

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 2014 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 COSHOCTON COUNTY MEMORIAL HOSPITAL TAX DEFERRED ANNUITY PLAN	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;">004</td> </tr> <tr> <td colspan="2">1c Effective date of plan 01/01/1992</td> </tr> </table>	1b Three-digit plan number (PN) ▶	004	1c Effective date of plan 01/01/1992	
1b Three-digit plan number (PN) ▶	004				
1c Effective date of plan 01/01/1992					
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC. 1460 ORANGE ST COSHOCTON, OH 43812-2229	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) 31-4387577</td> </tr> <tr> <td>2c Plan Sponsor's telephone number 740-622-6411</td> </tr> <tr> <td>2d Business code (see instructions) 622000</td> </tr> </table>	2b Employer Identification Number (EIN) 31-4387577	2c Plan Sponsor's telephone number 740-622-6411	2d Business code (see instructions) 622000	
2b Employer Identification Number (EIN) 31-4387577					
2c Plan Sponsor's telephone number 740-622-6411					
2d Business code (see instructions) 622000					

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2015	SCOTT SILVERSTRI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)			Preparer's telephone number (optional)

3a Plan administrator's name and address ☐ Same as Plan Sponsor COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC. 1460 ORANGE ST COSHOCTON, OH 43812-2229	3b Administrator's EIN 31-4387577
	3c Administrator's telephone number 614-318-2200
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5 525
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) 525
a(2) Total number of active participants at the end of the plan year	6a(2) 396
b Retired or separated participants receiving benefits	6b 0
c Other retired or separated participants entitled to future benefits.....	6c 48
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 444
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e	6f 444
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 324
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h 0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2L	
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 COSHOCOTON COUNTY MEMORIAL HOSPITAL TAX DEFERRED ANNUITY PLAN	B Three-digit plan number (PN) ▶ 004
C Plan sponsor's name as shown on line 2a of Form 5500 COSHOCOTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.	D Employer Identification Number (EIN) 31-4387577

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

NATIONWIDE 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
31-4156830	66869	GAP-B2-HM60	324	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
8375	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

INVEST FINANCIAL CORPORATION
5555 GRANDE MARKET DRIVE
APPLETON, WA 54913

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3350	0	INVESTMENT	3

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

LINCOLN FINANCIAL ADVISORS CO.
1300 S. CLINTON STREET
SUITE 150
FORT WAYNE, IN 46802

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3350	0	INVESTMENT	3

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

EDWARD SOMMER

300 WEST WILSON BRIDGE ROAD
SUITE 300
WORTHINGTON, OH 43085

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1675	0	INVESTMENT	3

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

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

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

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

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

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

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

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

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	
5 Current value of plan's interest under this contract in separate accounts at year end	5	88475

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 ▶

b Balance at the end of the previous year.....	7b	1256330
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c Additions: (1) Contributions deposited during the year.....	7c(1)	154022	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	110595	
(4) Transferred from separate account.....	7c(4)	48000	
(5) Other (specify below)	7c(5)	10941	
▶ LOAN PAYMENT - PRINCIPAL			

(6) Total additions.....	7c(6)	323558
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d Total of balance and additions (add lines 7b and 7c(6))	7d	1579888
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	837267	
(2) Administration charge made by carrier	7e(2)		
(3) Transferred to separate account.....	7e(3)		
(4) Other (specify below)	7e(4)	22522	
▶ LOAN WITHDRAWALS			

(5) Total deductions.....	7e(5)	859789
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	720099
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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)	0
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110
		2014
		This Form is Open to Public Inspection

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

A Name of plan COSHOCTON COUNTY MEMORIAL HOSPITAL TAX DEFERRED ANNUITY PLAN	B Three-digit plan number (PN) ► 004
C Plan sponsor's name as shown on line 2a of Form 5500 COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.	D Employer Identification Number (EIN) 31-4387577

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

HARTFORD LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0974148	88072	GA-082390	32	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

