

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 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 2016 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information		
For calendar plan year 2016 or fiscal plan year beginning <u>01/01/2016</u> and ending <u>12/31/2016</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.) ☒ 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.	10/13/2017	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	5 815
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) 333 6a(2) 313 6b 330 6c 78 6d 721 6e 28 6f 749 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) ☐ 0 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 2016 Form M-1 annual report. If the plan was not required to file the 2016 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 2016 This Form is Open to Public Inspection
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For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

▶ **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 <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 or 5500-SF <u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u>	D Employer Identification Number (EIN) <u>31-4391798</u>
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>2016</u>	
2 Assets:	
a Market value	2a <u>48647542</u>
b Actuarial value	2b <u>51216364</u>
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.....	<u>339</u> <u>32357781</u> <u>32357781</u>
b For terminated vested participants.....	<u>143</u> <u>5037346</u> <u>5037346</u>
c For active participants.....	<u>333</u> <u>15401630</u> <u>16881101</u>
d Total.....	<u>815</u> <u>52796757</u> <u>54276228</u>
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 <u>6.08 %</u>
6 Target normal cost.....	6 <u>748066</u>

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		<u>09/15/2017</u>
	Signature of actuary	Date
<u>JASON C. WELLS</u>	Type or print name of actuary	<u>17-07067</u>
<u>AON CONSULTING, INC.</u>	Firm name	Most recent enrollment number
<u>445 HUTCHINSON AVE, SUITE 900</u> <u>COLUMBUS, OH 43235-8619</u>	Address of the firm	<u>614-436-8100</u>
		Telephone number (including area code)

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 ☐

For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2016
v. 160205

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	2853226
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	1480151
9	Amount remaining (line 7 minus line 8)	0	1373075
10	Interest on line 9 using prior year's actual return of <u>-1.25</u> %	0	-17163
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		1071774
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>6.30</u> %		0
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return		-13397
c	Total available at beginning of current plan year to add to prefunding balance		1058377
d	Portion of (c) to be added to prefunding balance		1058377
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	2414289

Part III Funding Percentages			
14	Funding target attainment percentage	14	89.91%
15	Adjusted funding target attainment percentage	15	89.91%
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	90.54%
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
10/14/2016	600000	0			
01/13/2017	600000	0			
Totals ►			18(b)	1200000	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 1137380
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
		0

Part V	Assumptions Used to Determine Funding Target and Target Normal Cost					
21	Discount rate:					
a	Segment rates:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">1st segment: 4.43%</td> <td style="width: 33%;">2nd segment: 5.91%</td> <td style="width: 33%;">3rd segment: 6.65%</td> </tr> </table>	1st segment: 4.43%	2nd segment: 5.91%	3rd segment: 6.65%	☐ N/A, full yield curve used
1st segment: 4.43%	2nd segment: 5.91%	3rd segment: 6.65%				
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	748066			
b	Excess assets, if applicable, but not greater than line 31a	31b	0			
32	Amortization installments:	Outstanding Balance	Installment			
a	Net shortfall amortization installment	5474153	2334939			
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	3083005			
		Carryover balance	Prefunding balance			
35	Balances elected for use to offset funding requirement	0	1945625			
36	Additional cash requirement (line 34 minus line 35)	36	1137380			
37	Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	1137380			
38	Present value of excess contributions for current year (see instructions)					
a	Total (excess, if any, of line 37 over line 36)	38a	0			
b	Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0			
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
		2016
		This Form is Open to Public Inspection.

For calendar plan year 2016 or fiscal plan year beginning **01/01/2016** and ending **12/31/2016**

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
STATE STREET GLOBAL ADVISORS	ONE LINCOLN STREET BOSTON, MA 02111

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
LORD ABBOTT & CO LLC	PO BOX 219363 KANSAS CITY, MO 64121

(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

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

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

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

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

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

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

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

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	189291	Yes ☒ No ☐	Yes ☒ No ☐	0	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	50250	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) 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 2016 This Form is Open to Public Inspection
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For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016		
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
---------------	--------------------------------------

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....	1b(1)	1814000	600000
(2) Participant contributions	1b(2)		
(3) Other.....	1b(3)	54953	66805
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	436642	1563178
(2) U.S. Government securities	1c(2)	3566413	3462340
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	3769477	2794632
(B) All other.....	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common.....	1c(4)(B)	12937321	14139651
(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)	26200673	24621467
(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	48779479	47248073

