

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

Part II	Basic Plan Information —enter all requested information		
1a	Name of plan <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>	1b	Three-digit plan number (PN) ▶ <u>001</u>
		1c	Effective date of plan <u>07/01/1967</u>
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u> <u>1341 NORTH CLARK STREET</u> <u>CAMBRIDGE, OH 43725</u>	2b	Employer Identification Number (EIN) <u>31-4391798</u>
		2c	Plan Sponsor's telephone number <u>740-439-8179</u>
		2d	Business code (see instructions) <u>622000</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/12/2016	TIM EVANCHO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5 924
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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits..... d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits..... f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6a(1) 356 6a(2) 333 6b 319 6c 134 6d 786 6e 29 6f 815 6g 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: 1A 11 b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	
9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☒ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☐ A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☐ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
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11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

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

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

11c Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2015 This Form is Open to Public Inspection
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015	
Round off amounts to nearest dollar.	
Caution: A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.	
A Name of plan SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN	B Three-digit plan number (PN) 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER	D Employer Identification Number (EIN) 31-4391798
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☐ 100 or fewer ☐ 101-500 ☒ More than 500

Part I	Basic Information			
1	Enter the valuation date: Month 01 Day 01 Year 2015			
2	Assets:			
a	Market value	2a	52373703	
b	Actuarial value	2b	51737052	
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a	For retired participants and beneficiaries receiving payment	326	30840594	30840594
b	For terminated vested participants	242	5806894	5806894
c	For active participants	356	15738186	17338494
d	Total	924	52385674	53985982
4	If the plan is in at-risk status, check the box and complete lines (a) and (b) ☐			
a	Funding target disregarding prescribed at-risk assumptions	4a		
b	Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b		
5	Effective interest rate	5	6.30%	
6	Target normal cost	6	675963	

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE		10/07/2016
JASON C. WELLS	Signature of actuary	Date
AON CONSULTING, INC.	Type or print name of actuary	14-07067
445 HUTCHINSON AVE, SUITE 900 COLUMBUS, OH 43235-8619	Firm name	Most recent enrollment number
	Address of the firm	614-436-8100
		Telephone number (including area code)

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	3266493
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	2735588
9	Amount remaining (line 7 minus line 8)	0	530905
10	Interest on line 9 using prior year's actual return of <u>5.47</u> %	0	29041
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		2174343
b(1)	Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.51</u> %		0
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return		118937
c	Total available at beginning of current plan year to add to prefunding balance.....		2293280
d	Portion of (c) to be added to prefunding balance		2293280
12	Other reductions in balances due to elections or deemed elections	0	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12).....	0	2853226

Part III Funding Percentages			
14	Funding target attainment percentage.....	14	90.54 %
15	Adjusted funding target attainment percentage	15	90.54 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	87.17 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	17	%

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
01/15/2016	600000	0			
04/13/2016	600000	0			
07/13/2016	600000	0			
09/07/2016	14000	0			
			Totals ►	18(b)	1814000
				18(c)	0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date.....	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	1676948
20 Quarterly contributions and liquidity shortfalls:		
a Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No		
b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?..... ☒ Yes ☐ No		
c If line 20a is "Yes," see instructions and complete the following table as applicable:		
Liquidity shortfall as of end of quarter of this plan year		
(1) 1st	(2) 2nd	(3) 3rd
0	0	0
		(4) 4th
		0

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.72 %	2nd segment: 6.11 %	3rd segment: 6.81 %	☐ N/A, full yield curve used
b Applicable month (enter code).....				21b 4
22 Weighted average retirement age				22 62
23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute				

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes ☒ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes ☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	☒ Yes ☐ No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	675963	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	5102156	1409362	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)...	34	2085325	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....	0	1480151	1480151
36 Additional cash requirement (line 34 minus line 35)	36	605174	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	1676948	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	1071774	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	1071774	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years.....	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:			
a Schedule elected	☐ 2 plus 7 years ☐ 15 years		
b Eligible plan year(s) for which the election in line 41a was made	☐ 2008 ☐ 2009 ☐ 2010 ☐ 2011		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		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 <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>31-4391798</u>

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

STATE STREET GLOBAL ADVISORS ONE LINCOLN STREET
BOSTON, MA 02111

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

ALS ADVISORS, INC. 1290 BROADWAY
SUITE 110
DENVER, CO 80203

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

FEDERATED INVESTMENT MANAGEMENT CO 4000 ERICSSON DRIVE
WARRENDALE, PA 15086-7561

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

OPPENHEIMER

13-2527171

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

EATON VANCE INVESTMENT MANAGERS

74-6066759

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

FRANKLIN MUTUAL ADVISORS LLC

PO BOX 33030
ST. PETERSBURG, FL 33733-8030

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

BLACKROCK FUND ADVISORS

13-3806691

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

ARTISAN PARTNERS

PO BOX 8412
BOSTON, MA 02266-8412

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

DIMENSIONAL FUND ADVISORS

201 NORTH TRYON STREET
SUITE 2300
CHARLOTTE, NC 28202

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

HARBOR FUNDS

PO BOX 904660
CHICAGO, IL 60680-4108

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

LOOMIS SAYLES

04-3113274

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

INVESCO POWERSHARES

301 WEST ROOSEVELT ROAD
WHEATON, IL 60187

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

T. ROWE PRICE

52-6559833

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

THIRD AVENUE MANAGEMENT, LLC

622 THIRD AVENUE
NEW YORK, NY 10017

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

THE VANGUARD GROUP

23-2376849

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

WASTCH ADVISORS, INC

505 WAKARA WAY
3RD FLOOR
SALT LAKE CITY, UT 84108

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

FRANKLIN MUTUAL ADVISORS LLC

PO BOX 33030
ST. PETERSBURG, FL 33733-8030

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

HUNTINGTON ASSET ADVISORS

PO BOX 6110
INDIANAPOLIS, IN 46206-6110

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

WESTCHESTER CAPITAL MANAGEMENT LLC

100 SUMMITT LAKE DRIVE
VALHALLA, NY 10595

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

AMERICAN FUNDS

PO BOX 6007
INDIANAPOLIS, IN 46206-6007

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

PRUDENTIAL MUTUAL FUND SERVICES LLC

PO BOX 9658
PROVIDENCE, RI 02940

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

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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)

HUNTINGTON BANK

31-0966785

(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?
21 50	NONE	199851	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

AON CONSULTING

23-2293237

(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?
11 50	NONE	76532	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BLUE AND COMPANY LLC

35-1178661

(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?
10 50	NONE	12000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(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 H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 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 SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER	D Employer Identification Number (EIN) 31-4391798	