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	
5	Current value of plan's interest under this contract in separate accounts at year end	5	
6	Contracts With Allocated Funds:		
a	State the basis of premium rates ▶		
b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. 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 VARIABLE ANNUITY		
b	Balance at the end of the previous year	7b	55459
c	Additions: (1) Contributions deposited during the year	7c(1)	
	(2) Dividends and credits	7c(2)	
	(3) Interest credited during the year	7c(3)	2128
	(4) Transferred from separate account	7c(4)	
	(5) Other (specify below)	7c(5)	
	(6) Total additions	7c(6)	2128
d	Total of balance and additions (add lines 7b and 7c(6))	7d	57587
e	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	5033
	(2) Administration charge made by carrier	7e(2)	117
	(3) Transferred to separate account	7e(3)	
	(4) Other (specify below)	7e(4)	
	(5) Total deductions	7e(5)	5150
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	52437

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) 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 <u>COSHOCTON COUNTY MEMORIAL HOSPITAL TAX DEFERRED ANNUITY PLAN</u>	B Three-digit plan number (PN) ► <u>004</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.</u>	D Employer Identification Number (EIN) <u>31-4387577</u>

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

06-0974148

(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)

NATIONWIDE

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

31-1592130

(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	RECORD KEEPER	37179	Yes ☒ No ☐	Yes ☐ No ☒	45522	Yes ☐ No ☒

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

LINCOLN FINANCIAL ADVISORS COR

1300 S. CLINTON STREET
SUITE 150
FORT WAYNE, IN 46802

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	ADVISOR	0	Yes ☒ No ☐	Yes ☐ No ☒	27719	Yes ☐ No ☒

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

INVEST FINANCIAL CORPORATION

5555 GRANDE MARKET DR
APPLETON, WI 54913

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	INVESTMENT	0	Yes ☒ No ☐	Yes ☐ No ☒	23147	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)

EDWARD D.A. SOMMER

300 WEST WILSON BRIDGE ROAD
SUITE 300
WORTHINGTON, OH 43085

(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	INVESTMENT	4229	Yes ☒ No ☐	Yes ☐ No ☒	16809	Yes ☐ No ☒

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

CLARK LANZEN SKALLA INVESTMENT FIRM

17605 WRIGHT STREET
OMAHA, NE 68130

(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?
52	INVESTMENT	6234	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

INVEST FIN CORY AGY

5555 GRANDE MARKET DRIVE
APPLETON, WI 54913

(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	INVESTMENT	0	Yes ☒ No ☐	Yes ☐ No ☒	4571	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)

HARTFORD LIFE

06-0974148

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 23 37 38 50 54 59 66 62 63 64 65 66 99	NONE	342	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

NPH

401 WILSHIRE BLVD
SUITE 1200
SANTA MONICA, CA 90401

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 28	INVESTMENT	0	Yes ☒ No ☐	Yes ☐ No ☒	209	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
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(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: SS&G, INC.	b EIN: 34-1945695
c Position: ACCOUNTANT	
d Address: 301 SPRINGSIDE DRIVE AKRON, OH 44333	e Telephone: 330-668-9696

Explanation: AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2013, THE PLAN'S FINANCIAL STATEMENTS WERE REPORTED ON BY SS&G, INC., WHOSE PRACTICE WAS COMBINED BY BDO USA, LLP EFFECTIVE JANUARY 1, 2015

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

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

(Complete as many entries as needed to report all participating plans)

a Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN**a** Plan name**b** Name of
plan sponsor**c** EIN-PN

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 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>COSHOCTON COUNTY MEMORIAL HOSPITAL TAX DEFERRED ANNUITY PLAN</u>	B Three-digit plan number (PN) ►	<u>004</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.</u>	D Employer Identification Number (EIN) <u>31-4387577</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 47
b Receivables (less allowance for doubtful accounts):	
(1) Employer contributions.....	1b(1) 0 7647
(2) Participant contributions.....	1b(2) 0 23348
(3) Other.....	1b(3)
c General investments:	
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1) 108752 184256
(2) U.S. Government securities	1c(2)
(3) Corporate debt instruments (other than employer securities):	
(A) Preferred	1c(3)(A)
(B) All other	1c(3)(B)
(4) Corporate stocks (other than employer securities):	
(A) Preferred	1c(4)(A)
(B) Common.....	1c(4)(B)
(5) Partnership/joint venture interests	1c(5)
(6) Real estate (other than employer real property).....	1c(6)
(7) Loans (other than to participants)	1c(7)
(8) Participant loans.....	1c(8) 156759 171994
(9) Value of interest in common/collective trusts	1c(9)
(10) Value of interest in pooled separate accounts	1c(10) 92356 88475
(11) Value of interest in master trust investment accounts	1c(11)
(12) Value of interest in 103-12 investment entities.....	1c(12)
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13) 6755279 6231460
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14) 1311789 772536
(15) Other.....	1c(15)