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h	100532	74250
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	100532	74250

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	48678947	47173823
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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)	1200000	
(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)		1200000
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	5054	
(B) U.S. Government securities	2b(1)(B)	75525	
(C) Corporate debt instruments	2b(1)(C)	93588	
(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)		174167
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	292124	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	522243	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		814367
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	-544085	
(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)		-544085
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	1574944	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		1574944

		(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)		732018
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		3951411

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	4745334	
(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)		4745334
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)	251541	
(2) Contract administrator fees.....	2i(2)		
(3) Investment advisory and management fees.....	2i(3)		
(4) Other	2i(4)	459660	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		711201
j Total expenses. Add all expense amounts in column (b) and enter total	2j		5456535

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-1505124
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:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....

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

	Yes	No	Amount
4a		X	
4b		X	

		Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		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?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			
o Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	4o			

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
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year 3995395. (See instructions.)

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 sections 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 2016 This Form is Open to Public Inspection.
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016		
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	Distributions	
All references to distributions relate only to payments of benefits during the plan year.		
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions		1 0
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 31-0966785		
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 57
Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)	
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ☐ Yes ☐ No ☒ N/A If the plan is a defined benefit plan, go to line 8.		
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____ If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)		6a
b Enter the amount contributed by the employer to the plan for this plan year		6b
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)		6c
If you completed line 6c, skip lines 8 and 9.		
7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ☐ Yes ☐ No ☐ N/A		
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ☐ Yes ☐ No ☒ N/A		
Part III	Amendments	
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. ☒ Increase ☐ Decrease ☐ Both ☐ No		
Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.	
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ☐ Yes ☐ No		
11 a Does the ESOP hold any preferred stock? ☐ Yes ☐ No		
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ☐ Yes ☐ No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ☐ Yes ☐ No		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.		
Schedule R (Form 5500) 2016 v. 160205		

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

Part VII	IRS Compliance Questions
-----------------	---------------------------------

20a Is the plan a 401(k) plan? If "No," skip b	☐ Yes ☐ No
20b How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:	☐ Design-based safe harbor ☐ "Prior year" ADP test ☐ "Current year" ADP test ☐ N/A
21a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:	☐ Ratio percentage test ☐ Average benefit test ☐ N/A
21b Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?	☐ Yes ☐ No
22a If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter / / and the serial number .	
22b If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter / / .	

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

**FINANCIAL STATEMENTS
AND
SUPPLEMENTAL SCHEDULES**

DECEMBER 31, 2016 AND 2015

CPAs / ADVISORS



**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

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DECEMBER 31, 2016 AND 2015

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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.



Blue & Co., LLC / 8800 Lyra Drive, Suite 450 / Columbus, OH 43240

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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, 2016 and 2015, 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, 2016 and 2015, 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.

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 13, 2017

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2016 AND 2015

	2016	2015
Investments at fair value		
Cash and cash equivalents	\$ 1,563,178	\$ 436,642
Corporate notes	2,794,632	3,769,477
U.S. Governmental Agency and Municipal issues	3,462,340	3,566,413
Common stocks	14,139,651	12,937,321
Mutual funds	24,621,467	26,200,673
	46,581,268	46,910,526
 Contribution receivable	 600,000	 1,814,000
 Accrued investment income	 66,805	 54,953
Total assets		
	47,248,073	48,779,479
 Liabilities		
Accounts payable		
	74,250	100,532
 Net assets available for benefits	 	
	\$ 47,173,823	\$ 48,678,947

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, 2016 AND 2015

	2016	2015
Additions		
Employer contributions	\$ 1,200,000	\$ 1,814,000
Net appreciation in fair value of investments	1,762,877	-
Interest	174,167	203,539
Dividends	814,367	819,422
Total additions	<u>3,951,411</u>	<u>2,836,961</u>
Deductions		
Net depreciation in fair value of investments	-	1,632,614
Benefit payments	4,745,334	4,251,509
Administrative expenses	711,201	708,682
Total deductions	<u>5,456,535</u>	<u>6,592,805</u>
Net change	(1,505,124)	(3,755,844)
Net assets available for benefits		
Beginning of year	48,678,947	52,434,791
End of year	<u><u>\$ 47,173,823</u></u>	<u><u>\$ 48,678,947</u></u>

See accompanying notes to financial statements.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

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, 2016 AND 2015

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.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

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 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 13, 2017, the date the financial statements were available to be issued.

