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 01/01/2011 and ending 12/31/2011

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 01/01/2007

2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan)

CHARLESTON HOSPITAL, INC.

333 LAIDLEY STREET
CHARLESTON, WV 25322

2b Employer Identification Number (EIN) 61-1272692

2c Sponsor's telephone number 304-347-6633

2d Business code (see instructions) 622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/11/2012	RENEE CROSS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

333 LAIDLEY STREET
CHARLESTON, WV 25322

3b Administrator's EIN
61-1272692

3c Administrator's telephone number
304-347-6633

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	864
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**	687
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	222
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	909
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	0
f	Total. Add lines **6d** and **6e**	**6f**	909
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	809
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 2G 2J 2K 3D 3H 2T 2S

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

(1)	X		**H** (Financial Information)
(2)			**I** (Financial Information – Small Plan)
(3)	X	1	**A** (Insurance Information)
(4)	X		**C** (Service Provider Information)
(5)	X		**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

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

A Name of plan
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

JOHN HANCOCK LIFE INSURANCE COMPANY U.S.A.

(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
01-0233346	65838	58654	825	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
31469	8715

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

DUNBAR, BENDER & ZAPF, INC.
FRICK BUILDING, SUITE 1100
437 GRANT STREET
PITTSBURGH, PA 15219

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	1500	TPA FEE	5

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

DUNBAR, BENDER & ZAPF, INC.
FRICK BUILDING, SUITE 1100
437 GRANT STREET
PITTSBURGH, PA 15219

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	7215	TPA COMPENSATION NOT PAID FROM CONTRACT, PAID BY JOHN HANCOCK TO TPA	5

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

WELLS FARGO INSURANCE

SERVICE OF WV, INC.
ONE HILLCREST DRIVE EAST
CHARLESTON, WV 25311

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
31469			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	

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

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee 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)**	0
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)**	0
(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)**	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in **c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount.			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**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
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

JOHN HANCOCK

01-0233346

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

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

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

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

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

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

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

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

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

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

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

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

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

JOHN HANCOCK, USA

P. O. BOX 600
BUFFALO, NY 14201-0600

01-0233346

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 28 59 60 62 63 67	RECORDKEEPER	66	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] 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 [ ]

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 D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

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

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
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103 12 IE at end of year (see instructions)
01-0233346-000	P	696194

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103 12 IE at end of year (see instructions)
01-0233346-000	P	1013880

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103- 12 IE at end of year (see instructions)
01-0233346-000	P	6005296

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103- 12 IE at end of year (see instructions)
01-0233346-000	P	3262632

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103- 12 IE at end of year (see instructions)
01-0233346-000	P	690423

a Name of MTIA, CCT, PSA, or 103-12 IE: JH JOHN HANCOCK STABLE VAL

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103- 12 IE at end of year (see instructions)
01-0233346-000	P	608393

a Name of MTIA, CCT, PSA, or 103-12 IE: JH PIMCO TOTAL RETURN

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103- 12 IE at end of year (see instructions)
01-0233346-000	P	45362

a Name of MTIA, CCT, PSA, or 103-12 IE: JH DAVIS NEW YORK VENTURE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 71750

a Name of MTIA, CCT, PSA, or 103-12 IE: JH MUTUAL GLOBAL DISCOVERY

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 24784

a Name of MTIA, CCT, PSA, or 103-12 IE: THE GROWTH FUND OF AMERICA

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 82896

a Name of MTIA, CCT, PSA, or 103-12 IE: T ROWE PRICE EQUITY INC

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 83928

a Name of MTIA, CCT, PSA, or 103-12 IE: COLUMBIA MID CAP VALUE

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 52912

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 48376

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 122321

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

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 16971

a Name of MTIA, CCT, PSA, or 103-12 IE: JH FRANKLIN SMALL-MID GROWTH

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 32826

a Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP VALUE FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 44610

a Name of MTIA, CCT, PSA, or 103-12 IE: MID CAP INDEX FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 3228

a Name of MTIA, CCT, PSA, or 103-12 IE: MID CAP STOCK FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 22676

a Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP GROWTH FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 27963

a Name of MTIA, CCT, PSA, or 103-12 IE: SMALL CAP OPPORTUNITES FUND

b Name of sponsor of entity listed in (a): JOHN HANCOCK LIFE INSURANCE COMPANY

c EIN-PN 01-0233346-000	**d** Entity code P	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 9443

