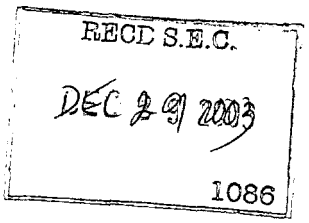
03043552

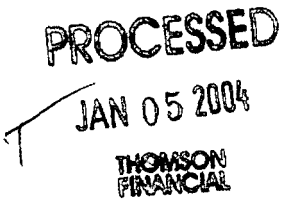
MANUALLY SIGNED

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549



FORM 11-K

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



(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 [NO FEE REQUIRED]**

For the fiscal year ended June 30, 2003

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 [NO FEE REQUIRED]**

For the transition period from _____ to _____

Commission file number: 333-40385

A. Full title of the plan and the address of the plan, if different from that of the issuer named below:

Salida Building & Loan Association 401(k) Profit Sharing Plan & Trust

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

High Country Bancorp, Inc.
7360 West Highway 50
Salida, Colorado 81201

REQUIRED INFORMATION

Form 5500-C/R Return/Report of Employee Benefit Plan

Form **5500**
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

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

2002

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 07/01/2002 and ending 06/30/2003

A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☒ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify) _____

B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ▶ ☐

D If filing under an extension of time or the DFVC program, check box and attach required information (see instructions) ▶ ☐

Part II Basic Plan Information -- enter all requested information.

1a Name of plan
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan (mo., day, yr.) 07/01/1979

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

7360 WEST HIGHWAY 50

SALIDA CO 81201

2b Employer Identification Number (EIN) 84-0311998

2c Sponsor's telephone number 719-539-2516

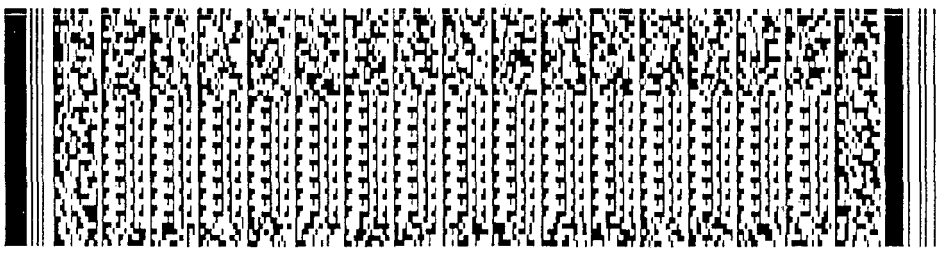
2d Business code (see instructions) 522120

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

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

SIGN HERE — Signature of plan administrator — 12/01/03 (Date) — LORIN SMITH, PRESIDENT (Type or print name of individual signing as plan administrator)

SIGN HERE — Signature of employer/plan sponsor/DFE — 12/01/03 (Date) — LORIN SMITH, PRESIDENT (Type or print name of individual signing as employer, plan sponsor or DFE)



Official Use Only

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

3b Administrator's EIN

3c Administrator's telephone number

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

b EIN

c PN

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

4155 E JEWELL AVENUE, SUITE 306

DENVER CO 80222

b EIN
84-1487357

c Telephone number
303-744-6479

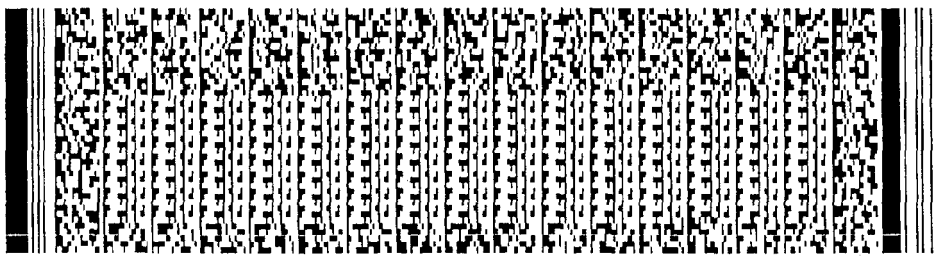
6 Total number of participants at the beginning of the plan year	6	68
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	58
b Retired or separated participants receiving benefits	7b	5
c Other retired or separated participants entitled to future benefits	7c	13
d Subtotal. Add lines 7a, 7b, and 7c	7d	76
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	76
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	76
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	17
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	1