3. ACCUMULATED PLAN BENEFITS

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

	January 1, 2016	2015
	(in 000's)	
Actuarial present value of accumulated Plan benefits:		
Vested benefits:		
Participants currently receiving payments	\$ 32,996	\$ 32,409
Other participants	21,636	23,836
	54,632	56,245
Nonvested benefits	1,444	1,597
Total actuarial present value of accumulated plan benefits	<u>\$ 56,076</u>	<u>\$ 57,842</u>

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2016 AND 2015

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

	(in 000's)
Balance at beginning of year	\$ 57,842
Interest accumulation	3,484
Benefits paid	(4,252)
Change in actuarial assumptions	(807)
Other	(191)
Balance at end of year	<u>\$ 56,076</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.

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.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

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, 2016 and 2015, the Plan owed the Medical Center \$74,250 and \$100,532, 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.

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.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

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, 2016 and 2015:

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.

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.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

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, 2016 and 2015. 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, 2016 are as follows:

	Level 1	Level 2	Level 3	Total
Money market funds	\$ -	\$ 1,463,418	\$ -	\$ 1,463,418
Corporate notes	-	2,794,632	-	2,794,632
US governmental agency and municipal issues	-	3,462,340	-	3,462,340
Common stocks	14,139,651	-	-	14,139,651
Mutual funds	24,621,467	-	-	24,621,467
Total assets at fair value	<u>\$ 38,761,118</u>	<u>\$ 7,720,390</u>	<u>\$ -</u>	<u>46,481,508</u>
Certificate of deposit				99,760
Total Investments				<u>\$ 46,581,268</u>

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>

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 2016 and 2015.

**SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER
PENSION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2016 AND 2015

10. PLAN AMENDMENT

During June 2016, the Medical Center's Board of Directors approved a lump sum cash buy out option to 94 plan participants with a pension value of \$60,000 or less. Approximately 58% of eligible participants accepted the offer, with a total payout of \$1,682,246. This payout terminated approximately 6% of plan participants from the plan.

Supplemental Schedules

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE H, LINE 4j - SCHEDULE OF ASSETS HELD AT END OF YEAR DECEMBER 31, 2016

Name of Plan Sponsor:		Southeastern Ohio Regional Medical Center Pension Plan		
Federal Employer Identification Number		31-4391798		
Plan Number:		001		
(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower, Lessor, or Similar Party		Description of Investment	Cost	Current Value
Cash and cash equivalents				
	Bank of America Secondary CD V/R	CD	100,000	99,760
*	Huntington Conservative Deposit Account	Money fund	1,463,418	1,463,418
	Total cash and cash equivalents		1,563,418	1,563,178
Corporate Notes				
	American Express Credit Co	\$250,000 face amount, 2.250%, due 05/05/2021	255,350	247,020
	FMC Technologies	\$500,000 face amount, 2.000%, due 10/01/2017	506,630	500,360
	Gilead Sciences Inc	\$250,000 face amount, 2.550% due 09/01/2020	259,683	252,635
	John Deere Capital Corp	\$500,000 face amount, 2.250%, due 04/17/2019	521,368	505,380
	JP Morgan Chase & Co	\$250,000 face amount, 2.700%, due 05/18/2023	253,693	244,598
	Oracle Corporation	\$250,000 face amount, 2.500%, due 10/15/2022	257,945	247,325
	PNC Bank NA Series BKNT	\$250,000 face amount, 1.450%, due 07/29/2019	250,943	246,600
	Thermo Fisher Scientific Inc	\$300,000 face amount, 1.850%, due 01/15/2018	305,529	300,429
	Wells Fargo & Company Series	\$250,000 face amount, 2.550%, due 12/07/2020	257,870	250,285
	Total Corporate Notes		2,869,011	2,794,632

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE H, LINE 4j - SCHEDULE OF ASSETS HELD AT END OF YEAR DECEMBER 31, 2016

