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UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549

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SEC  
Mail Processing  
Section

**FORM 11-K**

FOR ANNUAL REPORTS OF  
EMPLOYEE STOCK PURCHASE, SAVINGS AND SIMILAR PLANS  
PURSUANT TO SECTION 15(d) OF THE  
SECURITIES EXCHANGE ACT OF 1934

JUN 28 2012

Washington DC  
403

(Mark One):

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

For the fiscal year ended December 31, 2011

OR

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

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission file number 001-33246

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

**Millington Savings Bank Savings Plan**

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

**MSB Financial Corp.  
1902 Long Hill Road  
Millington, New Jersey 07946**

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## **REQUIRED INFORMATION**

The Millington Savings Bank Savings Plan is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). In accordance with Item 4 of the Form 11-K and in lieu of the requirements of Items 1-3, the Plan's Annual Report on Form 5500 for 2011 is being filed herewith as Exhibit 1.


## SIGNATURES

*The Plan.* Pursuant to the requirement 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.

Millington Savings Bank Savings Plan

Date: June 28, 2012

By:

  
Michael A. Shriner  
Plan Administrator

**EXHIBIT 1**

**2011 Form 5500**



|   |  |  |
|---|--|--|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br><br>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).<br><br><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2011</b><br><br>This Form is Open to Public Inspection |
|---|--|--|

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

|   |   |                   |  |
|---|---|-------------------|--|
| <b>Part II Basic Plan Information—enter all requested information</b>   |   |                   |  |
| <b>1a</b> Name of plan <u>Millington Savings Bank Savings Plan</u>  | <b>1b</b> Three-digit plan number (PN) ▶                            | <u>002</u>        |  |
|   |   | <u>01/01/1997</u> |  |
| <b>2a</b> Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan) | <b>2b</b> Employer Identification Number (EIN)<br><u>22-1118190</u> |                   |  |
| <u>Millington Savings Bank</u>  | <b>2c</b> Sponsor's telephone number<br><u>(908) 458-4041</u>       |                   |  |
| <u>122 Mooristown Rd, Rte. 202 South</u>  | <b>2d</b> Business code (see instructions)<br><u>522120</u>         |                   |  |
| <u>Bernardsville</u>  | <u>NJ 07924</u>   |                   |  |

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

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

|                      |   |                |  |
|----------------------|---|----------------|--|
| <b>SIGN<br/>HERE</b> |  | <u>6/28/12</u> | Katherine E. Stever  |
|                      | Signature of plan administrator   | Date           | Enter name of individual signing as plan administrator       |
| <b>SIGN<br/>HERE</b> |  | <u>6/28/12</u> | Katherine E. Stever  |
|                      | Signature of employer/plan sponsor  | Date           | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN<br/>HERE</b> |   |                |  |
|                      | Signature of DFE  | Date           | Enter name of individual signing as DFE                      |

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

Form 5500 (2011)  
v.012611

|   |           |  |
|---|-----------|--|
| <b>3a</b> Plan administrator's name and address (if same as plan sponsor, enter "Same")<br>SAME   |           | <b>3b</b> Administrator's EIN  |
|   |           | <b>3c</b> Administrator's telephone number   |
| <b>4</b> 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:<br><b>a</b> Sponsor's name   |           | <b>4b</b> EIN<br><br><b>4c</b> PN  |
| <b>5</b> Total number of participants at the beginning of the plan year   | <b>5</b>  | 56   |
| <b>6</b> Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  |           |  |
| <b>a</b> Active participants .....  | <b>6a</b> | 40   |
| <b>b</b> Retired or separated participants receiving benefits.....  | <b>6b</b> | 1  |
| <b>c</b> Other retired or separated participants entitled to future benefits.....   | <b>6c</b> | 13   |
| <b>d</b> Subtotal. Add lines 6a, 6b, and 6c. ....   | <b>6d</b> | 54   |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....   | <b>6e</b> | 0  |
| <b>f</b> Total. Add lines 6d and 6e.....  | <b>6f</b> | 54   |
| <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....  | <b>6g</b> | 54   |
| <b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....  | <b>6h</b> | 7  |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....  |           | <b>7</b>   |
| <b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:<br>2E 2F 2G 2J 2K 3D  |           |  |
| <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:  |           |  |
| <b>9a</b> Plan funding arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor  |           | <b>9b</b> Plan benefit arrangement (check all that apply)<br>(1) <input checked="" type="checkbox"/> Insurance<br>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br>(3) <input checked="" type="checkbox"/> Trust<br>(4) <input type="checkbox"/> General assets of the sponsor   |
| <b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)   |           |  |
| <b>a Pension Schedules</b><br>(1) <input checked="" type="checkbox"/> R (Retirement Plan Information)<br>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary<br>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary |           | <b>b General Schedules</b><br>(1) <input type="checkbox"/> H (Financial Information)<br>(2) <input checked="" type="checkbox"/> I (Financial Information - Small Plan)<br>(3) <input checked="" type="checkbox"/> <u>1</u> A (Insurance Information)<br>(4) <input checked="" type="checkbox"/> C (Service Provider Information)<br>(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)<br>(6) <input type="checkbox"/> G (Financial Transaction Schedules) |

