

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold;">2015</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information		
For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>			
A	This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or	
	☒ a single-employer plan; ☐ a DFE (specify) ____		
B	This return/report is:	☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).	
C	If the plan is a collectively-bargained plan, check here. ☐		
D	Check box if filing under:	☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)	

Part II	Basic Plan Information —enter all requested information		
1a	Name of plan <u>SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM</u>	1b	Three-digit plan number (PN) ▶ <u>002</u>
		1c	Effective date of plan <u>01/01/1990</u>
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>SOUTHERN OHIO MEDICAL CENTER</u> <u>1248 KINNEYS LANE</u> <u>PORTSMOUTH, OH 45662</u>	2b	Employer Identification Number (EIN) <u>31-0678022</u>
		2c	Plan Sponsor's telephone number <u>740-356-7660</u>
		2d	Business code (see instructions) <u>622000</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	08/23/2016	VICKI A. NOEL
	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)			Preparer's telephone number

3a Plan administrator's name and address ☒ Same as Plan Sponsor		3b Administrator's EIN	
		3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:		4b EIN	
a Sponsor's name		4c PN	
5 Total number of participants at the beginning of the plan year		5	3213
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)	2516
a(2) Total number of active participants at the end of the plan year		6a(2)	2589
b Retired or separated participants receiving benefits.....		6b	94
c Other retired or separated participants entitled to future benefits.....		6c	693
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	3376
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....		6e	0
f Total. Add lines 6d and 6e		6f	3376
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		6g	2996
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested		6h	139
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		7	
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2E 2F 2G 2L 3H			
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)		9b Plan benefit arrangement (check all that apply)	
(1) ☒ Insurance		(1) ☒ Insurance	
(2) ☐ Code section 412(e)(3) insurance contracts		(2) ☐ Code section 412(e)(3) insurance contracts	
(3) ☒ Trust		(3) ☒ Trust	
(4) ☐ General assets of the sponsor		(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		b General Schedules	
(1) ☒ R (Retirement Plan Information)		(1) ☒ H (Financial Information)	
(2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary		(2) ☐ I (Financial Information – Small Plan)	
(3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(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)
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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 2015 Form M-1 annual report. If the plan was not required to file the 2015 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 <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110
		2015
		This Form is Open to Public Inspection

For calendar plan year 2015 or fiscal plan year beginning **01/01/2015** and ending **12/31/2015**

A Name of plan SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM	B Three-digit plan number (PN) ►	002
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHERN OHIO MEDICAL CENTER	D Employer Identification Number (EIN) 31-0678022	

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
GREAT-WEST LIFE & ANNUITY 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
84-0467907	7692	85605-01	2989	01/01/2015	12/31/2015

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.

(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	12950741
5 Current value of plan's interest under this contract in separate accounts at year end	5	43656114

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

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

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

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

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

b Balance at the end of the previous year	7b	12508467
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c Additions: (1) Contributions deposited during the year	7c(1)	554448	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	386385	
(4) Transferred from separate account	7c(4)	2311171	
(5) Other (specify below)	7c(5)	91970	

▶ **LOAN PAYMENTS**

(6) Total additions	7c(6)	3343974
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d Total of balance and additions (add lines 7b and 7c(6))	7d	15852441
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	750396	
(2) Administration charge made by carrier	7e(2)	1144	
(3) Transferred to separate account	7e(3)	2150160	
(4) Other (specify below)	7e(4)		

(5) Total deductions	7e(5)	2901700
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	12950741
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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) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small>	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 <hr/> 2015 <hr/> This Form is Open to Public Inspection
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For calendar plan year 2015 or fiscal plan year beginning **01/01/2015** and ending **12/31/2015**

A Name of plan SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM	B Three-digit plan number (PN) ►	002
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHERN OHIO MEDICAL CENTER	D Employer Identification Number (EIN) 31-0678022	

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
GREAT WEST RETIREMENT SERVICES

(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
84-0467907	7692	93346-01	130	01/01/2015	12/31/2015

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.

(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	336925
5 Current value of plan's interest under this contract in separate accounts at year end	5	6313458

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

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

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

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

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

b Balance at the end of the previous year	7b	85950
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c Additions: (1) Contributions deposited during the year	7c(1)	9100	
(2) Dividends and credits	7c(2)	0	
(3) Interest credited during the year	7c(3)	3815	
(4) Transferred from separate account	7c(4)	232237	
(5) Other (specify below)	7c(5)	5848	

▶ **LOAN REPAYMENTS**

(6) Total additions	7c(6)	251000
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d Total of balance and additions (add lines 7b and 7c(6))	7d	336950
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0	
(2) Administration charge made by carrier	7e(2)	25	
(3) Transferred to separate account	7e(3)	0	
(4) Other (specify below)	7e(4)	0	

▶

(5) Total deductions	7e(5)	25
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	336925
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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. ▶

<div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>	OMB No. 1210-0110
		2015
		This Form is Open to Public Inspection.

