- (6) G (Financial Transaction Schedules)
- (7) 1 P (Trust Fiduciary Information)

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**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

- ▶ File as an attachment to Form 5500.
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2003

**This Form is Open to
Public Inspection.**

For calendar plan year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT S	B Three-digit plan number ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 FIRST KEYSTONE FEDERAL SAVINGS BANK	D Employer Identification Number 23-0469351	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions
Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

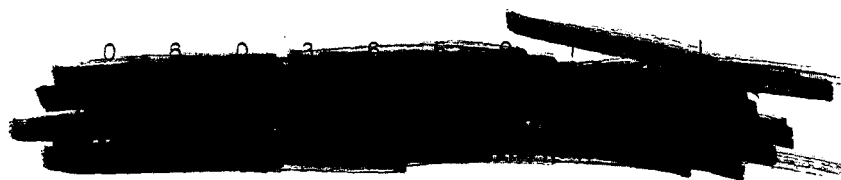
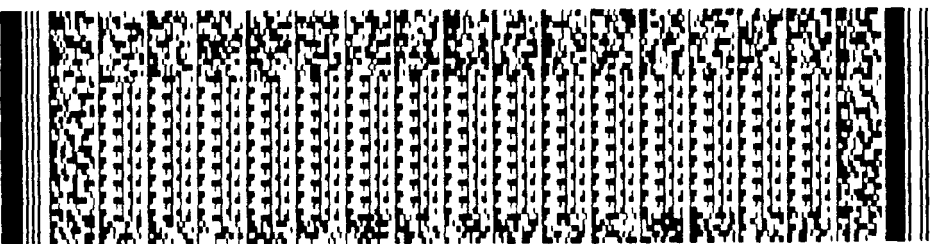
1 Coverage: _____
(a) Name of insurance carrier

THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5570651	62944	91663753	92	01/01/2003	12/31/2003

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	
Total amount of commissions paid	Total fees paid / amount
1837	0



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

ROBERT A CINALLI
40 MONUMENT ROAD
BALA CYNWYD PA 19004

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
1159			3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

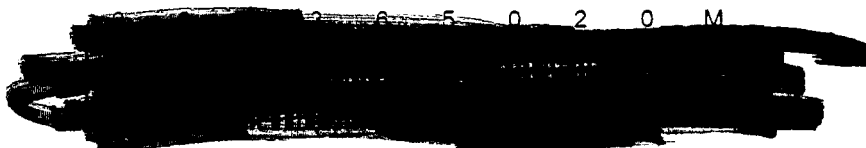
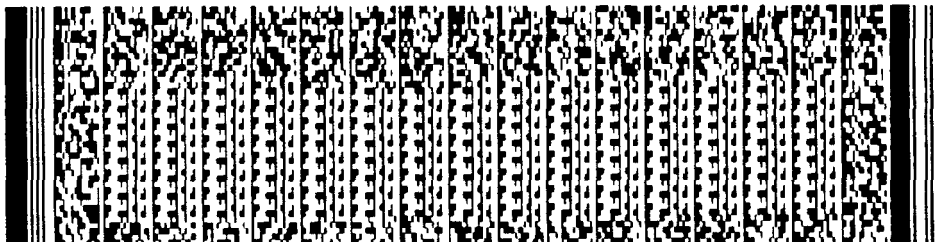
JOHN M STACK II
40 MONUMENT RD, 4TH FLOOR
BALA CYNWYD PA 19004

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
678			3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