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

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	19333	10414
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	33652	35574
(2) Participant contributions	1b(2)	45036	49925
(3) Other	1b(3)		93
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)		89363
(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)	11722524	12966864
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	11820545	13152233
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	11820545	13152233

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)	941868	
(B) Participants	2a(1)(B)	1308738	
(C) Others (including rollovers)	2a(1)(C)	14288	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		2264894
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)	605	
(F) Other	2b(1)(F)	93	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		698
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0

			(a) Amount	(b) Total
2b	**(5)** Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0
	(6) Net investment gain (loss) from common/collective trusts	2b(6)		
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-343345
c	Other income	2c		
d	Total income. Add all **income** amounts in column (b) and enter total	2d		1922247
	Expenses			
e	Benefit payment and payments to provide benefits:			
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	566731	
	(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)		566731
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)	23828	
	(3) Investment advisory and management fees	2i(3)		
	(4) Other	2i(4)		
	(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		23828
j	Total expenses. Add all **expense** amounts in column (b) and enter total	2j		590559
	Net Income and Reconciliation			
k	Net income (loss). Subtract line **2j** from line **2d**	2k		1331688
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)** [X] Disclaimer **(4)** [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [X] Yes [ ] No

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

(1) Name: ARNETT FOSTER TOOTHMAN PLLC **(2)** EIN: 55-0486667

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**	X		729702
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e	Was this plan covered by a fidelity bond?	**4e**	X		1000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	**4j**		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l	Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**			

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
C.H.I. D/B/A ST. FRANCIS HOSPITAL 401 (K) PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
CHARLESTON HOSPITAL, INC.

D Employer Identification Number (EIN)
61-1272692

Part I Distributions

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

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

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

EIN(s): 01-0233346

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

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

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

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

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

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

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

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

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):

C.H.I. d/b/a ST. FRANCIS HOSPITAL
401(k) PLAN

Financial Report

December 31, 2011

CONTENTS

INDEPENDENT AUDITOR'S REPORT	1
FINANCIAL STATEMENTS	
Statements of net assets available for benefits	2
Statements of changes in net assets available for benefits	3
Notes to financial statements	4 - 9
SUPPLEMENTARY INFORMATION - SUPPLEMENTAL SCHEDULES REQUIRED BY ERISA	
Schedule H, Line 4a – schedule of delinquent participant contributions	10
Schedule H, Line 4i - schedule of assets (held at end of year)	11

arnett foster toothman pllc
CPAs & Advisors

INDEPENDENT AUDITOR'S REPORT

To the Plan Trustees and Plan Administrator
C.H.I. d/b/a St. Francis Hospital 401(k) Plan
Charleston, West Virginia

We were engaged to audit the accompanying statements of net assets available for benefits for C.H.I. d/b/a St. Francis Hospital 401(k) Plan (the Plan) as of December 31, 2011 and 2010, and the related statements of changes in net assets available for benefits for the years then ended, and the supplemental schedules as listed in the accompanying table of contents as of and for the year ended 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 United States Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 6 to the financial statements, which was certified by John Hancock Life Insurance Company (USA), the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the plan administrator that the custodian holds the Plan's assets and executes transactions. The plan administrator has obtained certifications from the custodian regarding the completeness and accuracy of the information summarized in Note 6 that was provided to the plan administrator by the custodian as of and for the years ended December 31, 2011 and 2010.

