

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). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 1.5em; font-weight: bold;">2014</div> This Form is Open to Public Inspection
---	---	--

Part I	Annual Report Identification Information
For calendar plan year 2014 or fiscal plan year beginning <u>01/01/2014</u> and ending <u>12/31/2014</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or ☒ a single-employer plan; ☐ a DFE (specify) _____
B This return/report is:	☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>AMERICAN HEALTH IMAGING, INC. 401(K) PROFIT SHARING PLAN</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>08/01/2000</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>08/01/2000</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>08/01/2000</u>					
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>AMERICAN HEALTH IMAGING, INC.</u> <u>2200 CENTURY PKWY NE STE 600</u> <u>ATLANTA, GA 30345</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>58-2329279</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>404-296-5887</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>621510</u></td> </tr> <tr> <td style="height: 40px;"></td> </tr> </table>	2b Employer Identification Number (EIN) <u>58-2329279</u>	2c Plan Sponsor's telephone number <u>404-296-5887</u>	2d Business code (see instructions) <u>621510</u>	
2b Employer Identification Number (EIN) <u>58-2329279</u>					
2c Plan Sponsor's telephone number <u>404-296-5887</u>					
2d Business code (see instructions) <u>621510</u>					

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2015	SCOTT ARANT
	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 ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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	5 222
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	
a(1) Total number of active participants at the beginning of the plan year	6a(1) 132
a(2) Total number of active participants at the end of the plan year	6a(2) 150
b Retired or separated participants receiving benefits	6b 0
c Other retired or separated participants entitled to future benefits.....	6c 49
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 199
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e	6f 199
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 161
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: 2E 2F 2G 2J 2T 3D	
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) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☒ <u>1</u> A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☒ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)

Part III**Form M-1 Compliance Information (to be completed by welfare benefit plans)**

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

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 2014 This Form is Open to Public Inspection
---	---	---

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014		
A Name of plan AMERICAN HEALTH IMAGING, INC. 401(K) PROFIT SHARING PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 AMERICAN HEALTH IMAGING, INC.		
D Employer Identification Number (EIN) 58-2329279		

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
HARTFORD LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0974148	88072	GA-819391	161	01/01/2014	12/31/2014

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
2965	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
LPL FINANCIAL CORPORATION 9785 TOWNE CENTRE DRIVE SAN DIEGO, CA 92121

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2965			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end.....	4	0
5 Current value of plan's interest under this contract in separate accounts at year end	5	2083940

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 FUNDING AGREEMENT

b Balance at the end of the previous year.....	7b	0
---	-----------	---

c Additions: (1) Contributions deposited during the year.....	7c(1)	0	
(2) Dividends and credits	7c(2)		
(3) Interest credited during the year	7c(3)	0	
(4) Transferred from separate account.....	7c(4)	0	
(5) Other (specify below)	7c(5)	0	
▶			

(6) Total additions.....	7c(6)	0
--------------------------	--------------	---

d Total of balance and additions (add lines 7b and 7c(6))	7d	0
---	-----------	---

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

(5) Total deductions.....	7e(5)	0
---------------------------	--------------	---

f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0
---	-----------	---

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

<div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>	OMB No. 1210-0110
		2014
		This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014		
A Name of plan AMERICAN HEALTH IMAGING, INC. 401(K) PROFIT SHARING PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 AMERICAN HEALTH IMAGING, INC.	D Employer Identification Number (EIN) 58-2329279	

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
--

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

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

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

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

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

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

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

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

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

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

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

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

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

MASSMUTUAL LIFE INSURANCE CO.

04-1590850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 23 37 38 50 54 55 59 60 62 63 64 65 66 99	NONE	2217	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

RELiance TRUST COMPANY

58-1428634

(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?
25 99	NONE	0	Yes ☒ No ☐	Yes ☐ No ☒	400	Yes ☐ No ☒

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

MORNINGSTAR ASSOCIATES

36-4311783

(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?
49	NONE	0	Yes ☒ No ☐	Yes ☐ No ☒	16	Yes ☐ No ☒

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
MASSMUTUAL LIFE INSURANCE CO.	15 23 37 38 50 54 55 59 60 62 63 64 65 66 99	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.	
SEE ATTACHED	SEE ATTACHED	
04-1590850		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
RELIANCE TRUST COMPANY	25 99	400
(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.	
MASSACHUSETTS MUTUAL LIFE INSURANCE	SEE ATTACHED	
04-1590850		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
MORNINGSTAR ASSOCIATES	49	364317381
(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.	
MASSACHUSETTS MUTUAL LIFE INSURANCE	16	
04-1590850		

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

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:

