Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2015** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

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

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
- [x] a single-employer plan;
- [ ] a DFE (specify) ____

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

1b Three-digit plan number (PN) ▶ 012

1c Effective date of plan 01/01/1983

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)
CITY HOSPITAL ASSOCIATION
EAST LIVERPOOL CITY HOSPITAL

425 WEST 5TH STREET
EAST LIVERPOOL, OH 43920

2b Employer Identification Number (EIN) 34-0714583

2c Plan Sponsor's telephone number 330-386-2022

2d Business code (see instructions) 622000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/17/2016	TERI PASCO
	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)
AMERICAN UNITED LIFE INSURANCE CO.
AMERICAN UNITED LIFE INSURANCE CO.

ONE AMERICAN SQUARE, PO BOX 368
INDIANAPOLIS, IN 46206-0368

Preparer's telephone number 800-261-9618

3a Plan administrator's name and address [X] 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**	540
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)**	463
a(2) Total number of active participants at the end of the plan year	**6a(2)**	428
b Retired or separated participants receiving benefits	**6b**	1
c Other retired or separated participants entitled to future benefits	**6c**	83
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	512
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f Total. Add lines **6d** and **6e**.	**6f**	512
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	343
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

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

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G62040	49	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
1670	1008

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
NFP INS SERVICES INC
1250 S CAPITAL OF TEXAS HWY
STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
1670	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GARDNER & WHITE
P.O. BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	1008	N/A	3

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	475564
5	Current value of plan's interest under this contract in separate accounts at year end	5	577086

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	447511
c	Additions: (1) Contributions deposited during the year	7c(1)	11820	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	18082	
	(4) Transferred from separate account	7c(4)	0	
	(5) Other (specify below)	7c(5)	0	
	▶			
	(6)Total additions		7c(6)	29902
d	Total of balance and additions (add lines **7b** and **7c(6)**).		7d	477413
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	324	
	(2) Administration charge made by carrier	7e(2)	5	
	(3) Transferred to separate account	7e(3)	1520	
	(4) Other (specify below)	7e(4)	0	
	▶			
	(5) Total deductions		7e(5)	1849
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	475564

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)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	B01226	117	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
12937	8555

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
NFP INS SERVICES INC
1250 S CAPITAL OF TEXAS HWY STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
12937	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GARDNER & WHITE
P O BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	8555	N/A	3

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	3314899
5	Current value of plan's interest under this contract in separate accounts at year end	5	4896343

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	2903006
c	Additions: (1) Contributions deposited during the year	7c(1)	121532	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	117277	
	(4) Transferred from separate account	7c(4)	340158	
	(5) Other (specify below)	7c(5)	0	
	▶			
	(6)Total additions		7c(6)	578967
d	Total of balance and additions (add lines **7b** and **7c(6)**).		7d	3481973
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	149140	
	(2) Administration charge made by carrier	7e(2)	0	
	(3) Transferred to separate account	7e(3)	17934	
	(4) Other (specify below)	7e(4)	0	
	▶			
	(5) Total deductions		7e(5)	167074
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	3314899

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)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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	**B** Three-digit plan number (PN) ▶
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN	012
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
CITY HOSPITAL ASSOCIATION	34-0714583

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier

AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G62039	91	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
2237	1528

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
2237	0	N/A	3

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

GARDNER & WHITE
P O BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	1528	N/A	3

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	433390
5	Current value of plan's interest under this contract in separate accounts at year end	5	1080882

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	380571
c	Additions: (1) Contributions deposited during the year	7c(1)	44356	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	15770	
	(4) Transferred from separate account	7c(4)	15563	
	(5) Other (specify below)	7c(5)	0	
	▶			
	(6)Total additions		7c(6)	75689
d	Total of balance and additions (add lines **7b** and **7c(6)**).		7d	456260
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	20116	
	(2) Administration charge made by carrier	7e(2)	35	
	(3) Transferred to separate account	7e(3)	2719	
	(4) Other (specify below)	7e(4)	0	
	▶			
	(5) Total deductions		7e(5)	22870
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	433390

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)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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	**B** Three-digit plan number (PN) ▶
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN	012
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
CITY HOSPITAL ASSOCIATION	34-0714583

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

1 Coverage Information:

(a) Name of insurance carrier

AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G62042	24	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
731	496

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
731	0	N/A	3

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

GARDNER & WHITE
P O BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	496	N/A	3

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	254926
5	Current value of plan's interest under this contract in separate accounts at year end	5	220066

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	225105
c	Additions: (1) Contributions deposited during the year	7c(1)	16204	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	9435	
	(4) Transferred from separate account	7c(4)	22796	
	(5) Other (specify below)	7c(5)	0	
	▶			
	(6)Total additions		7c(6)	48435
d	Total of balance and additions (add lines **7b** and **7c(6)**).		7d	273540
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	18614	
	(2) Administration charge made by carrier	7e(2)	0	
	(3) Transferred to separate account	7e(3)	0	
	(4) Other (specify below)	7e(4)	0	
	▶			
	(5) Total deductions		7e(5)	18614
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	254926

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)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN UNITED LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
35-0145825	60895	G62043	84	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
4350	2973

