Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2013

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN

1b Three-digit plan number (PN) ▶ 003

1c Effective date of plan 01/01/2007

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

REYNOLDS MEMORIAL HOSPITAL, INC.

800 WHEELING AVE.
GLEN DALE, WV 26038

2b Employer Identification Number (EIN)
55-0357045

2c Sponsor's telephone number
304-845-3211

2d Business code (see instructions)
622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	09/24/2014	WM. ROBERT HUNT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional)

Preparer's telephone number (optional)

3a Plan administrator's name and address [X] Same as Plan Sponsor Name [ ] Same as Plan Sponsor Address

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:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	223
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	183
b	Retired or separated participants receiving benefits	**6b**	1
c	Other retired or separated participants entitled to future benefits	**6c**	45
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	229
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f	Total. Add lines **6d** and **6e**.	**6f**	229
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	199
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2F 2G 2M

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013

A Name of plan
REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN

B Three-digit plan number (PN) ▶ 003

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

D Employer Identification Number (EIN)
55-0357045

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

1 Coverage Information:

(a) Name of insurance carrier

VARIABLE ANNUITY LIFE INSURANCE CO.

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
74-1625348	70238	67861	33	01/01/2013	12/31/2013

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
505	0

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

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

SECURITIES, INC (GFIO), METLIF
2929 ALLEN PARKWAY
HOUSTON, TX 77019

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
505			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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	**4**	222071
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	173092
c	Additions: (1) Contributions deposited during the year	**7c(1)**	60045		
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**	3061		
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	63106
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	236198
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**	14127		
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	14127
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	222071

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount			**10b**	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2013** **This Form is Open to Public Inspection.**

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013

A Name of plan
REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN

B Three-digit plan number (PN) ▶ 003

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

D Employer Identification Number (EIN)
55-0357045

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

AMERICAN FUNDS
3500 WISEMAN BOULEVARD
SAN ANTONIO, TX 78251

95-1411037

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

OPPENHEIMER
TWO WORLD FINANCIAL CENTER
NEW YORK, NY 10281

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

VALIC
2929 ALLEN PARKWAY, L13-20
HOUSTON, TX 77019

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

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

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

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

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

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

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

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

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

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

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

CPI QUALIFIED PLAN CONSULTANTS, INC

1809 24TH STREET
P.O. BOX 1167
GREAT BEND, KS 67530

48-1205033

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 15 50 60 64	'NONE'	10356	Yes [X] No [ ]	Yes [ ] No [X]	6977	Yes [ ] No [X]

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

MORGAN STANLEY

36 EAST STREETSBORO STREET, SUITE 1
HUDSON, OH 44236

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	'NONE'	14970	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BODKIN WILSON & KOZICKI PLLC

55-0526247

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	'NONE'	9500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

MATRIX FINANCIAL SOLUTIONS

700 17TH STREET, STE 300
DENVER, CO 80202

20-1591048

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 19 99	'NONE'	150	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CPI QUALIFIED PLAN CONSULTANTS, INC	12 15 50 60 64	6107

(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 FUNDS 3500 WISEMAN BOULEVARD SAN ANTONIO, TX 78251 95-1411037	SUBSIDY TO OFFSET CUSTODIAL AND TRADING EXPENSES

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013

A Name of plan
REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN

B Three-digit plan number (PN) ▶ 003

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

D Employer Identification Number (EIN)
55-0357045

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	0	0
(2) Participant contributions	1b(2)	850	0
(3) Other	1b(3)	67997	35562
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	0	0
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	0	0
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	2276588	2980471
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	173097	222079
(15) Other	1c(15)	0	0

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	2518532	3238112
Liabilities			
g Benefit claims payable	1g	0	0
h Operating payables	1h	9500	10000
i Acquisition indebtedness	1i	0	0
j Other liabilities	1j	0	0
k Total liabilities (add all amounts in lines 1g through1j)	1k	9500	10000
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	2509032	3228112

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	457895	
(C) Others (including rollovers)	2a(1)(C)	15676	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		473571
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	69127	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		69127
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	0	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		370390
c Other income	2c		17093
d Total income. Add all **income** amounts in column (b) and enter total	2d		930181
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	176327	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		176327
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	9804	
(3) Investment advisory and management fees	2i(3)	14970	
(4) Other	2i(4)	10000	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		34774
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		211101
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		719080
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) ☐ Unqualified **(2)** ☐ Qualified **(3)** ☒ Disclaimer **(4)** ☐ Adverse

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

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

(1) Name: WILSON, KOZICKI, & GWYNN **(2)** EIN: 55-0526247

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	

			Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		2000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

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

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

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

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ..... ☐ Yes ☐ No ☐ Not determined

Part V Trust Information (optional)

6a Name of trust	**6b** Trust's EIN
REYNOLDS MEMORIAL HOSPITAL, INC. 4	753182674

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

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

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection.