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

a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2E 2F 2H 2J 2K 3E

b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

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



Official Use Only

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

a Pension Benefit Schedules

(1) [X] R (Retirement Plan Information)

(2) [X] 1 T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶ _____

(3) [ ] B (Actuarial Information)

(4) [ ] E (ESOP Annual Information)

(5) [X] SSA (Separated Vested Participant Information)

b Financial Schedules

(1) [ ] H (Financial Information)

(2) [X] I (Financial Information – Small Plan)

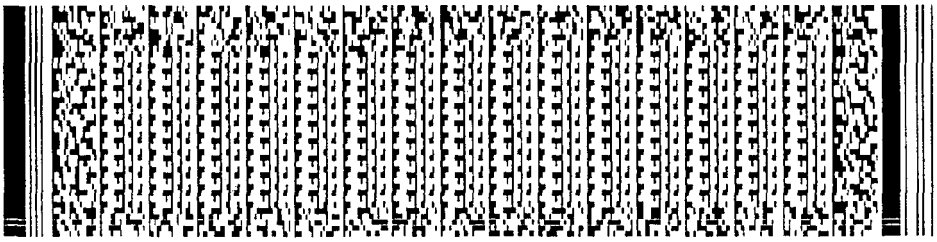
(3) [X] 1 A (Insurance Information)

(4) [ ] C (Service Provider Information)

(5) [X] D (DFE/Participating Plan Information)

(6) [ ] G (Financial Transaction Schedules)

(7) [X] 1 P (Trust Fiduciary Information)



SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection

For calendar year 2002 or fiscal plan year beginning 07/01/2002 and ending 06/30/2003

A Name of plan	B Three-digit plan number ▶
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST	001

C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number
HIGH COUNTRY BANK	84-0311998

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

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

1 Coverage:

(a) Name of insurance carrier

MASSACHUSETTS MUTUAL 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
04-1590850	65935	RM 83034-1		07/01/2002	06/30/2003

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

Totals

Total amount of commissions paid	Total fees paid / amount
451	32

Official Use Only

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

RENA K BREEDING
2160 KAY STREET
LONGMONT CO 80501

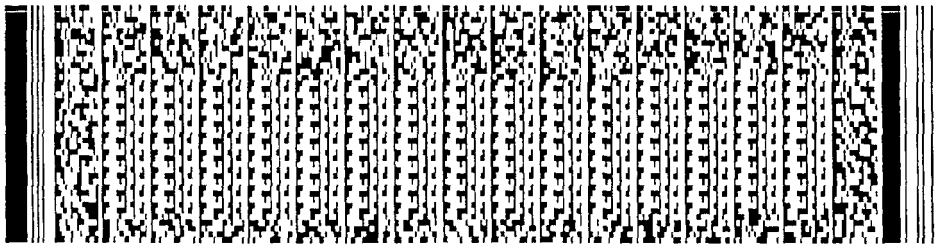
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
451	32	FEES PAID ON THE BASSIS OF AGG VALUE OF CONTRACTS PLACED & RETAIND	3

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

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

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

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



Official Use Only

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.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	194202
5	Contracts With Allocated Funds	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	
c	Premiums due but unpaid at the end of the year	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	
	Specify nature of costs ▶	
e	Type of contract (1) ☐ 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 ▶ ☐	

6 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 (specify below) ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		0
c	Additions: (1) Contributions deposited during the year	64089	
	(2) Dividends and credits	0	
	(3) Interest credited during the year	2814	
	(4) Transferred from separate account	2284	
	(5) Other (specify below)	306977	
	▶HOLDING ACCT:INTEREST, ROLLOVER,XFR		
	(6) Total additions		376164
d	Total of balance and additions (add b and c)		376164
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7788	
	(2) Administration charge made by carrier	871	
	(3) Transferred to separate account	187131	
	(4) Other (specify below)		
	▶		
	(5) Total deductions		195790
f	Balance at the end of the current year (subtract e (5) from d)		180374