|  |  |   |
|--|--|---|
| <b>SCHEDULE A</b><br><b>(Form 5500)</b><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><hr/> <small>Department of Labor<br/>Employee Benefits Security Administration</small><br><hr/> <small>Pension Benefit Guaranty Corporation</small> | <b>Insurance Information.</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>► File as an attachment to Form 5500.</b><br><br>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110<br><br><div style="text-align: center; font-size: 1.2em;"><b>2011</b></div><br><br>This Form is Open to Public Inspection |
|--|--|---|

|  |   |   |     |  |  |   |  |
|--|---|---|-----|--|--|---|--|
| For calendar plan year 2011 or fiscal plan year beginning <b>01/01/2011</b> and ending <b>12/31/2011</b> |   |   |     |  |  |   |  |
| <b>A</b> Name of plan<br><br>Millington Savings Bank Savings Plan  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;"><b>B</b> Three-digit plan number (PN) ►</td> <td style="width:40%; text-align: center;">002</td> </tr> <tr> <td colspan="2" style="height: 20px;"></td> </tr> <tr> <td colspan="2"><b>D</b> Employer Identification Number (EIN)<br/>22-1118190</td> </tr> </table> | <b>B</b> Three-digit plan number (PN) ► | 002 |  |  | <b>D</b> Employer Identification Number (EIN)<br>22-1118190 |  |
| <b>B</b> Three-digit plan number (PN) ►  | 002   |   |     |  |  |   |  |
|  |   |   |     |  |  |   |  |
| <b>D</b> Employer Identification Number (EIN)<br>22-1118190  |   |   |     |  |  |   |  |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><br>Millington Savings Bank             |   |   |     |  |  |   |  |

|               |   |
|---------------|---|
| <b>Part I</b> | <b>Information Concerning Insurance Contract Coverage, Fees, and Commissions</b> 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. |
|---------------|---|

| <b>1 Coverage Information:</b>  |               |                                       |   |                         |            |
|---|---------------|---------------------------------------|---|-------------------------|------------|
| (a) Name of insurance carrier<br>AMERICAN UNITED LIFE INSURANCE COMPANY |               |                                       |   |                         |            |
| (b) EIN   | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|   |               |                                       |   | (f) From                | (g) To     |
| 35-0145825  | 60895         | G34192                                | 52  | 01/01/2011              | 12/31/2011 |

|   |  |
|---|--|
| <b>2 Insurance fee and commission information.</b> 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<br><div style="text-align: right;">6,497</div>   | (b) Total amount of fees paid<br><div style="text-align: right;">0</div> |

|  |  |
|--|--|
| <b>3 Persons receiving commissions and fees.</b> (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             |  |
| WS INS SERVICES LLC<br>MAILCODE NC1409<br>401 S TRYON ST 19TH FLOOR<br>CHARLOTTE, NC 28202                   |  |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| 6,497   | 0                               | NA/A        | 3                     |

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

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

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

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

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

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

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

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

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

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

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

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



**Part II****Investment and Annuity Contract Information**

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

|  |          |           |
|--|----------|-----------|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> | 2,241,715 |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> | 924,271   |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier .....**6b****c** Premiums due but unpaid at the end of the year .....**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.....  
Specify nature of costs ▶**6d****e** Type of contract: (1) ☐ individual policies(2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee  
(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT**b** Balance at the end of the previous year .....**7b**

1,725,139

**c** Additions: (1) Contributions deposited during the year .....**7c(1)**

206,670

(2) Dividends and credits .....

**7c(2)**

0

(3) Interest credited during the year .....

**7c(3)**

66,763

(4) Transferred from separate account .....

**7c(4)**

269,354

(5) Other (specify below) .....

**7c(5)**

69,756

▶ LOAN REPAYMENT

(6) Total additions .....