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

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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.	<small>OMB No. 1210-0110</small> 2014 This Form is Open to Public Inspection
For calendar plan year 2014 or fiscal plan year beginning <u>01/01/2014</u> and ending <u>12/31/2014</u>		
A Name of plan <u>AMERICAN HEALTH IMAGING, INC. 401(K) PROFIT SHARING PLAN</u>		B Three-digit plan number (PN) ► <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>AMERICAN HEALTH IMAGING, INC.</u>		D Employer Identification Number (EIN) <u>58-2329279</u>

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
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	Total noninterest-bearing cash	1a		
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions.....	1b(1)		
	(2) Participant contributions.....	1b(2)		
	(3) Other.....	1b(3)		
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	0	0
	(2) U.S. Government securities	1c(2)		
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)		
	(B) All other.....	1c(3)(B)	0	0
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)		
	(B) Common.....	1c(4)(B)	0	0
	(5) Partnership/joint venture interests	1c(5)		
	(6) Real estate (other than employer real property).....	1c(6)		
	(7) Loans (other than to participants)	1c(7)		
	(8) Participant loans.....	1c(8)	52179	9081
	(9) Value of interest in common/collective trusts	1c(9)	0	0
	(10) Value of interest in pooled separate accounts	1c(10)	0	0
	(11) Value of interest in master trust investment accounts	1c(11)		
	(12) Value of interest in 103-12 investment entities.....	1c(12)		
	(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	1823675	2083941
	(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	0	0
	(15) Other.....	1c(15)	0	0

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	1875854	2093022

Liabilities

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

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	1875854	2093022
---	-----------	---------	---------

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 Contributions:**

		(a) Amount	(b) Total
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	0	
(B) Participants	2a(1)(B)	283109	
(C) Others (including rollovers)	2a(1)(C)	87199	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		370308

b Earnings on investments:**(1) Interest:**

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	0	
(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)	733	
(F) Other	2b(1)(F)	0	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		733

(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0

(3) Rents	2b(3)		
-----------------	--------------	--	--

(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0

(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)		0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		88635
(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)		0
c Other income	2c		0
d Total income. Add all income amounts in column (b) and enter total	2d		459676

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	202843	
(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)		202843
f Corrective distributions (see instructions)	2f		27
g Certain deemed distributions of participant loans (see instructions)	2g		37435
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	2203	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		2203
j Total expenses. Add all expense amounts in column (b) and enter total	2j		242508

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		217168
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		0

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: COHNREZNICK LLP

(2) EIN: 22-1478099

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:

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.)

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.)

	Yes	No	Amount
4a		X	
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.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
e Was this plan covered by a fidelity bond?	X		200000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?.....		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?.....		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?.....		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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 2014 This Form is Open to Public Inspection.
---	--	--

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan <u>AMERICAN HEALTH IMAGING, INC. 401(K) PROFIT SHARING PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>AMERICAN HEALTH IMAGING, INC.</u>	D Employer Identification Number (EIN) <u>58-2329279</u>

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

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>06-0974148</u>	
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.	
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3 <u>0</u>

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	<u>0</u>	
b Enter the amount contributed by the employer to the plan for this plan year.....	6b	<u>0</u>	
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	<u>0</u>	
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): _____

American Health Imaging, Inc. 401(k) Profit Sharing Plan

**Financial Statements
(With Supplementary Information)
and Independent Auditor's Report**

December 31, 2014

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Index

	<u>Page</u>
Independent Auditor's Report	2
Statements of Net Assets Available for Benefits	4
Statement of Changes in Net Assets Available for Benefits	5
Notes to Financial Statements	6
Schedule of Assets (Held at End of Year) (Schedule H, Line 4i)	13

Independent Auditor's Report

To the Trustees
American Health Imaging, Inc. 401(k) Profit Sharing Plan

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of American Health Imaging, Inc. 401(k) Profit Sharing Plan (the "Plan"), which comprise the statements of net assets available for benefits as of December 31, 2014 and 2013, and the related statement of changes in net assets available for benefits for the year ended December 31, 2014, and the related notes to financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal controls 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 of 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 8, which was certified by Massachusetts Mutual Life Insurance Company (custodian), the trustee of the Plan, except for comparing such 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 December 31, 2014 and 2013, and for the year ended December 31, 2014, 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 year end) (Schedule H, Line 4i) as of December 31, 2014 is required by the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and is presented for the 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.

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.

A handwritten signature in dark ink that reads "CohnReznick LLP". The signature is written in a cursive, flowing style.

Atlanta, Georgia
October 9, 2015

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Statements of Net Assets Available for Benefits

	<u>December 31, 2014</u>	<u>December 31, 2013</u>
Assets:		
Investments, at fair value	\$ 2,083,941	\$ 1,823,663
Receivables:		
Notes receivable from participants	<u>9,081</u>	<u>52,179</u>
Total assets	<u>2,093,022</u>	<u>1,875,842</u>
Net assets available for benefits	<u>\$ 2,093,022</u>	<u>\$ 1,875,842</u>

See Notes to Financial Statements.

