

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 24pt; font-weight: bold;">2014</div> This Form is Open to Public Inspection
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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>VAN WERT COUNTY HOSPITAL 401K PLAN</u>		1b Three-digit plan number (PN) ▶	<u>002</u>
			1c Effective date of plan	<u>08/01/1999</u>
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)	<u>VAN WERT COUNTY HOSPITAL ASSOCIATION</u>		2b Employer Identification Number (EIN)	<u>34-4429514</u>
	<u>1250 S WASHINGTON ST</u> <u>VAN WERT, OH 45891</u>		2c Plan Sponsor's telephone number	<u>419-238-8609</u>
			2d Business code (see instructions)	<u>622000</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.	10/14/2015	MICHAEL HOLLIDAY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2015	MICHAEL HOLLIDAY
	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)
<u>AMERICAN UNITED LIFE INSURANCE CO.</u> <u>AMERICAN UNITED LIFE INSURANCE CO.</u> <u>ONE AMERICAN SQUARE, PO BOX 368</u> <u>INDIANAPOLIS, IN 46206-0368</u>			<u>800-261-9618</u>

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name VAN WERT COUNTY HOSPITAL	4b EIN 34-4429514 4c PN 002
5 Total number of participants at the beginning of the plan year	5 377
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) 55
a(2) Total number of active participants at the end of the plan year	6a(2) 73
b Retired or separated participants receiving benefits	6b 0
c Other retired or separated participants entitled to future benefits.....	6c 47
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 120
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 1
f Total. Add lines 6d and 6e	6f 121
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 121
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h 1
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 2K 2T 3D 2J	
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>2</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
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For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan VAN WERT COUNTY HOSPITAL 401K PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 VAN WERT COUNTY HOSPITAL ASSOCIATION	D Employer Identification Number (EIN) 34-4429514

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.
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1 Coverage Information:

(a) Name of insurance carrier

AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0145825	60895	G62325	92	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
47880	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

NFP INS SERVICES INC
1250 S CAPITAL OF TEXAS HWY
STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
47880	0 N/A		3

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

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

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

Schedule A (Form 5500) 2014
v. 140124

(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	450865
5 Current value of plan's interest under this contract in separate accounts at year end	5	13249487

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☒ other ▶ **GROUP ANNUITY CONTRACT**

b Balance at the end of the previous year.....	7b	0
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c Additions: (1) Contributions deposited during the year.....	7c(1)	8324	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	7672	
(4) Transferred from separate account.....	7c(4)	40921	
(5) Other (specify below)	7c(5)	579464	
▶ LOAN REPAYMENT TRANSFER FROM OUTSIDE SOURCE			

(6) Total additions.....	7c(6)	636381
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d Total of balance and additions (add lines 7b and 7c(6))	7d	636381
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	73513	
(2) Administration charge made by carrier	7e(2)	824	
(3) Transferred to separate account.....	7e(3)	111179	
(4) Other (specify below)	7e(4)	0	
▶			

(5) Total deductions.....	7e(5)	185516
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	450865
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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. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> 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 VAN WERT COUNTY HOSPITAL 401K PLAN	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 VAN WERT COUNTY HOSPITAL ASSOCIATION	D Employer Identification Number (EIN) 34-4429514	

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.
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1 Coverage Information:

(a) Name of insurance carrier

AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-0145825	60895	G36148	0	01/01/2014	06/30/2014

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
0	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

(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	

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

Schedule A (Form 5500) 2014
v. 140124

(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	0

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☒ other ▶ **GROUP ANNUITY CONTRACT**

b Balance at the end of the previous year	7b	577760
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c Additions: (1) Contributions deposited during the year	7c(1)	0	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	342	
(4) Transferred from separate account	7c(4)	0	
(5) Other (specify below)	7c(5)	0	

(6) Total additions	7c(6)	342
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d Total of balance and additions (add lines 7b and 7c(6))	7d	578102
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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)	578102	

(5) Total deductions	7e(5)	578102
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	0
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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. ▶

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		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 VAN WERT COUNTY HOSPITAL 401K PLAN	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 VAN WERT COUNTY HOSPITAL ASSOCIATION	D Employer Identification Number (EIN) 34-4429514	

Part I	Service Provider Information (see instructions)
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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 AMERICAN UNITED LIFE INSURANCE CO 35-0145825
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(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

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

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

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

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

AMERICAN UNITED LIFE INSURANCE CO

35-0145825

(b) Service Code(s)	(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 64 37 50 52 59 60 63 66 67	NONE	2009	Yes ☒ No ☐	Yes ☐ No ☒	88543	Yes ☒ No ☐