**7c(6)**

612,543

**d** Total of balance and additions (add b and c(6)).**7d**

2,337,682

**e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

**7e(1)**

33,562

(2) Administration charge made by carrier .....

**7e(2)**

222

(3) Transferred to separate account .....

**7e(3)**

10,060

(4) Other (specify below) .....

**7e(4)**

52,123

▶ LOANS ISSUED

(5) Total deductions .....

**7e(5)**

95,967

**f** Balance at the end of the current year (subtract e(5) from d) .....**7f**

2,241,715

**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:**

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

**10 Nonexperience-rated contracts:**

|  |     |
|--|-----|
| <b>a</b> Total premiums or subscription charges paid to carrier.....   | 10a |
| <b>b</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. ▶

|  |  |  |
|--|--|--|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><small>Pension Benefit Guaranty Corporation</small> | <b>Service Provider Information</b><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2011</b><br><br><b>This Form is Open to Public Inspection.</b> |
| For calendar plan year 2011 or fiscal plan year beginning <b>01/01/2011</b> and ending <b>12/31/2011</b>   |  |  |
| <b>A</b> Name of plan<br><br>Millington Savings Bank Savings Plan  | <b>B</b> Three-digit plan number (PN) <b>►</b>   | 002  |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><br>Millington Savings Bank   | <b>D</b> Employer Identification Number (EIN)<br><br>22-1118190  |  |

**Part I Service Provider Information (see instructions)**

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

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

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

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation  
 ALLIANZ GLOBAL INVESTORS 06-1349805

**(b)** Enter name and EIN or address of person who provided you disclosure on eligible indirect compensation  
 AMERICAN CENTURY INVESTMENTS 20-2036524

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation  
 DREYFUS 13-2603136

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation  
 FIDELITY INVESTMENTS 04-2270522

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

FRANKLIN TEMPLETON INVESTMENTS  
94-3382187

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

INVESCO  
74-1881364

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

LORD ABBETT FUNDS  
13-5620131

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

NEUBERGER BERMAN  
13-5521910

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

OPPENHEIMER FUNDS INC  
13-2527171

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

PIONEER INVESTMENTS  
13-1961193

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

RUSSELL INVESTMENT COMPANY  
91-1175092

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

STATE STREET GLOBAL INVESTORS  
04-1867445

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

T ROWE PRICE  
52-1184650

(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)

AMERICAN UNITED LIFE INSURANCE CO  
35-0145825

(b) Service Code(s) 37 50 15 64 52 59 60 63 66 67

| (c)<br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | (d)<br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | (e)<br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | (f)<br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | (g)<br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | (h)<br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|---|---|--|--|---|--|
| SERVICE PROVIDER  | 1,033   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | 3,137   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                      |

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

(b) Service Code(s)

| (c)<br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | (d)<br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | (e)<br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | (f)<br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | (g)<br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | (h)<br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|---|---|--|--|---|--|
|   |   | Yes <input type="checkbox"/> No <input type="checkbox"/>   | Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | Yes <input type="checkbox"/> No <input type="checkbox"/>   |

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

(b) Service Code(s)

| (c)<br>Relationship to<br>employer, employee<br>organization, or<br>person known to be<br>a party-in-interest | (d)<br>Enter direct<br>compensation paid<br>by the plan. If none,<br>enter -0-. | (e)<br>Did service provider<br>receive indirect<br>compensation? (sources<br>other than plan or plan<br>sponsor) | (f)<br>Did indirect compensation<br>include eligible indirect<br>compensation, for which the<br>plan received the required<br>disclosures? | (g)<br>Enter total indirect<br>compensation received by<br>service provider excluding<br>eligible indirect<br>compensation for which you<br>answered "Yes" to element<br>(f). If none, enter -0-. | (h)<br>Did the service<br>provider give you a<br>formula instead of<br>an amount or<br>estimated amount? |
|---|---|--|--|---|--|
|   |   | Yes <input type="checkbox"/> No <input type="checkbox"/>   | Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | Yes <input type="checkbox"/> No <input type="checkbox"/>   |

**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<br>(see instructions)  | (c) Enter amount of indirect compensation |
|---|--|---|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 66 67  | 3,137                                     |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| AMERICAN UNITED LIFE INSURANCE CO<br>35-0145825                     | ASSET CHARGE   |   |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)  | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| ALLIANZ GLOBAL INVESTORS<br>06-1349805                              | REVENUE SHARING FORMULA<br>SEE ATTACHED  |   |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)  | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| AMERICAN CENTURY INVESTMENTS<br>20-2036524                          | REVENUE SHARING FORMULA<br>SEE ATTACHED  |   |