American Health Imaging, Inc. 401(k) Profit Sharing Plan
Statement of Changes in Net Assets Available for Benefits

	<u>Year Ended December 31, 2014</u>
Additions:	
Investment income (loss):	
Interest and dividends	\$ 135,326
Net depreciation in fair value of investments	<u>(46,678)</u>
Total investment income	<u>88,648</u>
Interest income on notes receivable from participants	<u>733</u>
Contributions:	
Participant contributions	283,109
Participant rollovers	<u>87,199</u>
Total contributions	<u>370,308</u>
Total additions	<u>459,689</u>
Deductions:	
Benefits paid to participants	240,306
Administrative expenses	<u>2,203</u>
Total deductions	<u>242,509</u>
Net increase	217,180
Net assets available for benefits:	
Beginning of year	<u>1,875,842</u>
End of year	<u><u>\$ 2,093,022</u></u>

See Notes to Financial Statements.

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Notes to Financial Statements December 31, 2014

Note 1 - Description of Plan

The following description of the American Health Imaging, Inc. 401(k) Profit Sharing Plan (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution plan covering all full-time employees of American Health Imaging, Inc. (the "Company") age twenty-one or older. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Board of Trustees is responsible for oversight of the Plan. The Investment Committee determines the appropriateness of the Plan's investment offerings, monitors investment performance and reports to the Plan's Board of Trustees.

Contributions

Each year, participants may contribute pre-tax annual compensation, as defined in the Plan, or the maximum statutory limits. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans (rollover). Participants direct the investment of their contributions into various investment options offered by the Plan. The Plan includes an auto-enrollment provision whereby all newly eligible employees are automatically enrolled in the Plan unless they affirmatively elect not to participate in the Plan. Automatically enrolled participants have their deferral rate set at 2% of eligible compensation and their contributions invested in a designated balanced fund until changed by the participant. At its discretion, the Company may make a matching contribution and may also make discretionary contributions. No matching contributions or discretionary contributions were made by the Company for the year ended December 31, 2014. Participants also direct the investment of Company contributions. Contributions are subject to certain Internal Revenue Service ("IRS") limitations.

The Company may make a qualified non-elective contribution ("QNEC") which would be allocated to non-highly compensated eligible employees, subject to certain limitations. No QNECs were made during the year ended December 31, 2014.

Participant accounts

Each participant's account is credited with the participant's contributions and Company matching contributions, as well as allocations of the Company's profit sharing contribution and Plan earnings. Participant accounts are charged with an allocation of administrative expenses that are paid by the Plan. Allocations are based on participant earnings, account balances or specific participant transactions, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting

Participants are vested immediately in their contributions, rollover contributions, QNECs, and actual earnings thereon. Vesting in the Company's contribution portion of their accounts is based on years of continuous service.

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Notes to Financial Statements December 31, 2014

<u>Years of service</u>	<u>Percent vested</u>
Less than 1	0%
1	20%
2	40%
3	60%
4	80%
5	100%

Notes receivable from participants

Participants may borrow from their fund accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their account balance. The loans are secured by the balance in the participant's account and bear a reasonable rate of interest. The loan interest rates range from 3.25% to 5.25% as of December 31, 2014. Principal and interest is paid ratably through monthly payroll deductions.

Payment of benefits

On termination of service due to death, disability or retirement, a participant may elect to receive either a lump-sum amount equal to the value of the participant's vested interest in his or her account, or annual installments over a ten-year period. For termination of service for other reasons, a participant may receive the value of the vested interest in his or her account as a lump-sum distribution.

Forfeited accounts

Upon withdrawal of a participant's vested balance, any nonvested balance is forfeited. Forfeited balances are used to reduce future Company contributions or to pay Plan expenses. As of December 31, 2014 and 2013, there were no forfeitures.

Note 2 - Summary of accounting policies

Basis of accounting

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

Use of estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Investment valuation and income recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Investment Committee determines the Plan's valuation policies utilizing information provided by the investment advisers, custodians and insurance company. See Note 3 for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Notes to Financial Statements December 31, 2014

depreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Notes receivable from participants

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expensed when they are incurred. No allowance for credit losses has been recorded as of December 31, 2014 or 2013.

Payment of benefits

Benefits are recorded when paid.

Expenses

Certain expenses of maintaining the Plan are paid directly by the Company and are excluded from these financial statements. Fees related to the administration of notes receivable from participants are charged directly to the participant's account and are included in administrative expenses. Investment related expenses are included in net depreciation of fair value of investments.

Subsequent events

The Plan has evaluated subsequent events through October 9, 2015, the date the financial statements were available to be issued.