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015		
A Name of plan SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM	B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHERN OHIO MEDICAL CENTER	D Employer Identification Number (EIN) 31-0678022	

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☐ Yes ☒ No
- b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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--

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(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)

ADVISED ASSET GROUP

8515 EAST ORCHARD ROAD
GREENWOOD VILLAGE, CO 80111

(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?
28	INVESTMENT MANAGEMENT	135361	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GREAT WEST LIFE AND ANNUITY

8515 EAST ORCHARD ROAD
GREENWOOD VILLAGE, CO 80111

(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?
64	RECORDKEEPER	11013	Yes ☒ No ☐	Yes ☐ No ☒	0	Yes ☒ No ☐

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(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:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<div>SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration</div>		<div>DFE/Participating Plan Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>		<div>OMB No. 1210-0110</div> <div>2015</div> <div>This Form is Open to Public Inspection.</div>	
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015					
A Name of plan SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM				B Three-digit plan number (PN) ▶ 002	
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 SOUTHERN OHIO MEDICAL CENTER				D Employer Identification Number (EIN) 31-0678022	
Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)					
a Name of MTIA, CCT, PSA, or 103-12 IE: FUTUREFUNDS SERIES ACCOUNT II					
b Name of sponsor of entity listed in (a): GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY					
c EIN-PN 84-0467907-003		d Entity code P		e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 49969572	
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)	

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

Schedule D (Form 5500) 2015 v. 150123

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

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

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

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

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 <div style="border: 1px solid black; padding: 5px; font-size: 1.2em; font-weight: bold;">2015</div> This Form is Open to Public Inspection
For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015		
A Name of plan SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM	B Three-digit plan number (PN) ►	002
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHERN OHIO MEDICAL CENTER	D Employer Identification Number (EIN) 31-0678022	

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.				
	Assets			
a	Total noninterest-bearing cash	1a	0	0
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)	0	557916
	(2) Participant contributions	1b(2)	0	0
	(3) Other.....	1b(3)	0	0
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	0	0
	(2) U.S. Government securities.....	1c(2)	0	0
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)	0	0
	(B) All other.....	1c(3)(B)	0	0
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)	0	0
	(B) Common	1c(4)(B)	0	0
	(5) Partnership/joint venture interests	1c(5)	0	0
	(6) Real estate (other than employer real property)	1c(6)	0	0
	(7) Loans (other than to participants)	1c(7)	0	0
	(8) Participant loans	1c(8)	1191582	1156661
	(9) Value of interest in common/collective trusts.....	1c(9)	0	0
	(10) Value of interest in pooled separate accounts.....	1c(10)	46881413	49969572
	(11) Value of interest in master trust investment accounts	1c(11)	0	0
	(12) Value of interest in 103-12 investment entities	1c(12)	0	0
	(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	13903846	12838669
	(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	12594415	13287666
	(15) Other	1c(15)	0	0

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	74571256	77810484

Liabilities

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

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	74571256	77810484
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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)	2082608	
(B) Participants	2a(1)(B)	4318579	
(C) Others (including rollovers)	2a(1)(C)	183973	
(2) Noncash contributions	2a(2)	0	6585160
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	0	
(B) U.S. Government securities	2b(1)(B)	0	
(C) Corporate debt instruments	2b(1)(C)	0	
(D) Loans (other than to participants)	2b(1)(D)	0	
(E) Participant loans	2b(1)(E)	59130	
(F) Other	2b(1)(F)	383254	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		442384
(2) Dividends: (A) Preferred stock	2b(2)(A)	0	
(B) Common stock	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	991630	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		991630
(3) Rents	2b(3)		0
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	0	
(B) Other	2b(5)(B)	0	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	-182050
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	-1378229
c Other income	2c	-41535
d Total income. Add all income amounts in column (b) and enter total	2d	6417360

Expenses**e** Benefit payment and payments to provide benefits:

(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	3012036	
(2) To insurance carriers for the provision of benefits	2e(2)	0	
(3) Other	2e(3)	0	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		3012036
f Corrective distributions (see instructions)	2f		0
g Certain deemed distributions of participant loans (see instructions)	2g		19722
h Interest expense	2h		0
i Administrative expenses: (1) Professional fees	2i(1)	0	
(2) Contract administrator fees	2i(2)	11013	
(3) Investment advisory and management fees	2i(3)	135361	
(4) Other	2i(4)	0	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		146374
j Total expenses. Add all expense amounts in column (b) and enter total	2j		3178132

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		3239228
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: PLANTE & MORAN LLP

(2) EIN: 38-1357951

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		☒		
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	N/A	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X		
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X		
e Was this plan covered by a fidelity bond?	X			1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)		X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X		
l Has the plan failed to provide any benefit when due under the plan?		X		
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X		
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X		
o Did the plan trust incur unrelated business taxable income?				
p Were in-service distributions made during the plan year?				

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

6a Name of trust	6b Trust's EIN
6c Name of trustee or custodian	6d Trustee's or custodian's telephone number

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 2015 This Form is Open to Public Inspection.
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A Name of plan <u>SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM</u>	B Three-digit plan number (PN) ▶ <u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SOUTHERN OHIO MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>31-0678022</u>

Part I	Distributions
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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>20-3691708</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)
----------------	--

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

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

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

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

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

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

Schedule R (Form 5500) 2015
v. 150123

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- a** Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%
- b** Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more
- c** What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