Official Use Only

Part III Welfare Benefit Contract Information

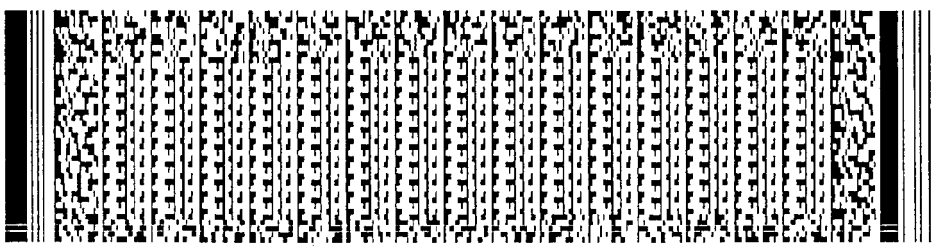
If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such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

7 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) 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) ▶

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

Specify nature of costs ▶



SCHEDULE D
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

DFE/Participating Plan Information

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

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection

For calendar plan year 2002 or fiscal plan year beginning 07/01/2002 , and ending 06/30/2003 ,

A Name of plan or DFE	B Three-digit plan number ▶	
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST		001
C Plan or DFE sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number	
HIGH COUNTRY BANK		84-0311998

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

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-E MM CORE BOND

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-014 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 32891

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AH MM OVERSEAS

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-155 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 12632

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AJ MM LARGE CAP VALUE

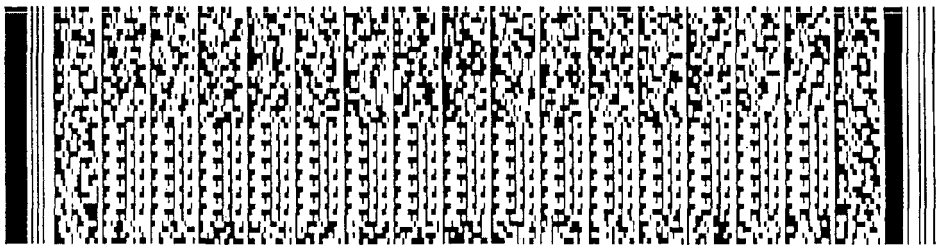
(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-018 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 144

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AK MM FUNDAMENTAL VALUE

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-175 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 47741



Official Use Only

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AT MM MID CAP GROWTH II

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-026 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 11387

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AU MM LARGE CAP GROWTH

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-176 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 3391

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AV MM FOCUSED VALUE

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-027 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 17139

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AX MM INDEXED EQUITY

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-028 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 415

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-AY MM SM CO VALUE

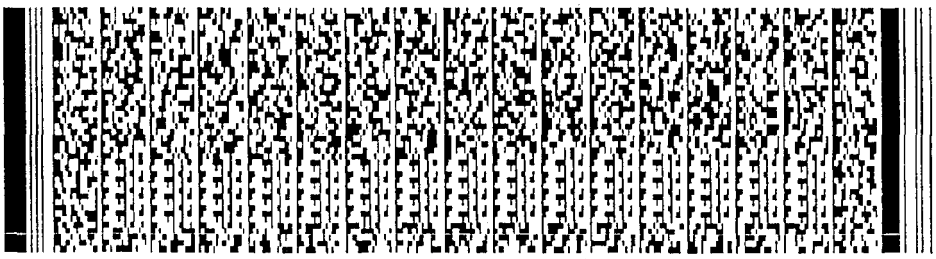
(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-177 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 10307

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-LB MM SMALL CO GROWTH

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-178 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 5132



Official Use Only

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-LB JCC BALANCED

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-050 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 17571

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-05 MAIN STREET

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-091 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 6437

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-OB QUEST BALANCED

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-096 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 2778

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-OC CAPITAL APPRECIATION

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-097 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 11977

