

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ► Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089
		2011
		This Form is Open to Public Inspection

Part I	Annual Report Identification Information
For calendar plan year 2011 or fiscal plan year beginning <u>01/01/2011</u> and ending <u>12/31/2011</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan; or ☒ a single-employer plan; ☐ a DFE (specify) ____
B This return/report is:	☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information
1a Name of plan <u>MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN</u>	1b Three-digit plan number (PN) ► <u>003</u> 1c Effective date of plan <u>01/01/1988</u>
2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan) <u>MADISON COUNTY COMMUNITY HOSPITAL</u> <u>210 N MAIN ST</u> <u>LONDON, OH 43140-1115</u>	2b Employer Identification Number (EIN) <u>31-1657206</u> 2c Sponsor's telephone number <u>740-852-1372</u> 2d Business code (see instructions) <u>622000</u>

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

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

SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>10/10/2012</u>	<u>BECKY ROZELL</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>10/11/2012</u>	<u>MICHAEL S BROWNING</u>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2011)
v.012611

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") MADISON COUNTY COMMUNITY HOSPITAL 210 N MAIN ST LONDON, OH 43140-1115	3b Administrator's EIN 31-1657206 3c Administrator's telephone number 740-852-1372
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	451
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	274
b Retired or separated participants receiving benefits.....	6b	0
c Other retired or separated participants entitled to future benefits.....	6c	174
d Subtotal. Add lines 6a , 6b , and 6c	6d	448
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	0
f Total. Add lines 6d and 6e	6f	448
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	417
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	0

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

2F 2G 2L 2M 2S 2T

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) ☒ Insurance	(1) ☒ Insurance
(2) ☐ Code section 412(e)(3) insurance contracts	(2) ☐ Code section 412(e)(3) insurance contracts
(3) ☒ Trust	(3) ☒ 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

- (1)** ☒ **R** (Retirement Plan Information)

(2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan <u>MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN</u>	B Three-digit plan number (PN) ►	<u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MADISON COUNTY COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>31-1657206</u>	

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

(a) Name of insurance carrier

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	G93190	12	01/01/2011	12/31/2011

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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** 54877**5** Current value of plan's interest under this contract in separate accounts at year end **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**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** 52893**c** Additions: (1) Contributions deposited during the year **7c(1)** 0(2) Dividends and credits **7c(2)** 0(3) Interest credited during the year **7c(3)** 1984(4) Transferred from separate account **7c(4)** 0(5) Other (specify below) **7c(5)** 0(6) Total additions **7c(6)** 1984**d** Total of balance and additions (add **b** and **c(6)**). **7d** 54877**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 0(2) Administration charge made by carrier **7e(2)** 0(3) Transferred to separate account **7e(3)** 0(4) Other (specify below) **7e(4)** 0(5) Total deductions **7e(5)** 0**f** Balance at the end of the current year (subtract **e(5)** from **d**) **7f** 54877

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 organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan <u>MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN</u>	B Three-digit plan number (PN) ►	<u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MADISON COUNTY COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>31-1657206</u>	

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

(a) Name of insurance carrier
HARTFORD 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
<u>06-0974148</u>	<u>88072</u>	<u>080137/082280</u>		<u>01/01/2011</u>	<u>12/31/2011</u>

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
<u>357</u>	<u>0</u>

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
G & W EQUITY SALES INC P.O. BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>357</u>			<u>3</u>

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end	4	859350
5 Current value of plan's interest under this contract in separate accounts at year end	5	253636

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. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☒ other ▶ **GROUP VARIABLE ANNUITY**

b Balance at the end of the previous year	7b	896142
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c Additions: (1) Contributions deposited during the year	7c(1)	0	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	35056	
(4) Transferred from separate account	7c(4)	0	
(5) Other (specify below)	7c(5)	0	

(6) Total additions	7c(6)	35056
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d Total of balance and additions (add b and c(6))	7d	931198
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	71786	
(2) Administration charge made by carrier	7e(2)	62	
(3) Transferred to separate account	7e(3)	0	
(4) Other (specify below)	7e(4)	0	

(5) Total deductions	7e(5)	71848
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f Balance at the end of the current year (subtract e(5) from d)	7f	859350
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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 organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2011 This Form is Open to Public Inspection
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For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN	B Three-digit plan number (PN) ▶ 003
C Plan sponsor's name as shown on line 2a of Form 5500 MADISON COUNTY COMMUNITY HOSPITAL	D Employer Identification Number (EIN) 31-1657206

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

(a) Name of insurance carrier

METLIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0566090	87726	916316		01/01/2011	12/31/2011

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
53	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

METLIFE SECURITIES INC
1095 AVENUE OF THE AMERICAS
NEW YORK, NY 10036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
53			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end	4	128876
5 Current value of plan's interest under this contract in separate accounts at year end	5	165950

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. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	124517
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c Additions: (1) Contributions deposited during the year	7c(1)	2032	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	4359	
(4) Transferred from separate account	7c(4)	12768	
(5) Other (specify below)	7c(5)	0	