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.				
	Assets			
a	Total noninterest-bearing cash	1a		
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)	2675939	1814000
	(2) Participant contributions	1b(2)		
	(3) Other	1b(3)	71091	54953
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1905867	436642
	(2) U.S. Government securities	1c(2)	4471708	3566413
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)	5868269	3769477
	(B) All other	1c(3)(B)		
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)		
	(B) Common	1c(4)(B)	12863506	12937321
	(5) Partnership/joint venture interests	1c(5)		
	(6) Real estate (other than employer real property)	1c(6)		
	(7) Loans (other than to participants)	1c(7)		
	(8) Participant loans	1c(8)		
	(9) Value of interest in common/collective trusts	1c(9)		
	(10) Value of interest in pooled separate accounts	1c(10)		
	(11) Value of interest in master trust investment accounts	1c(11)		
	(12) Value of interest in 103-12 investment entities	1c(12)		
	(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	24846675	26200673
	(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
	(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	52703055	48779479

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h	268264	100532
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	268264	100532

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	52434791	48678947
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Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	1814000	
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		1814000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)	203539	
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		203539
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	819422	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		819422
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	-1632614	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		-1632614

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		1204347

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	4251509	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		4251509
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	288382	
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	420300	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		708682
j Total expenses. Add all expense amounts in column (b) and enter total	2j		4960191

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-3755844
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

☐ Yes ☒ No

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

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

	Yes	No	N/A	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X		
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X		
e Was this plan covered by a fidelity bond?	X			500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	X			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X		
l Has the plan failed to provide any benefit when due under the plan?		X		
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				
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.				
o Did the plan trust incur unrelated business taxable income?				
p Were in-service distributions made during the plan year?				

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?

If "Yes," enter the amount of any plan assets that reverted to the employer this year. ☐ Yes ☒ No Amount:

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

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

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

Part V Trust Information

6a Name of trust
HUNTINGTON BANK

6b Trust's EIN
310966785

6c Name of trustee or custodian

6d Trustee's or custodian's telephone number

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2015 This Form is Open to Public Inspection.
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A Name of plan <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>31-4391798</u>

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

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	<u>0</u>
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>31-0966785</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3	<u>100</u>

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

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?	☐ Yes	☐ No	☒ N/A
If the plan is a defined benefit plan, go to line 8.			
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____	If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)	6a		
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
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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
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Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

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

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

Schedule R (Form 5500) 2015
v. 150123

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

14	Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:		
	a The current year	14a	
	b The plan year immediately preceding the current plan year	14b	
	c The second preceding plan year	14c	
15	Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:		
	a The corresponding number for the plan year immediately preceding the current plan year	15a	
	b The corresponding number for the second preceding plan year	15b	
16	Information with respect to any employers who withdrew from the plan during the preceding plan year:		
	a Enter the number of employers who withdrew during the preceding plan year	16a	
	b If line 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	
17	If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment. ☐		

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

18	If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment ☐
19	If the total number of participants is 1,000 or more, complete lines (a) through (c)
	a Enter the percentage of plan assets held as: Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%
	b Provide the average duration of the combined investment-grade and high-yield debt: ☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more
	c What duration measure was used to calculate line 19(b)? ☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

Part VII	IRS Compliance Questions
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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

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

**FINANCIAL STATEMENTS
AND
SUPPLEMENTAL SCHEDULES**

DECEMBER 31, 2015 AND 2014

CPAs / ADVISORS



**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

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DECEMBER 31, 2015 AND 2014

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* 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.



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blueandco.com

REPORT OF INDEPENDENT AUDITORS

Board of Directors
Southeastern Ohio Regional Medical Center Pension Plan
Cambridge, Ohio

Report on the Financial Statements

We have audited the accompanying financial statements of the Southeastern Ohio Regional Medical Center Pension Plan (the Plan), which comprise the statements of net assets available for benefits as of December 31, 2015 and 2014, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Plan as of December 31, 2015 and 2014, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Change in Accounting Principle

As discussed in Note 3 to the financial statements, the Plan early adopted new accounting guidance, Accounting Standards Update 2015-12, *Plan Accounting Part II*, which eliminates certain disclosures in the notes to the financial statements. Our opinion is not modified with respect to this matter.

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules as listed in the table of contents referred to as "supplemental schedules," are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Blue Co., LLC

Columbus, Ohio

October 4, 2016

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2015 AND 2014

	2015	2014
Investments at fair value		
Cash and cash equivalents	\$ 436,642	\$ 1,905,867
Corporate notes	3,769,477	5,868,269
U.S. Governmental Agency and Municipal issues	3,566,413	4,471,708
Common stocks	12,937,321	12,863,506
Mutual funds	26,200,673	24,846,675
	46,910,526	49,956,025
 Contribution receivable	 1,814,000	 2,675,939
 Accrued investment income	 54,953	 71,091
Total assets		
	48,779,479	52,703,055
 Liabilities		
Accounts payable		
	100,532	268,264
 Net assets available for benefits	 	
	\$ 48,678,947	\$ 52,434,791

See accompanying notes to financial statements.

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

STATEMENTS OF CHANGES IN NET ASSETS
AVAILABLE FOR BENEFITS
YEARS ENDED DECEMBER 31, 2015 AND 2014

	2015	2014
Additions		
Employer contributions	\$ 1,814,000	\$ 2,675,939
Net appreciation in fair value of investments	-	1,415,421
Interest	203,539	271,731
Dividends	819,422	917,738
Total additions	<u>2,836,961</u>	<u>5,280,829</u>
Deductions		
Net depreciation in fair value of investments	1,632,614	-
Benefit payments	4,251,509	2,804,972
Administrative expenses	708,682	453,101
Total deductions	<u>6,592,805</u>	<u>3,258,073</u>
Net change	(3,755,844)	2,022,756
Net assets available for benefits		
Beginning of year	52,434,791	50,412,035
End of year	<u><u>\$ 48,678,947</u></u>	<u><u>\$ 52,434,791</u></u>

See accompanying notes to financial statements.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2015 AND 2014

1. DESCRIPTION OF THE PLAN

The following description of the Southeastern Ohio Regional Medical Center Pension Plan (the Plan) is provided for general information purposes only. Participants should refer to the *Summary Plan Description* for more complete information. Copies of this pamphlet are available from the Southeastern Ohio Regional Medical Center's administrative personnel.

The Plan is a noncontributory defined benefit plan, which provides benefits to all employees of Southeastern Ohio Regional Medical Center (the Medical Center and Plan Sponsor) who meet certain age and length of service requirements and provides for retirement and disability benefits. Benefits under the Plan are generally based on an employee's years of service and compensation. The Plan provides for 100 percent vesting of such benefits after an employee completes five years of service or satisfies the early retirement requirements.

The board of directors resolved to freeze the retirement plan effective April 30, 2007. Accrued benefits for individual participants will not increase; however, service will continue to be credited for vesting and retirement purposes.

Funding Policy

The Medical Center contributes such amounts as are deemed necessary on an actuarial basis to provide the Plan with assets sufficient to meet the benefits to be paid to Plan members. Contributions from the Medical Center have met the Employee Retirement Income Security Act of 1974 (ERISA) minimum funding requirements.

Plan Benefits

Upon retirement, death or permanent disability, a participant's distribution will commence in the form of one of the various annuity options, as selected by the participant. In certain instances, it may be paid in lump sum.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The accompanying financial statements have been prepared on the accrual basis of accounting.

Cash and Cash Equivalents

The Plan defines cash as currency on hand and cash equivalents as highly liquid investments such as certificate deposits, deposit accounts and money market funds.