v6.1

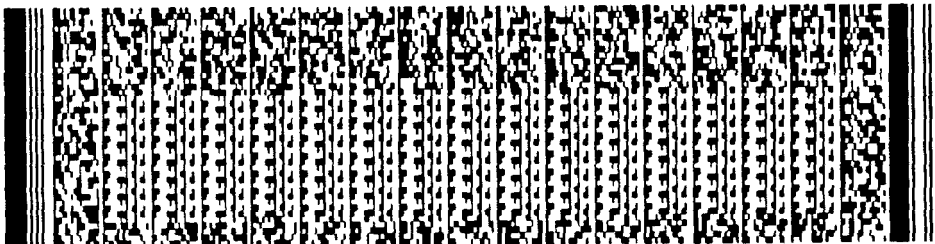


Part I Investment and Annuity Contract Information

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

3	Current value of plan's interest under this contract in the general account at year end		336527
4	Current value of plan's interest under this contract in separate accounts at year end		973416
5	Contracts With Allocated Funds		
a	State the basis of premium rates		
b	Premiums paid to carrier		
c	Premiums due but unpaid at the end of the year		
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount		
	Specify nature of costs		
e	Type of contract (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify)		
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	<input type="checkbox"/>	
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a	Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input checked="" type="checkbox"/> other (specify below)	<p>▶ GUARANTEED INTEREST CONTRACT</p>	
b	Balance at the end of the previous year		236962
c	Additions: (1) Contributions deposited during the year	41886	
	(2) Dividends and credits	0	
	(3) Interest credited during the year	9883	
	(4) Transferred from separate account	55809	
	(5) Other (specify below)	5149	
	▶ LOAN REPAYMENTS		
	(6) Total additions		112727
d	Total of balance and additions (add b and c (6))		349689
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	1190	
	(2) Administration charge made by carrier	178	
	(3) Transferred to separate account	0	
	(4) Other (specify below)	11794	
	▶ LOANS/SURRENDER CHARGES/ROLLOVERS		
	(5) Total deductions		13162
f	Balance at the end of the current year (subtract e (5) from d)		336527

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Part III

Welfare Benefit Contract Information

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

7 Benefit and contract type (check all applicable boxes)

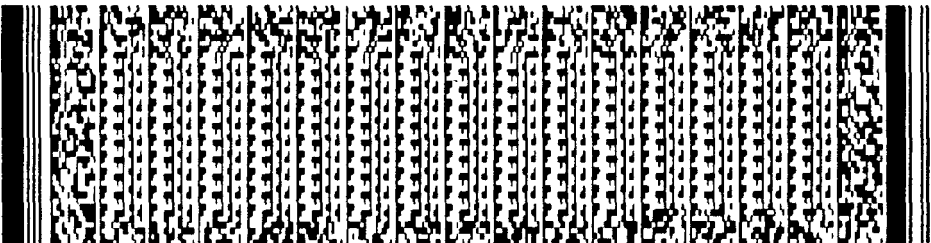
- a Health (other than dental or vision)
- e Temporary disability (accident and sickness)
- i Stop loss (large deductible)
- m Other (specify) ▶
- b Dental
- f Long-term disability
- j HMO contract
- c Vision
- g Supplemental unemployment
- k PPO contract
- d Life Insurance
- h Prescription drug
- l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

8 Experience-rated contracts

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

9 Nonexperience-rated contracts:

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



**SCHEDULE D
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan 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.

Official Use Only

OMB No. 1210-0110

2003

This Form is Open to
Public Inspection.

For calendar plan year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan or DFE
FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT S

B Three-digit
plan number ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
FIRST KEYSTONE FEDERAL SAVINGS BANK

D Employer Identification Number
23-0469351

Part 1 Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(a) Name of MTIA, CCT, PSA, or 103-12IE POOLED SEPARATE ACCOUNT 65

(b) Name of sponsor of entity listed in (a) EQUITABLE LIFE

(c) EIN-PN 13-5570651-065 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 973416

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

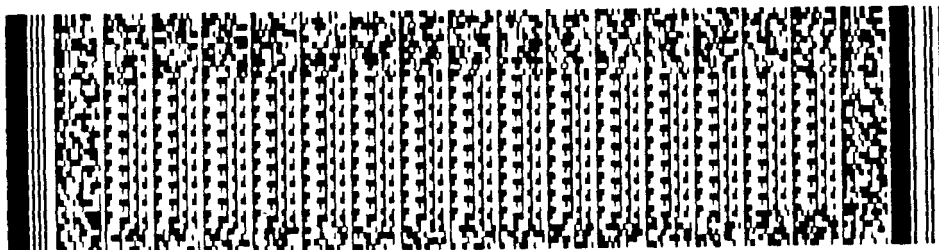
(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v6.1 Schedule D (Form 5500) 2003