(6) Total additions	7c(6)	19159
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d Total of balance and additions (add b and c(6))	7d	143676
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	14800	
(2) Administration charge made by carrier	7e(2)	0	
(3) Transferred to separate account	7e(3)	0	
(4) Other (specify below)	7e(4)	0	

(5) Total deductions	7e(5)	14800
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f Balance at the end of the current year (subtract e(5) from d)	7f	128876
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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 organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110
		2011
		This Form is Open to Public Inspection

For calendar plan year 2011 or fiscal plan year beginning **01/01/2011** and ending **12/31/2011**

A Name of plan MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN	B Three-digit plan number (PN) ►	003
C Plan sponsor's name as shown on line 2a of Form 5500 MADISON COUNTY COMMUNITY HOSPITAL	D Employer Identification Number (EIN) 31-1657206	

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

(a) Name of insurance carrier

VARIABLE ANNUITY LIFE INSURANCE CO.

(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
74-1625348	70238	69113	417	01/01/2011	12/31/2011

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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** 1435177**5** Current value of plan's interest under this contract in separate accounts at year end **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**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 ▶**b** Balance at the end of the previous year **7b** 1224518**c** Additions: (1) Contributions deposited during the year **7c(1)** 151265(2) Dividends and credits **7c(2)** 0(3) Interest credited during the year **7c(3)** 45168(4) Transferred from separate account **7c(4)** 148015(5) Other (specify below) **7c(5)** 0(6) Total additions **7c(6)** 344448**d** Total of balance and additions (add **b** and **c(6)**). **7d** 1568966**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 122825(2) Administration charge made by carrier **7e(2)** 0(3) Transferred to separate account **7e(3)** 10739(4) Other (specify below) **7e(4)** 225▶ **CONTRACT SURRENDER CHARGES**(5) Total deductions **7e(5)** 133789**f** Balance at the end of the current year (subtract **e(5)** from **d**) **7f** 1435177

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 organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2011
		This Form is Open to Public Inspection.

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan <u>MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN</u>	B Three-digit plan number (PN) ▶ <u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MADISON COUNTY COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>31-1657206</u>

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☒ Yes ☐ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

51-0396365

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

06-0566090

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

06-0974148

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

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

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

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

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

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

VALIC RETIREMENT SERVICES COMPANY

51-0396365

(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?
65 37 19 28 29 33 49 52 59 60 61 63 64 72 99	NO RELATIONSHIP	8786	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

METLIFE INSURANCE COMPANY

06-0566090

(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?
65	SERVICE PROVIDER	364	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

HARTFORD LIFE INS. CO.

06-0974148

(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?
62 64 66	NONE	4227	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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 ☐

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110
		2011
		This Form is Open to Public Inspection

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011		
A Name of plan MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN	B Three-digit plan number (PN) ►	003
C Plan sponsor's name as shown on line 2a of Form 5500 MADISON COUNTY COMMUNITY HOSPITAL	D Employer Identification Number (EIN) 31-1657206	

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)	83259	92945
(9) Value of interest in common/collective trusts.....	1c(9)		
(10) Value of interest in pooled separate accounts.....	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	3394706	3050974
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	2298070	2478280
(15) Other	1c(15)		

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	5776035	5622199

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	0

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	5776035	5622199
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Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	558011	
(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)		558011
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	3287	
(F) Other	2b(1)(F)	86565	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		89852
(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)	45749	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		45749
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		0
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		-111052
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		582560

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	723019	
(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)		723019
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)	13377	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		13377
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		736396

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		-153836
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: SCHNEIDER DOWNS & CO. (2) EIN: 25-1408703

d The opinion of an independent qualified public accountant is **not attached** because:
 (1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

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

During the plan year:

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

- 5a** Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?

If "Yes," enter the amount of any plan assets that reverted to the employer this year..... ☐ Yes ☒ No Amount:

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

5b(1) Name of plan(s)

5b(2) EIN(s)	5b(3) PN(s)

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2011 This Form is Open to Public Inspection.
---	--	--

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan <u>MADISON COUNTY COMMUNITY HOSPITAL TAX DEFERRED BENEFIT PLAN</u>	B Three-digit plan number (PN) ▶ <u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MADISON COUNTY COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>31-1657206</u>

Part I	Distributions
---------------	----------------------

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>51-0396365</u> Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.	
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?.....	☐ Yes	☐ No	☐ N/A
If the plan is a defined benefit plan, go to line 8.			
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____ If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.			
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a		
b Enter the amount contributed by the employer to the plan for this plan year	6b		
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c		
If you completed line 6c, skip lines 8 and 9.			
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?	☐ Yes	☐ No	☐ N/A
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?.....	☐ Yes	☐ No	☐ N/A

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

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

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?.....	☐ Yes	☐ No
11 a Does the ESOP hold any preferred stock?	☐ Yes	☐ No
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.).....	☐ Yes	☐ No
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?	☐ Yes	☐ No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN
London, Ohio