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	8424935	7479763

Liabilities

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

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	8424935	7479763
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Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	290287	
(B) Participants	2a(1)(B)	854876	
(C) Others (including rollovers)	2a(1)(C)	2475	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		1147638
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	-1399	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)	4926	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		3527
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		381674
c Other income.....	2c		1391
d Total income. Add all income amounts in column (b) and enter total.....	2d		1534230

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	2424489	
(2) To insurance carriers for the provision of benefits.....	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		2424489
f Corrective distributions (see instructions).....	2f		9380
g Certain deemed distributions of participant loans (see instructions).....	2g		45191
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees.....	2i(1)		
(2) Contract administrator fees.....	2i(2)	342	
(3) Investment advisory and management fees.....	2i(3)		
(4) Other.....	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		342
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		2479402

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		-945172
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan.....	2l(2)		

Part III Accountant's Opinion

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

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

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

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)?

☒ Yes ☐ No

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

(1) Name: BDO USA, LLP

(2) EIN: 13-5381590

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		278921
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	
4c			
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	
4d			
e Was this plan covered by a fidelity bond?	X		500000
4e			
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	
4f			
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	
4g			
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	
4h			
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		
4i			
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	
4j			
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	
4k			
l Has the plan failed to provide any benefit when due under the plan?.....		X	
4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			
4n			

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

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

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

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

Part V Trust Information (optional)

6a Name of trust	6b Trust's EIN

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2014 This Form is Open to Public Inspection.
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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 <u>COSHOCTON COUNTY MEMORIAL HOSPITAL TAX DEFERRED ANNUITY PLAN</u>	B Three-digit plan number (PN) ▶ <u>004</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC.</u>	D Employer Identification Number (EIN) <u>31-4387577</u>

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

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	<u>0</u>
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>31-1592130</u> <u>06-0974148</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3	

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

Part III	Amendments
-----------------	-------------------

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

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

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?	☐ Yes	☐ No
11 a Does the ESOP hold any preferred stock?	☐ Yes	☐ No
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)	☐ Yes	☐ No
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?	☐ Yes	☐ No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

e Contribution rate information (If more than one rate applies, check this box ☐ and see instructions regarding required attachment. Otherwise, complete lines 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: ☐ Hourly ☐ Weekly ☐ Unit of production ☐ Other (specify): _____

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

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

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

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

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

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

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

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

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

- 19** If the total number of participants is 1,000 or more, complete lines (a) through (c)

- a** Enter the percentage of plan assets held as:
 Stock: 0.0% 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): _____

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Financial Statements and
Supplemental Schedules
Years Ended December 31, 2014 and 2013

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Financial Statements and Supplemental Schedules
Years Ended December 31, 2014 and 2013

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

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Independent Auditor's Report

To the Board of Trustees of the
Coshocton County Memorial Hospital
Tax Deferred Annuity Plan
Coshocton, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Coshocton County Memorial Hospital Tax Deferred Annuity Plan, which comprise the statement of net assets available for benefits as of December 31, 2014, the related statement of changes in net assets available for benefits for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal 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 3, which was certified by Nationwide Financial Services, Inc., the custodian of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the Plan administrator that the custodian holds the Plan's investment assets and executes investment transactions. The Plan administrator has obtained a certification from the custodian as of and for the year ended December 31, 2014, that the information provided to the Plan administrator by the custodian is complete and accurate.

Disclaimer of Opinion

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

Other Matter - Supplemental Schedules

The supplemental schedules of Assets (Held at End of Year) and Delinquent Participant Contributions are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for the purpose of additional analysis and are 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.