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
NFP INS SERVICES INC
1250 S CAPITAL OF TEXAS HWY STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
4350	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GARDNER & WHITE
P O BOX 40948
INDIANAPOLIS, IN 46240

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
0	2973	N/A	3

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	939855
5	Current value of plan's interest under this contract in separate accounts at year end	5	1882465

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT

b	Balance at the end of the previous year		7b	1054577
c	Additions: (1) Contributions deposited during the year	7c(1)	59183	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	38314	
	(4) Transferred from separate account	7c(4)	31402	
	(5) Other (specify below)	7c(5)	0	
	▶			
	(6)Total additions		7c(6)	128899
d	Total of balance and additions (add lines **7b** and **7c(6)**).		7d	1183476
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	129783	
	(2) Administration charge made by carrier	7e(2)	0	
	(3) Transferred to separate account	7e(3)	113838	
	(4) Other (specify below)	7e(4)	0	
	▶			
	(5) Total deductions		7e(5)	243621
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	939855

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)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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	**B** Three-digit plan number (PN) ▶
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN	012
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
CITY HOSPITAL ASSOCIATION	34-0714583

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

1 Coverage Information:

(a) Name of insurance carrier

HARTFORD LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
06-0974148	88072	082089	84	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 **(c)** Amount	**(d)** Purpose	**(e)** Organization code

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

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

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	1043920
5	Current value of plan's interest under this contract in separate accounts at year end	5	1535871

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP VARIABLE ANNUITY

b	Balance at the end of the previous year		7b	1047924
c	Additions: (1) Contributions deposited during the year	7c(1)	0	
	(2) Dividends and credits	7c(2)	0	
	(3) Interest credited during the year	7c(3)	41224	
	(4) Transferred from separate account	7c(4)	0	
	(5) Other (specify below)	7c(5)	0	
	▶			
	(6)Total additions		7c(6)	41224
d	Total of balance and additions (add lines **7b** and **7c(6)**).		7d	1089148
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	43601	
	(2) Administration charge made by carrier	7e(2)	627	
	(3) Transferred to separate account	7e(3)	1000	
	(4) Other (specify below)	7e(4)	0	
	▶			
	(5) Total deductions		7e(5)	45228
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		7f	1043920

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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

Specify nature of costs ▶

Part IV Provision of Information

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

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

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

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

A Name of plan
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

AMERICAN UNITED LIFE INSURANCE CO

35-0145825

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

MASSMUTUAL

04-1590850

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

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

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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)

AMERICAN UNITED LIFE INSURANCE CO

35-0145825

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50 64 52 59 60 63 66 67	NONE	140	Yes [X] No [ ]	Yes [ ] No [X]	20373	Yes [X] No [ ]

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

MASSMUTUAL

04-1590850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 23 37 38 50 54 59 60 62 63 64 65 66 99	NONE	1646	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	66 67	20373

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN UNITED LIFE INSURANCE CO 35-0145825	ASSET CHARGE

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN CENTURY INVESTMENTS 20-2036524	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
AMERICAN FUNDS 95-1411037	REVENUE SHARING FORMULA - SEE ATTACHED

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
FIDELITY INVESTMENTS 04-2270522	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
FRED ALGER & COMPANY INC 13-2510833	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
GOLDMAN SACHS ASSET MANAGEMENT 13-4166989	REVENUE SHARING FORMULA - SEE ATTACHED

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
INVESCO 74-1881364	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
JANUS CAPITAL GROUP INC 75-3019319	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
OPPENHEIMER FUNDS INC. 13-2527171	REVENUE SHARING FORMULA - SEE ATTACHED

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
PIONEER INVESTMENTS 13-1961193	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
PRUDENTIAL INVESTMENTS 22-3468527	REVENUE SHARING FORMULA - SEE ATTACHED

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
STATE STREET INSTITUTIONAL TRUST 04-2456637	REVENUE SHARING FORMULA - SEE ATTACHED

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	63 60 52 59	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
T ROWE PRICE 52-1184650	REVENUE SHARING FORMULA - SEE ATTACHED

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**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
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT II

b Name of sponsor of entity listed in (a): AMERICAN UNITED LIFE INSURANCE CO

c EIN-PN 35-0145825-000 | **d** Entity code P | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 8456841

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT DC II

b Name of sponsor of entity listed in (a): HARTFORD LIFE INSURANCE COMPANY

c EIN-PN 06-0974148-000 | **d** Entity code P | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 1535871

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN | **d** Entity code | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

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

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

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**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
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	0	0
(2) Participant contributions	1b(2)	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)	1960	0
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	11318189	10192714
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	6058694	6462553
(15) Other	1c(15)	0	0

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	17378843	16655267
Liabilities			
g Benefit claims payable	1g	0	0
h Operating payables	1h	0	0
i Acquisition indebtedness	1i	0	0
j Other liabilities	1j	0	0
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	17378843	16655267