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-OD GOLBAL

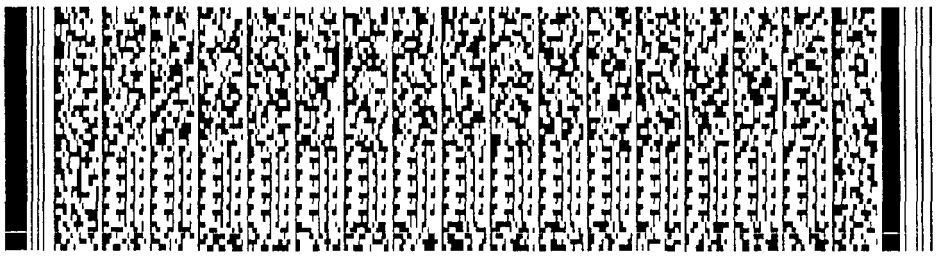
(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-098 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 13003

(a) Name of MTIA, CCT, PSA, or 103-12IE SIA-U MM GOVERNMENT MONEY MARKET

(b) Name of sponsor of entity listed in (a) MASSACHUSETTS MUTUAL LIFE INSURANCE

(c) EIN-PN 04-1590850-109 (d) Entity code P (e) Dollar value of interest in MTIA, CCT, PSA, or 103-12IE at end of year (see instructions) 1256



Official Use Only

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

(a) Plan name

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

(a) Plan name

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

(a) Plan name

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

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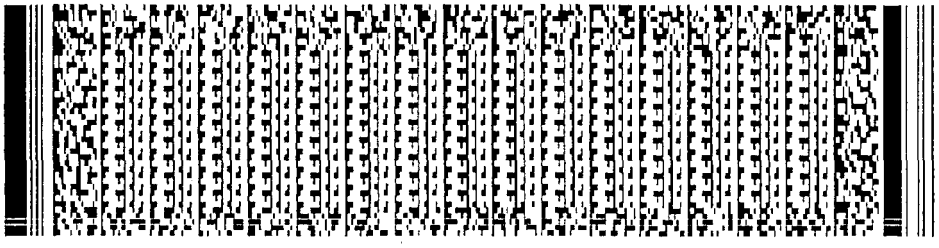
(a) Plan name

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



SCHEDULE I
(Form 5500)
Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning 07/01/2002 , and ending 06/30/2003 ,

A Name of plan	B Three-digit plan number ▶
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST	001
C Plan sponsor's name as shown on line 2a of Form 5500	**D Employer Identification Number**
HIGH COUNTRY BANK	84-0311998

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

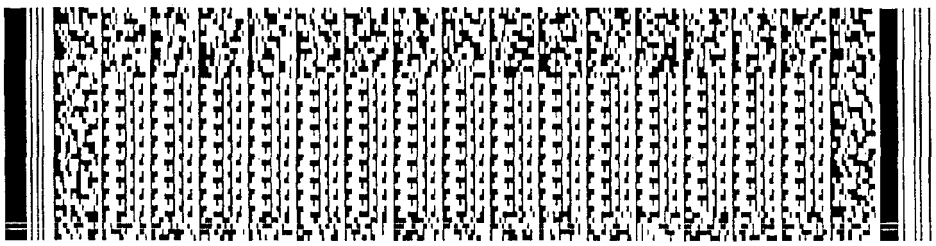
Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

			(a) Beginning of Year	(b) End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	1a	1330735	1902570
b	Total plan liabilities	1b		
c	Net plan assets (subtract line 1b from line 1a)	1c	1330735	1902570
2	**Income, Expenses, and Transfers for this Plan Year:**		(a) Amount	(b) Total
a	Contributions received or receivable			
	(1) Employers	2a(1)	326	
	(2) Participants	2a(2)	90892	
	(3) Others (including rollovers)	2a(3)	214	
b	Noncash contributions	2b		
c	Other income	2c	506633	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		598065
e	Benefits paid (including direct rollovers)	2e	17495	
f	Corrective distributions (see instructions)	2f	7194	
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Other expenses	2h	1541	
i	Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		26230
j	Net income (loss) (subtract line 2i from line 2d)	2j		571835
k	Transfers to (from) the plan (see instructions)	2k		

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

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



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			Yes	No	Amount
3c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d	X		1442347
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Transactions During Plan Year

	During the plan year:		Yes	No	Amount
4a	Did the employer fail to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Did the plan engage in any nonexempt transaction with any party-in-interest?	4d		X	
e	Was the 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 at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i	X		1442347
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		