Other Matter - 2013 Financial Statements

The 2013 financial statements of the Plan were audited by SS&G, Inc. (SS&G) whose directors and professional staff joined BDO USA, LLP effective January 1, 2015 and has subsequently ceased operations. 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 SS&G not to perform, and they did not perform, any auditing procedures with respect to the information certified by Nationwide Financial Services, Inc., the custodian of the Plan. SS&G's report, dated October 15, 2014, indicated that (a) because of the significance of the information that they did not audit, they were unable to, and did not, express an opinion on the financial statements taken as a whole and (b) the form and content of the information included in the financial statements other than that derived from the information certified by the custodian, were 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.

Report on Form and Content in Compliance With Department of Labor Rules and Regulations - 2014

The form and content of the information included in the 2014 financial statements and supplemental schedules, other than that derived from the information certified by the custodian, have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

BDO USA, LLP

October 15, 2015

Financial Statements

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Statements of Net Assets Available for Benefits

<i>December 31,</i>	2014	2013
Assets		
Investments, at Fair Value:		
Money market fund	\$ 184,256	\$ 108,752
Mutual funds	6,233,666	6,755,278
Guaranteed investment contract	720,098	1,256,330
Total Investments	7,138,020	8,120,360
Receivables:		
Employee contributions	23,348	-
Employer contributions	7,647	-
Notes receivable from participants	159,683	144,449
Total Receivables	190,678	144,449
Noninterest-bearing cash	47	-
Net Assets Available for Benefits	\$ 7,328,745	\$ 8,264,809

See accompanying notes to financial statements.

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Statements of Changes in Net Assets Available for Benefits

<i>Year ended December 31,</i>	2014	2013
Additions to Net Assets Attributed to:		
Investment income:		
Net appreciation in fair value of investments	\$ -	\$ 716,932
Interest and dividends	384,824	343,327
Other income	410	69,919
	385,234	1,130,178
Interest on notes receivable from participants	4,926	5,740
Contributions:		
Employee	854,876	969,890
Employer	290,287	306,028
Rollover	2,475	12,704
	1,147,638	1,288,622
Total Additions	1,537,798	2,424,540
Deductions from Net Assets Attributed to:		
Net depreciation in fair value of investments	82,742	-
Benefits paid to participants	2,295,257	511,186
Deemed distributions	43,819	-
Administrative expenses	52,044	84,313
Total Deductions	2,473,862	595,499
Net (Decrease) Increase in Assets	(936,064)	1,829,041
Net Assets Available for Benefits:		
Beginning of period	8,264,809	6,435,768
End of year	\$ 7,328,745	\$ 8,264,809

See accompanying notes to financial statements.

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

1. Description of Plan

The following is a brief description of the Coshocton County Memorial Hospital Employees Tax Deferred Annuity Plan (the Plan) which is provided for general information purposes only. Reference to the Plan document should be made for more complete information.

General

Coshocton County Memorial Hospital Tax Deferred Annuity Plan (the Plan) is a defined contribution plan covering all full-time employees of Coshocton County Memorial Hospital (the Hospital) who have one year of service, are age 21 or older, and have completed 1,000 hours of service during the Plan year. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Plan participants may contribute up to 100% of their annual compensation, limited to the maximum salary deferral permitted by the Internal Revenue Code (IRC). Effective August 27, 2014, the Plan provides for Hospital matching contributions for participants covered under the Ohio Nurses Association, Collective Bargaining Agreement (CBA), in the amount of 3% of a participant's compensation if they defer a minimum of 6% from their compensation. Prior to that date, the Hospital made matching contributions for participants covered by the CBA equal to 2.5% of a participant's compensation if they defer a minimum of 5% from their compensation. Additionally, the Plan provides for Hospital matching contributions for participants not covered by the CBA in the amount of 50% of elective deferrals from 2% of compensation deferred up to 6% of compensation deferred.

Participant accounts

Each participant's account is credited with the participant's contributions and allocations of (a) the Hospital's contribution, (b) the Plan's investment results, and (c) is charged with an allocation of administrative expenses. Allocations are based on participant 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 vested account.

Vesting

Participants are immediately vested in their contributions and earnings. Vesting of the Hospital's contributions and related earnings is based on years of service as follows:

Years of Service	Vesting Percentage
1-2	0%
3	100%

The years of vesting for the matching contribution are calculated based on the number of hours of service. A minimum of 1,000 hours of service must be provided to complete a year of vesting service.