Part VII IRS Compliance Questions

20a Is the plan a 401(k) plan?.....	☐ Yes	☐ No
20b If "Yes," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?.....	☐ Design-based safe harbor method	☐ ADP/ACP test
20c If the ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "current year testing method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.401(m)-2(a)(2)(ii))?	☐ Yes	☐ No
21a Check the box to indicate the method used by the plan to satisfy the coverage requirements under section 410(b):	☐ Ratio percentage test	☐ Average benefit test
21b Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules?	☐ Yes	☐ No
22a Has the plan been timely amended for all required tax law changes?.....	☐ Yes	☐ No ☐ N/A
22b Date the last plan amendment/restatement for the required tax law changes was adopted ____/____/____. Enter the applicable code _____. (See instructions for tax law changes and codes).		
22c If the plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter plan that is subject to a favorable IRS opinion or advisory letter, enter the date of that favorable letter ____/____/____ and the letter's serial number _____.		
22d If the plan is an individually-designed plan and received a favorable determination letter from the IRS, enter the date of the plan's last favorable determination letter ____/____/____.		
23 Is the Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2) has been made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin Islands)?	☐ Yes	☐ No

Southern Ohio Medical Center Retirement Savings Program

**Financial Report
December 31, 2015**

Southern Ohio Medical Center Retirement Savings Program

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Independent Auditor's Report

To the Plan Administrator
Southern Ohio Medical Center
Retirement Savings Program

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Southern Ohio Medical Center Retirement Savings Program (the "Plan"), which comprise the statement of net assets available for benefits as of December 31, 2015 and 2014 and the related statement of changes in net assets available for benefits for the year ended December 31, 2015, 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 audits 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 (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA), 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 Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC (collectively, the "Trustee"), except for comparing such information with the related information included in the financial statements. We have been informed by the plan administrator that the Trustee holds the Plan's investment assets and participant notes receivable and executes related transactions. The plan administrator has obtained certifications from the Trustee as of December 31, 2015 and 2014 and for the year ended December 31, 2015 that the information provided to the plan administrator by the Trustee is complete and accurate.

To the Plan Administrator
Southern Ohio Medical Center
Retirement Savings Program

Disclaimer of Opinion

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

Other Matter

The supplemental schedule of assets held at end of year as of December 31, 2015 is required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA and is presented for the purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the *Basis for Disclaimer of Opinion* paragraph, we do not express an opinion on this supplemental schedule.

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

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

Plante & Moran, PLLC

Columbus, Ohio
July 25, 2016

Southern Ohio Medical Center Retirement Savings Program

Statement of Net Assets Available for Benefits

	December 31, 2015	December 31, 2014
Assets		
Participant-directed investments at fair value:		
Mutual funds	\$ 12,838,668	\$ 13,903,846
Pooled separate accounts	49,969,569	46,881,413
Total participant-directed investments at fair value	62,808,237	60,785,259
Fully benefit-responsive investment contracts at contract value	13,287,666	12,594,415
Total participant-directed investments	76,095,903	73,379,674
Contributions receivable	557,916	-
Participant notes receivable	1,156,661	1,191,582
Net Assets Available for Benefits	\$ 77,810,480	\$ 74,571,256

Southern Ohio Medical Center

Retirement Savings Program

Statement of Changes in Net Assets Available for Benefits Year Ended December 31, 2015

Additions to Net Assets

Contributions:	
Employee	\$ 4,317,966
Employer	2,083,104
Rollovers	<u>183,973</u>
Total contributions	6,585,043
Investment income (loss):	
Interest and dividends	1,381,829
Net realized and unrealized loss on investments:	
Mutual funds	(1,132,017)
Pooled separate accounts	<u>(428,262)</u>
Net realized and unrealized loss	<u>(1,560,279)</u>
Total investment loss	(178,450)
Interest from participant notes receivable	<u>59,616</u>
Total additions	6,466,209

Deductions from Net Assets

Benefits paid directly to participants or beneficiaries	3,080,680
Administrative expenses	<u>146,305</u>
Total deductions	<u>3,226,985</u>

Net Increase 3,239,224

Net Assets Available for Benefits

Beginning of year	<u>74,571,256</u>
End of year	<u>\$ 77,810,480</u>

Southern Ohio Medical Center Retirement Savings Program

Notes to Financial Statements December 31, 2015 and 2014

Note 1 - Plan Description

The following description of Southern Ohio Medical Center Retirement Savings Program (the "Plan") provides only general information. Participants should refer to the plan agreement for a more complete description of the Plan's provisions.

General - The Plan is a defined contribution plan covering all eligible employees of Southern Ohio Medical Center, SOMC Medical Care Foundation, and any affiliate of Southern Ohio Medical Center (collectively, the "Organization") who are age 18 or older. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Effective January 1, 2014, the Plan was amended to exclude certain compensation from the definition of eligible compensation when calculating employee contributions.

Contributions - The Plan provides for employee contributions up to maximum tax-deferred limitations established by the Internal Revenue Code. Participants may also make contributions to the Plan in the form of a rollover of funds from another qualified plan.

The Plan provides for employer matching contributions of 100 percent of the participant's contribution not to exceed 2 percent of the employee's compensation.

Participant Accounts - Each participant's account is credited with the participant's contribution, allocations of the Organization's contributions, and plan earnings and charged with an allocation of administrative expenses. Allocations are based on the participants' compensation 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. Participants may direct the investments of their account balances into various investment options offered by the Plan.

Participant Notes Receivable - Participants may borrow from their accounts subject to certain maximum and minimum amounts as prescribed in the Plan and in the Internal Revenue Code. Participant notes receivable are collateralized by the participant's account balance and bear interest at a market rate.