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 purposes 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 the Employee Retirement Income Security Act of 1974. 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 custodian, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the United States Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

ARNETT FOSTER TOOTHMAN PLLC

Arnett Foster Toothman PLLC

Charleston, West Virginia
October 8, 2012

101 Washington Street East | P.O. Box 2629
Charleston, WV 25329
304.346.0441 | 800.642.2601

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2011 and 2010

	2011	2010
ASSETS		
Cash	**$ 10,414**	$ 19,333
Investments at fair value	**12,944,088**	11,722,524
Receivables:		
Employer contribution	**35,574**	33,652
Employee contribution	**50,018**	45,036
Notes receivable from participants	**89,363**	-
	174,955	78,688
Total assets	**13,129,457**	11,820,545
LIABILITIES	**-**	-
NET ASSETS AVAILABLE FOR BENEFITS AT FAIR VALUE	**13,129,457**	11,820,545
Adjustment of fair value of contract value for fully benefit-responsive investment contracts	**22,776**	-
NET ASSETS AVAILABLE FOR BENEFITS	**$ 13,152,233**	$ 11,820,545

See Notes to Financial Statements

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years ended December 31, 2011 and 2010

	2011	2010
Additions to net assets attributed to:		
Net appreciation in fair value of investments	**$ -**	$ 1,329,789
Interest income from notes receivable from participants	**605**	-
Contributions:		
Employer	**941,868**	901,352
Participant	**1,308,831**	1,243,592
Rollovers from other qualified plans	**14,288**	30,648
	2,264,987	2,175,592
Total additions	**2,265,592**	3,505,381
Deductions from net assets attributed to:		
Net depreciation in fair value of investments	**343,345**	-
Benefits paid to participants	**566,731**	487,699
Administrative expenses	**23,828**	17,541
Total deductions	**933,904**	505,240
Net increase	**1,331,688**	3,000,141
Net assets available for benefits:		
Beginning of year	**11,820,545**	8,820,404
Ending of year	**$ 13,152,233**	$ 11,820,545

See Notes to Financial Statements

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS

Note 1. Description of Plan

Plan description: The following description of the C.H.I. d/b/a St. Francis Hospital 401(k) Plan (the Plan), provides only general information. Participants should refer to the Plan document for more complete information.

General: The Plan, which was established January 1, 2007 and restated effective January 1, 2010, is a defined contribution 401(k) safe harbor plan covering all employees who have attained age 18 and who have 90 days of service. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Amendments: The Plan was amended August 29, 2011, to allow participants to borrow from their Plan account balances attributable to their pre-tax and Roth elected deferrals.

Contributions: Participants may elect to defer a portion of their compensation, as defined in the Plan document, limited to the maximum allowed under the Internal Revenue Code for such Plan year. The employer's matching contribution is an Enhanced Safe Harbor Matching Contribution which is an amount equal to 100% of the participant's deferral contributions up to 4% of participant's compensation and an additional 50% of the participant's elective deferrals from 4% to 6% of participant's compensation.

The Plan allows rollovers from other qualified plans.

Participant investment options: Each Plan participant has the right to direct contributions and earnings of their account among alternative investment funds provided under the Plan. Participants should refer to the most recent annual report of each investment fund for information on risk factors, asset concentrations, use of derivative financial instruments and other financial data. Participants may transfer funds between investment options at any time.

Participant accounts: Each participant account is credited with the participant's elective deferrals, participant rollover contributions and any employer contributions. In addition, each participant's account is credited with their share of appreciation/depreciation in the value of investments and charged with an allocation of administrative expenses. 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 deferral and employer contributions and actual earnings thereon which are credited to their respective account.

Payment of benefits: Upon retirement (normal retirement age is 65), attainment of age 59½, death, disability or other termination of employment, as defined in the Plan document, participants or their spouses and/or beneficiaries receive their account as a lump sum cash payment. If the participant's account balance has never exceeded $1,000, the entire vested balance will be paid in a lump sum. Early retirement is permitted if the participant has attained age 60 and has completed five years of service. Further, upon termination of employment, the participant may elect to transfer his or her account balances to another qualified plan or individual retirement account. Minimum distributions for a participant must begin the later of April 1 of the calendar year after a participant attains age 70½ or when the participant actually retires.