**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<br>(see instructions)  | (c) Enter amount of indirect compensation |
|---|--|---|
| AMERICAN UNITED LIFE INSURANCE CO   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation<br>FIDELITY INVESTMENTS<br>04-2270522           | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><del>REVENUE SHARING FORMULA</del><br>SEE ATTACHED |   |
| AMERICAN UNITED LIFE INSURANCE CO   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation<br>FRANKLIN TEMPLETON INVESTMENTS<br>94-3382187 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><del>REVENUE SHARING FORMULA</del><br>SEE ATTACHED |   |
| AMERICAN UNITED LIFE INSURANCE CO   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation<br>INVESCO<br>74-1881364                        | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><del>REVENUE SHARING FORMULA</del><br>SEE ATTACHED |   |



**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<br>(see instructions) | (c) Enter amount of indirect<br>compensation |
|---|---|--|
| AMERICAN UNITED LIFE INSURANCE CO                       | 52 59 60 63                             | 0  |

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---|--|
| NEUBERGER BERMAN<br>13-5521910                                      | <del>REVENUE SHARING FORMULA</del><br>SEE ATTACHED   |

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

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---|--|
| OPPENHEIMER FUNDS INC<br>13-2527171                                 | <del>REVENUE SHARING FORMULA</del><br>SEE ATTACHED   |

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

| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any<br>formula used to determine the service provider's eligibility<br>for or the amount of the indirect compensation. |
|---|--|
| PIONEER INVESTMENTS<br>13-1961193                                   | <del>REVENUE SHARING FORMULA</del><br>SEE ATTACHED   |

**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<br>(see instructions)  | (c) Enter amount of indirect compensation |
|---|--|---|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| RUSSELL INVESTMENT COMPANY<br>91-1175092                            | REVENUE SHARING FORMULA<br>SEE ATTACHED  |   |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)  | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| STATE STREE GLOBAL ADVISORS<br>04-1867445                           | REVENUE SHARING FORMULA<br>SEE ATTACHED  |   |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)  | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 52 59 60 63  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| T ROWE PRICE<br>52-1184650  | REVENUE SHARING FORMULA<br>SEE ATTACHED  |   |

**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)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

**SCHEDULE D  
(Form 5500)**Department of the Treasury  
Internal Revenue ServiceDepartment 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

Millington Savings Bank Savings Plan

**B** Three-digit  
plan number (PN) ▶

002

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

Millington Savings Bank

**D** Employer Identification Number (EIN)  
22-1118190**Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**  
(Complete as many entries as needed to report all interests in DFEs)**a** Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT II**b** Name of sponsor of entity listed in (a): AMERICAN UNITED LIFE INSURANCE CO.**c** EIN-PN 35-0145825 000**d** Entity  
code P**e** Dollar value of interest in MTIA, CCT, PSA, or 103-  
12 IE at end of year (see instructions)

924,271

**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)

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

Schedule D (Form 5500) 2011  
v.012611

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

**Part II** **Information on Participating Plans (to be completed by DFEs)**  
(Complete as many entries as needed to report all participating plans)**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN**a** Plan name**b** Name of  
plan sponsor**c** EIN-PN

|  |   |  |
|--|---|--|
| <b>SCHEDULE I</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration<br/>Pension Benefit Guaranty Corporation</small> | <b>Financial Information—Small Plan</b><br><br>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).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2011</b><br><br>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

|  |   |  |
|--|---|--|
| <b>A</b> Name of plan<br><br>Millington Savings Bank Savings Plan                            | <b>B</b> Three-digit plan number (PN) <b>►</b> <u>002</u>   |  |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><br>Millington Savings Bank | <b>D</b> Employer Identification Number (EIN)<br>22-1118190 |  |