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)	10808	
(B) Participants	2a(1)(B)	834619	
(C) Others (including rollovers)	2a(1)(C)	0	
(2) Noncash contributions	2a(2)	0	
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		845427
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)	0	
(F) Other	2b(1)(F)	219781	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		219781
(2) Dividends: **(A)** Preferred stock	2b(2)(A)	0	
(B) Common stock	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	0	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		0
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)	0	
(B) Other	2b(5)(B)	0	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		0
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		21343
c Other income	2c		0
d Total income. Add all **income** amounts in column (b) and enter total	2d		1086551
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1806320	
(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)		1806320
f Corrective distributions (see instructions)	2f		0
g Certain deemed distributions of participant loans (see instructions)	2g		1960
h Interest expense	2h		0
i Administrative expenses: (1) Professional fees	2i(1)	0	
(2) Contract administrator fees	2i(2)	1847	
(3) Investment advisory and management fees	2i(3)	0	
(4) Other	2i(4)	0	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		1847
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		1810127
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-723576
l Transfers of assets:			
(1) To this plan	2l(1)		0
(2) From this plan	2l(2)		0

Part III Accountant's Opinion

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

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

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

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

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

(1) Name: BLUE & CO., LLC **(2)** EIN: 35-1178661

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

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

Part IV Compliance Questions

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

During the plan year:

		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.)	4a		X		
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X		

			Yes	No	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.)	4c		X		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X		
e	Was this plan covered by a fidelity bond?	4e	X			250000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X		
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X		
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X			
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X		
l	Has the plan failed to provide any benefit when due under the plan?	4l		X		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X		
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n				
o	Did the plan trust incur unrelated business taxable income?	4o				
p	Were in-service distributions made during the plan year?	4p				

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)	Retirement Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 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.**	**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
CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN

B Three-digit plan number (PN) ▶ 012

C Plan sponsor's name as shown on line 2a of Form 5500
CITY HOSPITAL ASSOCIATION

D Employer Identification Number (EIN)
34-0714583

Part I Distributions

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

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

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

EIN(s): 35-0145825 _____

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

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

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

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

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

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

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

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

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

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

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

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

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

Part III Amendments

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

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

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

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

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

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

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

a Name of contributing employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a Enter the percentage of plan assets held as:
Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%

b Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

c What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify):

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

THE CITY HOSPITAL ASSOCIATION D/B/A
EAST LIVERPOOL CITY HOSPITAL
TAX DEFERRED ANNUITY PLAN

MODIFIED CASH BASIS
FINANCIAL STATEMENTS

DECEMBER 31, 2015 AND 2014

CPAs / ADVISORS

blue

THE CITY HOSPITAL ASSOCIATION D/B/A
EAST LIVERPOOL CITY HOSPITAL
TAX DEFERRED ANNUITY PLAN

TABLE OF CONTENTS
DECEMBER 31, 2015 AND 2014

Page

Report of Independent Auditors 1

Financial Statements

Statements of Net Assets Available for Benefits (Modified Cash Basis) 4

Statement of Changes in Net Assets Available for Benefits (Modified Cash Basis) (Year Ended December 31, 2015) 5

Notes to Financial Statements 6

Supplemental Schedule (December 31, 2015) *

Schedule H, line 4i – Schedule of Assets (Held at End of Year) 14

* Other Schedules required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.

CPAs · ADVISORS

blue

Blue & Co., LLC / 8800 Lyra Drive, Suite 450 / Columbus, OH 43240
main 614.885.BLUE (2583) fax 614.885.0580 email blue@blueandco.com

blueandco.com

REPORT OF INDEPENDENT AUDITORS

To the Board of Trustees
The City Hospital Association d/b/a East Liverpool City Hospital Tax Deferred Annuity Plan
East Liverpool, Ohio

We were engaged to audit the accompanying financial statements (modified cash basis) of The City Hospital Association d/b/a East Liverpool City Hospital Tax Deferred Annuity Plan (the "Plan"), which comprise the statements of net assets available for benefits (modified cash basis) as of December 31, 2015 and 2014, and the related statement of changes in net assets available for benefits (modified cash basis) for the year ended December 31, 2015, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting described in Note 2; this includes determining that the modified cash basis of accounting in an acceptable basis for the presentation of the financial statements in the circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by American United Life Insurance Company and Massachusetts Mutual Life Insurance Company, the trustees of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the plan administrator that the trustees hold the Plan's investment assets and executes investment transactions. The plan administrator has obtained certifications from the trustees as of and for the years ended December 31, 2015 and 2014, that the information provided to the plan administrator by the trustees is complete and accurate.

Disclaimer of Opinion

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

Basis of Accounting

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements and supplemental schedule were prepared on the modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America. Our disclaimer of opinion is not modified with respect to that matter.

Subsequent Event – Terminating Plan

The accompanying financial statements have been prepared assuming that the Plan will continue as a going concern. As discussed in Note 10 to the financial statements, the Board of Trustees decided in February 2016 to terminate the Plan, which indicates that the Plan is not a going concern. The financial statements do not include any adjustments that might be necessary upon termination. Our disclaimer of opinion is not modified with respect to this matter.

Change in Accounting Principles

As discussed in Note 3 to the financial statements, the Plan early adopted new accounting guidance, Accounting Standards Update 2015-12, *Plan Accounting Parts I and II*, which simplified the financial statement presentation for its fully benefit-responsive investment contract and eliminates certain disclosures in the notes to the financial statements. Our disclaimer of opinion is not modified with respect to these matters.