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2015 AND 2014

Investment Valuation

Investments are stated at fair value as determined by quoted market prices. The fair value represents the market value of listed debt and equity securities. Securities traded on a national securities exchange are valued at the last reported sales price on the last business day of the plan year. Securities traded in the over-the-counter market and listed securities for which no sales were reported on that date are valued at the average of the last reported bid and ask prices.

For certain investments that do not have an established fair value, the Plan's investment advisors have established fair values based on independent appraisals and yields currently available on comparable securities of issuers with similar credit ratings.

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

The Plan presents in the accompanying statements of changes in net assets available for benefits the net appreciation (depreciation) in the fair value of its investments which consists of the realized gains or losses and the unrealized appreciation (depreciation) on those investments.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts in the financial statements and the accompanying notes. Actual results could differ from those estimates.

Payment of Benefits

Benefits are recorded upon distribution.

Administrative Expenses

All costs incurred with regard to the operation of the Plan are paid by the Medical Center and reimbursed by the Plan.

Actuarial Present Value of Accumulated Plan Benefits

Accumulated plan benefits are those estimated future periodic payments, including lump-sum distributions that are attributable under the Plan's provisions to services rendered by the employees to the valuation date. Accumulated plan benefits include benefits expected to be paid to retired or terminated employees or their beneficiaries, and present employees or their

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2015 AND 2014

beneficiaries. Benefits for retired or terminated employees or their beneficiaries are based on employees' compensation during their period of benefit service.

Prior to the freezing of plan benefits, accumulated plan benefits for active employees were based on their annual compensation during the period of benefit service preceding the valuation date. After the freezing of the plan benefits, accumulated plan benefits for active employees is based on years of service and the employee's average last 60-month salary prior to the plan being frozen. Benefits payable under all circumstances are included, to the extent they are deemed attributable to employee service rendered to the valuation date.

The actuarial present value of accumulated plan benefits is determined by the actuarial firm, AON Hewitt, and is that amount which results from applying actuarial assumptions to adjust the accumulated plan benefits earned by the participants to reflect the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

Subsequent Events

The Plan has evaluated subsequent events through October 4, 2016, the date the financial statements were available to be issued.

3. CHANGE IN ACCOUNTING PRINCIPLE

During 2015, the Plan adopted Accounting Standards Update 2015-12, *Plan Accounting, Part II* which eliminated previously required disclosure requirements.

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.

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2015 AND 2014

4. ACCUMULATED PLAN BENEFITS

The accumulated plan benefit information as of the beginning of each plan year is as follows:

	January 1,	
	2015	2014
	(in 000's)	
Actuarial present value of accumulated Plan benefits:		
Vested benefits:		
Participants currently receiving payments	\$ 32,409	\$ 29,535
Other participants	23,836	24,496
	<u>56,245</u>	<u>54,031</u>
Nonvested benefits	1,597	1,725
Total actuarial present value of accumulated plan benefits	<u><u>\$ 57,842</u></u>	<u><u>\$ 55,756</u></u>

The actuarial present value of changes in accumulated plan benefits follows:

	(in 000's)
Balance at beginning of year	\$ 55,756
Interest accumulation	3,398
Benefits paid	(2,805)
Change in actuarial assumptions	1,329
Other	164
Balance at end of year	<u><u>\$ 57,842</u></u>

Significant assumptions underlying the actuarial computations are:

Assumed rate of return on investments	6.25%
Retirement	At normal retirement age (65)
Mortality table	2015 static mortality table for annuitants and non-annuitants
Actuarial cost method	Standard unit credit cost method

These actuarial assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of accumulated plan benefits.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2015 AND 2014

5. INCOME TAX STATUS

The underlying non-standardized prototype plan has received an opinion letter from the Internal Revenue Service (IRS) dated April 16, 2015, stating that the form of the plan is qualified under Section 401 (a) of the Internal Revenue Code and, therefore, the related trust is exempt in accordance with Revenue Procedure 2002-6 and Announcement 2001-77, the Plan Sponsor has determined that it is eligible to and has chosen to rely on the current IRS prototype plan opinion letter. Once qualified, the Plan is required to operate in conformity with the Code to maintain its qualification.

6. RELATED-PARTY TRANSACTIONS AND PARTIES-IN-INTEREST

Parties-in-interest are defined under Department of Labor regulations as any fiduciary of the Plan, any party rendering service to the Plan, the Plan Sponsor and certain others. Investment management fees are paid to Huntington Bank, the trustee. Aon Hewitt serves as the Plan Actuary. Blue & Co., LLC is the independent auditor for the Plan. The aforementioned parties generally receive payment from the Medical Center. Certain administrative expenses, including costs to prepare the annual IRS Form 5500 and the audit of the annual financial statements, are paid by the Medical Center, who is reimbursed by the Plan. As of December 31, 2015 and 2014, the Plan owed the Medical Center \$100,532 and \$268,264, respectively.

7. PLAN TERMINATION

Should the Plan terminate at some future time, the assets of the Plan shall be first used to pay expenses of administration, and then to provide benefits to participants in accordance with Section 4044 of ERISA. If the Plan's net assets are inadequate, the Pension Benefit Guaranty Corporation generally guarantees the payment of vested benefits subject to certain limitations prescribed by ERISA. Whether a particular participant's accumulated plan benefits will be paid depends on the priority of those benefits guaranteed by the Pension Benefit Guaranty Corporation (PBGC) at that time. Some benefits may be fully or partially paid provided for by the then existing assets and the PBGC guarantee, while other benefits may not be provided for at all.

8. RISKS AND UNCERTAINTIES

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

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2015 AND 2014

Plan contributions are made and the actuarial present value of accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption processes, it is at least reasonably possible that changes in these estimates and assumptions in the near term could materially affect the amounts reported and disclosed in the financial statements.

9. FAIR VALUE MEASUREMENTS

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

Mutual funds: Valued at the daily closing prices as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2015 AND 2014

Money market funds: Valued based at the subscription and redemption activity at a \$1 stable net asset value (NAV). However, on a daily basis the funds are valued at their daily NAV calculated using the amortized cost of the securities held in the fund.

Common stocks and preferred stocks: Valued at the closing price reported on the active market on which the individual securities are traded.

Corporate notes: Valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

U.S. Government Agency and Municipal Issues: Valued using pricing models maximizing the use of observable inputs for similar securities.