Financial Statements
and
Supplementary Financial Information
As of December 31, 2011 and 2010
and for the year ended December 31, 2011

and Independent Auditors' Report Thereon



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INDEPENDENT AUDITORS' REPORT

To the Plan Administrator
Madison County Community Hospital
d/b/a Madison County Hospital, Inc. Tax Deferred Benefit Plan
London, Ohio

We were engaged to audit the accompanying statements of net assets available for benefits of Madison County Community Hospital d/b/a Madison County Hospital, Inc. Tax Deferred Benefit Plan (the Plan) as of December 31, 2011 and 2010, the related statement of changes in net assets available for benefits for the year ended December 31, 2011, and the supplemental schedules of delinquent participant contributions as of December 31, 2011 and assets (held at end of year) as of December 31, 2011. These financial statements and supplemental schedules 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 (ERISA), the Plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by AIG Federal Savings Bank, MetLife Insurance Company, American United Life Insurance Company, and Hartford Life Insurance Company, the trustees of the Plan, except for comparing such information with the related information included in the financial statements and supplemental schedules. We have been informed by the Plan administrator that the trustees hold the Plan's investment assets and execute investment transactions. The Plan administrator has obtained certification from the trustees as of and for the years ended December 31, 2011 and 2010 that the information provided to the Plan administrator by the trustees is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not express an opinion on the accompanying financial statements and supplemental schedules taken as a whole. The supplemental schedules are presented for the purpose of additional analysis and are not a required part of the financial statements but are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. The form and content of the information included in the financial statements and supplemental schedules, other than that derived from the information certified by the trustees, 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 ERISA.

Schneider Downs & Co., Inc.

Columbus, Ohio
September 26, 2012

Schneider Downs & Co., Inc.
www.schneiderdowns.com

IGAF POLARIS
A Global Association of Independent Firms

1133 Penn Avenue
Pittsburgh, PA 15222
TEL 412.261.3644
FAX 412.261.4876

41 S. High Street
Suite 2100
Columbus, OH 43215
TEL 614.621.4060
FAX 614.621.4062

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	December 31	
	2011	2010
ASSETS		
INVESTMENTS, AT FAIR VALUE		
Mutual funds	\$ 3,050,974	\$ 3,394,706
Guaranteed investment contract	1,494,849	1,201,032
Guaranteed annuity contracts	1,043,103	1,073,552
	<u>5,588,926</u>	<u>5,669,290</u>
RECEIVABLES		
Notes receivable from participants	<u>92,945</u>	<u>83,259</u>
Net Assets Available For Benefits, At Fair Value	<u>5,681,871</u>	<u>5,752,549</u>
Adjustments from fair value to contract value for fully benefit-responsive investment contract	<u>(59,672)</u>	<u>23,486</u>
Net Assets Available For Benefits	<u>\$ 5,622,199</u>	<u>\$ 5,776,035</u>

See notes to financial statements.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEAR ENDED DECEMBER 31, 2011

ADDITIONS TO NET ASSETS ATTRIBUTABLE TO:

Contributions:

Participants	\$ 558,011
--------------	------------

Investment Income:

Interest	45,919
----------	--------

Dividends	45,749
-----------	--------

	91,668
--	--------

Interest income on notes receivable from participants	3,287
---	-------

	3,287
--	-------

Total Additions	652,966
-----------------	---------

	652,966
--	---------

DEDUCTIONS FROM NET ASSETS ATTRIBUTABLE TO:

Benefits paid to participants	723,019
-------------------------------	---------

Net depreciation in fair value of investments	70,406
---	--------

Plan administrative expenses	13,377
------------------------------	--------

	13,377
--	--------

Total Deductions	806,802
------------------	---------

	806,802
--	---------

Net Decrease In Net Assets Available For Benefits	(153,836)
---	-----------

NET ASSETS AVAILABLE FOR BENEFITS

Beginning of year	5,776,035
-------------------	-----------

	5,776,035
--	-----------

End of year	\$ 5,622,199
-------------	--------------

	5,622,199
--	-----------

See notes to financial statements.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 1 - DESCRIPTION OF THE PLAN

The following description of the Madison County Community Hospital d/b/a Madison County Hospital, Inc. Tax Deferred Benefit Plan (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General - The Plan is a defined contribution plan covering all employees of the Madison County Community Hospital d/b/a Madison County Hospital, Inc. (Hospital). The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions - Participants may contribute a portion of pretax annual compensation, as defined in the Plan. The contributions are subject to certain limitations as defined in the Internal Revenue Code (IRC). Participants direct the investment of their contributions into various investment options offered by the Plan. Employee rollover contributions are also permitted. The Plan allows for automatic enrollment at a deferral rate of 3% of the employee's eligible compensation. Employees are automatically enrolled unless the employee elects not to participate.

