Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2010** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 04/15/2010

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN

1b Three-digit plan number (PN) ▶ 003

1c Effective date of plan 07/03/1978

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
MEDCENTRAL HEALTH SYSTEM

335 GLESSNER AVE.
MANSFIELD, OH 44903

335 GLESSNER AVE.
MANSFIELD, OH 44903

2b Employer Identification Number (EIN) 34-4429972

2c Sponsor's telephone number 419-683-1212

2d Business code (see instructions) 622000

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	01/20/2011	RICHARD HOBACK
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") MEDCENTRAL HEALTH SYSTEM 335 GLESSNER AVE. MANSFIELD, OH 44903	**3b** Administrator's EIN 34-4429972 **3c** Administrator's telephone number 419-683-1212

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:		**4b** EIN
a Sponsor's name		**4c** PN

5 Total number of participants at the beginning of the plan year	**5**	121
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:
2C 2F 2G

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

9a Plan funding arrangement (check all that apply)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	**(1)** [ ] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	**(2)** [ ] Code section 412(e)(3) insurance contracts
(3) [ ] Trust	**(3)** [X] Trust
(4) [ ] General assets of the sponsor	**(4)** [ ] General assets of the sponsor

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

a Pension Schedules	**b General Schedules**
(1) [X] **R** (Retirement Plan Information)	**(1)** [X] **H** (Financial Information)
(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	**(2)** [ ] **I** (Financial Information – Small Plan)
	(3) [X] 2 **A** (Insurance Information)
	(4) [X] **C** (Service Provider Information)
(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	**(5)** [X] **D** (DFE/Participating Plan Information)
	(6) [ ] **G** (Financial Transaction Schedules)

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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	**B** Three-digit plan number (PN) ▶
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN	003
C Plan sponsor's name as shown on line 2a of Form 5500.	**D** Employer Identification Number (EIN)
MEDCENTRAL HEALTH SYSTEM	34-4429972

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

1 Coverage Information:

(a) Name of insurance carrier

AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G91898	0	01/01/2010	03/31/2010

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	0
5	Current value of plan's interest under this contract in separate accounts at year end	5	0

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	344912
c	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)	2615	
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below) ▶	7c(5)		
	(6) Total additions		7c(6)	2615
d	Total of balance and additions (add **b** and **c(6)**).		7d	347527
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	347527	
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below) ▶	7e(4)		
	(5) Total deductions		7e(5)	347527
f	Balance at the end of the current year (subtract **e(5)** from **d**)		7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned (**(1)** + **(2)** - **(3)**)			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add **(1)** and **(2)**)			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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	**B** Three-digit plan number (PN) ▶
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN	003
C Plan sponsor's name as shown on line 2a of Form 5500.	**D** Employer Identification Number (EIN)
MEDCENTRAL HEALTH SYSTEM	34-4429972

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

1 Coverage Information:

(a) Name of insurance carrier

AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G93123	0	01/01/2010	03/31/2010

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	0
5	Current value of plan's interest under this contract in separate accounts at year end	5	0

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	354017
c	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits	7c(2)		
	(3) Interest credited during the year	7c(3)	2926	
	(4) Transferred from separate account	7c(4)	46529	
	(5) Other (specify below) ▶	7c(5)		
	(6) Total additions		7c(6)	49455
d	Total of balance and additions (add **b** and **c(6)**).		7d	403472
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	403472	
	(2) Administration charge made by carrier	7e(2)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below) ▶	7e(4)		
	(5) Total deductions		7e(5)	403472
f	Balance at the end of the current year (subtract **e(5)** from **d**)		7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned (**(1)** + **(2)** - **(3)**)			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add **(1)** and **(2)**)			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).	2010
Department of Labor Employee Benefits Security Administration	▶ **File as an attachment to Form 5500.**	**This Form is Open to Public Inspection.**
Pension Benefit Guaranty Corporation		

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 04/15/2010

A Name of plan
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 003

C Plan sponsor's name as shown on line 2a of Form 5500
MEDCENTRAL HEALTH SYSTEM

D Employer Identification Number (EIN)
34-4429972

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).. . . . . [X] 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