Note 3 - Fair value measurements

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

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

Level 2: Inputs to the valuation methodology include:

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

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

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

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Notes to Financial Statements December 31, 2014

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

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2014 and 2013.

Pooled Separate Accounts: Valued at the net asset value ("NAV") of shares held by the Plan at year end. The NAV is determined daily based on fair value published by the issuer. Quoted prices are determined daily based on the fair value of the mutual funds and other securities in the accounts. The pooled separate accounts can be traded daily at their NAV.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2014 and 2013:

Assets at Fair Value as of December 31, 2014

	Level 1	Level 2	Level 3	Total
Pooled Separate Accounts	\$ -	\$ 2,083,941	\$ -	\$ 2,083,941

Assets at Fair Value as of December 31, 2013

	Level 1	Level 2	Level 3	Total
Pooled Separate Accounts	\$ -	\$ 1,823,663	\$ -	\$ 1,823,663

Note 4 - Related party transactions and party-in-interest transactions

Certain Plan investments are shares of pooled separate accounts managed by Massachusetts Mutual Life Insurance Company ("Mass Mutual", or the "custodian"), who is the trustee as defined by the Plan and, therefore, these transactions qualify as party-in-interest transactions. Fees incurred by the Plan for the investment management services are included in net depreciation in fair value of the investment, as they are paid through revenue sharing, rather than a direct payment. As described in Note 2, the Plan made a direct payment to the Mass Mutual of \$2,203 which was not covered by revenue sharing. The Plan Sponsor pays directly any other fees related to the Plan's operations.

Note 5 - Plan termination

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, participants would become 100% vested in their employer contributions.

Note 6 - Tax status

The IRS has determined and informed the Company by a letter dated March 31, 2008, that the Plan and related trust are designed in accordance with applicable sections of the

American Health Imaging, Inc. 401(k) Profit Sharing Plan

Notes to Financial Statements December 31, 2014

Internal Revenue Code (the "IRC"). Although the Plan has been amended since receiving the determination letter, the Plan administrator and the Plan's tax counsel believe that the Plan is designed, and is currently being operated, in compliance with the applicable requirements of the IRC and, therefore, believe that the Plan is qualified and the related trust is tax exempt.

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

Note 7 - Risks and uncertainties

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

Note 8 - Certified investments

The Plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Investments and notes receivable from participants held at December 31, 2014 and 2013, and investment income and interest income on notes receivable from participants for the year ended December 31, 2014, that are disclosed in the accompanying financial statements and supplemental schedule, were obtained or derived from information supplied to the Plan administrator and certified as complete and accurate by the trustee of the Plan.

Note 9 - Reconciliation of financial statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500:

	December 31, 2014	December 31, 2013
Net assets available for benefits per the financial statements	\$ 2,093,022	\$ 1,875,842
Other reconciling difference	-	12
Net assets available for benefits per the Form 5500	<u>\$ 2,093,022</u>	<u>\$ 1,875,854</u>

American Health Imaging, Inc. 401(k) Profit Sharing Plan

**Notes to Financial Statements
December 31, 2014**

The following is a reconciliation of net increase in net assets per the financial statements to the Form 5500:

	Year Ended December 31, 2014
Increase in net assets available for benefits per the financial statements	\$ 217,180
Other reconciling difference	<u>(12)</u>
Net increase in net assets per the Form 5500	<u><u>\$ 217,168</u></u>

Supplementary Information

American Health Imaging, Inc. 401(k) Profit Sharing Plan
EIN #58-2329279
Plan #001