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment	Cost	Current Value
	<u>U.S. Governmental Agency and Municipal Issues</u>			
	Bladen County NC	\$500,000 par value, 1.77% due 5/1/2019	500,000	499,315
	Columbus GA Building Auth Lease	\$500,000 par value, 2.000% due 1/1/2017	520,430	500,000
	FFCB	\$250,000 par value, 2.000% due 11/16/2023	248,750	241,760
	FHLMC CMO Series 1316 CLZ	\$2,071,130 par value, 8.000% due 6/15/2022	1,043	1,134
	FHLMC SER-31 CL-Z CMO	\$8,581,400 par value, 8.000% due 4/25/2024	4,115	4,683
	FHLMC SER-1175 CL-D	\$621,450 par value, 8.000% due 11/15/2021	245	259
	FNMA	\$250,000 par value, 1.400%, due 11/25/2019	250,000	248,568
	FNMA Pool # 47868	\$120,790 par value, 9.000%, due 5/1/2017	16	16
	Myrtle Beach SC	\$500,000 par value, 3.000% due 3/1/2019	539,205	513,370
	Sioux Falls SD Sales Tax Revenue	\$500,000 par value, 2.000% due 11/15/2018	520,260	505,045
	Snohomish County Washington	\$500,000 par value, 2.000% due 12/1/2018	521,895	505,715
	Southampton Town NY	\$220,000 par value, 2.000% due 11/15/2018	226,255	222,171
	Southampton Town NY	\$220,000 par value, 2.000% due 11/15/2019	224,316	220,304
	Total U.S. Governmental Agency and Municipal Issues		3,556,530	3,462,340

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS HELD AT END OF YEAR DECEMBER 31, 2016

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment	Cost	Current Value	Current Value
<u>Common Stocks</u>				
Advansix Inc	141 shares	1,503	3,121	
Amgen Inc	2,670 shares	357,699	390,381	
Analog Devices Inc	6,132 shares	321,320	445,306	
Apple Inc	3,341 shares	290,675	386,955	
Applied Materials Inc	13,240 shares	319,144	427,255	
Automatic Data Processing	3,836 shares	258,104	394,264	
Becton Dickinson	2,524 shares	373,600	417,848	
Berkshire Hathaway Inc CL B	2,470 shares	236,261	402,561	
Blackrock Inc	1,086 shares	388,248	413,266	
Bristol-Myers Squibb Co	6,100 shares	379,718	356,484	
Broadcom LTD	1,970 shares	322,704	348,237	
Chubb Limited	2,896 shares	310,123	382,620	
Church & Dwight Co Inc w/1 RT/SH	8,104 shares	304,544	358,116	
Cisco Systems	12,458 shares	315,045	376,481	
Comcast Corp CL A	4,250 shares	267,668	293,463	
Constellation Brands Inc CL A	2,621 shares	317,798	401,826	
CVS Health Corporation	3,743 shares	377,994	295,360	
Dow Chemical	6,378 shares	308,157	364,949	
Exxon Mobil Corp	4,400 shares	344,960	397,144	
Facebook Inc	3,063 shares	224,862	352,398	
Ford Motor CO	22,200 shares	264,686	269,286	
Honeywell International Inc	3,525 shares	280,430	408,371	
Johnson & Johnson	3,610 shares	312,041	415,908	
JP Morgan Chase & Co	5,985 shares	319,220	516,446	
Lockheed Martin Corporation	1,700 shares	363,853	424,898	
Lowes Companies Inc	4,094 shares	203,314	291,165	
Masco Corp	12,786 shares	304,112	404,293	
Marriott International Inc	4,078 shares	247,540	337,169	
Microsoft Corp	6,346 shares	297,239	394,340	
Nextera Energy Inc	2,500 shares	264,693	298,650	
Nike Inc CL B	4,482 shares	168,214	227,820	

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS HELD AT END OF YEAR DECEMBER 31, 2016

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment	Cost	Current Value
	PNC Financial Services	4,147 shares	374,038	485,033
	Schlumberger LTD	4,250 shares	325,002	356,788
	Southern Co	5,800 shares	280,152	285,302
	T-Mobile US Inc	8,300 shares	324,396	477,333
	TJX Companies Inc	3,778 shares	219,653	283,841
	Valero Energy Corp	5,912 shares	379,498	403,908
	Visa Inc Class A Shares	4,471 shares	328,036	348,827
	Walt Disney CO	2,900 shares	276,599	302,238
	Total Common Stock		11,552,843	14,139,651
	Mutual Funds			
	American Funds - New World Fund - F2	27,477.17 units	1,356,944	1,409,854
	DFA US Small Cap Value Portfolio	44,870.141 units	1,411,130	1,677,695
	Federated Total Return Bond Fund-Institutional Shares	269,672.052 units	2,960,888	2,907,065
	Harbor International Fund	27,808.95 units	1,589,003	1,624,321
	Huntington Wealth Preservation Strategy Target Risk	824,402.308 units	10,000,000	10,667,766
	I Shares Core S&P Small-Cap ETF	7,096.000 units	761,853	975,842
	Lord Abbett Short Duration Fund - Institutional Shares	224,428.232 units	976,263	965,041
	Powershares Preferred Portfolio	50,025.000 units	741,315	711,854
	Prudential Jennison Mid Cap Growth Fund - Class Z	63,549.496 units	2,262,002	2,236,307
	T Rowe Price Real Estate Fund	50,727.075 units	1,313,323	1,445,722
	Total Mutual Funds		23,372,721	24,621,467
	Total Investments		\$ 42,914,523	\$ 46,581,268