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 measured at fair value on a recurring basis as of December 31, 2015 are as follows:

	Level 1	Level 2	Level 3	Total
Money market funds	\$ -	\$ 338,532	\$ -	\$ 338,532
Corporate notes	-	3,769,477	-	3,769,477
US governmental agency and municipal issues	-	3,566,413	-	3,566,413
Common stocks	12,937,321	-	-	12,937,321
Mutual funds	26,200,673	-	-	26,200,673
Total assets at fair value	<u>\$ 39,137,994</u>	<u>\$ 7,674,422</u>	<u>\$ -</u>	<u>46,812,416</u>
Certificate of deposit				98,110
Total Investments				<u>\$ 46,910,526</u>

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2015 AND 2014

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

	Level 1	Level 2	Level 3	Total
Money market funds	\$ -	\$ 1,809,193	\$ -	\$ 1,809,193
Corporate notes	-	5,868,269	-	5,868,269
US governmental agency and municipal issues	-	4,471,708	-	4,471,708
Common stocks	12,863,506	-	-	12,863,506
Mutual funds	24,846,675	-	-	24,846,675
Total assets at fair value	<u>\$ 37,710,181</u>	<u>\$ 12,149,170</u>	<u>\$ -</u>	<u>49,859,351</u>
Certificate of deposit				96,674
Total Investments				<u>\$ 49,956,025</u>

The Plan's policy is to recognize transfers, if any, between levels as of the actual date of the event or change in circumstances. No transfers between levels occurred in 2015 and 2014.

10. SUBSEQUENT EVENT

During June 2016, the Medical Center's Board of Directors approved a lump sum cash buy out option to 95 plan participants with a pension value of \$60,000 or less. Approximately 47% of eligible participants accepted the offer, with a total payout of \$1,413,574. This payout terminated approximately 5% of plan participants from the plan.

Supplemental Schedules

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE OF ASSETS HELD AT END OF YEAR
FORM 5500, SCHEDULE H, LINE 4i
DECEMBER 31, 2015

EIN: 31-4391798
PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value
<u>Cash and cash equivalents</u>				
	Bank of America Secondary CD V/R	CD	100,000	98,110
*	Huntington Conservative Deposit Account	Money fund	338,532	338,532
	Total cash and cash equivalents		438,532	436,642
<u>Corporate Notes</u>				
	Amgen Inc.	\$500,000 face amount, 2.500%, due 11/15/2016	527,080	505,185
	Broadcom Corp	\$500,000 face amount, 2.700%, due 11/01/2018	534,875	501,960
	Ecolab Inc	\$500,000 face amount, 3.000%, due 12/08/2016	538,095	507,175
	FMC Technologies	\$500,000 face amount, 2.000%, due 10/01/2017	506,630	492,205
	John Deere Capital Corp	\$500,000 face amount, 2.250%, due 04/17/2019	521,368	502,165
	Laboratory Corp American Holdings Inc	\$500,000 face amount, 3.125%, due 05/15/2016	528,860	503,170
	Murphy Oil Corp	\$500,000 face amount, 2.500%, due 12/01/2017	505,500	458,580
	Thermo Fisher Scientific Inc	\$300,000 face amount, 1.850%, due 01/15/2018	305,529	299,037
	Total Corporate Notes		3,967,937	3,769,477

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE OF ASSETS HELD AT END OF YEAR
FORM 5500, SCHEDULE H, LINE 4i
DECEMBER 31, 2015

EIN: 31-4391798
PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value	
<u>U.S. Government / Agency and Municipal Issues</u>				
Bladen County NC	\$500,000 par value, 1.77% due 5/1/2019	500,000	499,195	
Chargin Falls OH EXMP VLG SD	\$250,000 par value, 1.000% due 12/1/2016	250,000	250,290	
Columbus GA Building Auth Lease	\$500,000 par value, 2.000% due 1/1/2017	520,430	503,175	
FHLMC CMO Series 1316 CLZ	\$2,071,130 par value, 8.000% due 6/15/2022	1,413	1,553	
FHLMC SER-31 CL-Z CMO	\$8,581,400 par value, 8.000% due 4/25/2024	5,427	6,213	
FHLMC SER-1175 CL-D	\$621,450 par value, 8.000% due 11/15/2021	400	429	
FNMA Pool # 47868	\$120,790 par value, 9.000%, due 5/1/2017	54	54	
Loveland OH City School District	\$330,000 par value, 3.000% due 12/1/2016	355,357	336,828	
Myrtle Beach SC	\$500,000 par value, 3.000% due 3/1/2019	539,205	514,730	
Sioux Falls SD Sales Tax Revenue	\$500,000 par value, 2.000% due 11/15/2018	520,260	509,645	
Snohomish County Washington	\$500,000 par value, 2.000% due 12/1/2018	521,895	505,365	
Southampton Town NY	\$220,000 par value, 2.000% due 11/15/2018	226,255	221,280	

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE OF ASSETS HELD AT END OF YEAR FORM 5500, SCHEDULE H, LINE 4i DECEMBER 31, 2015

EIN: 31-4391798

PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)
		Description of Investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value

Southampton Town NY

\$220,000 par value, 2.000%
due 11/15/2019

224,316

3,665,012 **217,656**
3,566,413

Total U.S. Government / Agency and Municipal Issues

Common Stocks

Abbvie Inc	4,319 shares	182,079	255,858
Accenture PLC CL A	1,274 shares	91,031	133,133
Ace Limited	2,296 shares	244,341	268,288
Alphabet Inc - CL A	190 shares	69,532	147,822
Alphabet Inc - CL C	190 shares	69,517	144,187
American Electric Power	955 shares	28,734	55,648
Amgen Inc	1,670 shares	209,702	271,091
Anadarko Petroleum Corp W/1 RT/SH	3,061 shares	264,279	148,703
Analog Devices Inc	2,232 shares	132,558	123,474
Apple Inc	1,141 shares	78,468	120,102
Aqua America Inc	1,990 shares	30,702	59,302
Automatic Data Processing	1,636 shares	80,912	138,602
Ball Corp W/1 PFD STK PUR	790 shares	36,261	57,457
Baxalta Inc	1,525 shares	42,415	59,521
Baxter International Inc w/1 RT/SH	1,525 shares	49,773	58,179
Becton Dickinson	2,624 shares	388,442	404,332
Berkshire Hathaway Inc CL B	2,370 shares	217,155	312,935
Blackrock Inc	986 shares	358,699	335,753
Cardinal Health Inc	1,820 shares	54,213	162,471

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE OF ASSETS HELD AT END OF YEAR FORM 5500, SCHEDULE H, LINE 4i DECEMBER 31, 2015

EIN: 31-4391798

PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value
	Chevron Corporation	2,435 shares	223,575	219,053
	Church & Dwight Co Inc w/1 RT/SH	3,052 shares	226,184	259,054
	Cisco Systems	4,529 shares	130,843	126,488
	Comcast Corp CL A	4,181 shares	210,408	235,934
	Consolidated Edison Inc	880 shares	37,098	56,558
	Constellation Brands Inc CL A	2,721 shares	318,547	387,579
	Cooper Companies Inc	799 shares	131,749	107,226
	CVS Health Corporation	2,543 shares	263,288	248,629
	Dow Chemical	5,278 shares	264,184	271,711
	Du Pont E I DE Nemours & Co	1,687 shares	82,101	112,354
	Duke Energy corp	685 shares	37,999	48,902
	Ebay Inc	1,870 shares	37,125	51,388
	Facebook Inc	2,763 shares	187,652	289,176
	FedEx Corp	1,568 shares	273,255	233,616
	Franklin Res Inc	3,045 shares	133,857	112,117
	Gilead Sciences Inc	1,475 shares	55,379	149,255
	Honeywell International Inc	3,225 shares	252,155	334,013
	Intel Corp	4,529 shares	95,616	156,024
	Johnson & Johnson	1,010 shares	58,675	103,747
	JP Morgan Chase & Co	2,585 shares	125,430	170,688
	KLA-Tencor Corp	2,385 shares	150,347	165,400
	Lowes Companies Inc	3,894 shares	181,110	296,100
	Marriott International Inc	3,478 shares	207,418	233,165
	Mastercard Inc CL A	2,705 shares	262,277	263,359