(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

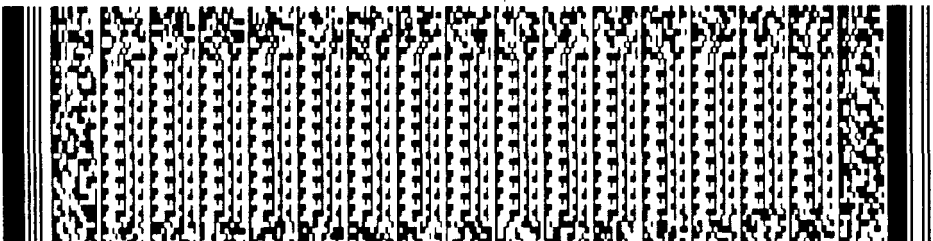
(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

(a) Name of MTIA, CCT, PSA, or 103-12IE _____

(b) Name of sponsor of entity listed in (a) _____

(c) EIN-PN _____ (d) Entity code _____ (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) _____

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

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

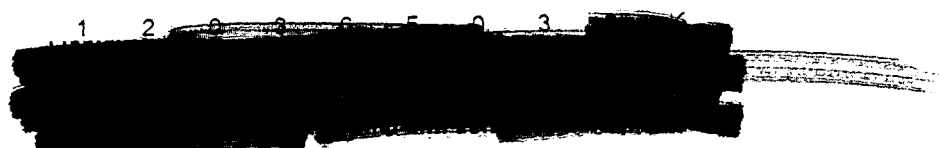
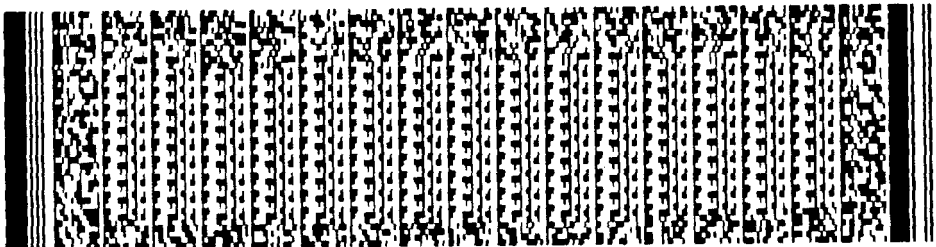
(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

(a) Plan name _____

(b) Name of plan sponsor _____ (c) EIN-PN _____

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**SCHEDULE I
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

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.**

Official Use Only

OMB No. 1210-0110

2003

**This Form is Open
to Public Inspection.**

For calendar year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 FIRST KEYSTONE FEDERAL SAVINGS BANK	D Employer Identification Number 23-0469351

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

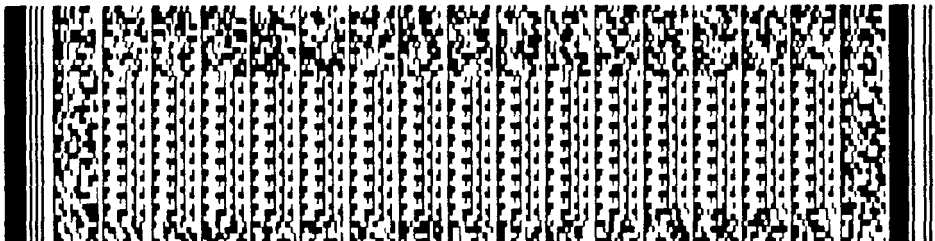
Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.