* Party-in-interest

See accompanying report of independent auditors.

SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN

SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS YEAR ENDED DECEMBER 31, 2016

Name of Plan Sponsor: Southeastern Ohio Regional Medical Center Pension Plan
Federal Employer Identification Number 31-4391798
Plan Number: 001

(a) Identity of party	(b) Description of asset	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) 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	\$ 14,201,460	\$ -	\$ -	\$ -	\$ 14,201,460	\$ 14,201,460	\$ -
Huntington Conservative Deposit Account	Money market fund	\$ -	\$ 13,076,573	\$ -	\$ -	\$ 13,076,573	\$ 13,076,573	\$ -

See accompanying report of independent auditors.

Schedule SB Attachment (Form 5500)—2016 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, 2016

Attained Age	Number of Participants 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	4	15	1							
35-39	5	20	15							
40-44	1	11	19	14						
45-49		13	8	9	20					
50-54	1	10	4	8	10	12				
55-59	5	14	9	9	12	19	3			
60-64	1	12	7	9	6	5	10	1		
65-69	2			3	1	2	1			
70+					2					

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Schedule SB Attachment (Form 5500)—2016 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 2015), each adjusted as needed to fall within the 25-year average interest rate corridor
1st Segment Rate	4.43%
2nd Segment Rate	5.91%
3rd Segment Rate	6.65%
Interest Rates for Maximum Tax Purposes	Based on segment rates with a four-month lookback (as of September 2015), without regard to interest rate stabilization
1st Segment Rate	1.34%
2nd Segment Rate	4.03%
3rd Segment Rate	5.06%
Retirement Age	
Active Participants	See Table 1
Terminated Vested Participants	Age 65
Mortality Rates	
Healthy and Disabled	2016 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)—2016 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

2014 Plan Year

6.25%

2015 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, 2016

Schedule SB Attachment (Form 5500)—2016 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)—2016 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%
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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 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 2016 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2016 or fiscal plan year beginning <u>01/01/2016</u> and ending <u>12/31/2016</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.) ☒ 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
		1c	Effective date of plan 07/01/1967
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	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>10/12/2017</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	5 815
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) 333
a(2) Total number of active participants at the end of the plan year	6a(2) 313
b Retired or separated participants receiving benefits.....	6b 330
c Other retired or separated participants entitled to future benefits	6c 78
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 721
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 28
f Total. Add lines 6d and 6e	6f 749
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)	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	(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	b General Schedules
(1) ☒ R (Retirement Plan Information)	(1) ☒ H (Financial Information)
(2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) ☐ I (Financial Information – Small Plan)
(3) ☒ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) ☐ 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 2016 Form M-1 annual report. If the plan was not required to file the 2016 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	12/31/2016

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

2016**This Form is Open to Public
Inspection**

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

▶ **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 2016			
2 Assets:			
a Market value.....	2a	48,647,542	
b Actuarial value.....	2b	51,216,364	
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.....	339	32,357,781	32,357,781
b For terminated vested participants.....	143	5,037,346	5,037,346
c For active participants.....	333	15,401,630	16,881,101
d Total.....	815	52,796,757	54,276,228
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	6.08%	
6 Target normal cost.....	6	748,066	

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	Jason C. Wells	09/15/2017
	Signature of actuary	Date
JASON C. WELLS	Type or print name of actuary	1707067
AON CONSULTING, INC.	Firm name	Most recent enrollment number
		614-436-8100
445 HUTCHINSON AVE, SUITE 900		Telephone number (including area code)
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 ☐