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE OF ASSETS HELD AT END OF YEAR FORM 5500, SCHEDULE H, LINE 4i DECEMBER 31, 2015

EIN: 31-4391798

PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value
	Microsoft Corp	7,046 shares	327,921	390,912
	National Grid PLC-SP ADR	730 shares	32,209	50,764
	Nike Inc CL B	4,782 shares	175,882	298,875
	Novartis AG ADR	1,540 shares	84,241	132,502
	Oracle Corporation	5,410 shares	173,432	197,627
	Phillips 66	3,286 shares	263,098	268,795
	PNC Financial Services	2,847 shares	263,208	271,348
	Praxair Inc	545 shares	59,996	55,808
	Schlumberger LTD	3,082 shares	252,064	214,970
	Southern Co	1,110 shares	42,881	51,937
	Stericycle Inc	2,353 shares	318,926	283,772
	T-Mobile US Inc	7,600 shares	298,539	297,312
	Texas Instruments Inc	2,615 shares	86,237	143,328
	The Kroger CO	8,652 shares	210,506	361,913
	TJX Companies Inc	3,878 shares	224,144	274,989
	United Health Group Inc	3,416 shares	308,525	401,858
	United Technologies Corp	2,124 shares	200,412	204,053
	Valero Energy Corp	4,012 shares	268,118	283,689
	VF Corp	3,455 shares	154,736	215,074
	Visa Inc Class A Shares	3,571 shares	262,897	276,931
	Wells Fargo & CO	6,852 shares	298,441	372,470
	Total Common Stock		10,881,498	12,937,321

See accompanying report of independent auditor.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE OF ASSETS HELD AT END OF YEAR
FORM 5500, SCHEDULE H, LINE 4i
DECEMBER 31, 2015

EIN: 31-4391798
PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value	
Mutual Funds				
Artisan International Value Fund	32,822.484 units	1,137,782	1,040,801	
Eaton Vance Atlanta Capital Smid-Cap Fund	16,680.721 units	352,151	432,364	
Federated Total Return Bond Fund-Institutional Shares	404,929.04 units	4,445,954	4,312,494	
* Huntington Wealth Preservation Strategy Target Risk	824,402.308 units	10,000,000	10,065,952	
I Shares Core S&P Mid-Cap ETF	8,675.000 units	990,173	1,208,601	
I Shares Core S&P Small-Cap ETF	14,385.000 units	1,181,758	1,583,932	
I Shares MSCI EAFE ETF	36,578.000 units	2,114,469	2,147,860	
I Shares MSCI Emerging Markets ETF	14,710.000 units	623,541	473,515	
Loomis Sayles Global Equity	45,631.291 units	870,831	824,101	
Oppenheimer Developing Markets Fund- Class Y	27,970.251 units	991,812	838,828	
Powershares DB Commodity Index Tracking Fund	9,825.000 units	250,718	131,262	
Powershares Preferred Portfolio	50,025.000 units	741,315	747,874	
SPDR Dow Jones Indust Av Fund	2,587.000 units	260,557	450,112	
T Rowe Price Real Estate Fund	11,451.517 units	272,546	314,802	
Third Avenue Real Estate Value Fund	24,595.739 units	712,190	706,636	
Vanguard Reit Fund	8,190.000 units	597,143	652,989	
Wasatch Long/Short Fund	23,871.084 units	395,699	268,550	
Total Mutual Funds		25,938,639	26,200,673	
Total Investments		\$ 44,891,618	\$ 46,910,526	

* denotes party-in-interest

See accompanying report of independent auditors.

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

SCHEDULE OF REPORTABLE TRANSACTIONS

FORM 5500, SCHEDULE H, LINE 4j

YEAR ENDED DECEMBER 31, 2015

EIN: 31-4391798

PLAN NUMBER: 001

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
Identity of party	Description of asset	Purchase price	Selling price	Lease rental	Expense incurred with transaction	Cost of asset transaction date	Current value of asset on transaction date	Net gain or (loss)
Single transactions representing 5% or more of assets available for plan benefits at the beginning of the year:								
None								
Aggregate transactions representing 5% or more of assets available for plan benefits at the beginning of the year:								
Huntington Conservative Deposit Account	Money market fund	7,293,486	-	-	-	7,293,486	7,293,486	-
Federated Total Return Bond Fund - Institutional Shares	Mutual fund	4,231,899	-	-	-	4,231,899	4,231,899	-
Huntington Conservative Deposit Account	Money market fund	-	7,204,955	-	-	7,204,955	7,204,955	-
Federated Municipal Obligations Fund - Institutional Shares	Mutual fund	-	2,716,860	-	-	2,716,860	2,716,860	-

See accompanying report of independent auditors.

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 26—Schedule of Active Participant Data as of January 1, 2015

Attained Age	Number of Participants and Average Compensation									
	Years of Credited Service									
	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40+
<25										
25-29										
30-34	7	22	4							
35-39	2	18	15							
40-44	2	13	19	17	2					
45-49	1	12	7	7	19	1				
50-54	1	10	7	7	12	15				
55-59	4	14	10	12	13	17	4			
60-64	2	11	8	6	4	4	13	1		
65-69	1	1		4	3	2				
70+				2						

N-356

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, Part V—Statement of Actuarial Assumptions/Methods

Interest Rates for Minimum Funding Purposes	Based on segment rates with a four-month lookback (as of September 2014), each adjusted as needed to fall within the 25-year average interest rate corridor under HATFA
1st Segment Rate	4.72%
2nd Segment Rate	6.11%
3rd Segment Rate	6.81%
Interest Rates for Maximum Tax Purposes	Based on segment rates with a four-month lookback (as of September 2014), without regard to interest rate stabilization
1st Segment Rate	1.15%
2nd Segment Rate	4.06%
3rd Segment Rate	5.15%
Retirement Age	
Active Participants	See Table 1
Terminated Vested Participants	65
Mortality Rates	
Healthy and Disabled	2015 static mortality table for annuitants and non-annuitants per §1.430(h)(3)-1(e)
Withdrawal Rates	See Table 2
Disability Rates	None
Decrement Timing	Beginning of year decrements
Surviving Spouse Benefit	It is assumed that 80% of males and 80% of females have an eligible spouse, and that males are three years older than their spouses.
Benefit Limits	Projected benefits are limited by the current IRC section 415 maximum benefit of \$210,000.

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Valuation of Plan Assets

Smoothed fair market value of assets over the current and prior two years, adjusted for contributions, benefit payments, administrative expenses, and expected earnings. The average value of assets calculated in this manner is further limited to not less than 90% nor more than 110% of fair market value.