Vesting - Participants are immediately 100 percent vested in employee salary and rollover contributions and any income or loss thereon. Vesting in the Organization's contribution portion of their accounts, plus actual earnings thereon, is based on years of service. Participants vest in contributions made by the Organization zero percent from their date of hire to year three and 100 percent after three years of service.

Benefit Payments - Distributions are payable upon the retirement, death, disability, or termination of employment in the form of a lump-sum amount or a monthly retirement benefit for life, which may continue to a spouse or other beneficiary upon the employee's death.

Southern Ohio Medical Center Retirement Savings Program

Notes to Financial Statements December 31, 2015 and 2014

Note 1 - Plan Description (Continued)

Forfeitures - If a participant is not fully vested on his or her termination date, the nonvested amount of the account is forfeited. Forfeitures are used to reduce administrative fees and to reduce future organization contributions. At December 31, 2015 and 2014, forfeited account balances totaled \$45,565 and \$45,032, respectively.

Party-in-interest Transactions - Certain plan assets are in investment funds managed by Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC. Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC are the trustees of the Plan and therefore, these transactions qualify as party-in-interest transactions as defined under ERISA guidelines.

Termination - While it has not expressed any intent to do so, the Organization has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions set forth in the plan agreement and ERISA. Upon termination of the Plan, participants become 100 percent vested in their account balances.

Note 2 - Summary of Significant Accounting Policies

Investment Valuation - The Plan's investments are stated at fair value except as noted below. The fully benefit-responsive unallocated contracts are valued at contract value. Contract value represents deposits made to the contract, plus earnings at guaranteed crediting rates, less withdrawals and fees.

The pooled separate accounts are valued at net asset value per share or its equivalent of the funds, which are based on the fair value of the funds' underlying assets. All other investments are valued based on quoted market prices. See Note 5 for additional information.

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

Participant Notes Receivable - Participant notes receivable are recorded at their unpaid principal balances plus any accrued interest. Participant notes receivable are written off when deemed uncollectible.

Administrative Expenses - Various administrative costs are paid by the Organization.

Benefit Payments - Benefits are recorded when paid.

Southern Ohio Medical Center Retirement Savings Program

Notes to Financial Statements December 31, 2015 and 2014

Note 2 - Summary of Significant Accounting Policies (Continued)

Use of Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of additions and deductions during the reporting period. Actual results could differ from those estimates.

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

New Accounting Pronouncements - During 2015, the Plan adopted Accounting Standards Update (ASU) Nos. 2015-07, *Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or Its Equivalent)*, and 2015-12, *Plan Accounting: Defined Benefit Pension Plans (Topic 960), Defined Contribution Pension Plans (Topic 962), and Health and Welfare Benefit Plans (Topic 965) - I. Fully Benefit-Responsive Investment Contracts, II. Plan Investment Disclosures, and III. Measurement Date Practical Expedient*. ASU No. 2015-07 amended ASC 820, *Fair Value Measurements*, and removed the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share as a practical expedient. Parts I and II of ASU No. 2015-12 were applicable to the Plan. Part I requires the fully benefit-responsive investment contract to be recorded contract value without presentation of fair value or the difference between fair value and contract value and reduces the related disclosures. Part II modified the investment disclosures under ASC 820 and 962. These standards were adopted retrospectively and had no impact on the Plan's net assets or changes in net assets.

Subsequent Events - The financial statements and related disclosures include evaluation of events up through and including July 25, 2016, which is the date the financial statements were available to be issued.

Note 3 - Unaudited Information

Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC (collectively, the "Trustee") hold the Plan's investments and participant notes receivable and execute all related transactions. The investment and participant notes receivable balances and related income and losses included in the accompanying financial statements and supplemental schedule of assets held at end of year are based solely on information provided by the Trustee.

Southern Ohio Medical Center Retirement Savings Program

Notes to Financial Statements December 31, 2015 and 2014

Note 4 - Tax Status

The Internal Revenue Service (IRS) is not currently accepting applications for 403(b) plan determination letters. The plan administrator has indicated that the Plan will apply for a determination letter when the IRS allows such applications to be made. The plan administrator believes that the Plan is designed and is currently being operated in compliance with applicable requirements of Internal Revenue Code Section 403(b). Therefore, no provision for income taxes has been included in the Plan's financial statements.

Note 5 - Fair Value Measurements

Accounting standards require certain assets and liabilities be reported at fair value in the financial statements and provide a framework for establishing that fair value. The framework for determining fair value is based on a hierarchy that prioritizes the inputs and valuation techniques used to measure fair value.

The following tables present information about the Plan's assets measured at fair value on a recurring basis at December 31, 2015 and 2014.

Level 1 - Fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the Plan has the ability to access.

Level 2 - Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets, quoted prices for identical or similar assets in markets that are not active, and inputs other than quoted prices that are observable for the asset.

Level 3 - Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset. These Level 3 fair value measurements are based primarily on management's own estimates using pricing models, discounted cash flow methodologies, or similar techniques taking into account the characteristics of the asset.

In instances whereby inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The Plan's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset.