1 Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
a Total plan assets	1a	2354370	3811365
b Total plan liabilities	1b		
c Net plan assets (subtract line 1b from line 1a)	1c	2354370	3811365
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable			
(1) Employers	2a(1)	38346	
(2) Participants	2a(2)	218786	
(3) Others (including rollovers)	2a(3)	1605	
b Noncash contributions	2b		
c Other income	2c	1201009	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		1459746
e Benefits paid (including direct rollovers)	2e	1190	
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g	1015	
h Other expenses	2h	546	
i Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		2751
j Net income (loss) (subtract line 2i from line 2d)	2j		1456995
k Transfers to (from) the plan (see instructions)	2k		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

	Yes	No	Amount
a Partnership/joint venture interests	3a	X	
b Employer real property	3b	X	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v6.1 Schedule I (Form 5500) 2003



	Yes	No	Amount
3c Real estate (other than employer real property)		X	
d Employer securities	X		2434860
e Participant loans	X		58542
f Loans (other than to participants)		X	
g Tangible personal property		X	

Part III Transactions During Plan Year

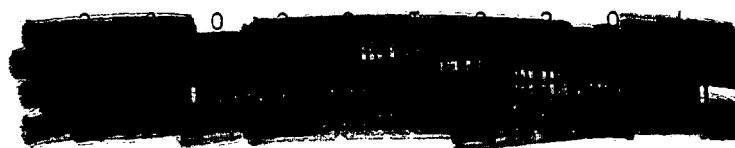
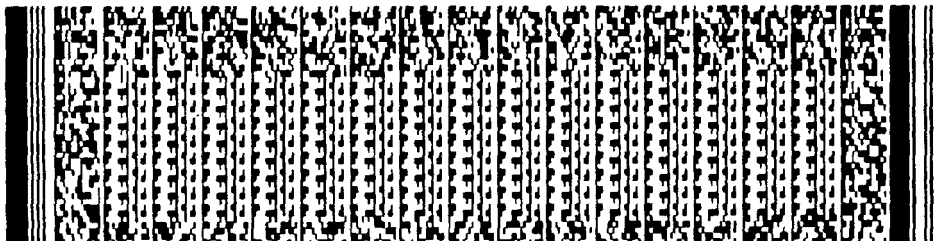
During the plan year:

	Yes	No	Amount
4a Did the employer fail to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (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 the participants' account balance		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)		X	
e Was the plan covered by a fidelity bond?	X		2910000
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 at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	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 P
(FORM 5500)

Annual Return of Fiduciary
of Employee Benefit Trust

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

File as an attachment to Form 5500 or 5500-EZ.

Official Use Only

OMB No. 1210-0110

2003

This Form is Open to
Public Inspection.

Department of the Treasury
Internal Revenue Service

For trust calendar year 2003 or fiscal year beginning _____ and ending _____

1a Name of trustee or custodian

THOMAS M KELLY

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

22 WEST STATE STREET

c City or town, state, and ZIP code

MEDIA PA 19063

2a Name of trust

FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT SHARING PLAN

b Trust's employer identification number 23-2747853

3 Name of plan if different from name of trust

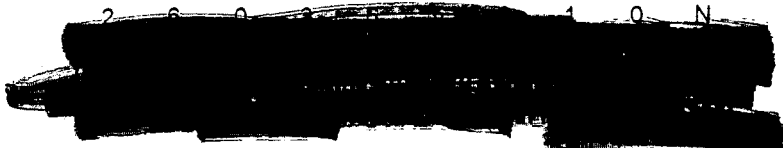
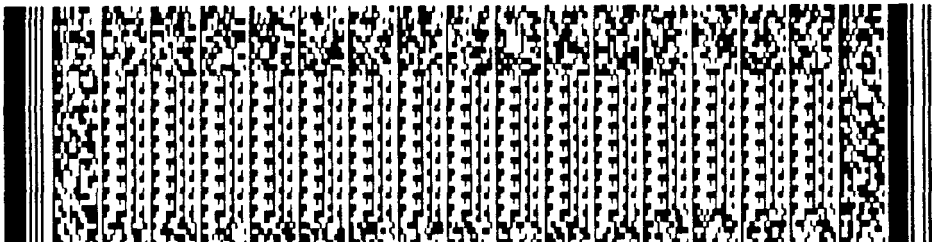
4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? Yes No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ 23-0469351

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

SIGNATURE HERE Signature of fiduciary Thomas M. Kelly Date 6/23/04

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ. v6.1 Schedule P (Form 5500) 2003



Official Use Only

OMB No. 1210-0110

2003

This Form is Open to Public Inspection.