Participant Investment Account Options - Investment account options available include various funds. Each participant has the option of directing his or her contributions into any of the separate investment accounts and may change the allocation daily. The Plan currently offers 17 mutual funds and 1 guaranteed investment account as investment options for participants.

Participant Accounts - Each participant's account is credited with the participant's contribution and an allocation of Plan earnings. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's account.

Vesting - Participants are immediately vested in all contributions and earnings thereon.

Payment of Benefits - Upon termination of service, retirement or death, an employee may elect to receive either a lump-sum amount equal to the value of his or her account, a life annuity, a certain and life annuity, an installment refund annuity, a fixed period annuity or a joint and survivor annuity. Participants may also withdraw their vested interest in the Plan under certain hardship conditions, as defined in the Plan document.

Notes Receivable from Participants - Participants may borrow from their accounts a minimum of \$1,000 up to a maximum of \$50,000 or 50% of their vested account balance. Loan terms range from 1-5 years or up to 15 years for the purchase of a primary residence. The loans are collateralized by the balance in the participant's accounts and bear interest rates that are commensurate with local prevailing rates as determined quarterly by the Plan Administrator. Principal and interest is paid ratably through payroll deductions.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A summary of significant accounting policies consistently applied by Plan management in the preparation of the accompanying financial statements follows:

Basis of Accounting - The accompanying financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

Use of 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 the reported amounts of net assets and changes in net assets and disclosure of contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates.

Investment Valuation and Income Recognition - The Plan's investments are stated at fair value, which is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 7 for discussion of fair value measurements. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Valuation of Investments - Investment contracts held by a defined contribution plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined contribution plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the Plan. The statement of net assets available for benefits presents the fair value of the investment contracts, as well as the adjustment of the fully benefit-responsive investment contracts from fair value to contract value relating to the investment contracts. The statement of changes in net assets available for benefits is prepared on a contract value basis.

Notes Receivable from Participants - These notes are measured at their unpaid principal balance plus any accrued but unpaid interest. Delinquent participant notes are reclassified as distributions based upon terms of the Plan document.

Administrative Expenses - Administrative expenses may be paid by the Hospital or the Plan, at the Hospital's discretion.

Payment of Benefits - Benefit payments to participants are recorded upon distribution.

Subsequent Events - Management has evaluated subsequent events through September 26, 2012, which is the date that the financial statements were available to be issued.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 3 - CERTIFICATION

The Plan administrator has received certifications from AIG Federal Savings Bank, MetLife Insurance Company, American United Life Insurance Company, and Hartford Life Insurance Company, the trustees of the Plan's assets, as to the completeness and accuracy of the investments and related investment income. Such information includes the composition and current value of the investments reported in the statement of net assets available for Plan benefits and the related investment income reported in the statement of changes in net assets available for Plan benefits.

NOTE 4 - INVESTMENTS

The following presents investments that represent 5% or more of the Plan's assets as of December 31:

	<u>2011</u>	<u>2010</u>
VALIC Fixed Interest Contract (Guaranteed investment contract), at contract value	\$ 1,435,177	\$ 1,224,518
Hartford Life Annuity Account	859,350	896,142
MFS Massachusetts Investors Growth Stock R3	594,862	-
American Funds Growth Fund	-	685,986
Pioneer Equity Income Fund	424,896	439,110
T Rowe Price Retirement 2010	290,274	337,663

NOTE 5 - FULLY BENEFIT-RESPONSIVE INVESTMENT CONTRACT

The Plan participates in a fully benefit-responsive investment contract with Variable Annuity Life Insurance Company (VALIC). VALIC maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate guaranteed to the Plan.

Contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to the guaranteed investment contract, because the guaranteed investment contract is fully benefit-responsive. The guaranteed investment contract is presented on the face of the statement of net assets available for benefits at fair value with an adjustment to contract value in arriving at net assets available for benefits. Contract value, as reported to the Plan by VALIC, represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

There are no reserves against the contract value for credit risk of the contract issuer or otherwise. The fair value of the investment contract at December 31, 2011 and 2010 was \$1,494,849 and \$1,201,032, respectively. The crediting interest rate is based on a formula agreed upon with the issuer, but it may not be less than 2%. Such interest rates are reviewed on a quarterly basis for resetting.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 5 - FULLY BENEFIT-RESPONSIVE INVESTMENT CONTRACT (Continued)

Certain events limit the ability of the Plan to transact at contract value with the issuer. Such events include the following: (1) amendments to the Plan documents (including complete or partial Plan termination or merger with another plan), (2) changes to Plan's prohibition on competing investment options or deletion of equity wash provisions, (3) bankruptcy of the Plan sponsor or other Plan sponsor events (for example, divestitures or spin-offs of a subsidiary) that cause a significant withdrawal from the Plan or (4) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The Plan administrator does not believe the occurrence of any such value event, which would limit the Plan's ability to transact at contract value with participants, is probable.

The guaranteed investment contract does not permit the insurance company to terminate the agreement prior to the scheduled maturity date.