Southern Ohio Medical Center

Retirement Savings Program

Notes to Financial Statements December 31, 2015 and 2014

Note 5 - Fair Value Measurements (Continued)

Assets Measured at Fair Value on a Recurring Basis at December 31, 2015

	Investments (at Fair Value)	Level 1	Level 2	Level 3
Mutual funds	\$ 12,838,668	\$ 12,838,668	\$ -	\$ -
Investments measured at NAV -				
Pooled separate accounts:				
Asset allocation funds (1)	18,394,953			
International equities funds (2)	5,474,465			
Small- and mid-cap funds (3)	5,161,899			
Large-cap funds (3)	9,580,812			
Bond funds and other (4)	11,357,440			
Total investments at fair value	\$ 62,808,237			

Assets Measured at Fair Value on a Recurring Basis at December 31, 2014

	Investments (at Fair Value)	Level 1	Level 2	Level 3
Mutual funds	\$ 13,903,846	\$ 13,903,846	\$ -	\$ -
Investments measured at NAV -				
Pooled separate accounts:				
Asset allocation funds (1)	17,342,561			
International equities funds (2)	3,949,807			
Small- and mid-cap funds (3)	5,011,909			
Large-cap funds (3)	9,162,065			
Bond funds and other (4)	11,415,071			
Total investments at fair value	\$ 60,785,259			

- (1) This class represents investments in actively managed pooled separate accounts with investments in both equity and debt securities. The investments may include common stock, corporate bonds, and U.S. and non-U.S. municipal securities.
- (2) This class represents investments in actively managed pooled separate accounts that invest primarily in foreign equity securities, which may include common stocks, options, and futures.
- (3) This class represents investments in actively managed pooled separate accounts with investments in both equity and debt securities. The investments may include common stock, corporate bonds, non-U.S. municipal securities, interest rate swaps, options, and futures.
- (4) This class invests primarily in fixed-income securities, including, but not limited to, bonds, notes, or other investments, such as government securities, commercial paper, certificates of deposit, master notes, or variable amount notes, with the objective of providing high current income consistent with the preservation of capital and the maintenance of liquidity.

Southern Ohio Medical Center Retirement Savings Program

Notes to Financial Statements December 31, 2015 and 2014

Note 5 - Fair Value Measurements (Continued)

There were no unfunded commitments or redemption restrictions on the investments described above.

The Plan's policy is to recognize transfers between levels of the fair value hierarchy as of the actual date of the event of change in circumstances that caused the transfer.

Note 6 - Investment Contracts

The Plan has benefit-responsive investment contracts with Great-West Life & Annuity Insurance Company (Great West), namely Great-West Daily Interest Guarantee Fund (in 1989) and Great-West Guaranteed Certificate Funds (in 1984). Great West maintains the contributions in two general accounts. Each account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer, but may not be less than 4 percent on Great-West Daily Interest Guarantee Fund and may not be less than 3 percent on Great-West Guaranteed Certificate Funds. Such interest rates are reviewed on a quarterly basis for resetting.

Certain events limit the ability of the Plan to transact at contract value with the insurance company. Such events include the following: (i) amendments to the plan documents (including complete or partial plan termination or merger with another plan) (ii) changes to the Plan's prohibition on competing investment options or deletion of equity wash provision; (iii) bankruptcy of the plan sponsor or other plan sponsor events (e.g. divestitures or spinoffs of a subsidiary), which cause a significant withdrawal from the Plan, or (iv) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The plan administrator believes that the occurrence of any such events, which would limit the Plan's ability to transact at contract value with participants, is not probable of occurring. There are not any events that allow the issuer to terminate the contract and which require the plan sponsor to settle an amount different than contract value paid either within 90 days or over time.

As described in Note 2, because the contract is fully benefit responsive, contract value is the relevant measurement attribute for that portion of the net assets attributable to the investment contract. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value.

Southern Ohio Medical Center

Retirement Savings Program

Schedule of Assets Held at End of Year

Form 5500, Schedule H, Line 4i

EIN 31-0678022, Plan No. 002

December 31, 2015

(a)(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC	Mutual funds:		
	Fidelity Spartan 500 Index Fund	*	\$ 5,677,722
	Artisan Mid Cap Value Fund	*	752,760
	Harbor International Fund	*	1,241,944
	Vanguard Index Trust - Extended Market Portfolio	*	1,914,793
	Allianz NFJ Small Cap Value fund	*	936,880
	BlackRock Equity Dividend A	*	1,680,529
	Buffalo Small Cap Fund	*	634,040
	Pooled separate accounts:		
	Fidelity VIP II Contrafund	*	8,677,668
	PIMCO Total Return Admin	*	6,625,360
	Great-West Conservative Profile Portfolio	*	7,633,387
	Great-West Moderate Profile Portfolio	*	4,625,610
	Great-West Moderately Aggressive Profile Portfolio	*	3,160,308
	Artisan International Fund	*	1,582,233
	Great-West Aggressive Profile Portfolio	*	2,184,736
	Great-West Money Market Portfolio	*	3,153,548
	Great-West MFS International Value Portfolio	*	3,843,443
	Alger American Midcap Growth Portfolio	*	1,340,391
	Royce Total Return K	*	397,707
	Great-West Moderately Conservative Profile	*	790,912
	American Funds Growth Fund R3	*	452,030
	Putnam International Capital OPP R	*	48,789
	Great-West Loomis Sayles Bond Fund	*	1,047,060
	Davis New York Venture Fund R	*	392,070
	Putnam High Yield Advantage R	*	482,615
	Columbia Mid Cap Value Fund R	*	1,650,092
	Invesco American Value	*	1,761,857
	Forfeitures: Maximum Money Market Portfolio	*	45,565
	Fidelity VIP Growth Portfolio	*	54,564
	Great-West T. Rowe Price Midcap Growth Fund	*	5,653
	Great-West T. Rowe Price Equity/Income Fund	*	4,480
	Great-West Bond Index Fund	*	3,292
	Great-West S&P Smallcap 600 Index Fund	*	2,540
	Ridgeworth Small Cap Growth Stock I	*	3,659