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

Participants are eligible to receive benefits from their vested portion upon the attainment of age 59 ½ or for the following reasons: death, disability, termination, or hardship.

Notes receivable from participants

The Plan permits loans to participants at origination of not less than \$1,000. The loans are secured by the participants' vested interest in the Plan's assets and are generally due in installment payments of principal plus interest, at an interest rate of 3.25%, with maturity dates ranging from one to five years. Principal and interest is paid ratably through monthly payroll deductions.

Forfeitures

Accounts forfeited by participants who terminate service prior to becoming fully vested are used to reduce future contributions made by the Hospital and pay Plan expenses. At December 31, 2014 and 2013, forfeited non-vested accounts totaled \$4,828 and \$3,084, respectively.

Benefits payable

At December 31, 2014 and 2013, amounts allocated to participants who had elected to withdraw from the Plan prior to December 31, but who were not yet paid as of that date, amounted to \$49,857 and \$0, respectively.

Plan expenses

Substantially all administrative expenses of the Plan are paid by the Hospital.

2. Summary of significant accounting policies

Basis of presentation

The accounting records of the Plan are maintained on the accrual basis.

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. The Plan's management determines the Plan's valuation policies utilizing information provided by the investment advisers and Nationwide Financial Services, Inc. (Nationwide), the custodian. See Note 4 for discussion of fair value measurements.

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

Payments of benefits

Benefits are recorded when paid.

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

Use of estimates

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

Events occurring after reporting date

The Hospital has evaluated events and transactions that occurred between December 31, 2014 and October 15, 2015, the date the financial statements were available to be issued, for possible recognition or disclosure in the financial statements.

3. Investments

All investment information disclosed in the accompanying financial statements, including net investment income at December 31, 2014 and 2013 and net (depreciation) appreciation in the fair value of investments for the years ended December 31, 2014 and 2013 has been derived from information certified as complete and accurate by Nationwide, the custodian of the Plan, in accordance with Section 2520.103-8 of the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

The following information represents 5% or more of the Plan's net assets at December 31:

<i>December 31,</i>	2014	2013
Nationwide Financial Services, Inc. Fixed Contract	\$ 720,098	\$ 1,256,330
Nationwide Destination 2020 R	511,652	-
Nationwide Destination 2025 R	432,992	-
Nationwide Destination 2030 R	971,415	-
Nationwide Destination 2040 R	431,833	-
Nationwide Destination 2030 R1	-	926,118
Nationwide Destination 2020 R1	-	551,881
Delaware Diversified Income A	-	464,230

During 2014 and 2013, the Plan's investments (including investments purchased, sold, as well as held during the year) (depreciated) appreciated in value by \$(82,742) and \$716,932, respectively, and all appreciation was attributed to the Plan's investment in mutual funds.

4. Fair value measurements

The Accounting Standards Codification Topic on Fair Value Measurements and Disclosures establishes a framework for measuring fair value. That framework 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 measurements) and the lowest priority to unobserved inputs (Level 3 measurements).

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.

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

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 measurements.

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 used need to maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

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

Money market fund: The fair value of investments in money market accounts is valued based on their reported net asset value (NAV). The NAV of short-term securities is based on the market value of their underlying investments, adjusted for changes and expenses. There are no redemption restrictions.

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are mutual funds that are registered with the SEC. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Guaranteed Investment Contract: 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.

The methods described above may produce a fair value 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.

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

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

<i>December 31, 2014</i>	Assets at Fair Value			
	Level 1	Level 2	Level 3	Total
Money market fund	\$ -	\$ 184,256	\$ -	\$ 184,256
Mutual funds:				
Balanced	3,485,749	-	-	3,485,749
Bond fund	798,337	-	-	798,337
Growth	1,571	-	-	1,571
International	605,417	-	-	605,417
Large-cap	555,207	-	-	555,207
Mid-cap	318,931	-	-	318,931
Small-cap	129,090	-	-	129,090
Specialty	339,364	-	-	339,364
Total mutual funds	6,233,666	184,256	-	6,233,666
Guaranteed investment contract	-	720,098	-	720,098
Total assets at fair value	\$ 6,233,666	\$ 904,354	\$ -	\$ 7,138,020