A characteristic of this method is that the expected distribution of the value of plan assets is skewed toward understatement relative to the corresponding market values for expected long-term rates of return in excess of the third segment rate under IRC section 430(h)(2)(C)(iii).

Expected Return on Assets

2013 Plan Year

6.25%

2014 Plan Year

6.25%

Trust Expenses Included in Target Normal Cost

Based on prior year administrative expenses and current year PBGC Premium

Actuarial Method

Standard unit credit cost method

Valuation Date

January 1, 2015

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Table 1

Retirement Rates

Age	Standard	Rule of 89
55	2.50%	7.50%
56	2.50%	7.50%
57	2.50%	7.50%
58	2.50%	7.50%
59	2.50%	7.50%
60	5.00%	15.00%
61	5.00%	15.00%
62	20.00%	60.00%
63	10.00%	30.00%
64	10.00%	30.00%
65	30.00%	90.00%
66	30.00%	90.00%
67	100.00%	100.00%

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Table 2

Withdrawal Rates

Age	Rate	Age	Rate
15	9.9384%	45	6.3540%
16	9.9384%	46	6.0053%
17	9.9384%	47	5.6227%
18	9.9384%	48	5.2000%
19	9.9384%	49	4.7337%
20	9.9384%	50	4.2247%
21	9.8898%	51	3.6823%
22	9.8398%	52	3.1228%
23	9.7877%	53	2.5661%
24	9.7331%	54	2.0347%
25	9.6742%	55	1.5488%
26	9.6114%	56	1.1247%
27	9.5438%	57	0.7718%
28	9.4704%	58	0.4939%
29	9.3906%	59	0.2879%
30	9.3031%	60	0.1465%
31	9.2065%	61	0.0594%
32	9.1000%	62	0.0152%
33	8.9820%	63	0.0000%
34	8.8511%	64	0.0000%
35	8.7062%		
36	8.5466%		
37	8.3717%		
38	8.1815%		
39	7.9756%		
40	7.7543%		
41	7.5151%		
42	7.2556%		
43	6.9760%		
44	6.6758%		

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

Part II Basic Plan Information—enter all requested information		
1a Name of plan SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN	1b Three-digit plan number (PN) ▶	001
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) SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER 1341 NORTH CLARK STREET CAMBRIDGE OH 43725		
1c Effective date of plan 07/01/1967		
2b Employer Identification Number (EIN) 31-4391798		
2c Plan Sponsor's telephone number 740-439-8179		
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		<u>10/12/2016</u>	TIM EVANCHO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

3a Plan administrator's name and address ☒ Same as Plan Sponsor		3b Administrator's EIN
		3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name		4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5	924
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)	356
a(2) Total number of active participants at the end of the plan year	6a(2)	333
b Retired or separated participants receiving benefits.....	6b	319
c Other retired or separated participants entitled to future benefits.....	6c	134
d Subtotal. Add lines 6a(2), 6b, and 6c.	6d	786
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	29
f Total. Add lines 6d and 6e.....	6f	815
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
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: 1A 1I		
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:		
9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)		
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☒ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information - Small Plan) (3) ☐ A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☐ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)	

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

Plan Name	Southeast Ohio Regional Medical Center Pension Plan
Plan Sponsor EIN	31-4391798
ERISA Plan No.	001
Plan Year End	12/31/2015

The required attachment noted below is included within the Accountant's Opinion attachment to the Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
5500 Schedule H	Line 4j	Schedule of Reportable Transactions

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2015 This Form is Open to Public Inspection
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

▶ **Round off amounts to nearest dollar.**
▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN	B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER	D Employer Identification Number (EIN) 31-4391798
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☐ 100 or fewer ☐ 101-500 ☒ More than 500

Part I Basic Information			
1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2015</u>			
2 Assets:			
a Market value		2a	52,373,703
b Actuarial value		2b	51,737,052
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	326	30,840,594	30,840,594
b For terminated vested participants	242	5,806,894	5,806,894
c For active participants	356	15,738,186	17,338,494
d Total	924	52,385,674	53,985,982
4 If the plan is in at-risk status, check the box and complete lines (a) and (b) ☐			
a Funding target disregarding prescribed at-risk assumptions		4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor		4b	
5 Effective interest rate	5	6.30%	
6 Target normal cost	6	675,963	

Statement by Enrolled Actuary
To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	<i>Jason C. Wells</i> <i>QCV</i>	10/07/2016
Signature of actuary		Date
JASON C. WELLS		1407067
Type or print name of actuary		Most recent enrollment number
AON CONSULTING, INC.		614-436-8100
Firm name		Telephone number (including area code)
445 HUTCHINSON AVE, SUITE 900		
COLUMBUS OH 43235-8619		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	3,266,493
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	2,735,588
9 Amount remaining (line 7 minus line 8)	0	530,905
10 Interest on line 9 using prior year's actual return of <u>5.47%</u>	0	29,041
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		2,174,343
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.51%</u>		0
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		118,937
c Total available at beginning of current plan year to add to prefunding balance		2,293,280
d Portion of (c) to be added to prefunding balance		2,293,280
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	2,853,226

Part III Funding Percentages

14 Funding target attainment percentage	14	90.54%
15 Adjusted funding target attainment percentage	15	90.54%
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	87.17%
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.	17	%

Part IV Contributions and Liquidity Shortfalls

18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
01/15/2016	600,000	0			
04/13/2016	600,000	0			
07/13/2016	600,000	0			
09/07/2016	14,000	0			
Totals ▶			18(b)	1,814,000	18(c) 0

19

Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a

Contributions allocated toward unpaid minimum required contributions from prior years.....

19a

0

b

Contributions made to avoid restrictions adjusted to valuation date

19b

0

c

Contributions allocated toward minimum required contribution for current year adjusted to valuation date

19c

1,676,948

20

Quarterly contributions and liquidity shortfalls:

a

Did the plan have a “funding shortfall” for the prior year?

☒

Yes

☐

No

b

If line 20a is “Yes,” were required quarterly installments for the current year made in a timely manner?

☒

Yes

☐

No

c

If line 20a is “Yes,” see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.72%	2nd segment: 6.11%	3rd segment: 6.81%	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 4
22 Weighted average retirement age				22 62
23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute				

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes ☒ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	☐ Yes ☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.	☒ Yes ☐ No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	675,963	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	5,102,156	1,409,362	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)	34	2,085,325	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	1,480,151	1,480,151
36 Additional cash requirement (line 34 minus line 35)	36	605,174	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	1,676,948	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	1,071,774	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	1,071,774	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:			
a Schedule elected	☐ 2 plus 7 years ☐ 15 years		
b Eligible plan year(s) for which the election in line 41a was made	☐ 2008 ☐ 2009 ☐ 2010 ☐ 2011		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 19—Discounted Employer Contributions

Year applied for contributions: 2015

Date	Amount	Days to Discount to 1/1/2015 at 6.30%	Interest Adjusted Contribution
January 15, 2016	\$ 600,000	379	\$ 563,119
April 13, 2016	600,000	468	554,792
July 13, 2016	600,000	559	546,406
September 7, 2016	14,000	615	12,631
Total Contribution	\$ 1,814,000		\$ 1,676,948

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 22—Description of Weighted Average Retirement Age

The average retirement age shown in line 22 has been calculated by assuming the following retirement rates and no decrements other than retirement for this calculation. All retirements are assumed to occur at beginning of year.