Other Matter

The supplemental schedule of assets (held at end of year) is required by the DOL's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and is presented for the purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedule referred to above.

Board of Trustees
The City Hospital Association d/b/a East Liverpool City Hospital
East Liverpool, Ohio

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 trustees, 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 DOL's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

Blue & Co., LLC

Columbus, Ohio
October 7, 2016

THE CITY HOSPITAL ASSOCIATION D/B/A
EAST LIVERPOOL CITY HOSPITAL
TAX DEFERRED ANNUITY PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
(MODIFIED CASH BASIS)
DECEMBER 31, 2015 AND 2014

	2015	2014
Investments		
Investments, at fair value	$ 10,192,714	$ 11,318,189
Fully benefit-responsive investment contracts, at contract value	6,462,553	6,058,694
Total investments	16,655,267	17,376,883
Notes receivable from participants	-	1,960
Net assets available for benefits	$ 16,655,267	$ 17,378,843

See accompanying notes to financial statements.

THE CITY HOSPITAL ASSOCIATION D/B/A
EAST LIVERPOOL CITY HOSPITAL
TAX DEFERRED ANNUITY PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
(MODIFIED CASH BASIS)
YEAR ENDED DECEMBER 31, 2015

	2015
Additions to net assets attributed to:	
Investment income:	
Interest income from investments	$ 219,781
Net appreciation in fair value of investments	21,343
Total investment income	241,124
Contributions:	
Participant	834,619
Employer	10,808
Total contributions	845,427
Total additions	1,086,551
Deductions from net assets attributed to:	
Benefit payments	1,808,280
Administrative expenses	1,847
Total deductions	1,810,127
Net change	(723,576)
Net assets available for benefits:	
Beginning of year	17,378,843
End of year	$ 16,655,267

See accompanying notes to financial statements.

1. DESCRIPTION OF PLAN

The following is a general description of The City Hospital Association d/b/a East Liverpool City Hospital Tax Deferred Annuity Plan (the "Plan"). Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General

The City Hospital Association d/b/a East Liverpool City Hospital (the Organization) established the Plan to cover its employees including non-union management and non-union non-management employees; members of the Service Employees International Union AFL-CIO, Local 257; members of Local 333 of the Glass Molders, Pottery, Plastics and Allied Workers International Union; and members of the Ohio Nurses Association. The Plan covers all employees upon hire and is subject to the provisions of the Employee Retirement Income Security Act (ERISA).

Contributions

Each year, participants may elect to defer a portion of their earnings (as defined) in a specified percentage or in even dollar amounts. Participants who have attained age 50 before the end of the plan year are eligible to make catch-up contributions. Participants may also contribute eligible rollover amounts from other plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Plan currently offers various pooled separate accounts and insurance investment contracts as investment options for participants. The Organization contributes matching contributions in varying amounts based on the group that the eligible employee belongs.

Participants Accounts

Each participant's account is credited with the participant's contribution and allocations of (a) the Organization's contribution (if applicable) and (b) Plan earnings, and charged with an allocation of Plan expenses. The benefit to which a participant is entitled is the benefit that can be provided from the participant's account.

Vesting

Participants are immediately vested in their accounts.

Participant Loans

Effective January 1, 2010, loans are no longer permitted in the Plan. Prior to January 1, 2010, participants were allowed to borrow from their fund accounts up to a maximum equal to lesser of $50,000 or 50 percent of their account balance, whichever was less. The loans are secured by the balance in the participant's account and bear interest at a rate determined by the Plan administrator, as is reasonable in the prevailing market. Principal and interest is paid ratably directly to the Plan by participants.

Payment of Benefits

Upon termination, a participant will receive benefit payment(s) under one of the following method(s) of distribution: a) lump sum b) installment c) annuity d) partial withdrawal.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying financial statements and supplemental schedules were prepared on the modified cash basis of accounting. The modified cash basis of accounting records investments at fair value and loans to participants as loans receivable, income and related assets when received rather than when earned and the expenses when the obligation is paid rather than when the obligation is incurred. Because this method differs from the accepted accrual method of accounting, these statements are not intended to be presented in conformity with accounting principles generally accepted in the United States of America.

Investments held by a defined contribution plan are required to be reported at fair value, except for fully benefit-responsive investment contracts. Contract value is the relevant measure for the portion of the net assets available for benefits of a defined contribution plan attributable to fully benefit-responsive investment contracts because contract value is the amount participants normally would receive if they were to initiate permitted transactions under the terms of the Plan.

Use of Estimates

The preparation of financial statements in conformity with modified cash basis of accounting principles requires management to make estimates that affect the amounts reported in the financial statements. Actual results could differ from those estimates.

Investment Valuation and Income Recognition

The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 5 for discussion of fair value measurements.

Purchases and sale of securities are recorded on a trade-date basis. Interest income and dividend income are recorded on the modified cash basis of accounting recognizing income and related assets when received. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Payment of Benefits

Benefits are recorded when paid.

Participant Loans

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are charged directly to the borrowing participant's account and are included in administrative expenses when incurred. As of December 31, 2015 and 2014, no allowance for credit losses has been recorded. If a participant does not make loan repayments and the plan administrator considers the participant loan to be in default, the loan balance is reduced, and the delinquent participant note receivable is recorded as a benefit payment based on the terms of the plan document.