For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013

A Name of plan
REYNOLDS MEMORIAL HOSPITAL, INC. 403(B) PLAN

B Three-digit plan number (PN) ▶ 003

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

D Employer Identification Number (EIN)
55-0357045

Part I Distributions

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

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

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

EIN(s): 75-3182674

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

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

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

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

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

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

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

6 **a** Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) **6a**

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

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

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

e Contribution rate information *(If more than one rate applies, check this box* ☐ *and see instructions regarding required attachment. Otherwise, complete lines 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 lines 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 lines 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 lines 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 lines 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 lines 13e(1) and 13e(2).)*
(1) Contribution rate (in dollars and cents) _____
(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

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

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

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

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

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

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

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

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

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

19 If the total number of participants is 1,000 or more, complete lines (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 line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

Reynolds Memorial Hospital, Inc.
403(b) Plan

Financial Statements
Together with Auditor's Report
and Supplemental Information
as of December 31, 2013 and 2012

WILSON KOZICKI & GWYNN PLLC
CERTIFIED PUBLIC ACCOUNTANTS

Reynolds Memorial Hospital, Inc. 403(b) Plan
Table of Contents

	Page
Independent Auditor's Report	2-3
Financial Statements:	
Statements of Net Assets Available for Benefits	4
Statements of Changes in Net Assets Available for Benefits	5
Notes to Financial Statements	6-12
Supplemental Information:	
Schedule of Assets Held at End of Year	13

WILSON KOZICKI & GWYNN PLLC

CERTIFIED PUBLIC ACCOUNTANTS

Wheeling Office

The Maxwell Centre
32 Twentieth Street
Suite 300
Wheeling, West Virginia 26003

304 232-2280
Fax 304 232-2322

Dan E Wilson, CPA, MBA
1955-2013

Dennis A. Kozicki, CPA
Nancy J. Gwynn, CPA

Doreen M. DeMeter, CPA
Amy R. Schmitt, CPA

Weirton Office

Three Springs Commons
204 Three Springs Drive
Suite C
Weirton, West Virginia 26062

304 748-5550
Fax 304 748-5551

1964 – 2014
Celebrating 50 Years
www.wkgcpas.com

Independent Auditor's Report

To the Retirement Committee of
Reynolds Memorial Hospital, Inc. 403(b) Plan:

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Reynolds Memorial Hospital, Inc. 403(b) Plan, which comprise the statements of net assets available for benefits as of December 31, 2013 and 2012 and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United Stated of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the Basis for Disclaimer Opinion paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 11, which was certified by MG Trust Company LLC, the custodian of the Plan, except for comparing the information with the related information included in the financial statements. We have been informed by the plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the custodian as of and for the years ended December 31, 2013 and 2012, that the information provided to the plan administrator by the custodian is complete and accurate.

Disclaimer of Opinion

Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion. Accordingly, we do not express an opinion on these financial statements.

Other Matter

The supplemental Schedule of Assets Held at End of Year is required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and is presented for purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedule referred to above.

Report on Form and Content in Compliance with DOL Rules and Regulations

The form and content of the information included in the financial statements and supplemental schedule, other than that derived from the information certified by the custodian, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

Wilson Kozicki & Gump PLLC

Wheeling, West Virginia,
September 19, 2014.

Reynolds Memorial Hospital 403(b) Plan
Statements of Net Assets Available for Benefits
December 31, 2013 and 2012

	2013	2012
Assets		
Investments	$ 3,202,550	$ 2,449,686
Receivable		
Dividends	35,562	33,664
Distribution	-	34,333
Employee contributions	-	850
	35,562	68,847
Total assets	3,238,112	2,518,533
Liabilities		
Accrued liabilities	10,000	9,500
Total liabilities	10,000	9,500
Net Assets Available for Benefits	$ 3,228,112	$ 2,509,033

The accompanying notes are an integral part of these financial statements.