<i>December 31, 2013</i>	Assets at Fair Value			
	Level 1	Level 2	Level 3	Total
Money market fund	\$ -	\$ 108,752	\$ -	\$ 108,752
Mutual funds:				
Balanced	3,396,691	-	-	3,396,691
Bond fund	960,154	-	-	960,154
International	429,426	-	-	429,426
Large-cap	938,256	-	-	938,256
Mid-cap	490,118	-	-	490,118
Small-cap	151,506	-	-	151,506
Specialty	389,127	-	-	389,127
Total mutual funds	6,755,278	-	-	6,755,278
Guaranteed investment contract	-	1,256,330	-	1,256,330
Total assets at fair value	\$ 6,755,278	\$ 1,365,082	\$ -	\$ 8,120,360

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

5. Guaranteed investment contract

The Plan has the following investment contract with Nationwide Life Insurance Company: the Fixed Contract investment. Nationwide Life Insurance Company 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 contract is included in the financial statements at fair value as reported to the Plan by Nationwide Life Insurance Company.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The average yield and crediting interest rate for the Fixed Contract investment was 2.00% and 2.40% at December 31, 2014 and 2013, respectively. The interest rate on the account is declared by Nationwide Life Insurance Company on a quarterly basis. During the years ended December 31, 2014 and 2013, the account earned interest income of \$19,277 and \$24,271, respectively.

6. Plan termination

Although it has not expressed an 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 100% vested in their accounts.

7. Income tax status

Final regulations under Section 403(b) were published by the IRS on July 26, 2007. Under the regulations, by December 31, 2009, a 403(b) plan sponsor must have adopted a written plan intended to satisfy the requirements of Section 403(b) and the regulations effective as of January 1, 2009. The IRS is in the process of establishing pre-approved and individually designed plan programs under which a plan sponsor can obtain assurance that the written form of its plan satisfies Section 403(b). Transition relief will be provided to 403(b) plan sponsors who have made appropriate efforts to comply with the written plan requirement in the final regulations. The Plan sponsor adopted a written plan in 2009 which it believes satisfies the written plan requirement. The Plan sponsor also believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the tax authorities. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2014, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan administrator believes it is no longer subject to income tax examinations for years prior to 2011.

8. Risks and uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

participants' account balances and the amounts reported in the statements of net assets available for benefits.

9. Transactions with parties-in-interest

Certain Plan investments are mutual funds, a money market fund, and guaranteed investment contract managed by Nationwide. In addition, the Plan paid administrative fees to Nationwide totaling \$35,248 and \$61,129 for the years ended December 31, 2014 and 2013, respectively. Nationwide is the Plan's custodian and, therefore, related investment transactions qualify as party-in-interest transactions.

Certain participants have borrowed on their vested account balances. As the individuals are participants in the Plan, these transactions qualify as party-in-interest transactions.

10. Reconciliation to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2014:

Total net assets available for benefits per the financial statements	\$ 7,328,745
Add: Allocated plan assets recorded on the Form 5500	151,018
Total net assets available for benefits per the 2014 Form 5500	\$ 7,479,763

The following is a reconciliation of net decrease in net assets per the financial statements for the year ended December 31, 2014 to the Form 5500:

Total decrease in net assets per the financial statements	\$ (936,064)
Add: Loss on allocated plan assets reported on the Form 5500	(9,108)
Net loss per the 2014 Form 5500	\$ (945,172)

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2013:

Total net assets available for benefits per the financial statements	\$ 8,264,809
Add: Allocated plan assets recorded on the Form 5500	160,126
Total net assets available for benefits per the 2013 Form 5500	\$ 8,424,935

The following is a reconciliation of net increase in net assets per the financial statements for the year ended December 31, 2013 to the Form 5500:

Total increase in net assets per the financial statements	\$ 1,829,041
Add: Income on allocated plan assets reported on the Form 5500	20,628
Less: Other income	(69,919)
Net income per the 2013 Form 5500	\$ 1,779,750

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Notes to Financial Statements

11. Prohibited transactions

During 2013, the Plan Sponsor failed to deposit participant contributions totaling \$278,921 within the required time frame stated by the United States Department of Labor (the DOL). The DOL considers late deposits to be prohibited transactions. The late contributions were remitted to the Plan during 2013. As noted in the Schedule of Delinquent Participant Contributions, during 2014, the Plan Sponsor filed a Form 5330, paid applicable excise tax, and remitted related interest on the late contributions to the Plan.