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

RT JONES CAPITAL EQUITIES MGMT INC

20-1090152

(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?
26 27 28 50 51	NONE	39074	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	66 67	88543
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN UNITED LIFE INSURANCE CO 35-0145825	ASSET CHARGE	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN CENTURY INVESTMENTS 20-2036524	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN FUNDS 95-1411037	REVENUE SHARING FORMULA - SEE ATTACHED	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
COLUMBIA MGMT INVESTMENT ADVISORS 04-3156901	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
FIDELITY INVESTMENTS 04-2270522	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
FIRST AMERICAN FUNDS 41-2003732	REVENUE SHARING FORMULA - SEE ATTACHED	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
FRANKLIN TEMPLETON INVESTMENTS 94-3382187	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
FRED ALGER & COMPANY INC 13-2510833	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
GOLDMAN SACHS ASSET MANAGEMENT 13-4166989	REVENUE SHARING FORMULA - SEE ATTACHED	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.
INVESCO 74-1881364	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.
JANUS CAPITAL GROUP INC 75-3019319	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.
LORD ABBETT FUNDS 13-5620131	REVENUE SHARING FORMULA - SEE ATTACHED

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
MARSHALL FUNDS INC. 39-1186267	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
ONEAMERICA FUNDS INC. 35-0145825	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
OPPENHEIMER FUNDS INC. 13-2527171	REVENUE SHARING FORMULA - SEE ATTACHED	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.
PIMCO 06-1349805	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.
PIONEER INVESTMENTS 13-1961193	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.
PRUDENTIAL INVESTMENTS 22-3468527	REVENUE SHARING FORMULA - SEE ATTACHED

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
RIDGEWORTH 58-1604573	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
RUSSELL INVESTMENT COMPANY 91-1175092	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
STATE STREET INSTITUTIONAL TRUST 04-2456637	REVENUE SHARING FORMULA - SEE ATTACHED	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
T ROWE PRICE 52-1184650	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	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.	
THORNBURG INVESTMENT MANAGEMENT 85-0301299	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III **Termination Information on Accountants and Enrolled Actuaries (see instructions)**
(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 <div style="border: 1px solid black; text-align: center; padding: 5px; font-weight: bold; font-size: 1.2em;">2014</div> This Form is Open to Public Inspection.
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For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014		
A Name of plan VAN WERT COUNTY HOSPITAL 401K PLAN	B Three-digit plan number (PN) ►	002
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 VAN WERT COUNTY HOSPITAL ASSOCIATION	D Employer Identification Number (EIN) 34-4429514	

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

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT II		
b Name of sponsor of entity listed in (a): AMERICAN UNITED LIFE INSURANCE CO		
c EIN-PN 35-0145825-000	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 13249525
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)**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>VAN WERT COUNTY HOSPITAL 401K PLAN</u>		B Three-digit plan number (PN) ► <u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>VAN WERT COUNTY HOSPITAL ASSOCIATION</u>		D Employer Identification Number (EIN) <u>34-4429514</u>

Part I Asset and Liability Statement			
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....	1b(1)	0	38
(2) Participant contributions.....	1b(2)	0	0
(3) Other.....	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	0	0
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common.....	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property).....	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans.....	1c(8)	234899	203056
(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)	0	0
(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)	13200334	13249487
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	577760	450865
(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)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	14012993	13903446

Liabilities

g Benefit claims payable	1g	0	0
h Operating payables	1h	0	0
i Acquisition indebtedness	1i	0	0
j Other liabilities	1j	0	0
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	14012993	13903446
---	-----------	----------	----------

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)	214837	
(B) Participants	2a(1)(B)	0	
(C) Others (including rollovers)	2a(1)(C)	0	
(2) Noncash contributions	2a(2)	0	
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		214837

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)	0	
(C) Corporate debt instruments	2b(1)(C)	0	
(D) Loans (other than to participants)	2b(1)(D)	0	
(E) Participant loans	2b(1)(E)	10790	
(F) Other	2b(1)(F)	8014	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		18804

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

(3) Rents	2b(3)		0
-----------------	--------------	--	---

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

(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	0	
(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)		0
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		734958
c Other income.....	2c		0
d Total income. Add all income amounts in column (b) and enter total.....	2d		968599

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	1024289	
(2) To insurance carriers for the provision of benefits.....	2e(2)	0	
(3) Other.....	2e(3)	0	
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		1024289
f Corrective distributions (see instructions).....	2f		14774
g Certain deemed distributions of participant loans (see instructions).....	2g		0
h Interest expense.....	2h		0
i Administrative expenses: (1) Professional fees.....	2i(1)	0	
(2) Contract administrator fees.....	2i(2)	41840	
(3) Investment advisory and management fees.....	2i(3)	0	
(4) Other.....	2i(4)	0	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		41840
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		1080903

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		-112304
l Transfers of assets:			
(1) To this plan.....	2l(1)		2783
(2) From this plan.....	2l(2)		26

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: BLUE & CO., LLC

(2) EIN: 35-1178661

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	
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.	X		