Operating Expenses

Operating expenses may be paid by the Plan or the Organization.

Subsequent Events

The Plan has evaluated subsequent events through October 7, 2016, the date the financial statements were available to be issued.

3. CHANGE IN ACCOUNTING PRINCIPLES

During 2015, the Plan early adopted Accounting Standards Update 2015-12, *Plan Accounting, Parts I and II* which simplified accounting for certain investments and eliminated previously required disclosure requirements.

Part I specifies that contract value is the relevant measure for fully benefit-responsive investment contracts to be recorded in the statement of net assets available for benefits. Previously, the contract value approximated fair value for these contracts and the adoption of this standard did not have a significant impact on the statement of net assets available for benefits. The accounting policy has been revised to reflect this change.

Part II eliminates certain disclosure requirements for plans. Specifically, investments will be disaggregated by general type (mutual funds, common stocks, bonds) whereas previously they were disaggregated in much greater detail such as by investment objective or industry. In addition, the disclosure of individual investments with a value equal to or greater than 5% of net assets available for benefits has been removed. And finally, plans will present the net appreciation (depreciation) in the aggregate whereas previously it was detailed by the general type of the investment. The 2014 notes to the financial statements have been retroactively restated as required by the standard.

4. INFORMATION CERTIFIED BY THE PLAN'S TRUSTEES

The plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, American United Life Insurance Company (AUL) and Massachusetts Mutual Life Insurance Company (MassMutual), the trustees of the Plan, have certified to the completeness and accuracy of all investments reflected on the accompanying statement of net assets available for benefits as of December 31, 2015 and 2014, and investment related activity reflected in the statement of changes in net assets available for benefits for the year ended December 31, 2015.

5. FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs. The three levels of the fair value hierarchy are described as follows:

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

- Level 2 - Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.

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

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

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2015 and 2014.

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

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2015 and 2014. Classification within the fair value hierarchy table is based on the lowest level of any input that is significant to the fair value measurement.

	Assets at Fair Value as of December 31, 2015			
	Level 1	Level 2	Level 3	Total
Pooled separate accounts	$ -	$ 10,192,714	$ -	$ 10,192,714
Total assets at fair value	$ -	$ 10,192,714	$ -	$ 10,192,714

	Assets at Fair Value as of December 31, 2014			
	Level 1	Level 2	Level 3	Total
Pooled separate accounts	$ -	$ 11,318,189	$ -	$ 11,318,189
Total assets at fair value	$ -	$ 11,318,189	$ -	$ 11,318,189

The Plan's policy is to recognize transfers between levels as of the end of the reporting period. There were no significant transfers between levels during 2015 and 2014.

6. FULLY BENEFIT-RESPONSIVE INVESTMENT CONTRACTS

The Plan holds a portfolio of investment contracts that are traditional investment contracts. These contracts meet the fully benefit-responsive investment contract criteria and therefore are reported at contract value.

Contract value is the relevant measure for fully benefit-responsive investment contracts because this is the amount received by participants if they were to initiate permitted transactions under the terms of the Plan. Contract value represents contributions made under each contract, plus earnings, less participant withdrawals, and administrative expenses.

The traditional investment contracts held by the Plan are guaranteed investment contracts. The contract issuers are contractually obligated to repay the principal and interest at a specified interest rate that is guaranteed to the Plan. The crediting rate is based on a formula established by the contract issuers but may not be less than 4 percent for all investment contracts held by the Plan. The crediting rates are reviewed on a quarterly basis for resetting. The contracts cannot be terminated before the scheduled maturity date.

The Plan's ability to receive amounts due in accordance with fully benefit-responsive investment contracts is dependent on the third-party issuer's ability to meet its financial obligations. The issuer's ability to meet its contractual obligations may be affected by future economic and regulatory developments.

Certain events might limit the ability of the Plan to transact at contract value with the contract issuers. These events may be different under each contract. Examples of such events include the following:

1. The Plan's failure to qualify under Section 401(a) of the Internal Revenue Code or the failure of the trust to be tax-exempt under Section 501(a) of the Internal Revenue Code
2. Premature termination of the contracts
3. Plan termination or merger
4. Changes to the Plan's prohibition on competing investment options
5. Bankruptcy of the plan sponsor or other plan sponsor events (for example, divestitures or spinoffs of a subsidiary) that significantly affect the Plan's normal operations.

No events are probable of occurring that might limit the ability of the Plan to transact at contract value with the contract issuers and that also would limit the ability of the Plan to transact at contract value with the participants.

In addition, certain events allow the issuer to terminate the contracts with the Plan and settle at an amount different from contract value. Those events may be different under each contract. Examples of such events include the following:

1. An uncured violation of the Plan's investment guidelines
2. A breach of material obligation under the contract
3. A material misrepresentation
4. A material amendment to the agreements without the consent of the issuer.

7. RELATED-PARTY TRANSACTIONS AND PARTY-IN-INTEREST TRANSACTIONS

Certain Plan investments are mutual funds managed by AUL and MassMutual. AUL and MassMutual are the trustees as defined by the Plan, and, therefore, these transactions qualify as party-in-interest transactions.