The Plan allows for hardship withdrawals for certain participant needs as defined in the Plan document from participant elective contributions, Roth deferrals and related earnings. The employer has sole authority to authorize hardship withdrawals, pursuant to the Plan specifications.

Notes Receivable from Participants: Participants may borrow from their account balances attributable to their pre-tax and Roth elected deferrals., subject to a maximum amount which is the lesser of one-half of a participant's elective deferral account balance or $50,000. The participant's elective deferral account balance serves as collateral for the loan. The minimum request for a loan is $1,000 and not more than one loan can be outstanding for a participant at a time. Loans bear interest of 1% above the prime rate. Loan payments shall be repaid up to five years; however, if the loan is for the purchase of a principal residence, a longer term may be permitted.

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN

NOTES TO FINANCIAL STATEMENTS

Note 2. Significant accounting policies

The accounting and reporting policies of the Plan conform to accounting principles generally accepted in the United States of America and to general practices within the employee benefit plan industry. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates. The principles and policies which significantly affect the determination of net assets and the changes in net assets are summarized below.

Basis of accounting: The financial statements of the Plan are prepared on the accrual basis of accounting.

Significant New Accounting Pronouncements: In May of 2011, the Financial Accounting Standards Board (FASB) issued *Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRS* ASU 2011-04 amends Accounting Standards Codification (ASC) Section 820 to provide for common fair value measurement and disclosure requirements for financial statements in accordance with accounting principles generally accepted in the United States of America as with those prepared under International Financial Reporting Standards. Consequently, the amendments of the ASU change the wording used to describe many of the requirements of accounting principles generally accepted in the United States of America for measuring fair value and for disclosing information about fair value measurements. For many of the requirements, the FASB did not intend for the amendments in this ASU to result in a change in the application of the requirements in ASC Section 820. This ASU is effective on a prospective basis for fiscal years, beginning after December 15, 2011, with early adoption not permitted. The Plan's management does not expect that the adoption of this ASU will have an impact on the statements of net assets available for benefits and statement of changes in net assets available for benefits.

Investment valuation and income recognition: Pursuant to provisions under the Plan's contract with John Hancock Life Insurance Company (USA), Plan assets are invested in various pooled separate accounts.

The value of a unit in a pooled separate account is the fair market value of investments in the account as of the valuation date, plus cash balances and accruals less accounts payable, expenses and taxes that are allocable to the account, divided by the number of outstanding participation units in the account. Securities held in the pooled separate accounts are valued based on quoted market prices. If there is no readily available market value for a particular security, the investment manager will determine the fair market value of such investment in accordance with accepted practices and applicable laws and regulations. As of any date, the value of the Plan's share of a separate account will equal the number of participation units held by the Plan multiplied by the participation unit value.

Included within the investment options of the Plan's Pooled Separate Accounts as of December 31, 2011 and 2010 is the John Hancock Stable Value Fund, which is a fully benefit responsive investment option. Accounting principles generally accepted in the United States of America require that investments held by defined contribution employee benefit plans are to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of net assets available for benefits of a defined contribution plan attributable to fully benefit responsive investment options because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the Plan. These professional standards require that the statement of net assets available for benefits present the fair value of investment assets as well as an adjustment of the fully benefit responsive investment assets from fair value to contract value. The statement of changes in net assets available for benefits is prepared on a contract value basis.

The Plan does not require collateral to secure investment instruments.

Payment of benefits: Benefit payments are recorded upon distribution.

Subsequent Events: The Plan has evaluated subsequent events through October 8, 2012, the date the financial statements were available to be issued.