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

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

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)
VAN WERT COUNTY HOSPITAL TAX DEFERRED 403B PLAN	34-4429514	008

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

<div>SCHEDULE R (Form 5500) <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>		<div>Retirement Plan Information</div> <div>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).</div> <div>▶ File as an attachment to Form 5500.</div>		<div>OMB No. 1210-0110</div> <div>2014</div> <div>This Form is Open to Public Inspection.</div>	
For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014					
A Name of plan VAN WERT COUNTY HOSPITAL 401K PLAN				B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 VAN WERT COUNTY HOSPITAL ASSOCIATION				D Employer Identification Number (EIN) 34-4429514	
Part I Distributions					
All references to distributions relate only to payments of benefits during the plan year.					
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....				1	0
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 35-0145825					
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.					
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....				3	
Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)					
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?..... ☐ Yes ☐ No ☐ N/A					
If the plan is a defined benefit plan, go to line 8.					
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____					
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.					
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived).....				6a	
b Enter the amount contributed by the employer to the plan for this plan year.....				6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)				6c	
If you completed line 6c, skip lines 8 and 9.					
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?..... ☐ Yes ☐ No ☐ N/A					
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?..... ☐ Yes ☐ No ☐ N/A					
Part III Amendments					
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... ☐ Increase ☐ Decrease ☐ Both ☐ No					
Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.					
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ☐ Yes ☐ No					
11 a Does the ESOP hold any preferred stock? ☐ Yes ☐ No					
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)..... ☐ Yes ☐ No					
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?..... ☐ Yes ☐ No					
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.					
Schedule R (Form 5500) 2014 v. 140124					

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): _____

**VAN WERT COUNTY HOSPITAL
401(k) PLAN**

**FINANCIAL STATEMENTS AND
SUPPLEMENTAL SCHEDULE**

DECEMBER 31, 2014 AND 2013

CPAs / ADVISORS



VAN WERT COUNTY HOSPITAL
401(k) PLAN

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REPORT OF INDEPENDENT AUDITORS

To the Board of Trustees
The Van Wert County Hospital 401(k) Plan
Van Wert, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of the Van Wert County Hospital 401(k) 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 the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the *Basis for Disclaimer 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 4, which was certified by American United Life Insurance Company, the trustee of the Plan, except for comparing the information with the related information included in the financial statements. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2014 and 2013, that the information provided to the plan administrator by the trustee is complete and accurate.

Disclaimer of Opinion

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

Other Matter

The supplemental schedule of Assets Held at End of Year is required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and is presented for 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 schedules referred to above.

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

The form and content of the information included in the financial statements and supplemental schedule, other than that derived from the investment information certified by the trustee, 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.

Blue: Co., LLC

Columbus, Ohio
October 9, 2015

VAN WERT COUNTY HOSPITAL
401(k) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2014 AND 2013

	<u>2014</u>	<u>2013</u>
Assets		
Investments		
Insurance contract, at contract value	\$ 450,865	\$ 577,760
Pooled separate accounts, at fair value	<u>13,249,487</u>	<u>13,200,334</u>
Total investments	<u>13,700,352</u>	<u>13,778,094</u>
Receivables		
Employer contributions	38	-
Participant loans	<u>203,056</u>	<u>234,899</u>
Total receivables	<u>203,094</u>	<u>234,899</u>
Net assets available for benefits	<u><u>\$ 13,903,446</u></u>	<u><u>\$ 14,012,993</u></u>

See accompanying notes to financial statements.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEAR ENDED DECEMBER 31, 2014

	<u>2014</u>
Additions	
Net appreciation in fair value of investments	\$ 734,958
Interest income from participant loans	10,790
Dividends and interest	8,014
Transfers in	2,783
Employer contributions	<u>214,837</u>
Total additions	971,382
 Deductions	
Benefit payments	1,039,063
Administrative expense	41,840
Transfers Out	<u>26</u>
Total deductions	<u>1,080,929</u>
 Net change	(109,547)
 Net assets available for benefits at beginning of year	<u>14,012,993</u>
Net assets available for benefits at end of year	<u><u>\$ 13,903,446</u></u>

See accompanying notes to financial statements.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

1. DESCRIPTION OF THE PLAN

General

The Van Wert County Hospital 401(k) Plan (the Plan), is a defined contribution plan covering eligible employees of The Van Wert County Hospital Association (the Hospital). Employees are eligible to participate in the Plan upon attainment of age 21. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Participants should refer to the Summary Plan Description for more complete information regarding the provisions of the Plan, a copy of which is available from the Hospital.

Contributions

Prior to January 1, 2014, participants were able to make contributions to the Plan, subject to certain limitations. Effective January 1, 2014 participants are no longer able to make contributions to the plan. In 2014 the Hospital made a profit sharing contribution of 2% for each participant based on their eligible wages. In 2013 the Hospital made a matching contribution of 50% of the first 2% contributed by the participants.

Participants Accounts

Each participant's account is credited with the participant's contribution, prior to 2014, and allocations of (a) the Hospital's contributions, (b) Plan earnings (losses), and charged with an allocation of administrative expenses paid by the Plan. Allocations are based on participant's earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's account.

Vesting

Participants are immediately vested in their contribution plus actual earnings thereon. Vesting in the Hospital contributions portion of their accounts plus actual earnings thereon is based on years of credited service. A participant is 100% vested after three years, with no vesting prior to three years of service. A participant or his or her beneficiary is immediately vested in his or her account upon death, retirement or termination of employment due to total permanent disability. Forfeitures of account balances by participants not fully vested are applied against Hospital contributions.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

Payment of Benefits

On termination, a participant will receive a lump sum amount or joint and survivor annuity, equal to the value of the participant's vested interest in his or her account.