	<u>2011</u>	<u>2010</u>
Average yields:		
Based on actual earnings	2.88%	3.93%
Based on interest rates credited to participants	3.25%	3.78%

NOTE 6 - ANNUITY CONTRACTS WITH INSURANCE COMPANY

Prior to 2009, the Plan participated in fixed annuity contracts with MetLife Insurance Company, American United Life Insurance Company and Hartford Life Insurance Company via an investment in various traditional annuity contracts. Under these contracts, participants were able to direct a portion of their contributions to purchase a specific amount of lifetime income based on the contractual rate schedule in effect at the time of the contribution. Contract value represents accumulated cash contributions to the contract, plus earnings at guaranteed crediting rates, less withdrawals, which approximates fair value. The contracts are affected directly between the Plan sponsor and the issuer. The repayment of principal and interest credited to participants is a financial obligation of the issuer.

NOTE 7 - FAIR VALUE MEASUREMENTS

Generally accepted accounting standards establish a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under generally accepted accounting standards are described below:

Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 7 - FAIR VALUE MEASUREMENTS (Continued)

Level 2: Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3: Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs. Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2011.

Mutual Funds: Valued at the net asset value (NAV) of shares held by the Plan at year-end.

Guaranteed Investment Contract: Valued at fair value by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the creditworthiness of the issuer (See Note 2).

Guaranteed Annuity Contracts: Valued at contract value, which approximates fair value, considering the claims-paying ability of the issuer.

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

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 7 - FAIR VALUE MEASUREMENTS (Continued)

The following tables set forth by level, within the fair value hierarchy, the fair value as of December 31, 2011 and 2010:

	Assets at Fair Value as of December 31, 2011			
	Level 1	Level 2	Level 3	Total
Mutual funds				
Hybrid Funds	\$ 851,374	-	-	\$ 851,374
Large Cap Funds	646,472	-	-	646,472
Large Growth Funds	600,887	-	-	600,887
Large Blend Funds	278,724	-	-	278,724
Fixed Income	217,579	-	-	217,579
Global Equity Funds	188,785	-	-	188,785
Asset Allocation Funds	101,362	-	-	101,362
Mid Cap Funds	100,216	-	-	100,216
Small Growth Funds	33,932	-	-	33,932
Mid Cap Value Funds	10,324	-	-	10,324
Small Cap Blend Funds	8,224	-	-	8,224
Small Cap Funds	7,445	-	-	7,445
Small Blend Funds	3,755	-	-	3,755
Mid Growth Funds	1,895	-	-	1,895
Guaranteed investment contract	-	-	\$ 1,494,849	1,494,849
Guaranteed annuity contracts	-	-	1,043,103	1,043,103
Total Assets At Fair Value	\$ 3,050,974	-	\$ 2,537,952	\$ 5,588,926

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 7 - FAIR VALUE MEASUREMENTS (Continued)

Assets at Fair Value as of December 31, 2010				
	Level 1	Level 2	Level 3	Total
Mutual funds				
Large Cap Funds	\$ 1,454,683	-	-	\$ 1,454,683
Hybrid Funds	810,172	-	-	810,172
Large Blend Funds	278,928	-	-	278,928
Global Equity Funds	249,723	-	-	249,723
Fixed Income	215,110	-	-	215,110
Asset Allocation Funds	121,315	-	-	121,315
Mid Cap Funds	166,351	-	-	166,351
Small Growth Funds	58,454	-	-	58,454
Mid Cap Value Funds	14,293	-	-	14,293
Small Cap Blend Funds	8,806	-	-	8,806
Large Growth Funds	5,976	-	-	5,976
Small Cap Funds	8,875	-	-	8,875
Mid Growth Funds	2,020	-	-	2,020
Guaranteed investment contract	-	-	\$ 1,201,032	1,201,032
Guaranteed annuity contracts	-	-	1,073,552	1,073,552
Total Assets At Fair Value	\$ 3,394,706	-	\$ 2,274,584	\$ 5,669,290

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 7 - FAIR VALUE MEASUREMENTS (Continued)

The following table sets forth a summary of changes in the fair value of the Plan's Level 3 assets for the year ended December 31, 2011:

	Level 3 Assets Year Ended December 31, 2011	
	Guaranteed Investment Contract	Guaranteed Annuity Contracts
Balance, beginning of year	\$ 1,201,032	\$ 1,073,552
Contributions	151,265	-
Interest	45,168	-
Transfers	137,276	-
Distributions	(122,825)	(71,785)
Fees	(225)	(62)
Unrealized gains / (losses) relating to instruments still held at the reporting date	83,158	41,398
Balance, End of Year	<u>\$ 1,494,849</u>	<u>\$ 1,043,103</u>

NOTE 8 - PLAN TERMINATION

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

NOTE 9 - TAX STATUS

The Plan was established under Section 403(b) of the IRC. At this time, the Internal Revenue Service (IRS) has not established a process for issuing determination and opinion letters for 403(b) plans. The Plan administrator believes that the Plan is currently designed and is currently being operated in compliance with the applicable requirements of the IRC and, therefore, believes that the Plan is qualified and the related trust is tax-exempt.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2011 AND 2010

NOTE 9 - TAX STATUS (Continued)

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2011, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan administrator believes that the Plan is no longer subject to income tax examinations for years prior to 2008.