Note 3. Tax Status

The Plan has adopted the Dunbar Bender & Zapf, Inc., Prototype Non-Standardized Profit-Sharing Plan with CODA. Dpb&z has received a determination letter dated March 31, 2008, that the prototype plan and related amendments qualify under Internal Revenue Code Section 401(a). An employer who has adopted the prototype plan will also be considered to have a plan qualified under Section 401(a) provided all of the terms of the plan are followed, and the eligibility requirements and contribution or benefit provisions are not more favorable for highly compensated employees than other employees. The Plan has been restated and amended since the date of the determination letter; however, the Plan Administrator believes that the C.H.I. d/b/a St. Francis Hospital 401(k) Plan is currently being operated in compliance with the aforementioned prototype plan and applicable provisions of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the plan. Management evaluated the Plan's tax positions and concluded that the Plan had maintained its tax exempt status and had taken no uncertain tax positions that require recognition or disclosure in the financial statements. Therefore, no provision or liability for income taxes has been included in the financial statements. With few exceptions, the Plan is no longer subject to income tax examinations by the U.S. federal, state, or local tax authorities for years before 2008.

Note 4. Plan Termination

The Plan Sponsor has the right under the Plan to terminate the Plan subject to the provisions of ERISA. In the event of plan termination, participant accounts will become fully vested and nonforfeitable.

Note 5. Parties-in-Interest and Related Party Transactions

Parties-in-interest are defined under United States Department of Labor Regulations as any fiduciary of the Plan, any party rendering service to the Plan, and certain others. The Plan Sponsor has contracted with John Hancock Life Insurance Company (USA) to administer the Plan assets. Administrative functions include participant account maintenance, and custodial services. During the years ended December 31, 2011 and 2010, fees for these services were $23,828 and $17,541, respectively. Certain other administrative expenses for legal, auditing, and other professional services are paid directly by the Plan Sponsor and certain administrative functions are performed by officers or employees of the Plan Sponsor at no cost to the Plan.

Note 6. Assets Certified

The following is a summary of the Plan's asset information as of December 31, 2011 and 2010, and for the years then ended, included throughout the Plan's financial statements and supplemental schedules that was prepared by or derived from information certified by the custodian and furnished to the Plan Administrator. The Plan Administrator has obtained certifications from the custodian that the information provided to the Plan Administrator by the custodian related to the following assets is complete and accurate. Accordingly, as permitted by 29 CFR 2520.103-8 of the U.S. Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA, the Plan Administrator instructed the Plan's independent auditors not to perform any auditing procedures with respect to information which appears throughout the financial statements and supplemental schedules related to the following assets. Investments that represent 5% or more of the Plan's net assets are separately identified.

	2011	2010
John Hancock Life Insurance Company (USA) – JH Lifestyle Conservative Fund	**$ 696,194**	$ **
John Hancock Life Insurance Company (USA) – JH Lifestyle Moderate Fund	**1,013,880**	949,464
John Hancock Life Insurance Company (USA) – JH Lifestyle Balanced Fund	**6,005,296**	5,435,568
John Hancock Life Insurance Company (USA) – JH Lifestyle Growth Fund	**3,262,632**	3,076,910
John Hancock Life Insurance Company (USA) – JH Lifestyle Aggressive Fund	**690,423**	639,300
Others, none in excess of 5% of net assets	**1,298,439**	1,621,282
Total investments	**$ 12,966,864**	$ 11,722,524
Notes Receivable from Participants	**$ 89,363**	$ -

** Investment was not in excess of 5% of net assets at year end.

As of December 31, 2011 and 2010, the John Hancock Stable Value Fund (Stable Value Fund) is presented as described in Note 2. The Stable Value Fund is fully benefit-responsive, therefore contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to this investment option. Contract value 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 contract value for credit risk of the Stable Value Fund issuer or otherwise. If an event occurs that may impair the ability of the issuer to perform in accordance with the terms of this investment option, fair value may be less than contract value. The average yield of this investment option was 2.09% and 2.33% and the crediting interest rate averaged approximately 1.80% and 2.14% for the years ended December 31, 2011 and 2010, respectively.