Participant Loans

Participants may borrow a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their vested balance. Loan terms range from 1 to 5 years or up to 30 years for the purchase of a primary residence. The loans are secured by the balance in the participant's account. Interest is calculated at a rate commensurate with loans from the trustee/record-keeper and at local prevailing rates as determined by the Plan's Administrator. Principal and interest is paid ratably through monthly payroll deductions. Loans that become in default status are treated as distributions to the participants.

Forfeitures

Forfeitures represent the non-vested portion of the Hospital contributions plus earnings thereon, which are not distributed to participants who terminate employment before they are 100% vested. In the event a terminated employee is not reemployed within five consecutive one year breaks in service, such forfeitures may be used to reduce the Hospital's contributions to the Plan. At December 31, 2014 and 2013, forfeited non-vested accounts totaled \$998 and \$7,672, respectively. Forfeitures used during 2014 and 2013 were \$8,034 and \$32,094, respectively. These accounts are used to reduce employer contributions.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with the accounting principles generally accepted in the United States of America.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America require the Hospital to make estimates and assumptions that affect certain reported amounts and disclosures. Actual results could differ from those estimates.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

Investment Valuation and Income Recognition

The Plan's 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. See Note 3 for discussion of fair value measurements.

Investment contracts held by a defined contribution plan are required to be reported at fair value. However, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined contribution plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants would receive if they were to initiate permitted transactions under the terms of the plan. Typically, the Statement of Net Assets Available for Benefits presents the fair value of the investment contracts as well as the adjustment of the fully benefit-responsive investment contract. However, as the contract value of these contracts approximates their fair values, no adjustment is considered necessary at December 31, 2014 and 2013.

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

Participant Loans

Loans 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 charged directly to the borrowing participant's account and are included in administrative expenses when incurred. As of December 31, 2014 and 2013, no allowance for credit losses has been recorded. If a participant does not make loan repayments and the Plan's administrator considers the participant loan to be in default, the loan balance is reduced, and the delinquent participant loan is recorded as a benefit payment based on the terms of the Plan document.

Operating Expenses

Expenses of maintaining the Plan may be paid by the Hospital or the Plan at the Hospital's discretion.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

Subsequent Events

The Plan has evaluated events or transactions occurring subsequent to the statement of net assets available for benefits date for recognition and disclosure in the accompanying financial statements through the date the financial statements are available to be issued which is October 9, 2015.

3. FAIR VALUE OF FINANCIAL INSTRUMENTS

Fair Value Measurement

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 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.

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.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

To assess the appropriate classification of investments within the fair value hierarchy, the availability of market data is monitored. Changes in economic conditions or valuation techniques may require the transfer of investments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. We evaluate the significance of transfers between levels based upon the nature of the investment and size of the transfer relative to total net assets available for benefits. For the year ended December 31, 2013, there was one transfer into Level 3. There were no such transfers for the year ended December 31, 2014. Transfers into Level 3 from Level 2 were made due to the absence of observable market data. No other transfers between Levels occurred in 2014 and 2013.

Following is a description of the valuation methodologies used for assets measured at fair value as of December 31, 2014 and 2013:

Pooled separate accounts: Represents accumulation units and the value is based on the underlying share values adjusted for dividends, distributions and the daily equivalent of any fee charged by the trustee. The value of each accumulation unit is published each day. Each investment account is exclusively invested in shares of a specific mutual fund as directed by the participant (Level 2).

Insurance contracts: Valued at fair value by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the credit-worthiness of the issuer (Level 3).

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

**VAN WERT COUNTY HOSPITAL
401(k) PLAN**

**NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013**

Assets measured at fair value on a recurring basis as of December 31, 2014 are as follows:

	Level 1	Level 2	Level 3	Total
Insurance contract	\$ -	\$ -	\$ 450,865	\$ 450,865
Pooled separate accounts:				
Small Cap	-	1,827,578	-	1,827,578
Mid Cap	-	2,237,202	-	2,237,202
Large Cap	-	4,528,426	-	4,528,426
Fixed Income	-	4,049,925	-	4,049,925
International	-	324,723	-	324,723
Balanced	-	281,633	-	281,633
Total assets at fair value	<u>\$ -</u>	<u>\$ 13,249,487</u>	<u>\$ 450,865</u>	<u>\$ 13,700,352</u>

Assets measured at fair value on a recurring basis as of December 31, 2013 are as follows:

	Level 1	Level 2	Level 3	Total
Insurance contract	\$ -	\$ -	\$ 577,760	\$ 577,760
Pooled separate accounts:				
Small Cap	-	2,393,401	-	2,393,401
Mid Cap	-	3,349,330	-	3,349,330
Large Cap	-	3,912,797	-	3,912,797
Fixed Income	-	2,874,720	-	2,874,720
International	-	319,261	-	319,261
Balanced	-	350,825	-	350,825
Total assets at fair value	<u>\$ -</u>	<u>\$ 13,200,334</u>	<u>\$ 577,760</u>	<u>\$ 13,778,094</u>

The following table sets forth the Plan's assets that are carried at fair value on a recurring basis, classified within Level 3 of the valuation hierarchy for the years ended December 31, 2014 and 2013:

	2014	2013
Beginning balance	\$ 577,760	\$ -
Contributions, net exchanges	290	11,908
Transfer in to level 3	-	719,164
Interest income	8,014	10,228
Sales, repayment settlements net	(135,199)	(163,540)
Ending balance	<u>\$ 450,865</u>	<u>\$ 577,760</u>

The fair value of the insurance contract is based on significant unobservable inputs, including the credit worthiness of the issuer, American United Life Insurance Company (AUL) and the terms of the contract. Significant fluctuations in any of the inputs in isolation could result in a significantly different fair value measurement.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

4. INVESTMENTS

The Plan has investments managed by AUL (trustee) whereby all the Hospital contributions are remitted to the trustee and invested. The accounts are credited with actual earnings on the underlying investments and charged for plan withdrawals. The plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the plan administrator has obtained certifications from the trustee of the Plan that all the information provided by them is complete and accurate. Information included in the accompanying financial statements as to investments, interest income, net appreciation in investments and all information in the supplemental schedule is presented in reliance solely upon those certifications.

The following table presents investments representing 5% or more of the Plan's assets:

	2014	2013
Pioneer Bond	\$ 2,260,011	*
Goldman Sachs Mid-Cap Value	1,613,834	1,873,490
Goldman Sachs Small-Cap Value	1,296,853	1,681,961
T. Rowe Price Equity-Income	1,151,778	*
American Century Ginnie Mae	949,124	1,267,693
T. Rowe Price Retirement 2025	777,433	*
American Century Real Estate	*	784,892
PIMCO Total Return	*	1,402,848
Russell Lifepoints 2025 Strategy	*	744,573

* Less than 5% of net assets available for benefits.

The following table presents investment income for the year ended December 31, 2014. This information has been certified as complete and accurate by the trustee of the Plan.

	2014
Net appreciation in fair value of investments - pooled separate accounts	\$ 734,958
Dividends and Interest	8,014
Total investment income	<u>\$ 742,972</u>

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

Insurance Contracts

The Plan has a benefit-responsive investment contract with AUL. AUL maintains the investments in the original fixed fund contract. This account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The contract is included in the financial statements at contract value, which is an appropriate determination of fair value for the contract as reported to the Plan by AUL. Contract value represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

American United Life Insurance Contracts – This is a common/collective trust which invests primarily in a diversified portfolio of insurance company contracts. The contracts are as follows:

- For insurance contract #G36148 fixed fund, the average yield was 1.50% for 2014 and the crediting interest rate as of December 31, 2014 was 1.50%.

Crediting interest rates are determined by dividing earned income for the day by the new contract value. On December 31, 2014 and 2013, fair value approximates contract value and there are no valuation reserves.

The Plan has a benefit-responsive investment contract with American United Life Insurance Company ("AUL"). AUL maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan.

Because the investment contracts are fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the net assets available for benefits attributable to the investment contract. Contract value represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on an agreed-upon formula with the issuer, but cannot be less than 1% as of December 31, 2014. Such interest rates are reviewed on an annual basis for resetting.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

Certain events limit the ability of the Plan to transact at contract value with AUL. Such events include the following: (a) amendments to the plan documents (including complete or partial plan termination or merger with another plan), (b) changes to the plan's prohibition on competing investment options or deletion of equity wash provisions, (c) bankruptcy of the plan sponsor or other plan sponsor events (for example, divestitures or spin-offs of a subsidiary) that cause a significant withdrawal from the plan, or (d) transaction exemption under ERISA. The Plan administrator does not believe that any events that would limit the Plan's ability to transact at contract value with Plan participants are probable of occurring.

The investment contracts do not permit the insurance company to terminate the agreements prior to the scheduled maturity dates.

5. INCOME TAX STATUS

The Internal Revenue Service (IRS) has determined and informed the Hospital by a letter dated March 31, 2008, that the Plan and related trust are designed in accordance with application sections of the Internal Revenue Code (Code). Although the Plan has been amended since the date of the letter, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the requirements of the Code.

Accounting principles generally accepted in the United States of America required 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 various federal and state taxing authorities. Management has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2014 and 2013, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the accompanying financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes it is no longer subject to income tax examinations for years prior to 2012.

6. TRANSACTIONS WITH PARTIES-IN-INTEREST

Certain Plan investments and shares of mutual funds are managed by American United Life Insurance Company (AUL). AUL is the trustee of the Plan. Blue & Co. serves as the Plan's auditor. These transactions qualify as party-in-interest transactions.

VAN WERT COUNTY HOSPITAL
401(k) PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

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 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.

8. PLAN TERMINATION

Although it has not expressed any intent to do so, the Hospital 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 will become fully vested in their accounts.