FIDELITY VARIABLE INS PRODUCTS FUND

04-2270522

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

STATE STREET INSTITUTIONAL TRUST

04-2456637

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

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

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

(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 ☐

(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
AMERICAN UNITED LIFE INSURANCE COM	66 67	716

(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.
AMERICAN UNITED LIFE INSURAN 35-0145825	ASSET CHARGE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE COMP	52 59 60 63	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
FIDELITY VARIABLE INS PRODUCT	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE COMP	52 59 60 63	0

(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.
STATE STREET INSTITUTIONAL T 04-2456637	REVENUE SHARING FORMULA

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 D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**2010** **This Form is Open to Public Inspection.**

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 04/15/2010

A Name of plan
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 003

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
MEDCENTRAL HEALTH SYSTEM

D Employer Identification Number (EIN)
34-4429972

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

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT II

b Name of sponsor of entity listed in (a): AMERICAN UNITED LIFE INSURANCE CO

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
35-0145825-000	P	0

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

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

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

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

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2010** **This Form is Open to Public Inspection**

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 04/15/2010

A Name of plan
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 003

C Plan sponsor's name as shown on line 2a of Form 5500
MEDCENTRAL HEALTH SYSTEM

D Employer Identification Number (EIN)
34-4429972

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(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)	307412	0
(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)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	698929	0
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	1006341	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 through1j)	1k		
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	1006341	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) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)		
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	5541	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		5541
(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)		
(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)		

		(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)		
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		7182
(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		12723
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1017268	
(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)		1017268
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	1796	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		1796
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		1019064
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-1006341
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) ☐ 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: RIESTER, LUMP & BURTON CPAS INC **(2)** EIN: 34-1323620

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

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

Part IV Compliance Questions

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

During the plan year:

			Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		1500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i		X	
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k	X		
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☒ **Yes** ☐ **No** **Amount:** 0

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

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

SCHEDULE R (Form 5500)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2010** **This Form is Open to Public Inspection.**

For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 04/15/2010

A Name of plan
MEDCENTRAL HEALTH SYSTEM CRESTLINE HOSPITAL EMPLOYEES PENSION PLAN

B Three-digit plan number (PN) ▶ 003

C Plan sponsor's name as shown on line 2a of Form 5500
MEDCENTRAL HEALTH SYSTEM

D Employer Identification Number (EIN)
34-4429972

Part I Distributions

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions **1** 0

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):

EIN(s): 35-0145825 _____

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** 121

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

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

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

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

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

6 a Enter the minimum required contribution for this plan year **6a** 0

b Enter the amount contributed by the employer to the plan for this plan year **6b** 0

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)*

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

---

a Name of contributing employer

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

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(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

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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 _____

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(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify):

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

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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):

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

FINANCIAL STATEMENTS

APRIL 15, 2010 (TERMINATION)

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INDEPENDENT AUDITOR'S REPORT

January 5, 2011

To the Board of Trustees of
MedCentral Health System,
Crestline Hospital Employees' Pension Plan
335 Glessner Avenue
Mansfield, OH 44903

We were engaged to audit the financial statements of MedCentral Health System, Crestline Hospital Employees' Pension Plan as of April 15, 2010 (Termination) and December 31, 2009, and for the period ended April 15, 2010 (Termination). These financial statements are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note C, which was certified by American United Life Insurance Company, the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the custodian as of and for the period ended April 15, 2010 (Termination) and the year ended December 31, 2009, that the information provided to the plan administrator by the custodian is complete and accurate.

As described in Note I to the financial statements, the Board of Trustees of MedCentral Health System, the Plan's sponsor, voted on May 25, 2005, to terminate the Plan. In accordance with accounting principles generally accepted in the United States of America, the Plan has changed its basis of accounting used to determine the amounts at which investments and the accumulated benefit information are stated, from the ongoing plan basis to the liquidation basis for periods after May 25, 2005.

MedCentral Health System,
Crestline Hospital Employees' Pension Plan
January 5, 2011

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

Riester, Lump & Burton CPA's, Inc.