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

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

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

SCHEDULE P
(FORM 5500)

Department of the Treasury
Internal Revenue Service

Annual Return of Fiduciary of Employee Benefit Trust

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

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

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

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For trust calendar year 2002 or fiscal year beginning 07/01/2002 and ending 06/30/2003

1a Name of trustee or custodian

R.YOUNG, L.SMITH, P.HARSH, T.GLENN

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

7360 WEST HIGHWAY 50

c City or town, state, and ZIP code

SALIDA CO 81201

2a Name of trust

HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST

b Trust's employer identification number 84-0982365

3 Name of plan if different from name of trust

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

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ ▶ 84-0311998

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

SIGN HERE Signature of fiduciary ▶ _____ Date ▶ 12/01/02

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

v5.0

Schedule P (Form 5500) 2002

Official Use Only

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning 07/01/2002 , and ending 06/30/2003 ,

A Name of plan	B Three-digit plan number ▶
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST	001
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number
HIGH COUNTRY BANK	84-0311998

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). _____ _____

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

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

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

4 Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? . . . . . ☐ Yes ☐ No ☐ N/A

If the plan is a defined benefit plan, go to line 7.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver. . . . . ▶ Month_____ Day_____ Year_____

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

6a Enter the minimum required contribution for this plan year . . . . . 6a $

b Enter the amount contributed by the employer to the plan for this plan year . . . . . 6b $

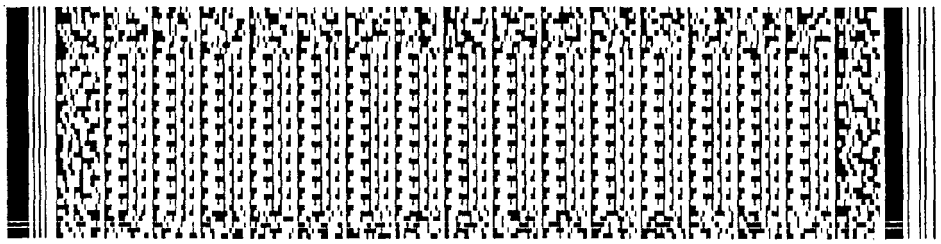
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) . . . . . 6c $

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

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

Part III Amendments

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



SCHEDULE SSA
(Form 5500)

Department of the Treasury
Internal Revenue Service

Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits

Under Section 6057(a) of the Internal Revenue Code

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

Official Use Only
OMB No. 1210-0110
2002
This Form is NOT Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning 07/01/2002 , and ending 06/30/2003 ,

A Name of plan	B Three-digit plan number ▶
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST	001
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number
HIGH COUNTRY BANK	84-0311998

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

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

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

City or town, state, and ZIP code

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

3b Administrator's EIN

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

City or town, state, and ZIP code

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

SIGN HERE **Signature of plan administrator** ▶

Phone number of plan administrator ▶ 719-539-2516 Date ▶

Official Use Only

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

Code A -- has not previously been reported.

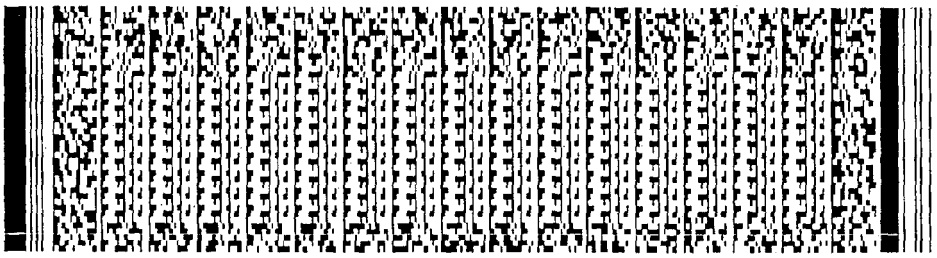
Code B -- has previously been reported under the above plan number but requires revisions to the information previously reported.