Supplemental Schedule

VAN WERT COUNTY HOSPITAL
401(k) PLAN

EIN: 34-4429514 Plan Number: 002

SCHEDULE H, PART IV, LINE 4i
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2014

(a)	(b)	(c)	(d)	(e)
	Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Fair Value
*	American United Life Insurance Company	American United Life Fixed Account	**	\$ 450,865
*	American United Life Insurance Company Pooled Separate Accounts:	Alger Capital Appreciation Instl	**	114,001
		American Century Equity Income	**	131,756
		American Century Ginnie Mae	**	949,124
		American Century Heritage	..	66,988
		American Century Mid-Cap Value	..	183,575
		American Century Real Estate	**	9,991
		American Century Small-Cap Value	**	1,869
		American Funds Europacific Growth	**	252,199
		American Funds Fundamental Investors	..	212,047
		BMO Small-Cap Growth Fund	**	28,568
		Franklin Flex Cap Growth	**	240,928
		Goldman Sachs Mid-Cap Value	**	1,613,834
		Goldman Sachs Small-Cap Value	**	1,296,853
		Invesco Small-Cap Growth	**	481,323
		Janus Balanced	**	280,539
		Lord Abbett Value Opportunities	**	40,909
		Nuveen Midcap Growth Ops	**	176,381
		Nuveen Midcap Index	**	273
		Nuveen Small Cap Index	**	18,965
		One America Asset Director	**	2,013
		Oppenheimer Global Fund	**	72,524
		PIMCO Total Return	**	147,704
		Pioneer Bond	**	2,260,011
		Prudential High-Yield	**	31,694
		Prudential Jennison Mid-Cap Growth	**	125,342
		Prudential Total Return Bond	**	340,950
		Ridgeworth High Income	..	52,406
		Ridgeworth Large-Cap Value	**	44,643
		Ridgeworth Mid-Cap Value	**	19,909
		State St Equity 500 Index	**	305,286

See accompanying report of independent auditors

VAN WERT COUNTY HOSPITAL
401(k) PLAN

EIN: 34-4429514 Plan Number: 002

SCHEDULE H, PART IV, LINE 4i
SCHEDULE OF ASSETS HELD AT END OF YEAR
DECEMBER 31, 2014

(a)	(b)	(c)	(d)	(e)
	Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Fair Value
		T. Rowe Price Equity-Income	**	1,151,778
		T. Rowe Price Retirement Balanced	**	1,094
		T. Rowe Price Retirement 2015	**	166,135
		T. Rowe Price Retirement 2020	**	62,137
		T. Rowe Price Retirement 2025	**	777,433
		T. Rowe Price Retirement 2030	**	331,644
		T. Rowe Price Retirement 2035	**	443,655
		T. Rowe Price Retirement 2040	**	240,373
		T. Rowe Price Retirement 2045	**	144,927
		T. Rowe Price Retirement 2050	**	140,772
		T. Rowe Price Retirement 2055	**	18,898
		Thornburg Limited-Term Income	**	268,036
		Total pooled separate accounts		13,249,487
	Loans receivable	Participant loans receivable, 5% - 6% with maturity dates ranging from 4/9/16 - 9/14/19	-0-	203,056
				\$ 13,903,408

* Indicates parties-in-interest to the Plan.

** All investments are participant directed; therefore, historical cost information is not required.

See accompanying report of independent auditors

Schedule C Attachment for Line Item 3(e)

Plan Name **G62325 VAN WERT COUNTY HOSPITAL 401K PLAN**

Plan Number **002** **Plan Year End** **12/31/2014**

EIN **34-4429514**

Revenue Sharing Formula:

The investment options of the Plan include various portfolios within an AUL separate account. The separate account in turn invests in investment portfolios of certain open-end management investment companies. AUL receives indirect compensation from these investment companies for the services provided by AUL.

The compensation received by AUL is computed by each investment company by multiplying the daily account balance of the AUL separate account's interest in a particular portfolio by a predetermined percentage rate negotiated with the investment company. This indirect compensation is not charged to the plan or participants accounts but is paid directly by the investment company.

The investment company, the underlying investment portfolio, and the annual compensation percentages are shown below.

Investment Company	Investment Portfolio	Annual Percentage
AMERICAN CENTURY INVESTMENTS	AmerCent MidCap Val A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent Ginnie Mae A	0.50
AMERICAN CENTURY INVESTMENTS	AmerCent Heritage A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent Eqty Inc A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent RealEstate A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent SmCap Val A	0.60
AMERICAN FUNDS	AmerFds EuroPac Grth R3	0.60
AMERICAN FUNDS	AmerFds Fdamental Invs R3	0.60
COLUMBIA MGMT INVESTMENT ADVISORS	Columbia Seligman Com & Info A	0.50
FIDELITY INVESTMENTS	Fidelity Adv SmCap T	0.75
FIRST AMERICAN FUNDS	Nuveen MidCap Indx R3	0.65
FIRST AMERICAN FUNDS	Nuveen MidCap Grth Ops R3	0.75
FIRST AMERICAN FUNDS	Nuveen SmCap Index R3	0.65
FRANKLIN TEMPLETON INVESTMENTS	Franklin Flex Cap Grth R	0.65
FRED ALGER & COMPANY, INC	Alger Cap App Inst R	0.75