Riester, Lump & Burton CPAs Inc

Mansfield, Ohio

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

STATEMENT OF NET ASSETS IN LIQUIDATION AVAILABLE FOR BENEFITS

APRIL 15, 2010 (TERMINATION) AND DECEMBER 31, 2009

	April 15, 2010 (Termination)	2009
Assets		
Investments:		
Insurance Contracts Managed by American United Life Insurance Company, at Liquidation Value	$ 0	$ 698,929
Mutual Funds Held in Pooled Separate Account, Liquidation Value	0	307,412
Total Assets	0	1,006,341
Liabilities	0	0
Net Assets Available for Benefits	**$ 0**	**$ 1,006,341**

The Accompanying Notes are an Integral Part of These Financial Statements.

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

STATEMENT OF CHANGES IN NET ASSETS IN LIQUIDATION AVAILABLE FOR BENEFITS

FOR THE PERIOD ENDED APRIL 15, 2010 (TERMINATION)

Additions to Net Assets Attributable to:	
Investment Income:	
Interest Income	$ 5,541
Net Appreciation in Liquidation Value of Investments	7,182
Total Additions	12,723
Deductions from Net Assets Attributed to:	
Benefits Paid to Participants	1,017,268
Fees	1,796
Total Deductions	1,019,064
Net Decrease	(1,006,341)
Net Assets Available for Benefits:	
Beginning of Period	1,006,341
End of Period	**$ 0**

The Accompanying Notes are an Integral Part of These Financial Statements.

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

NOTES TO FINANCIAL STATEMENTS

APRIL 15, 2010 (TERMINATION)

NOTE A. DESCRIPTION OF PLAN

The following description of the **MedCentral Health System, Crestline Hospital ("Hospital") Employees' Pension Plan ("Plan")** provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

1. **General.** The Plan is a defined contribution plan covering all full-time employees of the Hospital who have completed one year of service and are age twenty-one or older. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

2. **Contributions.** Through December 31, 1996, the Hospital made contributions for each participant equal to 3% to 7% of each participant's effective compensation, as defined. In January 1997, the Hospital merged with Mansfield General Hospital to become MedCentral Health System. As part of the merger agreement, Plan participants became participants of the Employees' Retirement Plan of MedCentral Health System on January 1, 1997. However, the assets of the Plan will remain intact and continue to accumulate earnings until employees withdraw them upon retirement or termination of employment from the Hospital. No further contributions will be made to the Plan.

3. **Participant Accounts.** Each participant's account is credited with a pro rata portion of Plan earnings. Earnings are allocated based on participants' 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.

4. **Vesting.** Vesting in the participants' accounts is based on years of continuous service. A participant is 100% vested after five years of credited service. As a result of the merger, as discussed in Note A(2), all plan participants became 100% vested in their accounts.

NOTE A. DESCRIPTION OF PLAN (Continued)

5. **Payment of Benefits.** Upon retirement, a participant may elect to receive either a lump-sum amount, a life annuity, a certain and life annuity, a survivorship annuity, a fixed period annuity, or an installment refund annuity, as defined. Normal retirement age is 65. Provisions exist for early, deferred, and disability retirements.

6. **Investment Options.** Prior to termination, participants could direct their contributions to one of ten diversified investment options.

7. **Insurance Contracts.** The insurance contracts are in a common/ collective trust that invests primarily in a diversified portfolio of insurance company contracts. The contracts are as follows:

   For insurance contract #93123 fixed fund, the average yield for 2010 and 2009 was 4.00% and the crediting interest rate as of December 31, 2009 was 4.00%.

   For insurance contract #93123 alternate fixed fund, the average yield for 2010 and 2009 was 3.75% and the crediting interest rate as of December 31, 2009 was 3.75%.

   For insurance contract #91898 fixed fund, the average yield for 2010 and 2009 was 3.75% and the crediting interest rate as of December 31, 2009 was 3.75%.

   Crediting interest rates are determined daily by dividing earned income for the day by new contract value. The fund, although fully benefit responsive, is valued at liquidation value. The liquidation value of the fund at April 15, 2010 and December 31, 2009 was $0 and $698,929, respectively. The contract value at April 15, 2010 and December 31, 2009 was $0 and $698,929, respectively.