Reynolds Memorial Hospital 403(b) Plan
Statements of Changes in Net Assets Available for Benefits
For the years ended December 31, 2013 and 2012

	2013	2012
Additions To Net Assets		
Investment income:		
Dividends	$ 69,127	$ 54,141
Net realized and unrealized appreciation of investments	370,389	216,099
	439,516	270,240
Net registered investment advisor fee (Note 1)	2,123	(2,936)
Net investment income	441,639	267,304
Contributions:		
Employee	457,895	428,626
Participant rollovers and transfers	15,676	19,462
Total contributions	473,571	448,088
Total additions	915,210	715,392
Deductions from Net Assets		
Benefits paid to participants	176,327	343,155
Professional fees	10,000	9,500
Administrative fees	9,804	8,773
Total deductions	196,131	361,428
Net increase	719,079	353,964
Net Assets Available for Benefits		
Beginning of year	2,509,033	2,155,069
End of year	$ 3,228,112	$ 2,509,033

The accompanying notes are an integral part of these financial statements.

1. Description of Plan

The following description of the Reynolds Memorial Hospital, Inc. 403(b) Plan (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions. The Plan is sponsored by Reynolds Memorial Hospital, Inc. (the Hospital).

General

The Plan, which was established January 1, 2008, is a defined contribution plan which allows participation by all Hospital employees. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The plan entered into a recordkeeping agreement with a third party administrator, CPI Qualified Plan Consultants, Inc. (CPI). CPI provides administration of the participant-level information. CPI has subcontracted the plan level reporting and custodial responsibilities to MG Trust Company, LLC (MG Trust). In addition, the Plan has employed an independent registered investment advisor to provide assistance to plan participants.

Employee Contributions

The contributions to the plan consist of participant salary deferrals. Each participant may elect to contribute a prescribed percentage or flat dollar amount of his or her compensation to the Plan. Participants direct the investment of their contributions into various investment options offered by the plan. The plan currently offers approximately 40 various mutual funds as investment options to participants.

Employer Contributions

No employer contributions are permitted.

Rollover Contributions and Transfers

Participants may rollover amounts that represent distributions from other qualified plans or transfer amounts directly from other qualified plans.

Funding Policy

The contributions are to be funded to the Plan as soon as they can be reasonably segregated.

Participant Accounts

Each participant's account is credited with the participant's contributions. The earnings (losses) allocation is based on the number of shares held by the participant of each particular investment. Expenses are allocated in the same proportion that each participant's account bears to the total of all participants' accounts as of the point in time when the expense is paid by the Plan, which is generally quarterly.

Vesting

Participants are fully vested immediately upon participation in the Plan.

1. Description of Plan (Continued)

Participant Loans

Participant loans are not permitted by the Plan.

Hardship Withdrawals

A withdrawal from a participant's account is permitted if the participant has a financial hardship as defined in the Plan document. There were no hardship distributions included in Benefits paid to participants in the Statements of Changes in Net Assets Available for Benefits for 2013 or 2012.

In-Service Distributions

A participant may withdraw all or a portion of his/her account balance, upon the attainment of age 59 ½. For the years ended 2013 and 2012, $10,953 and $191,449 of the benefits paid to participants were in-service distributions.

Payment of Benefits

On termination of service due to death, disability, or retirement, a participant may elect to receive either a lump-sum distribution equal to the value of the participant's vested interest in his or her account, or purchase an annuity which will pay annual installments over a term of years. For termination of service for other reasons, a participant may only receive the value of the vested interest in his or her account as a lump sum distribution.

Expense Reimbursement

The Plan receives a reimbursement based on the total asset value at the end of each quarter. The amount received is shown net of the fees charged to the Plan by the registered investment advisor on the accompanying Statements of Changes in Net Assets Available for Benefits.

	2013	2012
Investment consulting fee	$ 14,970	$ 17,727
Revenue sharing reimbursement	(17,093)	(14,792)
Net investment consulting fee	$ (2,123)	$ 2,936

2. Summary of Significant Accounting Policies

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting. Contributions are recorded by the Plan in the period the wages are earned. In accordance with ASC 965, benefits are recorded when paid.

2. Summary of Significant Accounting Policies (Continued)

Investments

Investments are 100% participant directed and are stated at fair value. Fair value is the price that would be received to sell an asset in an orderly transaction between market participants (Note 4). Purchases and sales of shares are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date.