Schedule of Assets (Held at End of Year) (Schedule H, Line 4i)
December 31, 2014

(a)	(b)	(c)	(e)
Identity of issuer, borrower, lessor or similar party		Description of investment including maturity date, rate of interest, collateral, par or maturity value	Current Value
*	PIMCO TOTAL RETURN FUND R	Pooled Separate Account	\$ 45,055
*	FRANKLIN TEMPLETON CONSERVATIVE ALLOCATION FUND R	Pooled Separate Account	12,898
*	FRANKLIN TEMPLETON GROWTH ALLOCATION FUND R	Pooled Separate Account	29,433
*	FRANKLIN TEMPLETON MODERATE ALLOCATION FUND R	Pooled Separate Account	13,550
*	SELIGMAN GLOBAL TECHNOLOGY FUND R	Pooled Separate Account	91,594
*	INVESCO REAL ESTATE FUND R	Pooled Separate Account	119,232
*	OPPENHEIMER INTERNATIONAL BOND FUND N	Pooled Separate Account	135,999
*	PIMCO REAL RETURN FUND R	Pooled Separate Account	10,354
*	PIONEER STRATEGIC INCOME FUND R	Pooled Separate Account	129,111
*	BLACKROCK GLOBAL ALLOCATION FUND R	Pooled Separate Account	96,677
*	ROYCE VALUE FUND R	Pooled Separate Account	113,129
*	RIDGEWORTH SMALL CAP VALUE EQUITY FUND A	Pooled Separate Account	43,854
*	VICTORY ESTABLISHED VALUE FUND R	Pooled Separate Account	2,254
*	RIDGEWORTH MID-CAP VALUE EQUITY FUND A	Pooled Separate Account	41,489
*	AMERICAN CENTURY EQUITY INCOME FUND R	Pooled Separate Account	64,346
*	VICTORY SMALL COMPANY OPPORTUNITY FUND R	Pooled Separate Account	29,153
*	LORD ABBETT FUNDAMENTAL EQUITY FUND R3	Pooled Separate Account	93,121
*	EATON VANCE WORLDWIDE HEALTH SCIENCES FUND R	Pooled Separate Account	2,706
*	LA DEVELOPING GROWTH R3	Pooled Separate Account	17,032
*	MFS INTL VALUE R2	Pooled Separate Account	66,516
*	JPMORGAN PRIME MM CASHMGT	Pooled Separate Account	513,877
*	AMCENT GROWTH R	Pooled Separate Account	180,515
*	OPPENHEIMER DEV MKTS N	Pooled Separate Account	232,046
	Total assets at fair value		2,083,941
		Interest rates ranging from 3.25% to 5.25%; varying maturities	
*	Participant loans		9,081
	Total		<u>\$ 2,093,022</u>

NOTE: Cost information is not required for participant-directed investments and, therefore, not included.

* Party-in-interest.

Fee and Compensation Disclosure Report

This document is intended to assist a plan administrator (“you”) in completing the Form 5500 Schedule C¹ by identifying different types of compensation paid with respect to the product utilized by your plan.

As permitted under the Schedule C rules, compensation is disclosed in the attached report as an actual dollar amount, an estimate or a formula or rate.

- Where an actual dollar amount of compensation is disclosed, no further notation regarding compensation calculations is generally provided.
- Where an estimate of the compensation amount is disclosed, we have used a reasonable method to arrive at the estimate and we have described the method used to arrive at the estimated amount.
- Where a formula or rate is provided to report compensation, we have used a reasonable method to arrive at the estimate and we have described the method used to arrive at the estimated amount. This formula or rate may be disclosed to describe the compensation to which it applies under the Schedule C rules. Alternatively, for purposes of Schedule C disclosure or in connection with your fiduciary review of the compensation paid with respect to the services, products and investment options utilized by the plan, you may calculate and disclose an actual or estimated dollar amount by multiplying the rate by the total assets to which it applies.

Please note that, unless otherwise indicated in the descriptions contained in this report, direct compensation is presented on a plan year basis 01/01/2014 - 12/31/2014 and indirect compensation is presented on a calendar year basis ending 12/31/2014.

This report includes compensation actually paid to or by MassMutual within the indicated plan year as part of your MassMutual-serviced product. *(Note: If the plan year period or plan year end indicated in this Schedule C reporting package is incorrect, please notify your MassMutual customer service representative immediately).* This report does not include amounts deducted from plan assets and paid to third parties (other than MassMutual). In addition, the report does not include compensation related to investments held by the plan that are not serviced on our recordkeeping system. You should contact your other service providers for reportable compensation information. You may also receive information on the compensation reported here from other service providers as is described below.

Please note that we have provided suggested service codes with respect to services provided through our product. Please review all Schedule C and other Form 5500 materials with your experienced benefits counsel and other professionals to determine the most appropriate codes for your plan. In addition, please note that because plans with fewer than 100 participants (as of the beginning of the plan year) are generally not required to file Schedule C, you should refer to the instructions provided by the IRS for Schedule C and/or review the applicability of Schedule C to your plan with your experienced tax/benefits counsel, to determine whether it is necessary for the plan to report the information contemplated by this report.

Please contact your MassMutual Service Team should you require additional information regarding the compensation paid to or by MassMutual with respect to your plan.

Information provided in this document and related materials we provide are not intended to be and shall not be deemed tax advice, tax form preparation services, legal advice, advice to plans regarding compliance with ERISA reporting compliance, or accounting or other professional services. As described above, the information contained in this report may not cover all of the compensation received by the plan’s service providers. We strongly encourage you to review all Schedule C and other Form 5500 materials with experienced benefits counsel and other professionals.

¹Please refer to the Schedule C of the Form 5500 and its instructions (available at: <http://www.dol.gov/ebsa/5500main.html>), and please confer with experienced benefits counsel and other professionals, to determine the applicability of Schedule C to your plan.