NOTE B. SUMMARY OF ACCOUNTING POLICIES

Basis of Accounting

As described in Note I, the Board of Trustees has elected to terminate the plan. As a result, the financial statements of the Plan are prepared under the liquidation method of accounting.

NOTE B. SUMMARY OF ACCOUNTING POLICIES (Continued)

Payment of Benefits

Benefits are recorded when paid.

Investment Valuation and Income Recognition

As of April 15, 2010 and December 31, 2009, the Plan's investments are stated at liquidation value. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

NOTE C. CERTIFIED INFORMATION

The Plan has investments managed by the American United Life Insurance Company (Custodian). The accounts are credited with actual earnings on the underlying investments and charged for Plan withdrawals. The plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the plan administrator has obtained certifications from the Custodian of the Plan that all of the information provided by them is complete and accurate. Information included in the accompanying financial statements as to investments in the trust fund administered by the Custodian, interest income, net appreciation in fair value of investments is presented in reliance solely upon those certifications.

NOTE D. TAX STATUS

The Internal Revenue Service (IRS) determined and informed the Company by a letter dated April 6, 1999 that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). Although the Plan has been amended since receiving the determination letter, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

NOTE E. NET ASSETS AVAILABLE FOR BENEFITS

Net assets available for benefits at December 31, 2009 include $627,984 allocated to the accounts of participants who terminated employment with MedCentral Health Systems prior to that date. Those balances were payable to the former participants on demand. All account balances have been distributed as of April 15, 2010.

NOTE F. PARTY IN INTEREST TRANSACTIONS

Parties-in-interest are defined under Department of Labor regulations as any fiduciary of the Plan, any party rendering services to the Plan, the employer and certain others. At December 31, 2009, $53,743 of the investments of the Plan are shares of mutual funds sponsored by One America, an affiliate of American United Life Insurance Company. In addition, the fixed funds totaling $698,929 were contracts administered American United Life Insurance Company. American United Life Insurance Company is the Plan custodian and, therefore, these investments qualify as party-in-interest investments.

NOTE G. INVESTMENTS

The following table presents the investments of the Plan as of April 15, 2010 and December 31, 2009, as certified by the Custodian. Investments that represent 5% or more of the Plan's assets available for benefits are separately identified.

	April 15, 2010	2009
Investments at indicated value as determined by liquidation value:		
Group annuity contract #93123:		
Fixed Fund	$ 0	$ 138,921
Alternate Fixed Fund	0	215,096
Group annuity contract #91898:		
Fixed Fund	0	344,912
State Street Equity 500 Index Fund	0	119,845
Fidelity VIP Growth Fund	0	69,047
Fidelity VIP Asset Manager Fund	0	59,468
Other	0	59,052
	$ 0	**$ 1,006,341**

NOTE G. INVESTMENTS (Continued)

All of the above assets are in participant directed accounts.

The following table presents investment income (loss) for the period ended April 15, 2010, accounted for on the liquidation basis, as certified to be complete and accurate by the Custodian:

	Interest Income	Net Appreciation (Depreciation) in Liquidating Value of Investments	Total Investment Income (Loss)
Insurance contracts at liquidation value:			
#93123 Alternate Fixed Fund	$ 1,643	$	$ 1,643
#93123 Fixed Fund	1,283		1,283
#91898 Fixed Fund	2,615		2,615
Investments at liquidation value:			
OneAmerica Investment Grade Bond Fund		14	14
OneAmerica Value Fund		999	999
OneAmerica Asset Director Fund		125	125
OneAmerica Money Market Fund		(41)	(41)
Fidelity VIP Asset Manager Fund		452	452
State Street Equity 500 Index Fund		2,644	2,644
Fidelity VIP Growth Fund		3,012	3,012
Fidelity VIP Overseas Fund		(23)	(23)
Total	**$ 5,541**	**$ 7,182**	**$ 12,723**

NOTE H. ADMINISTRATION COSTS

The expenses of administering this Plan are the responsibility of the Plan sponsor.