**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 sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

File as an Attachment to Form 5500.

For calendar year 2003 or fiscal plan year beginning and ending

A Name of plan FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT S	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 FIRST KEYSTONE FEDERAL SAVINGS BANK	D Employer Identification Number 23-0469351

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions	1 \$
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 13-5570651 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(c)(8) or ERISA section 302(c)(8)? Yes No N/A
If the plan is a defined benefit plan, go to line 7.

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

6a Enter the minimum required contribution for this plan year	\$
b Enter the amount contributed by the employer to the plan for this plan year	\$
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)	\$

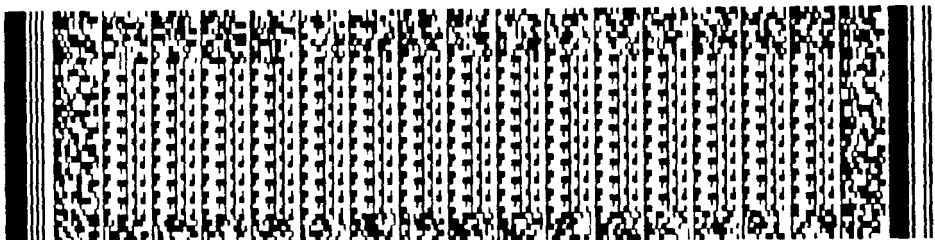
If you completed line 6c, do not complete the remainder of this schedule.

7 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

8 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) Yes No

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v6.1 Schedule R (Form 5500) 2003



**SCHEDULE SSA
(Form 5500)**

**Annual Registration Statement Identifying Separated
Participants With Deferred Vested Benefits**

Under Section 6057(a) of the Internal Revenue Code

▶ File as an attachment to Form 5500 unless box 1b is checked.

Department of the Treasury
Internal Revenue Service

Official Use Only

OMB No. 1210-0110

2003

**This Form is NOT Open-
to Public Inspection.**

For calendar year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT SH	B Three-digit plan number ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 FIRST KEYSTONE FEDERAL SAVINGS BANK	D Employer Identification Number 23-0469351

1a Check here if additional participants are shown on attachments. All attachments must include the sponsor's name, EIN, name of plan, plan number, and column identification letter for each column completed for line 4.

1b Check here if plan is a government, church or other plan that elects to voluntarily file Schedule SSA. If so, complete lines 2 through 3c, and the signature area. Otherwise, complete the signature area only.

2 Plan sponsor's address (number, street, and room or suite no.) (If a P.O. box, see the instructions for line 2.)

City or town, state, and ZIP code

3a Name of plan administrator (if other than sponsor)

3b Administrator's EIN

3c Number, street, and room or suite no. (If a P.O. box, see the instructions for line 2.)

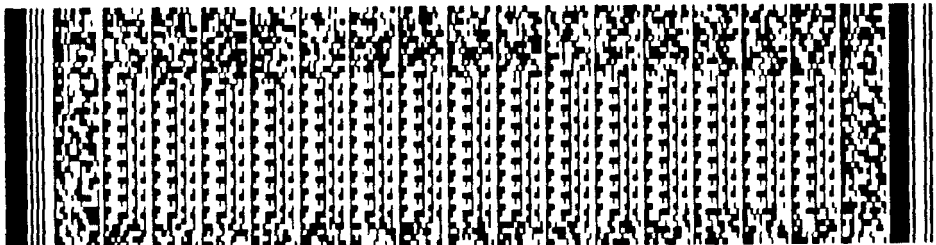
City or town, state, and ZIP code

Under penalties of perjury, I declare that I have examined this report, and to the best of my knowledge and belief, it is true, correct, and complete.

 Signature of plan administrator ▶

Phone number of plan administrator ▶ 610-565-6210 Date ▶ 6/23/04

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v6.1 Schedule SSA (Form 5500) 2003



4 Enter one of the following Entry Codes in column (a) for each separated participant with deferred vested benefits that:

Code A -- has not previously been reported.