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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**2014****This Form is Open to Public Inspection****Part I Annual Report Identification Information**

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

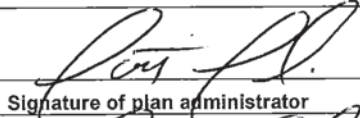
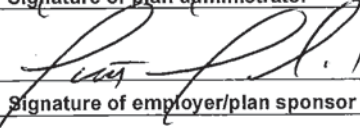
- A** This return/report is for: ☐ a multiemployer plan; ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or ☒ a single-employer plan; ☐ a DFE (specify) _____
- B** This return/report is: ☐ the first 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 Coshocton County Memorial Hospital Tax Deferred Annuity Plan	1b Three-digit plan number (PN) ▶ 004
	1c Effective date of plan 01/01/1992
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) COSHOCOTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC. 1460 ORANGE ST COSHOCOTON OH 43812-2229	2b Employer Identification Number (EIN) 31-4387577
	2c Plan Sponsor's telephone number 740-622-6411
	2d Business code (see instructions) 622000

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

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

SIGN HERE		10/15/2015	Scott Silverstri
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/15/2015	Scott Silverstri
	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)

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

Form 5500 (2014)
v. 140124

3a Plan administrator's name and address ☐ Same as Plan Sponsor COSHOCTON COUNTY MEMORIAL HOSPITAL ASSOCIATION, INC. 1460 ORANGE ST COSHOCTON OH 43812-2229	3b Administrator's EIN 31-4387577 3c Administrator's telephone number 614-318-2200
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5 525
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) 525
a(2) Total number of active participants at the end of the plan year	6a(2) 396
b Retired or separated participants receiving benefits	6b 0
c Other retired or separated participants entitled to future benefits	6c 48
d Subtotal. Add lines 6a(2), 6b, and 6c.	6d 444
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e.	6f 444
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 324
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h 0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2L	
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) ☒ 2 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 _____

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Schedule H, Line 4a - Schedule of Delinquent Participant Contributions

December 31, 2014

EIN: 31-4387577

Plan Number: 004

Participant Contributions Transferred Late to Plan	Total that Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under VFCP and PTE 2002-51
	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
Check here if Late Participant Loan Repayments are included: x		\$ 278,921 *		

* The late contributions were remitted to the Plan as of December 31, 2013. The related interest was remitted to the Plan during 2014.

Supplemental Schedules

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

Schedule H, Line 4i - Schedule of Assets (Held at End of Year)

December 31, 2014

EIN: 31-4387577
Plan Number: 004

(a)	(b)	(c) Description of Investment, including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d)	(e)
	Identity of Issuer, Borrower, Lessor or Similar Party		Cost	Current Value
	Advone CLS Dmstc	Mutual fund	**	\$ 2,249
	Advone CLS Gbl Divrs Eq N	Mutual fund	**	258,592
	Advone CLS Global Eq N	Mutual fund	**	48,627
	Advone CLS Global Gr N	Mutual fund	**	140,280
	Advone CLS Gr Inc	Mutual fund	**	186,505
	Advone CLS Int N	Mutual fund	**	1,413
	Advone CLS Long Short N	Mutual fund	**	13,053
	Advone CLS Flex Inc N	Mutual fund	**	17,504
	Allber Hi Income A	Mutual fund	**	26,444
	American Funds Gr Fd Am R6	Mutual fund	**	24,346
	AMGMgrs Ycktmn Focs Svc	Mutual fund	**	24,648
	Baron Growth	Mutual fund	**	29,881
	Blackrock Health Science Oppr Inv A	Mutual fund	**	56,595
	Blackrock International Oppr Inv A	Mutual fund	**	3,465
	Buffalo Small-Cap	Mutual fund	**	39,599
	Civrt Inc A	Mutual fund	**	66,239
	Delaware Diversified Income A	Mutual fund	**	318,419
	Dtsch CROCI Eq Divd	Mutual fund	**	23,315
	Eaton Vance WW Health Sciences A	Mutual fund	**	38,925
	Fidelity Advisor Leveraged Company Stock A	Mutual fund	**	149,712
	Fidelity Advisor Small Cap A	Mutual fund	**	5,388
	Franklin Templeton Mutual Beacon A	Mutual fund	**	33,306
	Harbor International Inv	Mutual fund	**	130,407
	Heartland Select Value Inv	Mutual fund	**	186
	Heartland Value Inv	Mutual fund	**	1,942
	Heartland Value Plus Inv	Mutual fund	**	8,378
	Invesco American Franchise A	Mutual fund	**	56,989
	Invesco Equity and Income A	Mutual fund	**	89,167
	Invesco Leisure Inv	Mutual fund	**	1,571
	Invesco Mid-cap Growth A	Mutual fund	**	2,854
	Invesco Real Estate A	Mutual fund	**	65,693
	Invesco Val Opp A	Mutual fund	**	9,168
	Ivy Asset Strategy Y	Mutual fund	**	21,169
	Ivy Science Tech Y	Mutual fund	**	87,398