NOTE I. PLAN TERMINATION

The MedCentral Health System Board of Trustees, the Plan's sponsor, voted on May 25, 2005 to proceed with the termination of the Plan. Final distributions will be determined based on all participants being 100% vested, and will be made as soon as possible after the plan of termination is approved by the IRS. In accordance with generally accepted accounting principles, the Plan has changed its basis of accounting used to value plan assets from the ongoing plan basis to the liquidation basis for periods after May 25, 2005. On July 3, 2008, the Plan received approval from the Internal Revenue Service to terminate the Plan. The termination was completed in April 2010 when the final distributions to participants were made.

NOTE J. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through January 5, 2011, the date the financial statements were available to be issued. No material subsequent events were noted.

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

FINANCIAL STATEMENTS

APRIL 15, 2010 (TERMINATION)

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INDEPENDENT AUDITOR'S REPORT

January 5, 2011

To the Board of Trustees of
MedCentral Health System,
Crestline Hospital Employees' Pension Plan
335 Glessner Avenue
Mansfield, OH 44903

We were engaged to audit the financial statements of MedCentral Health System, Crestline Hospital Employees' Pension Plan as of April 15, 2010 (Termination) and December 31, 2009, and for the period ended April 15, 2010 (Termination). These financial statements are the responsibility of the Plan's management.

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note C, which was certified by American United Life Insurance Company, the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the custodian as of and for the period ended April 15, 2010 (Termination) and the year ended December 31, 2009, that the information provided to the plan administrator by the custodian is complete and accurate.

As described in Note I to the financial statements, the Board of Trustees of MedCentral Health System, the Plan's sponsor, voted on May 25, 2005, to terminate the Plan. In accordance with accounting principles generally accepted in the United States of America, the Plan has changed its basis of accounting used to determine the amounts at which investments and the accumulated benefit information are stated, from the ongoing plan basis to the liquidation basis for periods after May 25, 2005.

MedCentral Health System,
Crestline Hospital Employees' Pension Plan
January 5, 2011

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

Riester, Lump & Burton CPA's, Inc.

Riester, Lump & Burton CPAs Inc

Mansfield, Ohio

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

STATEMENT OF NET ASSETS IN LIQUIDATION AVAILABLE FOR BENEFITS

APRIL 15, 2010 (TERMINATION) AND DECEMBER 31, 2009

	April 15, 2010 (Termination)	2009
Assets		
Investments:		
Insurance Contracts Managed by American United Life Insurance Company, at Liquidation Value	$ 0	$ 698,929
Mutual Funds Held in Pooled Separate Account, Liquidation Value	0	307,412
Total Assets	0	1,006,341
Liabilities	0	0
Net Assets Available for Benefits	**$ 0**	**$ 1,006,341**

The Accompanying Notes are an Integral Part of These Financial Statements.

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

STATEMENT OF CHANGES IN NET ASSETS IN LIQUIDATION AVAILABLE FOR BENEFITS

FOR THE PERIOD ENDED APRIL 15, 2010 (TERMINATION)

Additions to Net Assets Attributable to:	
Investment Income:	
Interest Income	$ 5,541
Net Appreciation in Liquidation Value of Investments	7,182
Total Additions	12,723
Deductions from Net Assets Attributed to:	
Benefits Paid to Participants	1,017,268
Fees	1,796
Total Deductions	1,019,064
Net Decrease	(1,006,341)
Net Assets Available for Benefits:	
Beginning of Period	1,006,341
End of Period	**$ 0**

The Accompanying Notes are an Integral Part of These Financial Statements.

MEDCENTRAL HEALTH SYSTEM,
CRESTLINE HOSPITAL EMPLOYEES' PENSION PLAN

NOTES TO FINANCIAL STATEMENTS

APRIL 15, 2010 (TERMINATION)

NOTE A. DESCRIPTION OF PLAN

The following description of the **MedCentral Health System, Crestline Hospital ("Hospital") Employees' Pension Plan ("Plan")** provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

1. **General.** The Plan is a defined contribution plan covering all full-time employees of the Hospital who have completed one year of service and are age twenty-one or older. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

2. **Contributions.** Through December 31, 1996, the Hospital made contributions for each participant equal to 3% to 7% of each participant's effective compensation, as defined. In January 1997, the Hospital merged with Mansfield General Hospital to become MedCentral Health System. As part of the merger agreement, Plan participants became participants of the Employees' Retirement Plan of MedCentral Health System on January 1, 1997. However, the assets of the Plan will remain intact and continue to accumulate earnings until employees withdraw them upon retirement or termination of employment from the Hospital. No further contributions will be made to the Plan.