FORM 5500 SCHEDULE C REPORT
SCHEDULE C, LINE 2(h) AND LINE 3(e) FORMULA DESCRIPTION

AMERICAN HEALTH IMAGING, INC. 401(K) PROFIT SHARING PLAN (819391)
EIN #: 58-2329279

Please note that, unless otherwise indicated in the descriptions contained in this report, direct compensation is presented on a plan year basis 01/01/2014 - 12/31/2014 and indirect compensation is presented on a calendar year basis ending 12/31/2014.

For use with lines 2(h), 3(c), 3(d), 3(e)

Total Direct Compensation Paid **\$2,217.09**

The total amount identified above reflects all fees deducted from plan assets at the plan administrator's direction for the plan year. Service providers which have received portions of these direct fees are listed below, along with the amount of fees they received. Please note that if there is a discrepancy between the total direct fees reported above and the sum of the direct fees reported below, you should contact your other service providers or your plan records to identify the recipient(s) of the fees and any other information relevant to your Schedule C filing.

Recipient: Massachusetts Mutual Life Insurance Company EIN: 04-1590850

Service Codes: 15, 23, 37, 38, 54, 55, 59, 60, 62, 63, 64, 65, 66, 99, 50 (if direct compensation amount reflected below)

Direct Compensation **\$2,217.09**

The total amount identified above reflects fees deducted from plan assets at the plan administrator's direction for the 2014 plan year for the above named recipient. Please review other service providers, below, to determine whether direct fees were also paid to them. Also, please review your records to determine whether other service providers may have received any compensation not reported below (e.g., a reimbursement paid to any plan fiduciary, your employee benefits counsel, or a plan auditor).

Note: Due to system accounting protocols (including 'cash basis' accounting), amounts reported as Direct Compensation and amounts reported as paid to Massachusetts Mutual Life Insurance Company ("MMLIC") are the net result of aggregating direct compensation after the effects of adjustments processed in 2014, some of which may have pertained to prior years.

Please review the detailed breakdown at the end of the report for further information.

Indirect Compensation

Float compensation **\$89.93**

Bank accounts and investments associated with short-term investment pool

This is an estimate based on the annual average rate of float (0.372% for 2014) earned on the bank accounts and investments associated with the short-term investment pool for the 2014 calendar year multiplied by an estimate of the assets related to uncashed checks.* This estimate does not include float earned for any other reason (e.g., if amounts remitted cannot be immediately invested because they are not in good order). Please review or request a copy of the current float disclosure for more information about the other circumstances in which float is earned.

* A complete listing of distribution checks that remain outstanding is available on the Retirement Plan Access web site under the Standard Reports section (Report R03998-Outstanding Distribution Checks). Uncashed check assets will continue to remain in a float-earning bank account until such time direction is received from the Plan Sponsor, subject to applicable regulation. The Plan Sponsor should consult with the Plan's/Plan Sponsor's tax advisor or benefits counsel to determine if assets attributable to uncashed checks should be included on the Form 5500 filing.

Non Monetary Compensation

Please note that items of nonmonetary compensation need to be reported for Schedule A or C (Form 5500) purposes if they exceed certain *de minimus* amounts. Transactions generating nonmonetary compensation may include gifts, gratuities, or certain types of in-kind benefits. MassMutual's Code of Conduct generally restricts MassMutual employees from giving to or receiving gifts from customers and/or business partners having a value of over \$100, in any individual situation, without prior approval. However, it is possible that one or more of your service providers for the calendar year, including MassMutual, engaged in transactions generating nonmonetary compensation. Information concerning reportable transactions undertaken between or among non-MassMutual parties may not be available to MassMutual.

Please consult with your legal or tax advisors if you have any questions.