Code B -- has previously been reported under the above plan number but requires revisions to the information previously reported.

Code C -- has previously been reported under another plan number but will be receiving their benefits from the plan listed above instead.

Code D -- has previously been reported under the above plan number but is no longer entitled to those deferred vested benefits.

(a) Entry Code	(b) Social Security Number	Use with entry code "A", "B", "C", or "D"			Use with entry code "A" or "B"		(f) Defined benefit plan - periodic payment	
		(c) Name of Participant (First) (M.I.) (Last)			Enter code for nature and form of benefit			Amount of vested benefit
					(d) Type of annuity	(e) Payment frequency		
A	171727380	RICHARD		BARBEZAT	A	A		
A	200603084	ROSEMARIE		PITNER	A	A		
A	171528745	SHARON		STREET	A	A		

(a) Entry Code	Use with entry code "A" or "B"			Use with entry code "C"	
	Defined contribution plan			(i) Previous sponsor's employer identification number	(j) Previous plan number
	(g) Units or shares	Share indicator	(h) Total value of account		
A			584.78		
A			18985.09		
A			24535.09		

v6.1



3 0 0 3 6 5 0 2 0 J

**SCHEDULE T
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the Internal Revenue Code (the Code).

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

Official Use Only

OMB No. 1210-0110

2003

**This Form is Open to
Public Inspection.**

For calendar year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan FIRST KEYSTONE FEDERAL SAVINGS BANK 401 (K) PROFIT SHA	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 FIRST KEYSTONE FEDERAL SAVINGS BANK	D Employer Identification Number 23-0469351

Note: If the plan is maintained by:

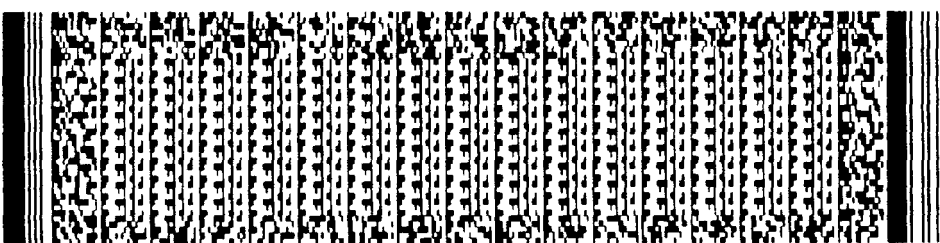
- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
 - An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).
- 1** If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer	1b Employer identification number
--	--

- 2** If the employer maintaining the plan operates QSLOBs, enter the following information:
- a** The number of QSLOBs that the employer operates is _____.
 - b** The number of such QSLOBs that have employees benefiting under this plan is _____.
 - c** Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ... Yes No
 - d** If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.
►

- 3** Exceptions – Check the box before each statement that describes the plan or the employer. Also see instructions. **If you check any box, do not complete the rest of this Schedule.**
- a** The employer employs only highly compensated employees (HCEs).
 - b** No HCEs benefited under the plan at anytime during the plan year.
 - c** The plan benefits only collectively-bargained employees.
 - d** The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.
 - e** The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v6.1 Schedule T (Form 5500) 2003



2 8 0 2 6 5 0 1 0 P

Official Use Only

4 Enter the date the plan year began for which coverage data is being submitted. Month _____ Day _____ Year _____

a Did any leased employees perform services for the employer at any time during the plan year? Yes No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? Yes No

c Complete the following:

- (1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals c(1)
- (2) Number of excludable employees as defined in IRS regulations (see instructions). c(2)
- (3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1)) c(3)
- (4) Number of nonexcludable employees (line 4c(3)) who are HCEs c(4)
- (5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan c(5)
- (6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs c(6)

d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) d _____ %

e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

Disaggregated part:

Ratio Percentage:

Exception:

- (1) _____
- (2) _____
- (3) _____

f This plan satisfies the coverage requirements on the basis of (check one): (1) the ratio percentage test (2) average benefit test