3. **Participant Accounts.** Each participant's account is credited with a pro rata portion of Plan earnings. Earnings are allocated based on participants' 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.

4. **Vesting.** Vesting in the participants' accounts is based on years of continuous service. A participant is 100% vested after five years of credited service. As a result of the merger, as discussed in Note A(2), all plan participants became 100% vested in their accounts.

NOTE A. DESCRIPTION OF PLAN (Continued)

5. **Payment of Benefits.** Upon retirement, a participant may elect to receive either a lump-sum amount, a life annuity, a certain and life annuity, a survivorship annuity, a fixed period annuity, or an installment refund annuity, as defined. Normal retirement age is 65. Provisions exist for early, deferred, and disability retirements.

6. **Investment Options.** Prior to termination, participants could direct their contributions to one of ten diversified investment options.

7. **Insurance Contracts.** The insurance contracts are in a common/ collective trust that invests primarily in a diversified portfolio of insurance company contracts. The contracts are as follows:

   For insurance contract #93123 fixed fund, the average yield for 2010 and 2009 was 4.00% and the crediting interest rate as of December 31, 2009 was 4.00%.

   For insurance contract #93123 alternate fixed fund, the average yield for 2010 and 2009 was 3.75% and the crediting interest rate as of December 31, 2009 was 3.75%.

   For insurance contract #91898 fixed fund, the average yield for 2010 and 2009 was 3.75% and the crediting interest rate as of December 31, 2009 was 3.75%.

   Crediting interest rates are determined daily by dividing earned income for the day by new contract value. The fund, although fully benefit responsive, is valued at liquidation value. The liquidation value of the fund at April 15, 2010 and December 31, 2009 was $0 and $698,929, respectively. The contract value at April 15, 2010 and December 31, 2009 was $0 and $698,929, respectively.

NOTE B. SUMMARY OF ACCOUNTING POLICIES

Basis of Accounting

As described in Note I, the Board of Trustees has elected to terminate the plan. As a result, the financial statements of the Plan are prepared under the liquidation method of accounting.

NOTE B. SUMMARY OF ACCOUNTING POLICIES (Continued)

Payment of Benefits

Benefits are recorded when paid.

Investment Valuation and Income Recognition

As of April 15, 2010 and December 31, 2009, the Plan's investments are stated at liquidation value. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

NOTE C. CERTIFIED INFORMATION

The Plan has investments managed by the American United Life Insurance Company (Custodian). The accounts are credited with actual earnings on the underlying investments and charged for Plan withdrawals. The plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the plan administrator has obtained certifications from the Custodian of the Plan that all of the information provided by them is complete and accurate. Information included in the accompanying financial statements as to investments in the trust fund administered by the Custodian, interest income, net appreciation in fair value of investments is presented in reliance solely upon those certifications.

NOTE D. TAX STATUS

The Internal Revenue Service (IRS) determined and informed the Company by a letter dated April 6, 1999 that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). Although the Plan has been amended since receiving the determination letter, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

NOTE E. NET ASSETS AVAILABLE FOR BENEFITS

Net assets available for benefits at December 31, 2009 include $627,984 allocated to the accounts of participants who terminated employment with MedCentral Health Systems prior to that date. Those balances were payable to the former participants on demand. All account balances have been distributed as of April 15, 2010.

NOTE F. PARTY IN INTEREST TRANSACTIONS

Parties-in-interest are defined under Department of Labor regulations as any fiduciary of the Plan, any party rendering services to the Plan, the employer and certain others. At December 31, 2009, $53,743 of the investments of the Plan are shares of mutual funds sponsored by One America, an affiliate of American United Life Insurance Company. In addition, the fixed funds totaling $698,929 were contracts administered American United Life Insurance Company. American United Life Insurance Company is the Plan custodian and, therefore, these investments qualify as party-in-interest investments.