(a)	(b)	(c)	(d) Product	(e)	(f)	(g) Product
Age	Rate	Weight	(a) × (b) × (c)	Rate	Weight	(a) × (e) × (f)
55	2.50%	1.0000	1.38	7.50%	1.0000	4.13
56	2.50%	0.9750	1.37	7.50%	0.9250	3.89
57	2.50%	0.9506	1.35	7.50%	0.8556	3.66
58	2.50%	0.9269	1.34	7.50%	0.7915	3.44
59	2.50%	0.9037	1.33	7.50%	0.7321	3.24
60	5.00%	0.8811	2.64	15.00%	0.6772	6.09
61	5.00%	0.8370	2.55	15.00%	0.5756	5.27
62	20.00%	0.7952	9.86	60.00%	0.4893	18.20
63	10.00%	0.6362	4.01	30.00%	0.1957	3.70
64	10.00%	0.5725	3.66	30.00%	0.1370	2.63
65	30.00%	0.5153	10.05	90.00%	0.0959	5.61
66	30.00%	0.3607	7.14	90.00%	0.0096	0.57
67	100.00%	0.2525	16.92	100.00%	0.0010	0.06
		Average	63.60			60.49
		Weight	50%			50%
				Weighted Average		62.05

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, Part V—Statement of Actuarial Assumptions/Methods

Interest Rates for Minimum Funding Purposes	Based on segment rates with a four-month lookback (as of September 2014), each adjusted as needed to fall within the 25-year average interest rate corridor under HATFA
1st Segment Rate	4.72%
2nd Segment Rate	6.11%
3rd Segment Rate	6.81%
Interest Rates for Maximum Tax Purposes	Based on segment rates with a four-month lookback (as of September 2014), without regard to interest rate stabilization
1st Segment Rate	1.15%
2nd Segment Rate	4.06%
3rd Segment Rate	5.15%
Retirement Age	
Active Participants	See Table 1
Terminated Vested Participants	65
Mortality Rates	
Healthy and Disabled	2015 static mortality table for annuitants and non-annuitants per §1.430(h)(3)-1(e)
Withdrawal Rates	See Table 2
Disability Rates	None
Decrement Timing	Beginning of year decrements
Surviving Spouse Benefit	It is assumed that 80% of males and 80% of females have an eligible spouse, and that males are three years older than their spouses.
Benefit Limits	Projected benefits are limited by the current IRC section 415 maximum benefit of \$210,000.

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Valuation of Plan Assets

Smoothed fair market value of assets over the current and prior two years, adjusted for contributions, benefit payments, administrative expenses, and expected earnings. The average value of assets calculated in this manner is further limited to not less than 90% nor more than 110% of fair market value.

A characteristic of this method is that the expected distribution of the value of plan assets is skewed toward understatement relative to the corresponding market values for expected long-term rates of return in excess of the third segment rate under IRC section 430(h)(2)(C)(iii).

Expected Return on Assets

2013 Plan Year

6.25%

2014 Plan Year

6.25%

Trust Expenses Included in Target Normal Cost

Based on prior year administrative expenses and current year PBGC Premium

Actuarial Method

Standard unit credit cost method

Valuation Date

January 1, 2015

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Table 1
Retirement Rates

<u>Age</u>	<u>Standard</u>	<u>Rule of 89</u>
55	2.50%	7.50%
56	2.50%	7.50%
57	2.50%	7.50%
58	2.50%	7.50%
59	2.50%	7.50%
60	5.00%	15.00%
61	5.00%	15.00%
62	20.00%	60.00%
63	10.00%	30.00%
64	10.00%	30.00%
65	30.00%	90.00%
66	30.00%	90.00%
67	100.00%	100.00%

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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Table 2

Withdrawal Rates

Age	Rate	Age	Rate
15	9.9384%	45	6.3540%
16	9.9384%	46	6.0053%
17	9.9384%	47	5.6227%
18	9.9384%	48	5.2000%
19	9.9384%	49	4.7337%
20	9.9384%	50	4.2247%
21	9.8898%	51	3.6823%
22	9.8398%	52	3.1228%
23	9.7877%	53	2.5661%
24	9.7331%	54	2.0347%
25	9.6742%	55	1.5488%
26	9.6114%	56	1.1247%
27	9.5438%	57	0.7718%
28	9.4704%	58	0.4939%
29	9.3906%	59	0.2879%
30	9.3031%	60	0.1465%
31	9.2065%	61	0.0594%
32	9.1000%	62	0.0152%
33	8.9820%	63	0.0000%
34	8.8511%	64	0.0000%
35	8.7062%		
36	8.5466%		
37	8.3717%		
38	8.1815%		
39	7.9756%		
40	7.7543%		
41	7.5151%		
42	7.2556%		
43	6.9760%		
44	6.6758%		

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, Part V—Summary of Plan Provisions

General Information

Original Effective Date	July 1, 1967
Effective Date of Last Amendment	January 1, 2009
Plan Year	January 1 to December 31
Employer Fiscal Year	January 1 to December 31
Employer ID Number	31-4391798
Plan Number	001
Plan Administrator	Southeastern Ohio Regional Medical Center

Eligibility

All employees of employer are eligible to participate in the plan on the January 1 nearest the completion of one year of service and attaining age 21. As of April 30, 2007, no new participants shall enter the plan.

Service

Service shall equal total years of service with the employer. A year of credited service is credited for each year in which an employee works 1,800 hours and a pro-rata year if less hours are earned, provided at least 500 hours of service are earned. A break in service occurs at the start of any plan year in which the employee works 500 hours or less for the employer in such year. Service will not be interrupted by:

- (1) A leave of absence granted by the employer;
- (2) A period of service in the Armed Forces of the United States under which employment rights are granted.

An employee will be given credit for his pre-break service if either of the following occurs:

- (1) The employee had a vested interest in his accrued benefit at the time of his break in service; or
- (2) The employee's period of absence was less than his pre-break service, or five years, whichever is greater.

A year of eligibility service is granted for a calendar year in which an employee worked at least 1,000 hours.

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

No credited service shall be earned after April 30, 2007.

Normal Retirement Date

Normal retirement date is the first day of the month coincident with or next following the later of 1) the attainment of age 65 and 2) the fifth anniversary of participation in the plan.

Normal Retirement Benefit

The amount of annual benefit to be paid in monthly installments for life is 1.5% of the average compensation up to covered compensation multiplied by the participant's years of credited service, limited to a maximum of 35, plus 2.15% of the participant's average compensation in excess of covered compensation multiplied by the participant's years of credited service, limited to a maximum of 35.

Average Compensation

The average of the final five years of compensation in which service was earned. Compensation for years were less than one year of service is earned shall be annualized to a 1,800 hour basis. Average compensation is frozen as of April 30, 2007.