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 |
|---|--------------|-----------------------|-----------------|
| <b>1 Plan Assets and Liabilities:</b>   |              |                       |                 |
| <b>a</b> Total plan assets .....  | <b>1a</b>    | 3,446,531             | 3,628,542       |
| <b>b</b> Total plan liabilities .....   | <b>1b</b>    |                       |                 |
| <b>c</b> Net plan assets (subtract line 1b from line 1a) .....                      | <b>1c</b>    | 3,446,531             | 3,628,542       |
| <b>2 Income, Expenses, and Transfers for this Plan Year:</b>                        |              | (a) Amount            | (b) Total       |
| <b>a</b> Contributions received or receivable:                                      |              |                       |                 |
| (1) Employers .....   | <b>2a(1)</b> | 128,613               |                 |
| (2) Participants .....  | <b>2a(2)</b> | 183,758               |                 |
| (3) Others (including rollovers) .....  | <b>2a(3)</b> |                       |                 |
| <b>b</b> Noncash contributions .....  | <b>2b</b>    |                       |                 |
| <b>c</b> Other income .....   | <b>2c</b>    | (26,764)              |                 |
| <b>d</b> Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c) .....             | <b>2d</b>    |                       | 285,607         |
| <b>e</b> Benefits paid (including direct rollovers) .....                           | <b>2e</b>    | 98,646                |                 |
| <b>f</b> Corrective distributions (see instructions) .....                          | <b>2f</b>    |                       |                 |
| <b>g</b> Certain deemed distributions of participant loans (see instructions) ..... | <b>2g</b>    | 4,557                 |                 |
| <b>h</b> Administrative service providers (salaries, fees, and commissions) .....   | <b>2h</b>    | 393                   |                 |
| <b>i</b> Other expenses .....   | <b>2i</b>    |                       |                 |
| <b>j</b> Total expenses (add lines 2e, 2f, 2g, 2h, and 2i) .....                    | <b>2j</b>    |                       | 103,596         |
| <b>k</b> Net income (loss) (subtract line 2j from line 2d) .....                    | <b>2k</b>    |                       | 182,011         |
| <b>l</b> Transfers to (from) the plan (see instructions) .....                      | <b>2l</b>    |                       |                 |

**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  |
|--|-----------|-----|----|---------|
| <b>a</b> Partnership/joint venture interests .....             | <b>3a</b> |     | X  |         |
| <b>b</b> Employer real property .....                          | <b>3b</b> |     | X  |         |
| <b>c</b> Real estate (other than employer real property) ..... | <b>3c</b> |     | X  |         |
| <b>d</b> Employer securities .....                             | <b>3d</b> | X   |    | 252,157 |
| <b>e</b> Participant loans .....                               | <b>3e</b> | X   |    | 127,549 |



|   | Yes | No | Amount |
|---|-----|----|--------|
| 3f Loans (other than to participants) ..... |     | X  |        |
| g Tangible personal property .....          |     | X  |        |

**Part II Compliance Questions****4 During the plan year:**

|   | Yes | No | Amount    |
|---|-----|----|-----------|
| a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.) ..... | X   |    | 4,255     |
| b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance .....  |     | X  |           |
| c Were any leases to which the plan was a party in default or classified during the year as uncollectible? .....  |     | X  |           |
| d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.) .....  |     | X  |           |
| e Was the plan covered by a fidelity bond? .....  | X   |    | 1,000,000 |
| f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....  |     | X  |           |
| g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser? .....   |     | X  |           |
| h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? .....   |     | X  |           |
| i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest? .....   |     | X  |           |
| j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....  |     | X  |           |
| k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.) .....                 | X   |    |           |
| l Has the plan failed to provide any benefit when due under the plan? .....   |     | X  |           |
| m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....   |     | X  |           |
| n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3 .....   |     |    |           |

**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 ServiceDepartment 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

Millington Savings Bank Savings Plan

**B** Three-digit plan number (PN) ▶

002

**C** Plan sponsor's name as shown on line 2a of Form 5500

Millington Savings Bank

**D** Employer Identification Number (EIN)  
22-1118190**Part I Distributions**

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

- 1** Total value of distributions paid in property other than in cash or the forms of property specified in the instructions ..... **1**
- 2** Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):  
EIN(s): 35-0145825  
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.
- 3** Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year ..... **3**

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

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

**Part III Amendments**

- 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

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

Schedule R (Form 5500) 2011  
v.012611

**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:

|  |            |  |
|--|------------|--|
| <b>a</b> The current year .....  | <b>14a</b> |  |
| <b>b</b> The plan year immediately preceding the current plan year ..... | <b>14b</b> |  |
| <b>c</b> The second preceding plan year .....                            | <b>14c</b> |  |

**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:

|   |            |  |
|---|------------|--|
| <b>a</b> The corresponding number for the plan year immediately preceding the current plan year ..... | <b>15a</b> |  |
| <b>b</b> The corresponding number for the second preceding plan year .....                            | <b>15b</b> |  |

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

|  |            |  |
|--|------------|--|
| <b>a</b> Enter the number of employers who withdrew during the preceding plan year .....   | <b>16a</b> |  |
| <b>b</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 ..... | <b>16b</b> |  |

**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): \_\_\_\_\_