NOTE 10 - PARTY-IN-INTEREST TRANSACTIONS

All Plan investments are shares of mutual funds, guaranteed investment contracts, and guaranteed annuity contracts managed by AIG Federal Savings Bank, MetLife Insurance Company, American United Life Insurance Company, and Hartford Life Insurance Company, trustees as defined by the Plan and, therefore, these transactions qualify as party-in-interest. In addition, notes receivable from participants are considered party-in-interest transactions, since these participants have a vested interest in Plan assets.

NOTE 11 - RISKS AND UNCERTAINTIES

The Plan invests in various investment securities that are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the participants' account balances and the amounts reported in the statement of net assets available for benefits.

SUPPLEMENTARY FINANCIAL INFORMATION

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

EIN: 31-1657206
PLAN NUMBER: 003

SCHEDULE H, LINE 4a - SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS
DECEMBER 31, 2011

Participant Contributions Transferred Late to Plan	Total That Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under Voluntary Fiduciary Correction Program (VCFP) and Prohibited Transaction Exemption 2002-51
	Contributions	Contributions Corrected	Contributions Pending	
Check here				
If Late Participation Loan Repayment Repayments Are Included	Not Corrected	Outside VCFP	Correction in VCFP	
2011	-	1,429	-	-

See independent auditors' report.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

EIN: 31-1657206
PLAN NUMBER: 003

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

(a)	(b) Identity of issues, borrower lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current Value
	Mutual funds:			
	MFS	MFS Massachusetts Investors Growth Stock R3	N/A	\$ 594,862
	Pioneer Equity Income	Pioneer Equity Income Fund A	N/A	424,896
	T Rowe	T Rowe Price Retirement 2010	N/A	290,274
	JP Morgan	JP Morgan Equity Index Fund A	N/A	274,199
	T Rowe	T Rowe Price Retirement 2040	N/A	207,400
	JP Morgan	JP Morgan Equity Government Bond A	N/A	193,579
	T Rowe	T Rowe Price Retirement Income	N/A	166,219
	The Growth Fund of America	American Funds Europacific R3	N/A	154,579
	T Rowe	T Rowe Price Retirement 2030	N/A	114,225
	Dreyfus	Dreyfus Midcap Index	N/A	81,368
	T Rowe	T Rowe Price Retirement 2020	N/A	73,256
*	MetLife	MetLife Moderate to Aggressive Allocation	N/A	69,285
*	Hartford	Hartford Stock	N/A	67,211
	Fidelity	Fidelity VIP Growth	N/A	55,098
	Fidelity	Fidelity VIP II Contra Fund	N/A	43,138
	Fidelity	Fidelity VIP II Asset Manager	N/A	26,599
*	Hartford	Hartford International Opportunities	N/A	23,638
	Barclays	Barclays Capital Aggregate Bond Index	N/A	22,008
*	MetLife	MetLife Stock Index	N/A	18,759
	T Rowe	T. Rowe Price Small Cap Growth	N/A	17,007
	Wells Fargo	Wells Fargo Advantage Emerging Growth A	N/A	16,925
	Janus Investment	Janus Enterprise S	N/A	13,558
*	Hartford	Hartford Dividend & Growth	N/A	13,230
*	Hartford	Hartford Index	N/A	10,600
	American Century Investments	Amcent Midcap Value Fund A	N/A	10,324
	Russell	Russell 2000 (R) Index	N/A	8,224
	Columbia	Columbia Small Cap Value I A	N/A	7,445
	Morgan Stanley	Morgan Stanley EAFE (R) Index	N/A	7,029
	Legg Mason	Legg Mason Variable Aggregate Growth	N/A	6,010
	American Century Investments	Amcent VP Capital Appreciation	N/A	5,290
	MFS	MFS Blended Research Core Equity R3	N/A	4,525
*	Hartford	Hartford Capital Appreciation	N/A	3,844
	Dreyfus	Dreyfus Small Cap Stock Index	N/A	3,755
*	Hartford	Hartford Advisers Fund	N/A	3,746
Balance Carried Forward				3,032,105

* Represents a party-in-interest

See independent auditors' report.