Estimates

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

3. Investments

During the years ended December 31, 2013 and 2012, the Plan's investments are:

	Level (Note 4)	2013	2012
Equity funds	1	$ 764,167	$ 553,242
Fixed income funds	1	323,862	354,967
Target date funds	1	1,892,442	1,368,380
Valic fixed interest option	2	222,079	173,097
Total		$ 3,202,550	$ 2,449,686

The following presents investments which individually represent 5% or more of the Plan's net assets:

Description	December 31 2013	2012
American Funds Bond Fund of America	$ *	$ 134,876
American 2015 Target Date Fund	$ 346,793	$ 264,098
American 2020 Target Date Fund	$ 680,108	$ 523,520
American 2025 Target Date Fund	$ 304,660	$ 185,802
American 2030 Target Date Fund	$ 266,403	$ 191,078
American Funds US Government Securities Fund	$ *	$ 185,742
Franklin Income Fund	$ *	$ 143,922
Valic Fixed-Interest Option	$ 222,079	$ 173,097

*Investment did not exceed threshold for the year indicated

3. Investments (Continued)

Valic Fixed-Interest Option

The Valic Fixed-Interest Option is a fixed annuity contract that is fully backed by the claims-paying ability of the Variable Annuity Life Insurance Company. The fund provides a guaranteed minimum rate of interest, and the potential for additional interest if declared by Valic. Additional interest, when declared, is declared monthly with interest credited on a daily basis at an annual effective rate. Additional interest is not guaranteed for future months. Participants are entitled to receive full contract value on demand.

In determining the rate of additional interest to be declared for the upcoming period, factors that are considered are: the totality of investments previously made by participants, their anticipated payout timing requirements, the current investment climate, contractual minimum interest rate guarantees, competitive requirements and required return on invested capital supporting the fund.

The guaranteed interest rate in effect on December 31, 2013 and 2012 was 2.00%. Due to the effect of realized and unrealized gains or losses, both the average yield earned by the Plan and the average yield credited to the Plan participants for the years ended December 31, 2013 and 2012 was 2.42% and 2.56%, respectively.

4. Fair Value

The framework for measuring fair value provides a fair value hierarchy which prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets (level 1) and the lowest priority to unobservable inputs (level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

Level 1		Inputs to the valuation methodology are unadjusted quoted prices for identical assets in active markets that the Plan has the ability to access.
Level 2		Inputs to the valuation methodology include: • Quoted prices for similar assets in active markets • Quoted prices for identical or similar assets in inactive markets • Inputs other than quoted prices that are observable for the asset • Inputs that are derived principally from or corroborated by observable market data by correlation or other means If the asset has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset.
Level 3		Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

4. Fair Value (Continued)

METHODOLOGIES

There have been no changes in the methodologies of the plan's investments. See Note 3 for identification of the level of each class of investments. The following is a description of the valuation methodologies used by this Plan:

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value and to transact at that price. The mutual funds held by the Plan are actively traded.

Fixed-Interest Option Fund: The fund is reported at contract value. Contract value is equal to the accumulated cash contributions and interest credited to the Plan's contracts, less any withdrawals. Generally there are no events that could limit the ability of the Plan to transact at contract value. Additionally, there are no events that allow the issuer to terminate the contract and which require the Plan to settle at an amount other than contract value.

5. Plan Termination

The Hospital may terminate the Plan at any time by delivering to the Plan Administrator written notice of such termination. However, to the extent that the Plan holds participant accounts, Plan termination is only permitted if the Hospital does not make contributions to any 403(b) plan during the period beginning on the date of Plan termination and ending 12 months after the distribution of all assets from the terminated Plan.

6. Distribution Receivable

In 2012, the Plan erroneously processed plan to plan transfers to a plan that did not allow contributions, resulting in a plan operational error that was resolved in 2013.

7. Prohibited Transaction

In 2013, the Plan processed payments to the registered investment advisor even though the proper disclosures were not made as required by the Department of Labor under section 408(b) (2) of ERISA. Amounts paid to the registered investment advisor between January 1, 2013 and October 2, 2013 totaled $14,970. According to the regulation, when payments are made to a covered service provider without the proper disclosures in place, a prohibited transaction has occurred.

8. Tax Status

The Internal Revenue Service has no program for 403(b) plan sponsors to apply for a determination of tax exempt status. Management believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income tax has been included in the Plan's financial statements.