NOTE G. INVESTMENTS

The following table presents the investments of the Plan as of April 15, 2010 and December 31, 2009, as certified by the Custodian. Investments that represent 5% or more of the Plan's assets available for benefits are separately identified.

	April 15, 2010	2009
Investments at indicated value as determined by liquidation value:		
Group annuity contract #93123:		
Fixed Fund	$ 0	$ 138,921
Alternate Fixed Fund	0	215,096
Group annuity contract #91898:		
Fixed Fund	0	344,912
State Street Equity 500 Index Fund	0	119,845
Fidelity VIP Growth Fund	0	69,047
Fidelity VIP Asset Manager Fund	0	59,468
Other	0	59,052
	$ 0	**$ 1,006,341**

NOTE G. INVESTMENTS (Continued)

All of the above assets are in participant directed accounts.

The following table presents investment income (loss) for the period ended April 15, 2010, accounted for on the liquidation basis, as certified to be complete and accurate by the Custodian:

	Interest Income	Net Appreciation (Depreciation) in Liquidating Value of Investments	Total Investment Income (Loss)
Insurance contracts at liquidation value:			
#93123 Alternate Fixed Fund	$ 1,643	$	$ 1,643
#93123 Fixed Fund	1,283		1,283
#91898 Fixed Fund	2,615		2,615
Investments at liquidation value:			
OneAmerica Investment Grade Bond Fund		14	14
OneAmerica Value Fund		999	999
OneAmerica Asset Director Fund		125	125
OneAmerica Money Market Fund		(41)	(41)
Fidelity VIP Asset Manager Fund		452	452
State Street Equity 500 Index Fund		2,644	2,644
Fidelity VIP Growth Fund		3,012	3,012
Fidelity VIP Overseas Fund		(23)	(23)
Total	**$ 5,541**	**$ 7,182**	**$ 12,723**

NOTE H. ADMINISTRATION COSTS

The expenses of administering this Plan are the responsibility of the Plan sponsor.

NOTE I. PLAN TERMINATION

The MedCentral Health System Board of Trustees, the Plan's sponsor, voted on May 25, 2005 to proceed with the termination of the Plan. Final distributions will be determined based on all participants being 100% vested, and will be made as soon as possible after the plan of termination is approved by the IRS. In accordance with generally accepted accounting principles, the Plan has changed its basis of accounting used to value plan assets from the ongoing plan basis to the liquidation basis for periods after May 25, 2005. On July 3, 2008, the Plan received approval from the Internal Revenue Service to terminate the Plan. The termination was completed in April 2010 when the final distributions to participants were made.

NOTE J. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through January 5, 2011, the date the financial statements were available to be issued. No material subsequent events were noted.

MedCentral
HEALTH SYSTEM

January 14, 2011

PERSONAL AND CONFIDENTIAL

EFAST2
Department of Labor/EBSA
200 Constitution Avenue, NW
Washington, DC 20210

To Whom It May Concern:

This letter is attached to the 2010 Final Form 5500 Annual Return/Report for the Medcentral Health System Crestline Hospital Employees' Pension Plan 003 (the Plan) for the final plan year ending April 15, 2010.

An Application for Extension of Time (Form 5558) to file the 5500 return was filed for the Plan with a year ending March 31, 2010 as this was the date the last participant account was distributed by. An approval was granted by the Internal Revenue Service (IRS) giving the Plan until January 15, 2011 to file the Form 5500 (originally due October 31, 2010).

We later learned that the Plan's final distribution of the plan assets from the forfeiture account was made on April 15, 2010. Thus, attached you will find the 2010 Form 5500 filed for the plan year ending April 15, 2010. In a call to the IRS made January 4, 2011, our accountant spoke with Agent #1000143706 to determine if the extension was valid as filed since the Form 5500 would need to be filed with a year ending date of April 15, 2010. The IRS Agent stated that as long as the Form 5500 was filed by the January 15, 2011 extension date, the Form 5500 would not be considered late. We have been asked to attach this statement to our Form 5500 to explain the difference in the plan year ending date and the Application for Extension.

Please contact me if you have any questions regarding this return or extension.

Sincerely,

MEDCENTRAL HEALTH SYSTEM

Richard Hoback
Director of Human Resources

/smh - 65418 - 011411