Parties-in-interest are defined under Department of Labor regulations as any fiduciary of the Plan, any party rendering service to the Plan, the Organization and certain others. Investment management fees are paid to AUL and MassMutual, the trustees. AUL is also the Plan's record keeper. Blue & Co., LLC is the independent auditor for the Plan. The aforementioned parties generally receive payment from the Organization.

8. TAX STATUS

The Plan has been designed to qualify under Section 403(b) of the Internal Revenue Code (Code). The terms of the Plan have been prepared to conform with the sample language provided by the Internal Revenue Service (IRS) in Revenue Procedure 2007-71. The plan administrator intends to apply for a determination letter on the Plan once the IRS opens such a program. The Plan is required to operate in conformity with the Code to maintain the tax-exempt status for plan participants under Section 403(b).

9. 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. Because of the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

10. SUBSEQUENT EVENT - PLAN TERMINATION

The Plan's Board of Trustees (the "Board") has determined that this Plan will be terminated under the provisions of ERISA. The Board decided to terminate the Plan in February 2016 and believes that the liquidation of Plan assets will be completed prior to October 31, 2016.

SUPPLEMENTARY INFORMATION

THE CITY HOSPITAL ASSOCIATION D/B/A
EAST LIVERPOOL CITY HOSPITAL
TAX DEFERRED ANNUITY PLAN

SCHEDULE H, LINE 4i – SCHEDULE OF ASSETS
(MODIFIED CASH BASIS)
DECEMBER 31, 2015

Name of Plan Sponsor: The City Hospital Association D/B/A East Liverpool City Hospital Tax Deferred Annuity Plan
EIN: 34-07144583
PIN: 012

(a)	(b) Identity of Issue, Borrower, Lessor, or Similar Party	(c) Description of Investment, including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current Value
		Insurance contracts:		
*	MassMutual	MassMutual Fixed Account	**	$ 1,043,920
*	American United Life Insurance Company (AUL) One America	AUL Fixed Accounts	**	5,418,633
		Total insurance contracts		6,462,553
		Pooled separate accounts:		
*	MassMutual	Hartford Capital Appreciation HLS	**	460,355
		Fidelity VIP II Contrafund	**	148,667
		Fidelity VIP II Asset Manager	**	44,858
		Hartford Total Return Bond HLS	**	9,413
		Hartford Ultrashort Bond	**	1,160
		Calvert VP SRI Balanced Port	**	2,411
		Fidelity VIP Growth	**	108,058
		Oppenheimer Global	**	2,732
		Hartford Stock HLS	**	118,137
		Hartford International Opps HLS	**	6,180
		Hartford Balanced HLS	**	170,283
		American Century VP Capital Appreciation	**	28,718
		Hartford Dividend & Growth HLS	**	128,614
		UIF Mid Cap Growth Portfolio	**	887
		HIMCO VIT Index	**	161,696
		UIF US Real Estate Portfolio	**	16,229
		Hartford Small Cap Growth	**	29,103
		Fidelity VIP Overseas	**	53,842
		Hartford US Govt Sec HLS	**	1,241
		Franklin Income VIP	**	2,334
		Royce Capital SM-Cap Portfolio	**	14,828
		Pioneer VCT Mid Cap Value	**	199
		American Funds INS Series GR	**	1,489
		Putnam VT Small Cap Value	**	18,469
		PIMCO VIT Real Return	**	2,605
		AB VPS International Value	**	2,826
		Fidelity VIP Freedom 2030	**	411
		Fidelity VIP Freedom 2020	**	126

See Report of Independent Auditors

THE CITY HOSPITAL ASSOCIATION D/B/A
EAST LIVERPOOL CITY HOSPITAL
TAX DEFERRED ANNUITY PLAN

SCHEDULE H, LINE 4i – SCHEDULE OF ASSETS
(MODIFIED CASH BASIS)
DECEMBER 31, 2015

Name of Plan Sponsor: The City Hospital Association D/B/A East Liverpool City Hospital Tax Deferred Annuity Plan
EIN: 34-07144583
PIN: 012

(a)	(b) Identity of Issue, Borrower, Lessor, or Similar Party	(c) Description of Investment, including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current Value
*	American United Life Insurance Company (AUL) One America	American Funds Cap World Growth & Inc	**	278,912
		American Funds Europac Growth	**	252,028
		Goldman Sachs Small Cap Val Inst	**	36,725
		OneAmerica Val O	**	579,802
		OneAmerica Asset Director O	**	331,552
		Fidelity VIP Grth Init	**	79,317
		Fidelity VIP Asset Mngr Init	**	5,895
		Prudential High-Yield Z	**	464,607
		American Century Strat Alloc Agrsv Inv		334,356
		American Century Strat Alloc Mod Inv		913,349
		Alger Cap App Inst	**	1,545,714
		T. Rowe Price Eqty Inc Ins	**	475,797
		T. Rowe Price Midcap Grth R	**	563,810
		T. Rowe Price Ret 2010 Adv	**	859
		T. Rowe Price Ret 2015 Adv	**	90
		T. Rowe Price Ret 2020 Adv	**	618
		T. Rowe Price Ret 2025 Adv	**	95,477
		T. Rowe Price Ret 2030 Adv	**	27,940
		T. Rowe Price Ret 2035 Adv	**	17,082
		T. Rowe Price Ret 2040 Adv	**	227,234
		T. Rowe Price Ret 2045 Adv	**	51,234
		T. Rowe Price Ret 2050 Adv	**	24,448
		T. Rowe Price Ret 2055 Adv	**	11,013
		T. Rowe Price Ret Bal Adv	**	215
		State Street Equity 500 Indx Adm	**	979,658
		Oppenheimer Intl Growth Y	**	348,501
		Prudential Total Return Bond Z	**	338,227
		Vanguard VIF Small Comp Growth Ins	**	672,383
		Total pooled separate accounts		10,192,714
		Total investments		$ 16,655,267