Southern Ohio Medical Center Retirement Savings Program

Schedule of Assets Held at End of Year (Continued) Form 5500, Schedule H, Line 4i EIN 31-0678022, Plan No. 002 December 31, 2015

(a)(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC	Unallocated insurance contracts: Great-West Guaranteed Certificate Fund - 84 months Great-West Guaranteed Certificate Fund - 36 months Great-West Guaranteed Certificate Fund - 60 months Great-West Daily Interest Guarantee Fund	* * * *	\$ 7,307,713 5,412,118 408,105 159,730
Participants	Participant notes receivable - Interest ranging from 5.25 to 10.5 percent	-	<u>1,156,661</u>
	Total		<u><u>\$ 77,252,564</u></u>

* Cost information not required

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

**Southern Ohio Medical Center ERTSA Plan
01-JAN-15 to 31-DEC-15**

27-JAN-16 04:04:03

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
IPS5R			1,391,739.19	2,065,583.70
IPS4R			1,962,286.66	2,811,459.29
IPS3R			3,285,082.19	4,604,668.16
IPS2R			570,927.57	781,906.16
IPS1R			6,045,506.77	6,785,235.32
IAI			1,125,813.14	1,288,048.09
IEF			2,736,558.33	3,121,275.41
IHR-INT			1,008,328.99	955,230.95
IPIO			30,957.04	41,153.23
IPCVAX			1,059,428.47	855,202.17
IBUFSX			718,333.98	550,884.62
IMR2			1,508.97	2,540.22
ISSG			3,154.23	3,659.32
IRTK			310,047.12	299,189.01
IAAM			587,566.20	961,680.83
IARTQX			753,994.81	674,070.91
ICVR			1,329,582.43	1,317,990.74
ITMC			3,017.91	5,653.08
IVAV			1,469,146.19	1,337,778.54
IEXTMKT			1,282,560.13	1,476,805.90
IAFG			219,277.55	289,961.99
IMDDVX			1,239,809.83	1,384,344.71
IDVR			252,248.60	392,069.68
IFVG			45,647.62	54,564.34
IFCF			4,700,174.94	7,990,151.46
ITEI			3,017.98	4,480.32
IFUSEX			3,689,089.46	4,418,137.61
IBI			3,294.25	3,292.47
ICBF			817,117.08	840,549.55
IPTR			5,138,469.88	5,493,113.44
IPHA			430,325.81	416,899.25
IGCF 36	31-MAR-2016	3.000	240,545.00	261,229.00
IGCF 36	30-JUN-2016	3.000	284,523.68	306,790.70
IGCF 36	30-SEP-2016	3.000	399,166.83	427,090.85
IGCF 36	31-DEC-2016	3.000	339,316.11	360,563.43
IGCF 36	31-MAR-2017	3.000	382,746.41	404,581.44
IGCF 36	30-JUN-2017	3.000	383,081.43	400,931.94
IGCF 36	30-SEP-2017	3.000	486,059.38	505,312.82
IGCF 36	31-DEC-2017	3.000	678,471.31	699,413.03
IGCF 36	31-MAR-2018	3.000	442,889.88	453,617.10
IGCF 36	30-JUN-2018	3.000	484,507.45	492,228.42
IGCF 36	30-SEP-2018	3.000	346,465.17	349,518.66
IGCF 36	31-DEC-2018	3.000	511,920.42	513,273.14
IGCF 60	31-MAR-2016	3.000	8,871.34	10,222.52
IGCF 60	30-JUN-2016	3.000	68,811.91	79,418.07
IGCF 60	30-SEP-2016	3.000	12,621.21	14,334.56
IGCF 60	31-DEC-2016	3.000	15,215.44	17,158.26
IGCF 60	31-MAR-2017	3.000	11,332.57	12,679.14
IGCF 60	30-JUN-2017	3.000	13,679.78	15,199.10
IGCF 60	30-SEP-2017	3.000	10,154.91	11,194.54
IGCF 60	31-DEC-2017	3.000	13,493.88	14,776.98

SCHEDULE OF ASSETS (HELD AT END OF YEAR)**Southern Ohio Medical Center ERTSA Plan
01-JAN-15 to 31-DEC-15**