Other Investment Information Certified by Custodian: During the years ended December 31, 2011 and 2010, the Plan's investments with John Hancock appreciated (depreciated) in value by $(343,345) and $1,329,789, respectively. Interest income from notes receivable from participants was $605 for the year ended December 31, 2011.

Note 7. Fair Value Measurement

ASC Topic 820 *"Fair Value Measurements and Disclosure"* (ASC 820), establishes 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 ASC 820 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.
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.

The following is a description of the valuation methodologies used for assets measured at fair value.

Pooled separate accounts, valued at the net asset value of units held by the Plan at year end.

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

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at 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**
Small Cap Equities	$ -	**$ 82,016**	$ -	**$ 82,016**
Mid Cap Equities	-	**111,643**	-	**111,643**
Large Cap Equities	-	**4,191,629**	-	**4,191,629**
Conservative	-	**2,295,691**	-	**2,295,691**
Moderate	-	**6,005,296**	-	**6,005,296**
Bonds	-	**45,362**	-	**45,362**
World	-	**73,160**	-	**73,160**
Foreign	-	**139,291**	-	**139,291**
Total assets at fair value	$ -	**$12,944,088**	$ -	**$12,944,088**

	Assets at Fair Value as of December 31, 2010			
	Level 1	Level 2	Level 3	Total
Small Cap Equities	$ -	$ 85,866	$ -	$ 85,866
Mid Cap Equities	-	98,932	-	98,932
Large Cap Equities	-	3,925,480	-	3,925,480
Conservative	-	1,940,862	-	1,940,862
Moderate	-	5,435,568	-	5,435,568
Bonds	-	32,955	-	32,955
World	-	65,901	-	65,901
Foreign	-	136,960	-	136,960
Total assets at fair value	$ -	$11,722,524	$ -	$ 11,722,524

Note 8. Risks and Uncertainties

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

Note 9. Subsequent Events

Subsequent to the Plan year end, the Thomas Memorial Hospital Tax Sheltered Annuity Plan (the TSA Plan) was merged into the St. Francis 401(k) Plan, and the Plan was renamed the Thomas Health System 401(k) Plan (THS 401(k) Plan). The Plan was amended and restated effective July 1, 2012. In addition to the merger of these two Plans, service providers were changed at the same time. The Plan's assets were transferred from John Hancock Life Insurance Company to the Variable Annuity Life Insurance Company (VALIC) initially on July 3, 2012.

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN
EIN: 61-1272692
Plan No: 001

SUPPLEMENTARY INFORMATION
SCHEDULE H, Line 4a - SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS
Year Ended December 31, 2011

	Participant Contributions Transferred Late To Plan	Total That Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under Voluntary Fiduciary Correction Program (VFCP) and Prohibited Transaction Exemption 2002-51
	Check Here If Late Participant Loan Repayments Are Included	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
	2011				
*	$ 348,752	$ 348,752	$	$	$
	2010				
*	$ 380,950	$ 380,950	$	$	$

* Delinquent participant contributions were subsequently corrected in 2012

C.H.I. d/b/a ST. FRANCIS HOSPITAL 401(k) PLAN
EIN: 61-1272692

SUPPLEMENTARY INFORMATION
SCHEDULE H, Line 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
December 31, 2011