* Indicate parties-in-interest to the Plan

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

See Report of Independent Auditors

Schedule C Attachment for Line Item 3(e)

Plan Name **G62040 CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN**

Plan Number **012** **Plan Year End** **12/31/2015**

EIN **34-0714583**

Revenue Sharing Formula:

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

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

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

Investment Company	Investment Portfolio	Annual Percentage
AMERICAN CENTURY INVESTMENTS	AmerCent Vista A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent Vista Inv	0.35
AMERICAN CENTURY INVESTMENTS	AmerCent Strat Alloc Agrsv Inv	0.35
AMERICAN CENTURY INVESTMENTS	AmerCent Strat Alloc: Mod Inv	0.35
AMERICAN FUNDS	AmerFds EuroPac Grth R4	0.35
AMERICAN FUNDS	AmerFds Cap World Grth&Inc R4	0.35
FIDELITY INVESTMENTS	Fidelity VIP Grth Init	0.15
FIDELITY INVESTMENTS	Fidelity VIP High Inc Init	0.15
FIDELITY INVESTMENTS	Fidelity VIP Overseas Init	0.15
FIDELITY INVESTMENTS	Fidelity VIP Asset Mngr Init	0.15
FRED ALGER & COMPANY, INC	Alger Cap App Inst	0.25
FRED ALGER & COMPANY, INC	Alger SmCap Grth Inst	0.25
GOLDMAN SACHS ASSET MANAGEMENT	GoldmanSachs SmCapVal Inst	0.10
INVESCO	Invesco Glbl Low Vol Eq Yld A	0.50
INVESCO	Invesco Glbl Low Vol Eq Yld R5	0.20
JANUS CAPITAL GROUP, INC	Janus Asp Global Research Inst	0.15
OPPENHEIMER FUNDS INC.	Oppenheimer Intl Grth A	0.50
OPPENHEIMER FUNDS INC.	Oppenheimer Intl Growth Y	0.25

Investment Company	Investment Portfolio	Annual Percentage
PIONEER INVESTMENTS	Pioneer VCT Inst	0.25
PIONEER INVESTMENTS	Pioneer Sel Mid Cap Grth VCT I	0.25
PRUDENTIAL INVESTMENTS	Prudential High-Yield Z	0.25
PRUDENTIAL INVESTMENTS	Prudential Total Return Bond Z	0.25
STATE STREET INSTITUTIONAL TRUST	State Street Equty 500 Idx Adm	0.15
T ROWE PRICE	TRowePrice Ret 2005 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2010 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2015 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2020 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2025 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2030 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2035 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2040 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2045 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2050 Adv	0.40
T ROWE PRICE	TRowePrice Ret 2055 Adv	0.40
T ROWE PRICE	TRowePrice Ret Bal Adv	0.40
T ROWE PRICE	TRowePrice MidCap Grth R	0.65
T ROWE PRICE	TRowePrice Eqty Inc Ins	0.25

Plan Type **3 403ER**

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

Name of Plan: CITY HOSPITAL ASSOCIATION DBA EAST LIVERPOOL HOSPITAL TAX DEFERRED ANNUITY PLAN
Employer Identification Number: 34-0714583
For plan year (beginning/ending): 01-01-2015 TO 12-31-2015 Plan number: 012