8. Tax Status (Continued)

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the Department of Labor. The Plan is subject to routine audits by federal authorities; however, there are currently no audits for any tax periods in progress. The plan annually files Form 5500, *Annual Report/ Report of Employee Benefit Plan.* The current year return, as well as the prior three years (2010-2012), is subject to examination for generally up to three years after they are filed.

9. Investment Risk and Market Activity

Investments of the Plan are not insured by the FDIC; are not deposits or other obligations of, or guaranteed by any bank or affiliates; and are subject to investment risks, including possible loss of the principal amount invested.

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

10. Parties in Interest Transactions

Parties-in-interest is defined by IRS Section 4785(e)(2) and ERISA Section 3(14)(c) to include, among others, any entity that provides services to the Plan. Therefore, all the plan expenses included in the accompanying financial statements are considered parties-in-interest transactions.

11. Information Certified by the Plan's Custodian

The plan administrator has elected the method of annual reporting compliance permitted by 29 CFR 2520.103-8 of the Department of Labor Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, the custodian has certified that the following data included in the accompanying financial statements and supplemental schedule is complete and accurate:

- Investments, as shown in the Statements of Net Assets Available for Benefits as of December 31, 2013 and 2012.
- Investment income, as shown in the Statements of Changes in Net Assets Available for Benefits for the years ended December 31, 2013 and 2012.
- The Schedule of Assets Held at End of Year, as shown in the Supplemental Information, as of December 31, 2013.

The Plan's independent certified public accountants did not perform auditing procedures with respect to this information, except for comparing such information to the related information included in the financial statements and supplemental information.

12. Classification Differences

Form 5500 has certain assets and liabilities that differ from amounts shown on the accompanying financial statements. These differences relate to classifications only and have no effect upon net assets available for benefits for either the year ended December 31, 2013 or 2012.

13. Subsequent Events

Management has evaluated subsequent events through the date that the financial statements were issued, September 19, 2014, and determined that other than the event described in the preceding paragraph, no events occurring after this date have been evaluated for inclusion in these financial statements.

Supplemental Information

Reynolds Memorial Hospital 403(b) Plan
Schedule of Assets Held at End of Year
December 31, 2013

Face/Shares	Description	Fair Value
Mutual Funds		
62,406	American 2020 Target Date Retirement Fund	$ 680,108
33,551	American 2015 Target Date Retirement Fund	346,793
26,326	American 2025 Target Date Retirement Fund	304,660
22,156	American 2030 Target Date Retirement Fund	266,403
3,246	American Funds Growth Fund of America	135,682
10,919	American Funds Bond Fund of America	135,392
9,771	American Funds US Government Securities Fund	131,912
10,944	American 2035 Target Date Retirement Fund	131,831
48,980	Franklin Income Fund	117,062
7,923	American 2040 Target Date Retirement Fund	96,601
1,838	American Funds Smallcap World Fund	85,580
1,768	American Funds Europacific Growth	84,432
1,805	American Funds Washington Mutual Investors	70,428
1,562	American Funds Capital World Growth/Income	70,074
2,841	American Funds American Balanced Fund	69,046
625	Franklin Small Cap Value	54,595
2,992	Aberdeen International Equity	45,383
1,238	American Funds Income Fund of America	25,338
1,942	American 2050 Target Date Retirement Fund	23,376
380	American Funds Capital Income Builder	22,267
2,249	American 2010 Target Date Retirement Fund	21,562
1,729	American 2045 Target Date Retirement Fund	21,107
232	American Funds New Economy	8,540
148	American Funds New World Fund	8,437
290	American Funds AmCap Fund	7,511
305	Columbia Mid Cap Value	5,463
173	American Funds High-Income Trust	1,963
89	Invesco Real Estate Fund	1,935
37	American Funds Fundamental Investors	1,921
63	Eaton Vance Large-Cap	1,514
34	American Funds Investments Co. America	1,250
32	Federated Kaufmann SmallCap Fund	899
121	Federated Kaufmann Fund	744
48	Oppenheimer Equity Fund	577
2	American Funds American Mutual	84
	Total mutual funds	2,980,471
Fixed-Interest Option		
	Valic Fixed Interest Option	222,079
Total Investments		$ 3,202,550

Schedule H, Line 4i

Schedule of Assets (Held At End of Year)

Name of Plan:

▶ Reynolds Memorial Hospital, Inc. 403(b) Plan

Employer Identification Number: ▶ 55-0357045

For plan year (beginning/ending): ▶ 01/01/2013 to 12/31/2013 Plan number: ▶ 003

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current value
	ABERDEEN INTL EQUITY	VALUE OF INT IN REGIST INVEST CO	N/A	45,383
	AMERICAN FUNDS AMCAP FUND	VALUE OF INT IN REGIST INVEST CO	N/A	7,511
	AMERICAN FUNDS AMER BALNCED	VALUE OF INT IN REGIST INVEST CO	N/A	69,046
	AMERICAN FUNDS BOND FUND AM	VALUE OF INT IN REGIST INVEST CO	N/A	135,392
	AMERICAN FUNDS CAP INC BLDR	VALUE OF INT IN REGIST INVEST CO	N/A	22,267
	AMERICAN FUNDS CAP WLD G&I	VALUE OF INT IN REGIST INVEST CO	N/A	70,074
	AMERICAN FUNDS EUROPACIFIC	VALUE OF INT IN REGIST INVEST CO	N/A	84,432
	AMERICAN FUNDS FUNDMNTL INV	VALUE OF INT IN REGIST INVEST CO	N/A	1,921
	AMERICAN FUNDS GROWTH FUND	VALUE OF INT IN REGIST INVEST CO	N/A	135,682
	AMERICAN FUNDS HIGH INC TR	VALUE OF INT IN REGIST INVEST CO	N/A	1,963
	AMERICAN FUNDS INCOME FUND	VALUE OF INT IN REGIST INVEST CO	N/A	25,338
	AMERICAN FUNDS INV CO AMER	VALUE OF INT IN REGIST INVEST CO	N/A	1,250
	AMERICAN FUNDS AMER MTUAL	VALUE OF INT IN REGIST INVEST CO	N/A	84
	AMERICAN FUNDS NEW ECONOMY	VALUE OF INT IN REGIST INVEST CO	N/A	8,540
	AMERICAN FUNDS NEW WORLD FD	VALUE OF INT IN REGIST INVEST CO	N/A	8,437
	AMERICAN FUNDS SMALLCAP WLD	VALUE OF INT IN REGIST INVEST CO	N/A	85,580
	AMERICAN FUNDS US GOVT SEC	VALUE OF INT IN REGIST INVEST CO	N/A	131,912
	AMERICAN FUNDS WASH MUTUAL	VALUE OF INT IN REGIST INVEST CO	N/A	70,428
	AMERICAN FUNDS 2010 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	22,577
	AMERICAN FUNDS 2015 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	356,648
	AMERICAN FUNDS 2020 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	692,083
	AMERICAN FUNDS 2025 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	309,333
	AMERICAN FUNDS 2030 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	270,528
	AMERICAN FUNDS 2035 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	133,730
	AMERICAN FUNDS 2040 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	98,081
	AMERICAN FUNDS 2045 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	21,388
	AMERICAN FUNDS 2050 TDATE	VALUE OF INT IN REGIST INVEST CO	N/A	23,636
	COLUMBIA MID CAP VALUE	VALUE OF INT IN REGIST INVEST CO	N/A	5,463
	EATON VANCE LARGE CAP VALUE	VALUE OF INT IN REGIST INVEST CO	N/A	1,514
	FEDERATED KAUFMAN SMALL CAP	VALUE OF INT IN REGIST INVEST CO	N/A	899
	FED KAUFMANN	VALUE OF INT IN REGIST INVEST CO	N/A	744
	FRANKLIN INCOME	VALUE OF INT IN REGIST INVEST CO	N/A	117,062
	FRANKLIN SMALL CAP VALUE	VALUE OF INT IN REGIST INVEST CO	N/A	54,595
	INVESCO REAL ESTATE	VALUE OF INT IN REGIST INVEST CO	N/A	1,935

Schedule H, Line 4i

Schedule of Assets (Held At End of Year)

Name of Plan:

▶ Reynolds Memorial Hospital, Inc. 403(b) Plan

Employer Identification Number: ▶ 55-0357045

For plan year (beginning/ending): ▶ 01/01/2013 to 12/31/2013 Plan number: ▶ 003

(a)	**(b)** Identity of issue, borrower, lessor, or similar party	**(c)** Description of investment including maturity date, rate of interest, collateral, par or maturity value	**(d)** Cost	**(e)** Current value
	OPPENHEIMER EQUITY	VALUE OF INT IN REGIST INVEST CO	N/A	577
	VALIC FIXD INTERST OPT	VALUE OF FUNDS HELD IN INSUR CO	N/A	222,079