	(b) Identity of Issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or market value	(d) Cost	(e) Current Value
	Pooled separate accounts with John Hancock Life Insurance Company (U.S.A.):			
*	John Hancock Life Insurance Company (USA)	JH Lifestyle Conservative Fund	**	$ 696,194
*	John Hancock Life Insurance Company (USA)	JH Lifestyle Moderate Fund	**	1,013,880
*	John Hancock Life Insurance Company (USA)	JH Lifestyle Balanced Fund	**	6,005,296
*	John Hancock Life Insurance Company (USA)	JH Lifestyle Grow th Fund	**	3,262,632
*	John Hancock Life Insurance Company (USA)	JH Lifestyle Aggressive Fund	**	690,423
*	John Hancock Life Insurance Company (USA)	JH Stable Value Fund	**	585,617
*	John Hancock Life Insurance Company (USA)	JH American Funds Grow th	**	82,896
*	John Hancock Life Insurance Company (USA)	JH PIMCO Total Return Fund	**	45,362
*	John Hancock Life Insurance Company (USA)	JH Davis New York Venture Fund	**	71,750
*	John Hancock Life Insurance Company (USA)	JH Franklin Small Mid Grow th Fund	**	32,826
*	John Hancock Life Insurance Company (USA)	JH Mutual Discovery Fund	**	24,784
*	John Hancock Life Insurance Company (USA)	JH Oppenheimer Global Fund	**	48,376
*	John Hancock Life Insurance Company (USA)	JH American Funds EuroPacific Fund	**	122,321
*	John Hancock Life Insurance Company (USA)	JH Small Cap Fund	**	27,963
*	John Hancock Life Insurance Company (USA)	Small Cap Value Fund	**	44,610
*	John Hancock Life Insurance Company (USA)	Small Cap Opportunities Fund	**	9,443
*	John Hancock Life Insurance Company (USA)	Mid Cap Index Fund	**	3,229
*	John Hancock Life Insurance Company (USA)	T. Row e Price Equity Income Fund	**	83,928
*	John Hancock Life Insurance Company (USA)	DFA International Value	**	16,971
*	John Hancock Life Insurance Company (USA)	Mid Cap Stock Fund	**	22,676
*	John Hancock Life Insurance Company (USA)	Columbia Mid Cap Value Fund	**	52,911
	Total pooled separate accounts with John Hancock Life Insurance Company (U.S.A.)			12,944,088
*	Notes receivable from participants	Interest at 4.25% and various maturity dates through December 2016	**	89,363
	Total Assets Held			$ 13,033,451

* Denotes issuer or sponsor considered to be a party-in-interest to the Plan.

** Historical cost information is not required to be presented for participant directed investments.

Schedule H, Line 4i
Schedule of Assets (Held At End of Year)

Name of Plan: C.H.I. d/b/a St. Francis Hospital 401(k) Plan

► Charleston Hospital, Inc.

Employer Identification Number: 61-1272692

For plan year (beginning/ending): 01/01/2011 to 12/31/2011 Plan number:► 001

(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
	John Hancock USA	Lifestyle Aggressive		690,423.38
	John Hancock USA	Lifestyle Growth		3,262,631.89
	John Hancock USA	Lifestyle Balanced		6,005,295.77
	John Hancock USA	Lifestyle Moderate		1,013,879.59
	John Hancock USA	Lifestyle Conservative		696,194.05
	John Hancock USA	DFA International Value		16,970.60
	John Hancock USA	Mid Cap Stock Fund		22,676.12
	John Hancock USA	Small Cap Growth Fund		27,962.88
	John Hancock USA	Europacific Growth Fund		122,321.40
	John Hancock USA	Franklin Small-Mid Growth		32,825.88
	John Hancock USA	Small Cap Opportunities Fund		9,443.49
	John Hancock USA	Columbia Mid Cap Value		52,912.46
	John Hancock USA	Small Cap Value Fund		44,609.53
	John Hancock USA	Mid Cap Index Fund		3,228.49
	John Hancock USA	Oppenheimer Global		48,375.77
	John Hancock USA	T. Rowe Price Equity Inc		83,927.82
	John Hancock USA	The Growth Fund of America		82,895.87
	John Hancock USA	Davis New York Venture		71,749.85
	John Hancock USA	Mutual Global Discovery		24,784.35
	John Hancock USA	PIMCO Total Return		45,361.90
	John Hancock USA	John Hancock Stable Val		608,392.75
	John Hancock USA	Cash Account		10,414.54
		Participant Loans		89,363.02
				13,066,641.40