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current value
	FRED ALGER & COMPANY INC	ALGER CAP APP INST MUTUAL FUND SHARES	0	1,546,050
	AMERICAN CENTURY INVESTMENTS	AMERCENT STRAT ALLOC AGRSV INV MUTUAL FUND SHARES	0	334,356
	AMERICAN CENTURY INVESTMENTS	AMERCENT STRAT ALLOC: MOD INV MUTUAL FUND SHARES	0	913,349
	AMERICAN FUNDS	AMERFDS CAP WORLD GRTH&INC R4 MUTUAL FUND SHARES	0	278,913
	AMERICAN FUNDS	AMERFDS EUROPAC GRTH R4 MUTUAL FUND SHARES	0	252,028
*	AMERICAN UNITED LIFE INS CO	AUL FIXED ACCOUNT	0	5,418,633
	GOLDMAN SACHS ASSET MANAGEMENT	GOLDMANSACHS SMCAPVAL INST MUTUAL FUND SHARES	0	36,725
*	ONEAMERICA FUNDS INC.	ONEAMERICA ASSET DIRECTOR O MUTUAL FUND SHARES	0	331,217
*	ONEAMERICA FUNDS INC.	ONEAMERICA VAL O MUTUAL FUND SHARES	0	579,802
	OPPENHEIMER FUNDS INC.	OPPENHEIMER INTL GROWTH Y MUTUAL FUND SHARES	0	348,500
	PRUDENTIAL INVESTMENTS	PRUDENTIAL HIGH-YIELD Z MUTUAL FUND SHARES	0	464,607
	PRUDENTIAL INVESTMENTS	PRUDENTIAL TOTAL RETURN BOND Z MUTUAL FUND SHARES	0	338,227
	STATE STREET INSTITUTIONAL TRUST	STATE STREET EQUTY 500 IDX ADM MUTUAL FUND SHARES	0	979,658
	T ROWE PRICE	TROWEPRICE EQTY INC INS MUTUAL FUND SHARES	0	475,797
	T ROWE PRICE	TROWEPRICE MIDCAP GRTH R MUTUAL FUND SHARES	0	563,810
	T ROWE PRICE	TROWEPRICE RET 2010 ADV MUTUAL FUND SHARES	0	859
	T ROWE PRICE	TROWEPRICE RET 2015 ADV MUTUAL FUND SHARES	0	90
	T ROWE PRICE	TROWEPRICE RET 2025 ADV MUTUAL FUND SHARES	0	95,477
	T ROWE PRICE	TROWEPRICE RET 2030 ADV MUTUAL FUND SHARES	0	27,939
	T ROWE PRICE	TROWEPRICE RET 2035 ADV MUTUAL FUND SHARES	0	17,082
	T ROWE PRICE	TROWEPRICE RET 2040 ADV MUTUAL FUND SHARES	0	227,234
	T ROWE PRICE	TROWEPRICE RET 2045 ADV MUTUAL FUND SHARES	0	51,234
	T ROWE PRICE	TROWEPRICE RET 2050 ADV MUTUAL FUND SHARES	0	24,448
	T ROWE PRICE	TROWEPRICE RET BAL ADV MUTUAL FUND SHARES	0	215
	THE VANGUARD GROUP INC	VANGUARD VIF SMALLCOMPGRTH INS MUTUAL FUND SHARES	0	672,383
	HARTFORD LIFE INSURANCE COMPANY	GENERAL ACCOUNT	0	1,043,920
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD CAPITAL APPRECTN HLS	0	460,355
	HARTFORD LIFE INSURANCE COMPANY	FIDELITY VIP II CONTRAFUND	0	148,667
	HARTFORD LIFE INSURANCE COMPANY	FIDELITY VIP II ASSET MANAGER	0	44,858
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD TOTAL RETURN BOND HLS	0	9,413
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD ULTRASHORT BOND	0	1,160
	HARTFORD LIFE INSURANCE COMPANY	CALVERT VP SRI BALANCED PORT	0	2,411
	HARTFORD LIFE INSURANCE COMPANY	FIDELITY VIP GROWTH	0	108,058
	HARTFORD LIFE INSURANCE COMPANY	OPPENHEIMER GLOBAL	0	2,732
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD STOCK HLS	0	118,137
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD INTERNAT'L OPPS HLS	0	6,180
	HARTFORD LIFE INSURANCE COMPANY	LOAN FUND	0	96,602
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD BALANCED HLS	0	170,283
	HARTFORD LIFE INSURANCE COMPANY	AMCENT VP CAPITAL APPRECIATION	0	28,718

	HARTFORD LIFE INSURANCE COMPANY	HARTFORD DIVIDEND & GROWTH HLS	0	128,613
	HARTFORD LIFE INSURANCE COMPANY	UIF MID CAP GROWTH PORTFOLIO	0	887
	HARTFORD LIFE INSURANCE COMPANY	HIMCO VIT INDEX	0	161,696
	HARTFORD LIFE INSURANCE COMPANY	UIF US REAL ESTATE PORTFOLIO	0	16,228
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD SMALLCAP GROWTH	0	29,103
	HARTFORD LIFE INSURANCE COMPANY	FIDELITY VIP OVERSEAS	0	53,842
	HARTFORD LIFE INSURANCE COMPANY	HARTFORD US GOVT SEC HLS	0	1,241
	HARTFORD LIFE INSURANCE COMPANY	FRANKLIN INCOME VIP	0	2,334
	HARTFORD LIFE INSURANCE COMPANY	ROYCE CAPITAL SM-CAP PORTFOLIO	0	14,828
	HARTFORD LIFE INSURANCE COMPANY	PIMCO VIT REAL RETURN	0	2,605
	HARTFORD LIFE INSURANCE COMPANY	AB VPS INTERNATIONAL VALUE	0	2,826
	HARTFORD LIFE INSURANCE COMPANY	PIONEER VCT MID CAP VALUE	0	199
	HARTFORD LIFE INSURANCE COMPANY	AMERICAN FUNDS INS SERIES GR	0	1,489
	HARTFORD LIFE INSURANCE COMPANY	PUTNAM VT SMALL CAP VALUE	0	18,469
	HARTFORD LIFE INSURANCE COMPANY	FIDELITY VIP FREEDOM 2030	0	411