MADISON COUNTY COMMUNITY HOSPITAL
D/B/A MADISON COUNTY HOSPITAL, INC.
TAX DEFERRED BENEFIT PLAN

EIN: 31-1657206
PLAN NUMBER: 003

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
(Continued)

(a)	(b) Identity of issues, borrower lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current Value
		Balance Brought Forward		\$ 3,032,105
	Fidelity	Fidelity VIP Equity Income	N/A	3,024
	Fidelity	Fidelity Contra Fund - SC2	N/A	2,962
	T Rowe	T. Rowe Price Large Cap Value	N/A	2,617
	Oppenheimer	Oppenheimer Global Equity	N/A	2,298
	BlackRock	BlackRock Bond Income	N/A	1,992
	Franklin	Franklin Small-Medium Capital Growth	N/A	1,895
*	MetLife	MetLife Moderate Allocation	N/A	1,732
	Fidelity	Fidelity VIP Overseas	N/A	1,241
	Legg Mason	Legg Mason Variable Fundamental	N/A	1,093
	Janus	Janus Forty Portfolio	N/A	8
	Oppenheimer	Oppenheimer Capital Appreciation	N/A	7
				<u>3,050,974</u>
	Investment Contracts:			
*	The Variable Annuity Life Insurance Company	Contract rate interest (approximately 2.88%)	N/A	<u>1,435,177</u>
	Annuity Contracts:			
*	Hartford Life Insurance Company	Contract rate interest (approximately 4.00%)	N/A	859,350
*	MetLife Insurance Company	Contract rate interest (approximately 3.50%)	N/A	128,876
*	American United Life Insurance Company	Contract rate interest (approximately 4.00%)	N/A	<u>54,877</u>
				1,043,103
*	Participant Loans	Loans to participants (with rates of interest ranging from 4.25% to 8.25% with various maturity dates through 2016)	N/A	<u>92,945</u>
		Total Investments		<u>\$ 5,622,199</u>

* Represents a party-in-interest

See independent auditors' report.

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Form 5500

Attachment

Schedule H, line 4i--Schedule of Assets (Held at End of Year)

Name of plan MADISON COUNTY COMMUNITY HOSPITAL TAX-DEFERRED BENEFIT PLAN		Three-digit ERISA plan number 003		
Name of plan sponsor as shown on line 2a of Form 5500 MADISON COUNTY COMMUNITY HOSPITAL		Employer Identification Number 31-1657206		
Contract Number: 69113 Plan Number: 002				
(a)	(b) Identity of Issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
	VALIC FIXED-INTEREST	VALIC FIXED-INTEREST		1,435,177
	AMCENT MIDCAP VAL A	MUTUAL FUND - AMCENT MIDCAP VAL A		10,324
	AMER FUNDS EUROPAC R3	MUTUAL FUND - AMER FUNDS EUROPAC R3		154,579
	COLUMBIA SM CAP VAL I A	MUTUAL FUND - COLUMBIA SM CAP VAL I A		7,445
	DREYFUS MIDCAP INDEX	MUTUAL FUND - DREYFUS MIDCAP INDEX		81,368
	DREYFUS SM CAP STK INDX	MUTUAL FUND - DREYFUS SM CAP STK INDX		3,755
	JANUS ENTERPRISE S	MUTUAL FUND - JANUS ENTERPRISE S		13,558
	JP MORGAN EQUITY INDEX FUND A	MUTUAL FUND - JP MORGAN EQUITY INDEX FUND A		274,199
	JP MORGAN GOVT BOND A	MUTUAL FUND - JP MORGAN GOVT BOND A		193,579
	MFS BLENDED RESEARCH COR EQ R3	MUTUAL FUND - MFS BLENDED RESEARCH COR EQ R3		4,525
	MFS MASS INVEST GR STK R3	MUTUAL FUND - MFS MASS INVEST GR STK R3		594,862
	PIONEER EQUITY-INCOME A	MUTUAL FUND - PIONEER EQUITY-INCOME A		424,896
	T ROWE PRICE RTMT 2010 R	MUTUAL FUND - T ROWE PRICE RTMT 2010 R		290,274
	T ROWE PRICE RTMT 2020 R	MUTUAL FUND - T ROWE PRICE RTMT 2020 R		73,256
	T ROWE PRICE RTMT 2030 R	MUTUAL FUND - T ROWE PRICE RTMT 2030 R		114,225
	T ROWE PRICE RTMT 2040 R	MUTUAL FUND - T ROWE PRICE RTMT 2040 R		207,400
	T ROWE PRICE RTMT INC R	MUTUAL FUND - T ROWE PRICE RTMT INC R		166,219
	WELLS FARGO ADV EMERGING GRW A	MUTUAL FUND - WELLS FARGO ADV EMERGING GRW A		16,925
*	PARTICIPANT LOANS	(4.25% - 8.25%)		51,903

Form 5500

Attachment

Schedule H, line 4i--Schedule of Assets (Held at End of Year)