Investment Company	Investment Portfolio	Annual Percentage
GOLDMAN SACHS ASSET MANAGEMENT	GoldmanSachs MidCap Val S	0.60
GOLDMAN SACHS ASSET MANAGEMENT	GoldmanSachs SmCapVal Svc	0.60
GOLDMAN SACHS ASSET MANAGEMENT	GoldmanSachs Tollkeeper Svc	0.60
INVESCO	Invesco SmCap Grth R	0.75
JANUS CAPITAL GROUP, INC	Janus Balanced R	0.75
LORD ABBETT FUNDS	Lord Abbett Val Ops R3	0.65
MARSHALL FUNDS INC.	BMO SmCap Grth Y	0.40
ONEAMERICA FUNDS INC.	OneAmerica Asset Director Adv	0.30
OPPENHEIMER FUNDS INC.	Oppenheimer Global A	0.50
PIMCO	PIMCO Total Return R	0.60
PIONEER INVESTMENTS	Pioneer Bond A	0.60
PRUDENTIAL INVESTMENTS	Prudential Jenn Midcap Grth A	0.55
PRUDENTIAL INVESTMENTS	Prudential High-Yield A	0.55
PRUDENTIAL INVESTMENTS	Prudential Total Return Bond A	0.55
RIDGEWORTH	RidgeWorth LarCap ValEqty A	0.60
RIDGEWORTH	RidgeWorth MidCapVal Eqty A	0.60
RIDGEWORTH	RidgeWorth High Inc R	0.60
RUSSELL INVESTMENT COMPANY	Russell LP In Ret Fd R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2020 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2030 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2040 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2050 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2055 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2015 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2025 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2035 Strat FD R5	0.70
RUSSELL INVESTMENT COMPANY	Russell LP 2045 Strat FD R5	0.70
STATE STREET INSTITUTIONAL TRUST	State St Eqty 500 Indx R	0.60
T ROWE PRICE	TRowePrice Ret 2005 R	0.65
T ROWE PRICE	TRowePrice Ret 2010 R	0.65

Investment Company	Investment Portfolio	Annual Percentage
T ROWE PRICE	TRowePrice Ret 2015 R	0.65
T ROWE PRICE	TRowePrice Ret 2020 R	0.65
T ROWE PRICE	TRowePrice Ret 2025 R	0.65
T ROWE PRICE	TRowePrice Ret 2030 R	0.65
T ROWE PRICE	TRowePrice Ret 2035 R	0.65
T ROWE PRICE	TRowePrice Ret 2040 R	0.65
T ROWE PRICE	TRowePrice Ret 2045 R	0.65
T ROWE PRICE	TRowePrice Ret 2050 R	0.65
T ROWE PRICE	TRowePrice Ret 2055 R	0.65
T ROWE PRICE	TRowePrice Eqty Inc R	0.65
T ROWE PRICE	TRowePrice Ret Bal R	0.65
THORNBURG INVESTMENT MANAGEMENT	Thornburg Intl Val R3	0.70
THORNBURG INVESTMENT MANAGEMENT	Thornburg Ltd-Term Inc R3	0.55

Plan Type 1 401PS

Attachment to 2014 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name VAN WERT COUNTY HOSPITAL 401K PLAN

EIN: 34-4429514

Plan Sponsor's Name VAN WERT COUNTY HOSPITAL ASSOCIATION

PN: 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	FRED ALGER & COMPANY INC	ALGER CAP APP INST R MUTUAL FUND SHARES	0	114,001
	AMERICAN CENTURY INVESTMENTS	AMERCENT EQTY INC A MUTUAL FUND SHARES	0	131,756
	AMERICAN CENTURY INVESTMENTS	AMERCENT GINNIE MAE A MUTUAL FUND SHARES	0	949,124
	AMERICAN CENTURY INVESTMENTS	AMERCENT HERITAGE A MUTUAL FUND SHARES	0	66,988
	AMERICAN CENTURY INVESTMENTS	AMERCENT MIDCAP VAL A MUTUAL FUND SHARES	0	183,575
	AMERICAN CENTURY INVESTMENTS	AMERCENT REALESTATE A MUTUAL FUND SHARES	0	9,991
	AMERICAN CENTURY INVESTMENTS	AMERCENT SMCAP VAL A MUTUAL FUND SHARES	0	1,869

Attachment to 2014 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name VAN WERT COUNTY HOSPITAL 401K PLAN

EIN: 34-4429514

Plan Sponsor's Name VAN WERT COUNTY HOSPITAL ASSOCIATION

PN: 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	AMERICAN FUNDS	AMERFDS EUROPAC GRTH R3 MUTUAL FUND SHARES	0	252,199
	AMERICAN FUNDS	AMERFDS FDAMENTAL INVS R3 MUTUAL FUND SHARES	0	212,047
*	AMERICAN UNITED LIFE INS CO	AUL FIXED ACCOUNT	0	450,865
	MARSHALL FUNDS INC.	BMO SMCAP GRTH Y MUTUAL FUND SHARES	0	28,568
	FRANKLIN TEMPLETON INVESTMENTS	FRANKLIN FLEX CAP GRTH R MUTUAL FUND SHARES	0	240,928
	GOLDMAN SACHS ASSET MANAGEMENT	GOLDMANSACHS MIDCAP VAL S MUTUAL FUND SHARES	0	1,613,834
	GOLDMAN SACHS ASSET MANAGEMENT	GOLDMANSACHS SMCAPVAL SVC MUTUAL FUND SHARES	0	1,296,853