Delayed Retirement

A participant may continue in the employment of the employer after his normal retirement date. In such event he will receive at actual retirement or death the greater of the actuarial equivalent of his normal retirement benefit or the accrued benefit as of the delayed retirement date based on service and average compensation to that date.

Accrued Benefit

The accrued benefit at any time prior to a participant's normal retirement date shall be the benefit as calculated in the normal retirement benefit section above, using average compensation and service as of the date of determination.

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Early Retirement Benefits

Upon the completion of 10 years of service and the attainment of age 55, a participant may elect to retire. He may receive a monthly benefit for life beginning at his normal retirement date equal to the accrued benefit at early retirement date. Payments may begin immediately, with the benefit being reduced 1/180th per month for each of the first five years and then 1/360th per month for each additional year that the early retirement date precedes the normal retirement date. If a participant's age plus service sum to at least 89 (called the "Rule of 89"), they may receive their accrued benefit without reduction at early retirement.

Death Benefit

In the event of a married active participant's death, after having become eligible for early retirement, the benefit payable to the spouse will be calculated assuming that the participant had retired on the day prior to death and elected a joint and one-half survivor benefit.

In the event of a married vested participant's death prior to having become eligible for early retirement, the benefit payable to the spouse will be calculated assuming the participant had terminated on the date of death, survived to the earliest retirement age, elected a joint and one-half survivor benefit, and died the next day.

Severance Benefits

Upon the termination of employment after five or more years of vesting service or after reaching normal retirement age, a participant shall be 100% vested in his accrued benefit which will be payable at normal retirement date.

A participant who terminates with 10 or more years of service may elect to receive a reduced benefit as early as age 55.

Optional Methods of Settlement

All optional methods of settlement are actuarially equivalent to the normal form of annuity. If a married participant does not elect the normal form of annuity or does not elect one of the optional methods of settlement described below, then the participant's retirement benefit shall automatically be paid under option [1] below. The options are:

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

- (1) A reduced benefit to be paid during the participant's lifetime with one half the reduced benefit to be continued to his spouse for her lifetime after his death.
- (2) A reduced benefit to be paid during the participant's lifetime with either 66⅔%, 75% or 100% of the reduced benefit to be continued to his spouse for her lifetime after his death.
- (3) A reduced benefit to be paid for either 120 months certain or 180 month certain and thereafter for life.

All optional methods of settlement are actuarially equivalent to the normal form of annuity and are based on the 1971 GAM table for males and 8% interest.

Amendment or Termination of Plan

The employer reserves the right to amend or terminate the plan at any time. Generally, the Pension Benefit Guaranty Corporation reserves the right to terminate the plan if the employer fails to meet the minimum funding standards, or is unable to pay benefits when due.

If the plan is terminated, the plan assets will be distributed among the plan participants based upon a priority allocation procedure and the employer shall be liable for any unfunded vested benefits to the extent required by law.

The above description is a summary only; for additional details, reference should be made to the formal plan document.

Plan Changes Since the Prior

The funding, financial accounting, and plan reporting valuations do not reflect any plan changes.

Other Information to Fully and Fairly Disclose the Actuarial Position of the Plan

Due to software limitations with the electronic filing process, information filed electronically cannot be controlled by the Enrolled Actuary. The values on the signed Schedule SB will govern to the extent there are any differences in the entries filed electronically and the actual data contained on the signed Schedule SB.

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 26—Schedule of Active Participant Data as of January 1, 2015

Number of Participants and Average Compensation

Attained Age	Years of Credited Service									
	<1	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40+
<25										
25-29										
30-34	7	22	4							
35-39	2	18	15							
40-44	2	13	19	17	2					
45-49	1	12	7	7	19	1				
50-54	1	10	7	7	12	15				
55-59	4	14	10	12	13	17	4			
60-64	2	11	8	6	4	4	13	1		
65-69	1	1		4	3	2				
70+				2						

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Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 32—Schedule of Amortization Bases

Type of Base	Present Value of Installment	Date Established	Years Remaining	Amortization Installment
Shortfall	\$ (666,070)	January 1, 2009	1	\$ (666,070)
Shortfall	\$ 2,653,089	January 1, 2010	2	\$ 1,357,129
Shortfall	\$ 2,000,018	January 1, 2011	3	\$ 697,645
Shortfall	\$ (2,764,837)	January 1, 2012	4	\$ (739,736)
Shortfall	\$ 1,508,295	January 1, 2013	5	\$ 330,105
Shortfall	\$ 1,635,760	January 1, 2014	6	\$ 307,906
Shortfall	\$ 735,901	January 1, 2015	7	\$ 122,383

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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Schedule SB, line 19—Discounted Employer Contributions

Year applied for contributions: 2015

Date	Amount	Days to Discount to 1/1/2015 at 6.30%	Interest Adjusted Contribution
January 15, 2016	\$ 600,000	379	\$ 563,119
April 13, 2016	600,000	468	554,792
July 13, 2016	600,000	559	546,406
September 7, 2016	14,000	615	12,631
Total Contribution	\$ 1,814,000		\$ 1,676,948

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 22—Description of Weighted Average Retirement Age

The average retirement age shown in line 22 has been calculated by assuming the following retirement rates and no decrements other than retirement for this calculation. All retirements are assumed to occur at beginning of year.

(a)	(b)	(c)	(d) Product	(e)	(f)	(g) Product
Age	Rate	Weight	(a) × (b) × (c)	Rate	Weight	(a) × (e) × (f)
55	2.50%	1.0000	1.38	7.50%	1.0000	4.13
56	2.50%	0.9750	1.37	7.50%	0.9250	3.89
57	2.50%	0.9506	1.35	7.50%	0.8556	3.66
58	2.50%	0.9269	1.34	7.50%	0.7915	3.44
59	2.50%	0.9037	1.33	7.50%	0.7321	3.24
60	5.00%	0.8811	2.64	15.00%	0.6772	6.09
61	5.00%	0.8370	2.55	15.00%	0.5756	5.27
62	20.00%	0.7952	9.86	60.00%	0.4893	18.20
63	10.00%	0.6362	4.01	30.00%	0.1957	3.70
64	10.00%	0.5725	3.66	30.00%	0.1370	2.63
65	30.00%	0.5153	10.05	90.00%	0.0959	5.61
66	30.00%	0.3607	7.14	90.00%	0.0096	0.57
67	100.00%	0.2525	16.92	100.00%	0.0010	0.06
		Average	63.60			60.49
		Weight	50%			50%
				Weighted Average		62.05

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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Schedule SB, Part V—Summary of Plan Provisions

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Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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Plan Name	Southeast Ohio Regional Medical Center Pension Plan
Plan Sponsor EIN	31-4391798
ERISA Plan No.	001
Plan Year End	12/31/2015

The required attachment noted below is included within the Accountant's Opinion attachment to the Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line Item	Description
5500 Schedule H	Line 4i	Schedule of Assets (Held at End of Year)

Schedule SB Attachment (Form 5500)—2015 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

Schedule SB, line 32—Schedule of Amortization Bases

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