Name of plan MADISON COUNTY COMMUNITY HOSPITAL TAX-DEFERRED BENEFIT PLAN			Three-digit plan number 003	
Name of plan sponsor as shown on line 2a of Form 5500 MADISON COUNTY COMMUNITY HOSPITAL			Employer Identification Number 31-1657206	
Contract Number: 69113 Plan Number: 002				
(a)	(b) Identity of Issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
	FIXED RIDER	METLIFE - FIXED RIDER		11,873
	T-FLEX	METLIFE - T-FLEX		117,003
	BARCLAYS CAPAGGBOND INDEX	METLIFE - BARCLAYS CAPAGGBOND INDEX		22,008
	BLACKROCK BND INC-CL A	METLIFE - BLACKROCK BND INC-CL A		1,992
	FIDELITY CONTRAFUND - SC2	METLIFE - FIDELITY CONTRAFUND - SC2		2,962
	FIDELITY VIP EQTY INCOME	METLIFE - FIDELITY VIP EQTY INCOME		3,024
	FRANK SM-MID CAP GRO SEC	METLIFE - FRANK SM-MID CAP GRO SEC		1,895
	JANUS FORTY PORTFOLIO	METLIFE - JANUS FORTY PORTFOLIO		8
	LGG MSN CLRBR VAR FUN VAL	METLIFE - LGG MSN CLRBR VAR FUN VAL		1,093
	LGG MSN CLRBRG VAR AGG GR	METLIFE - LGG MSN CLRBRG VAR AGG GR		6,010
	MET MODER-AGGR ALLOC PORT	METLIFE - MET MODER-AGGR ALLOC PORT		69,285
	METLIFE MODER ALLOC PORT	METLIFE - METLIFE MODER ALLOC PORT		1,732
	METLIFE STOCK INDEX PORT	METLIFE - METLIFE STOCK INDEX PORT		18,759
	MORGAN STNLY EAFE (R) IND	METLIFE - MORGAN STNLY EAFE (R) IND		7,029
	OPP CAPITAL APPRECIATION	METLIFE - OPP CAPITAL APPRECIATION		7
	OPPEN GLOBAL EQUITY PORT	METLIFE - OPPEN GLOBAL EQUITY PORT		2,298
	RUSSELL 2000 (R) INDEX	METLIFE - RUSSELL 2000 (R) INDEX		8,224
	T ROWE PRICE LG CAP VAL	METLIFE - T ROWE PRICE LG CAP VAL		2,617
	T ROWE PRICE SMALL CAPGR	METLIFE - T ROWE PRICE SMALL CAPGR		17,007
*	PARTICIPANT LOANS			28,962
	ALTERNATE FIXED ACCOUNT	AUL - ALTERNATE FIXED ACCOUNT		54,877

Form 5500

Attachment

Schedule H, line 4i--Schedule of Assets (Held at End of Year)

Name of plan MADISON COUNTY COMMUNITY HOSPITAL TAX-DEFERRED BENEFIT PLAN			Three-digit ERISA plan number 003	
Name of plan sponsor as shown on line 2a of Form 5500 MADISON COUNTY COMMUNITY HOSPITAL			Employer Identification Number 31-1657206	
Contract Number: 69113 Plan Number: 002				
(a)	(b) Identity of Issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
	GENERAL ACCOUNT	HARTFORD# 080137 - GENERAL ACCOUNT		808,651
	FIDELITY VIP GROWTH	HARTFORD# 080137 - FIDELITY VIP GROWTH		10,683
	FIDELITY VIP II ASSET MANAGER	HARTFORD# 080137 - FIDELITY VIP II ASSET MANAGER		9,292
	FIDELITY VIP II CONTRAFUND	HARTFORD# 080137 - FIDELITY VIP II CONTRAFUND		35,651
	GENERAL ACCOUNT	HARTFORD# 082280 - GENERAL ACCOUNT		50,700
	AMCENT VP CAPITAL APPRECIATION	HARTFORD# 082280 - AMCENT VP CAPITAL APPRECIATION		5,290
	FIDELITY VIP GROWTH	HARTFORD# 082280 - FIDELITY VIP GROWTH		44,415
	FIDELITY VIP II ASSET MANAGER	HARTFORD# 082280 - FIDELITY VIP II ASSET MANAGER		17,307
	FIDELITY VIP II CONTRAFUND	HARTFORD# 082280 - FIDELITY VIP II CONTRAFUND		7,487
	FIDELITY VIP OVERSEAS	HARTFORD# 082280 - FIDELITY VIP OVERSEAS		1,241
	HARTFORD ADVISERS HLS	HARTFORD# 082280 - HARTFORD ADVISERS HLS		3,746
	HARTFORD CAPITAL APPRECTN HLS	HARTFORD# 082280 - HARTFORD CAPITAL APPRECTN HLS		3,844
	HARTFORD DIVIDEND & GROWTH HLS	HARTFORD# 082280 - HARTFORD DIVIDEND & GROWTH HLS		13,230
	HARTFORD INDEX HLS	HARTFORD# 082280 - HARTFORD INDEX HLS		10,600
	HARTFORD INTERNAT'L OPPS HLS	HARTFORD# 082280 - HARTFORD INTERNAT'L OPPS HLS		23,638
	HARTFORD STOCK HLS	HARTFORD# 082280 - HARTFORD STOCK HLS		67,211
*	PARTICIPANT LOANS	HARTFORD# 082280 - PARTICIPANT LOANS		12,081