27-JAN-16 04:04:03

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
IGCF 60	31-MAR-2018	3.000	10,681.17	11,602.44
IGCF 60	30-JUN-2018	3.000	13,990.12	15,093.47
IGCF 60	30-SEP-2018	3.000	22,006.53	23,537.68
IGCF 60	31-DEC-2018	3.000	25,859.53	27,466.38
IGCF 60	31-MAR-2019	3.000	11,508.63	12,137.34
IGCF 60	30-JUN-2019	3.000	15,160.70	15,879.85
IGCF 60	30-SEP-2019	3.000	14,821.74	15,398.89
IGCF 60	31-DEC-2019	3.000	13,495.04	13,916.70
IGCF 60	31-MAR-2020	3.000	45,082.86	46,291.00
IGCF 60	30-JUN-2020	3.000	18,729.13	19,035.77
IGCF 60	30-SEP-2020	3.000	16,458.18	16,596.49
IGCF 60	31-DEC-2020	3.000	16,148.25	16,166.25
IGCF 84	31-MAR-2016	3.000	112,722.83	137,806.25
IGCF 84	31-MAR-2016	3.400	60,664.00	76,467.64
IGCF 84	30-JUN-2016	3.000	62,798.83	76,513.83
IGCF 84	30-JUN-2016	3.600	102,482.20	129,025.90
IGCF 84	30-SEP-2016	3.600	66,524.74	83,435.19
IGCF 84	30-SEP-2016	3.000	124,415.85	149,867.61
IGCF 84	31-DEC-2016	3.000	167,322.14	200,108.82
IGCF 84	31-MAR-2017	3.000	184,222.27	218,738.44
IGCF 84	30-JUN-2017	3.000	214,941.58	254,324.74
IGCF 84	30-SEP-2017	3.000	188,906.41	221,005.23
IGCF 84	31-DEC-2017	3.000	217,020.40	251,928.62
IGCF 84	31-MAR-2018	3.000	176,940.66	203,836.02
IGCF 84	30-JUN-2018	3.000	268,940.22	307,899.68
IGCF 84	30-SEP-2018	3.000	189,507.70	215,131.02
IGCF 84	31-DEC-2018	3.000	225,297.05	253,920.80
IGCF 84	31-MAR-2019	3.000	211,141.36	236,406.67
IGCF 84	30-JUN-2019	3.000	226,535.55	251,544.34
IGCF 84	30-SEP-2019	3.000	212,524.55	234,192.20
IGCF 84	31-DEC-2019	3.000	233,469.00	255,482.49
IGCF 84	31-MAR-2020	3.000	214,336.60	232,732.82
IGCF 84	30-JUN-2020	3.000	240,307.89	259,095.86
IGCF 84	30-SEP-2020	3.000	261,921.28	280,350.85
IGCF 84	31-DEC-2020	3.000	293,595.60	311,838.43
IGCF 84	31-MAR-2021	3.000	218,528.44	230,658.06
IGCF 84	30-JUN-2021	3.000	285,985.36	299,305.01
IGCF 84	30-SEP-2021	3.000	380,593.33	395,162.81
IGCF 84	31-DEC-2021	3.000	380,716.45	392,663.91
IGCF 84	31-MAR-2022	3.000	229,454.85	234,785.23
IGCF 84	30-JUN-2022	3.000	236,548.00	240,292.16
IGCF 84	30-SEP-2022	3.000	246,708.45	248,714.63
IGCF 84	31-DEC-2022	3.000	324,896.17	325,119.86
1DIGF		4.000	53,799.21	159,730.07
IMMF			2,660,173.07	2,714,909.86
			56,845,771.35	66,893,231.48
PARTICIPANT LOANS	VARIOUS	5.250-11.500	1,089,613.12	1,090,603.32
FORFEITURES			28,300.77	28,300.83

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Southern Ohio Medical Center ERTSA Plan
01-JAN-15 to 31-DEC-15

27-JAN-16 04:04:03

INVESTMENT OPTION

MATURITY DATE

INTEREST RATE

COST OF ASSETS

CURRENT VALUE

Attachment to Form 5500, Schedule H, Part 4, Item I
 EIN # 310678022

LEGEND

INVESTMENT OPTION:

1PS5R Great-West Aggressive Profile I Fund I
 1PS3R Great-West Moderate Profile I Fund I
 1PS1R Great-West Conserv Profile I Fund I
 1IEF Great-West MFS Intl Value Fund I
 1PIO Putnam International Capital Opp R
 1BUFSX Buffalo Small Cap
 1SSG RidgeWorth Small Cap Growth Stock - I
 1AAM Alger Mid Cap Growth I-2
 1CVR Columbia Mid Cap Value Fund R
 1VAV Invesco American Value R
 1AFG American Funds Growth Fund R3
 1DVR Davis New York Venture Fund - R
 1FCF Fidelity VIP II ContraFund
 1FUSEX Fidelity Spartan 500 Index Inv
 1CBF Great-West Loomis Sayles Bond Fund I
 1PHA Putnam High Yield Advantage R
 1GCF 60 Great-West Guaranteed Certificate Fund
 1DIGF Great-West Daily Interest Guarantee Fund

1PS4R Great-West Mod Aggr Profile I Fund I
 1PS2R Great-West Mod Conserv Profile I Fund I
 1AI Artisan International Fund
 1HR-INT Harbor International Instl
 1PCVAX AllianzGI NFJ Small-Cap Value A
 1MR2 Great-West S&P SmallCap 600 Index Fund I
 1RTK Royce Total Return K
 1ARTQX Artisan Mid Cap Value Investor
 1TMC Great-West T Rowe Price MidCap Gr Fund I
 1EXTMKT Vanguard Index Trust-Ext. Market Port
 1MDDVX BlackRock Equity Dividend A
 1FVG Fidelity VIP Growth Portfolio
 1TEI Great-West T. Rowe Price Eq Inc Fund I
 1BI Great-West Bond Index Fund I
 1PTR PIMCO Total Return Admin
 1GCF 36 Great-West Guaranteed Certificate Fund
 1GCF 84 Great-West Guaranteed Certificate Fund
 1MMF Great-West Money Market Fund I