Compensation paid with respect to Funds

<i>Investment Option Name</i>	<i>EIN</i>	<i>Revenue Sharing Rate (%) Paid to MassMutual (rates as of 12/31/2014)</i>	<i>Underlying Fund Gross Expense Ratio as of the Fund's Year End*</i>
AMERICAN CENTURY EQUITY INCOME R	43-1646043	0.85% x assets	1.43%
AMERICAN CENTURY GROWTH R	44-6006315	0.85% x assets	1.47%
BLACKROCK GLOBAL ALLOCATION R	22-2937779	0.80% x assets	1.49%
COL SELI GLOBAL TECHNOLOGY R	13-3586464	0.75% x assets	1.75%
EATON VANCE WORLDWIDE HLTH SCI R	04-2325690	0.80% x assets	1.71%
FRANKLIN CONSERVATIVE ALLOC R	13-3151768	0.60% x assets plus \$12/participant	1.47%
FRANKLIN GROWTH ALLOCATION R	13-3151768	0.60% x assets plus \$12/participant	1.57%
FRANKLIN MODERATE ALLOCATION R	13-3151768	0.60% x assets plus \$12/participant	1.50%
INVESCO REAL ESTATE R	76-0343427	0.80% x assets	1.50%
JPMORGAN PRIME MONEY MKT CASHMGT	33-1043149	0.00% x assets	0.96%
LORD ABBETT DEVELOPING GROWTH R3	13-2958970	0.75% x assets	1.26%
LORD ABBETT FNDAMENTAL EQUITY R3	13-3712440	0.75% x assets	1.21%
MFS INTERNATIONAL VALUE R2	04-3158862	0.80% x assets	1.34%
OPPENHEIMER DEVELOPING MARKETS R	93-6305075	0.80% x assets	1.87%
OPPENHEIMER INTERNATIONAL BOND R	84-1308320	0.80% x assets	1.25%
PIMCO REAL RETURN R	95-2632339	0.65% x assets	1.12%
PIMCO TOTAL RETURN R	95-2632339	0.65% x assets	1.10%
PIONEER STRATEGIC INCOME R	04-3453709	0.80% x assets	1.34%
RIDGEWORTH MIDCAP VALUE EQUITY A	23-2678674	0.75% x assets	1.40%
RIDGEWORTH SM CAP VALUE EQUITY A	23-2678674	0.75% x assets	1.53%
ROYCE VALUE R	13-3139046	0.75% x assets	1.83%
VICTORY ESTABLISHED VALUE R	31-6364605	0.65% x assets plus \$16/participant	1.23%
VICTORY SMALL CO OPPORTUNITY R	31-6364605	0.65% x assets plus \$16/participant	1.57%

Under the variable investment options available through your plan's group annuity contract or funding agreement, contract values are invested in Massachusetts Mutual Life Insurance Company separate accounts that, in turn, invest in underlying registered investment companies (i.e., mutual funds) and collective investment funds.

The above list includes any investment option held by the plan on at least one month end during the 2014 calendar year. To arrive at an estimate of the dollar amount that MassMutual received from each investment option, multiply the rate of fees received from each investment option by your plan's year-end balance (or if the investment option was liquidated prior to year end, the balance on the liquidation date) and, if applicable, the per participant fee by the number of participants in the investment option at year end (or the liquidation date if earlier). This will be an estimate because your plan's balance and number of participants will vary over the course of the year, so the year-end balance and number of participants may be higher or lower than the daily balance. In addition, these fees are calculated on a daily basis.

*This amount is the sum of the fund's distribution, management and other fees, which are also identified in the fund's prospectus. Please note that some of the funds available through your service contract or arrangement are funds from the Oppenheimer family of mutual funds, which are affiliated with MassMutual (The Oppenheimer Funds). These affiliated mutual funds have contracts for services with companies that are affiliated with MassMutual. The MassMutual-affiliated companies that provide these services, and are compensated in connection with those services, are listed below. For more information about these affiliated mutual funds, see the applicable fund prospectus.

MassMutual Affiliate	Services	Compensation
OppenheimerFunds Distributor, Inc.	Principal Underwriter to The Oppenheimer Funds	As Principal Underwriter paid by the Fund in the form of dealer concessions
OFI Global Asset Management, Inc.	Transfer Agent to The Oppenheimer Funds	Paid by the Fund in the form of fees for services
Shareholder Services, Inc. (doing business as OppenheimerFunds Services)	Sub-Transfer Agent to The Oppenheimer Funds	Paid by the Transfer Agent in the form of fees for services
OFI Global Asset Management, Inc.	Investment Adviser to The Oppenheimer Funds	Paid by the Fund in the form of investment advisory fees based on assets under management
OppenheimerFunds, Inc.	Sub-Adviser to The Oppenheimer Funds	Paid by the Investment Adviser in the form of investment advisory fees based on assets under management

Recipient: LPL FINANCIAL LLC EIN: 95-2834236

Service Codes:

Please contact your Service Provider for the list of applicable services performed and Service Codes.

Direct Compensation

\$0.00

Our records indicate that this recipient did not receive any Direct Compensation. Please review your records to determine whether this service provider may have received any compensation not reported.

Indirect Compensation

* **Sales commission** Payor: Massachusetts Mutual Life Insurance Company EIN: 04-1590850 **\$2,964.71**
 * Sales Commissions are reported on a Plan Year basis.

Non Monetary Compensation

Please note that items of nonmonetary compensation need to be reported for Schedule A or C (Form 5500) purposes if they exceed certain *de minimus* amounts. Transactions generating nonmonetary compensation may include gifts, gratuities, or certain types of in-kind benefits. MassMutual's Code of Ethics and Business Conduct generally restricts MassMutual employees from giving to or receiving gifts from customers and/or business partners having a value of over \$100, in any individual situation, without prior approval. However, it is possible that one or more of your service providers for the 2014 calendar year, including MassMutual, engaged in transactions generating nonmonetary compensation. Information concerning reportable transactions undertaken between or among non-MassMutual parties may not be available to MassMutual.