Coshocton County Memorial Hospital Tax Deferred Annuity Plan

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December 31, 2014

EIN: 31-4387577

Plan Number: 004

(a)	(b)	(c) Description of Investment, including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d)	(e)
	Identity of Issuer, Borrower, Lessor or Similar Party		Cost	Current Value
	Janus Twenty T	Mutual fund	**	133,706
	MFS Value A	Mutual fund	**	114,810
*	Nationwide Destination 2010 R	Mutual fund	**	127,522
*	Nationwide Destination 2015 R	Mutual fund	**	239,215
*	Nationwide Destination 2020 R	Mutual fund	**	511,652
*	Nationwide Destination 2025 R	Mutual fund	**	432,992
*	Nationwide Destination 2030 R	Mutual fund	**	971,415
*	Nationwide Destination 2035 R	Mutual fund	**	43,101
*	Nationwide Destination 2040 R	Mutual fund	**	431,833
*	Nationwide Destination 2045 R	Mutual fund	**	155,462
*	Nationwide Destination 2050 R	Mutual fund	**	135,436
	Neuberger Genesis TR	Mutual fund	**	124,274
	Neuberger Mid-cap Intrinsic Value TR	Mutual fund	**	7,076
	Oppenheimer Developing Market A	Mutual fund	**	115,111
	Oppenheimer Global A	Mutual fund	**	28,118
	PIMCO Low Duration A	Mutual fund	**	52,314
	PIMCO Real Return A	Mutual fund	**	41,751
	PIMCO Total Return A	Mutual fund	**	2,734
	PNC Multiple Factor Small-cap Value A	Mutual fund	**	1,623
	Principal Mid-cap A	Mutual fund	**	1,248
	Prudential Jenison 20 20 Focus A	Mutual fund	**	98,409
	Prudential Jenison Mid-cap Growth A	Mutual fund	**	3,700
	Prudential Jenison Natural Resource A	Mutual fund	**	10,893
	RS Partners A	Mutual fund	**	72,160
	Rydex SGI S&P500 2X Strategy	Mutual fund	**	521
	TCW Total Return Bond I	Mutual fund	**	43,784
	Thornburg International Value I	Mutual fund	**	19,684
	Thornburg Value I	Mutual fund	**	14,416
	Van Eck International Investors Gold A	Mutual fund	**	11,443
	Vanguard 500 Index Fd AS	Mutual fund	**	19,845
	Wells Fargo Advange Government Sec Inv	Mutual fund	**	229,148
	Wells Fargo Advantage Utility and Telecom A	Mutual fund	**	54,843

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December 31, 2014

EIN: 31-4387577
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		(c)	(d)	(e)
		Description of Investment, including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value
(a)	(b)			
*	Nationwide Financial Services, Inc. Nw Mny Mkt Inst	Money market fund	**	184,256
*	Nationwide Financial Services, Inc. Fixed Contract	Guaranteed investment contract	**	720,098
*	Participant loans	Interest rate of 3.25% with maturity dates through 2019.	- 0 -	159,683
				\$ 7,297,703

* Identified as a party-in-interest.

** Cost is not required to be disclosed for participant-directed investments.