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

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

	Use with entry code "A", "B", "C", or "D"				Use with entry code "A" or "B"		
					Enter code for nature and form of benefit		Amount of vested benefit
(a) Entry Code	(b) Social Security Number	(c) Name of Participant (First)	(M.I.)	(Last)	(d) Type of annuity	(e) Payment frequency	(f) Defined benefit plan -- periodic payment
A	523541389	DAN		ROSS	A	A	

	Use with entry code "A" or "B"			Use with entry code "C"	
	Amount of vested benefit				
	Defined contribution plan				
(a) Entry Code	(g) Units or shares	Share indicator	(h) Total value of account	(i) Previous sponsor's employer identification number	(j) Previous plan number
			239841.00		



Official Use Only

SCHEDULE T (Form 5500)

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

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

▶ File as an attachment to Form 5500.

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning 07/01/2002 and ending 06/30/2003

A Name of plan	B Three-digit plan number ▶
HIGH COUNTRY BANK PROFIT SHARING PLAN & TRUST	001

C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number
HIGH COUNTRY BANK	84-0311998

Note: If the plan is maintained by:

- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
- An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer	1b Employer identification number

2 If the employer maintaining the plan operates QSLOBs, enter the following information:

a The number of QSLOBs that the employer operates is_____.

b The number of such QSLOBs that have employees benefiting under this plan is_____.

c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? . . . ☐ Yes ☐ No

d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.
▶

3 Exceptions -- Check the box before each statement that describes the plan or the employer. Also see instructions.
If you check any box, do not complete the rest of this Schedule.

a ☐ The employer employs only highly compensated employees (HCEs).

b ☐ No HCEs benefited under the plan at anytime during the plan year.

c ☐ The plan benefits only collectively-bargained employees.

d ☒ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.

e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

Official Use Only

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

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

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

c Complete the following

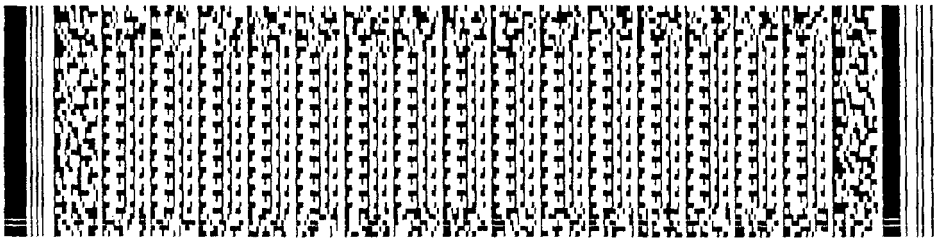
(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals	c(1)	
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	
(3) Number of nonexcludable employees. (Subtract line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

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

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

	Disaggregated part:	Ratio Percentage:	Exception:
(1)			
(2)			
(3)			

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



SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the trustees (or other persons who administer the employee benefit plan) have duly caused this annual report to be signed on its behalf by the undersigned hereunto duly authorized.

SALIDA BUILDING & LOAN ASSOCIATION 401(k) PROFIT SHARING PLAN & TRUST
(Name of Plan)

By: High Country Bank, as Plan Administrator

Date: December 29, 2003

By: _____
Larry D. Smith, President

INDEX TO EXHIBITS

Exhibit No.	Description
32	Certification Pursuant to 18 U.S.C. Section 1350

Exhibit 32

Exhibit 32

CERTIFICATION PURSUANT TO 18. U.S.C. SECTION 1350
AS ADOPTED PURSUANT TO SECTION 906 OF THE
SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 11-K of the Salida Building & Loan Association 401(k) Profit Sharing Plan and Trust (the "Plan"), as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Larry D. Smith, in my capacity as President and Chief Executive Officer of High Country Bancorp, Inc. and High Country Bank, the Plan Administrator, and I, Frances Pasquale, in my capacity as Chief Financial Officer of High Country Bancorp, Inc. and High Country Bank, each hereby certify that the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, and the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Plan.

By: _____
Name: Larry D. Smith
Title: President and Chief Executive Officer

By: _____
Name: Frances Pasquale
Title: Chief Financial Officer

Date: December 29, 2003

A signed original of this written statement required by Section 906 has been provided to the Plan and will be retained by the Plan and furnished to the Securities and Exchange Commission or its staff upon request.