Please consult with your legal or tax advisors if you have any questions.

Recipient: Morningstar Associates, LLC EIN: 36-4317381

Service Code: 49

Indirect Compensation

"Managed by You" services fee Payor: Massachusetts Mutual Life Insurance Company EIN: 04-1590850 **\$16.36**

This is an estimate determined by dividing a flat annual fee paid to Morningstar by the number of plans to whom this feature is made available.

Recipient: Reliance Trust Company EIN: 58-1428634

Indirect Compensation

Trust Service Fee (if Reliance Trust Company is acting as directed trustee) **\$400.00**

Service Codes: 25, 99

Payors: Massachusetts Mutual Life Insurance Company EIN: 04-1590850
MassMutual Retirement Services, LLC EIN: 26-1589907

Recipient: Mesirow Financial Investment Management, Inc. EIN: 36-3429599

Indirect Compensation

Annual fee and basis point fee for Mesirow plan fiduciary service

Service code: 27

Payor: Massachusetts Mutual Life Insurance Company EIN: 04-1590850

MassMutual paid Mesirow an annual flat fee plus a tiered percentage of assets in total equal to 1.445 bps of the aggregate assets of all participating plans in the Fiduciary Assure Program with respect to Mesirow's investment advisory services.

Direct Revenue Detail

Recipient: *Massachusetts Mutual Life Insurance Company*

<u>Fee Description</u>	<u>Dollar Amount</u>
Loan Set-up Fee	\$300.00
Holding Account: Internal Fee	\$10.94
One-Time Distribution Fee	\$509.09
Loan Administration Fee	\$168.00
Ad-Hoc Fee	\$1,229.06
Total Direct Revenue:	<hr/> \$2,217.09
 Grand Total Direct Fees:	 <hr/> \$2,217.09

American Health Imaging, Inc. 401(k) Profit Sharing Plan
EIN #58-2329279
Plan #001

Schedule of Assets (Held at End of Year) (Schedule H, Line 4i)
December 31, 2014

(a)	(b)	(c)	(e)
Identity of issuer, borrower, lessor or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Current Value	
* PIMCO TOTAL RETURN FUND R	Pooled Separate Account	\$ 45,055	
* FRANKLIN TEMPLETON CONSERVATIVE ALLOCATION FUND R	Pooled Separate Account	12,898	
* FRANKLIN TEMPLETON GROWTH ALLOCATION FUND R	Pooled Separate Account	29,433	
* FRANKLIN TEMPLETON MODERATE ALLOCATION FUND R	Pooled Separate Account	13,550	
* SELIGMAN GLOBAL TECHNOLOGY FUND R	Pooled Separate Account	91,594	
* INVESCO REAL ESTATE FUND R	Pooled Separate Account	119,232	
* OPPENHEIMER INTERNATIONAL BOND FUND N	Pooled Separate Account	135,999	
* PIMCO REAL RETURN FUND R	Pooled Separate Account	10,354	
* PIONEER STRATEGIC INCOME FUND R	Pooled Separate Account	129,111	
* BLACKROCK GLOBAL ALLOCATION FUND R	Pooled Separate Account	96,677	
* ROYCE VALUE FUND R	Pooled Separate Account	113,129	
* RIDGEWORTH SMALL CAP VALUE EQUITY FUND A	Pooled Separate Account	43,854	
* VICTORY ESTABLISHED VALUE FUND R	Pooled Separate Account	2,254	
* RIDGEWORTH MID-CAP VALUE EQUITY FUND A	Pooled Separate Account	41,489	
* AMERICAN CENTURY EQUITY INCOME FUND R	Pooled Separate Account	64,346	
* VICTORY SMALL COMPANY OPPORTUNITY FUND R	Pooled Separate Account	29,153	
* LORD ABBETT FUNDAMENTAL EQUITY FUND R3	Pooled Separate Account	93,121	
* EATON VANCE WORLDWIDE HEALTH SCIENCES FUND R	Pooled Separate Account	2,706	
* LA DEVELOPING GROWTH R3	Pooled Separate Account	17,032	
* MFS INTL VALUE R2	Pooled Separate Account	66,516	
* JPMORGAN PRIME MM CASHMGT	Pooled Separate Account	513,877	
* AMCENT GROWTH R	Pooled Separate Account	180,515	
* OPPENHEIMER DEV MKTS N	Pooled Separate Account	232,046	
Total assets at fair value		2,083,941	
* Participant loans	Interest rates ranging from 3.25% to 5.25%; varying maturities	9,081	
Total		<u>\$ 2,093,022</u>	

NOTE: Cost information is not required for participant-directed investments and, therefore, not included.

* Party-in-interest.

See Independent Auditor's Report.