COST OF ASSETS: The original cost of the assets in each investment option as of the last day of the plan year

CURRENT VALUE: The value of all assets in each investment option as of the last day of the plan year

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

SOMC Medical Care Foundation, Inc TSA Plan
01-JAN-15 to 31-DEC-15

27-JAN-16 04:49:42

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
IPS5R			98,602.52	119,152.64
IPS4R			260,349.45	348,848.21
IPS3R			20,465.50	20,941.72
IPS2R			6,517.79	9,005.61
IPS1R			744,134.92	848,152.02
IAI			268,865.81	294,185.15
IEF			684,566.82	722,167.83
IHR-INT			309,470.63	286,713.54
IPIO			7,863.10	7,635.78
IPCVAX			97,543.26	81,677.79
IBUFSX			121,468.91	83,155.33
IRTK			104,624.29	98,518.46
IAAM			263,077.81	378,710.33
IARTQX			90,809.91	78,688.74
ICVR			341,835.66	332,100.82
IVAV			467,381.18	424,078.69
IEXTMKT			426,349.65	437,987.56
IAFG			140,430.36	162,069.57
IMDDVX			307,380.66	296,184.24
IDVR			0.08	0.13
IFCF			448,119.80	687,516.58
IFUSEX			1,102,021.67	1,259,584.67
ICBF			199,902.67	206,510.05
IPTR			1,095,681.84	1,132,246.47
IPHA			66,820.84	65,715.55
IGCF 36	30-JUN-2017	3.000	201.65	211.29
IGCF 36	30-SEP-2017	3.000	245.00	254.75
IGCF 36	31-DEC-2017	3.000	227.50	234.83
IGCF 36	31-MAR-2018	3.000	227.50	233.00
IGCF 36	30-JUN-2018	3.000	227.50	231.41
IGCF 36	30-SEP-2018	3.000	227.50	229.57
IGCF 36	31-DEC-2018	3.000	235,129.00	236,172.73
IGCF 84	31-DEC-2017	3.750	341.20	410.20
IGCF 84	30-JUN-2018	3.700	887.12	1,049.62
IGCF 84	31-DEC-2018	3.500	924.19	1,065.19
IGCF 84	30-JUN-2019	3.000	938.91	1,045.49
IGCF 84	31-DEC-2019	3.000	973.46	1,067.92
IGCF 84	30-JUN-2020	3.000	60,190.71	65,039.88
IGCF 84	30-SEP-2020	3.000	1,943.96	2,084.06
IGCF 84	31-DEC-2020	3.000	3,231.77	3,442.40
IGCF 84	31-MAR-2021	3.000	2,618.80	2,768.63
IGCF 84	30-JUN-2021	3.000	3,181.05	3,338.73
IGCF 84	30-SEP-2021	3.000	3,124.06	3,252.59
IGCF 84	31-DEC-2021	3.000	3,172.82	3,277.75
IGCF 84	31-MAR-2022	3.000	2,813.09	2,884.26
IGCF 84	30-JUN-2022	3.000	3,105.40	3,161.40
IGCF 84	30-SEP-2022	3.000	2,812.38	2,841.24
IGCF 84	31-DEC-2022	3.000	2,618.92	2,628.17
IMMF			436,911.72	438,638.53
			8,440,560.34	9,157,111.12

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

SOMC Medical Care Foundation, Inc TSA Plan
01-JAN-15 to 31-DEC-15

27-JAN-16 04:49:42

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
PARTICIPANT LOANS	VARIOUS	5.250-5.250	66,157.82	66,057.50
FORFEITURES			17,263.91	17,263.93

LEGEND

INVESTMENT OPTION:

1PS5R	Great-West Aggressive Profile I Fund I	1PS4R	Great-West Mod Aggr Profile I Fund I
1PS3R	Great-West Moderate Profile I Fund I	1PS2R	Great-West Mod Conserv Profile I Fund I
1PS1R	Great-West Conserv Profile I Fund I	1AI	Artisan International Fund
1IEF	Great-West MFS Intl Value Fund I	1HR-INT	Harbor International Instl
1PIO	Putnam International Capital Opp R	1PCVAX	AllianzGI NFJ Small-Cap Value A
1BUFSX	Buffalo Small Cap	1RTK	Royce Total Return K
1AAM	Alger Mid Cap Growth I-2	1ARTQX	Artisan Mid Cap Value Investor
1CVR	Columbia Mid Cap Value Fund R	1VAV	Invesco American Value R
1EXTMKT	Vanguard Index Trust-Ext. Market Port	1AFG	American Funds Growth Fund R3
1MDDVX	BlackRock Equity Dividend A	1DVR	Davis New York Venture Fund - R
1FCF	Fidelity VIP II ContraFund	1FUSEX	Fidelity Spartan 500 Index Inv
1CBF	Great-West Loomis Sayles Bond Fund I	1PTR	PIMCO Total Return Admin
1PHA	Putnam High Yield Advantage R	1GCF 36	Great-West Guaranteed Certificate Fund
1GCF 84	Great-West Guaranteed Certificate Fund	1MMF	Great-West Money Market Fund I

COST OF ASSETS: The original cost of the assets in each investment option as of the last day of the plan year

CURRENT VALUE: The value of all assets in each investment option as of the last day of the plan year