Attachment to 2014 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name VAN WERT COUNTY HOSPITAL 401K PLAN

EIN: 34-4429514

Plan Sponsor's Name VAN WERT COUNTY HOSPITAL ASSOCIATION

PN: 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	INVESCO	INVESCO SMCAP GRTH R MUTUAL FUND SHARES	0	481,323
	JANUS CAPITAL GROUP INC	JANUS BALANCED R MUTUAL FUND SHARES	0	280,539
	PARTICIPANTS	LOANS 5% TO 6%	0	203,056
	LORD ABBETT FUNDS	LORD ABBETT VAL OPS R3 MUTUAL FUND SHARES	0	40,909
	FIRST AMERICAN FUNDS	NUVEEN MIDCAP GRTH OPS R3 MUTUAL FUND SHARES	0	176,381
	FIRST AMERICAN FUNDS	NUVEEN MIDCAP INDX R3 MUTUAL FUND SHARES	0	273
	FIRST AMERICAN FUNDS	NUVEEN SMCAP INDX R3 MUTUAL FUND SHARES	0	18,965

Attachment to 2014 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name VAN WERT COUNTY HOSPITAL 401K PLAN

EIN: 34-4429514

Plan Sponsor's Name VAN WERT COUNTY HOSPITAL ASSOCIATION

PN: 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
*	ONEAMERICA FUNDS INC.	ONEAMERICA ASSET DIRECTOR ADV MUTUAL FUND SHARES	0	2,013
	OPPENHEIMER FUNDS INC.	OPPENHEIMER GLOBAL A MUTUAL FUND SHARES	0	72,524
	PIMCO	PIMCO TOTAL RETURN R MUTUAL FUND SHARES	0	147,704
	PIONEER INVESTMENTS	PIONEER BOND A MUTUAL FUND SHARES	0	2,260,011
	PRUDENTIAL INVESTMENTS	PRUDENTIAL HIGH-YIELD A MUTUAL FUND SHARES	0	31,694
	PRUDENTIAL INVESTMENTS	PRUDENTIAL JENN MIDCAP GRTH A MUTUAL FUND SHARES	0	125,342
	PRUDENTIAL INVESTMENTS	PRUDENTIAL TOTAL RETURN BOND A MUTUAL FUND SHARES	0	340,950

Attachment to 2014 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name VAN WERT COUNTY HOSPITAL 401K PLAN

EIN: 34-4429514

Plan Sponsor's Name VAN WERT COUNTY HOSPITAL ASSOCIATION

PN: 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	RIDGEWORTH	RIDGEWORTH HIGH INC R MUTUAL FUND SHARES	0	52,406
	RIDGEWORTH	RIDGEWORTH LARCAP VALEQTY A MUTUAL FUND SHARES	0	44,643
	RIDGEWORTH	RIDGEWORTH MIDCAPVAL EQTY A MUTUAL FUND SHARES	0	19,909
	STATE STREET INSTITUTIONAL TRUST	STATE ST EQTY 500 INDX R MUTUAL FUND SHARES	0	305,286
	THORNBURG INVESTMENT MANAGEMENT	THORNBURG LTD-TERM INC R3 MUTUAL FUND SHARES	0	268,036
	T ROWE PRICE	TROWEPRICE EQTY INC R MUTUAL FUND SHARES	0	1,151,778
	T ROWE PRICE	TROWEPRICE RET 2015 R MUTUAL FUND SHARES	0	166,135

Attachment to 2014 Form 5500
Schedule H, line 4i - Schedule of Assets (Held at End of Year)

Plan Name VAN WERT COUNTY HOSPITAL 401K PLAN
Plan Sponsor's Name VAN WERT COUNTY HOSPITAL ASSOCIATION

EIN: 34-4429514
PN: 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value.	(d) Cost	(e) Current value
	T ROWE PRICE	TROWEPRICE RET 2020 R MUTUAL FUND SHARES	0	62,137
	T ROWE PRICE	TROWEPRICE RET 2025 R MUTUAL FUND SHARES	0	777,433
	T ROWE PRICE	TROWEPRICE RET 2030 R MUTUAL FUND SHARES	0	331,644
	T ROWE PRICE	TROWEPRICE RET 2035 R MUTUAL FUND SHARES	0	443,655
	T ROWE PRICE	TROWEPRICE RET 2040 R MUTUAL FUND SHARES	0	240,373
	T ROWE PRICE	TROWEPRICE RET 2045 R MUTUAL FUND SHARES	0	144,927
	T ROWE PRICE	TROWEPRICE RET 2050 R MUTUAL FUND SHARES	0	140,772

Plan Name	<u>VAN WERT COUNTY HOSPITAL 401K PLAN</u>	EIN:	<u>34-4429514</u>
Plan Sponsor's Name	<u>VAN WERT COUNTY HOSPITAL ASSOCIATION</u>	PN:	<u>002</u>

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