For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2016
v. 160205

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	2,853,226
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	1,480,151
9	Amount remaining (line 7 minus line 8).....	0	1,373,075
10	Interest on line 9 using prior year's actual return of <u>-1.25%</u>	0	-17,163
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year).....		1,071,774
	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>6.30%</u>		0
	b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return.....		-13,397
	c Total available at beginning of current plan year to add to prefunding balance.....		1,058,377
	d Portion of (c) to be added to prefunding balance.....		1,058,377
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	2,414,289

Part III		Funding Percentages	
14	Funding target attainment percentage	14	89.91%
15	Adjusted funding target attainment percentage.....	15	89.91%
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	90.54%
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
10/14/2016	600,000	0			
01/13/2017	600,000	0			
Totals ▶			18(b)	1,200,000	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	1,137,380

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	0

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

21 Discount rate:				
a Segment rates:	1st segment: 4.43 %	2nd segment: 5.91 %	3rd segment: 6.65 %	☐ 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	748,066	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	5,474,153	2,334,939	
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	3,083,005	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	0	1,945,625	1,945,625
36 Additional cash requirement (line 34 minus line 35)	36	1,137,380	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	1,137,380	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	0	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
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)—2016 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: 2016

Date	Amount	Days to Discount to 1/1/2016 at 6.08%	Interest Adjusted Contribution
October 14, 2016	\$ 600,000	287	\$ 572,863
January 13, 2017	600,000	378	564,517
Total Contribution	\$ 1,200,000		\$ 1,137,380

Schedule SB Attachment (Form 5500)—2016 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 2015), each adjusted as needed to fall within the 25-year average interest rate corridor
1st Segment Rate	4.43%
2nd Segment Rate	5.91%
3rd Segment Rate	6.65%
Interest Rates for Maximum Tax Purposes	Based on segment rates with a four-month lookback (as of September 2015), without regard to interest rate stabilization
1st Segment Rate	1.34%
2nd Segment Rate	4.03%
3rd Segment Rate	5.06%
Retirement Age	
Active Participants	See Table 1
Terminated Vested Participants	Age 65
Mortality Rates	
Healthy and Disabled	2016 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)—2016 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

2014 Plan Year

6.25%

2015 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, 2016

Schedule SB Attachment (Form 5500)—2016 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)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

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36	8.5466%		
37	8.3717%		
38	8.1815%		
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40	7.7543%		
41	7.5151%		
42	7.2556%		
43	6.9760%		
44	6.6758%		

Schedule SB Attachment (Form 5500)—2016 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	October 1, 2015
Plan Year / 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.

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

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

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.
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.

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

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:

- (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.

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
EIN: 31-4391798 PN: 001

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 Year

The funding valuation reflects a plan change to allow a temporary window during which former employees with deferred vested benefits may elect to take the full value of their benefit, subject to certain limitations, in the form of a lump sum payment as of October 1, 2015. This additional option was available only during the temporary window period.

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

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Schedule SB Attachment (Form 5500)—2016 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, 2016

Attained Age	Number of Participants 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	4	15	1							
35-39	5	20	15							
40-44	1	11	19	14						
45-49		13	8	9	20					
50-54	1	10	4	8	10	12				
55-59	5	14	9	9	12	19	3			
60-64	1	12	7	9	6	5	10	1		
65-69	2			3	1	2	1			
70+					2					

N-333

Schedule SB Attachment (Form 5500)—2016 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	\$ 1,357,129	January 1, 2010	1	\$ 1,357,129
Shortfall	\$ 1,365,695	January 1, 2011	2	\$ 697,645
Shortfall	\$ (2,126,399)	January 1, 2012	3	\$ (739,736)
Shortfall	\$ 1,238,751	January 1, 2013	4	\$ 330,105
Shortfall	\$ 1,414,338	January 1, 2014	5	\$ 307,906
Shortfall	\$ 653,996	January 1, 2015	6	\$ 122,383
Shortfall	\$ 1,570,643	January 1, 2016	7	\$ 259,507

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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Schedule SB, line 19—Discounted Employer Contributions

Year applied for contributions: 2016

Date	Amount	Days to Discount to 1/1/2016 at 6.08%	Interest Adjusted Contribution
October 14, 2016	\$ 600,000	287	\$ 572,863
January 13, 2017	600,000	378	564,517
Total Contribution	\$ 1,200,000		\$ 1,137,380

Schedule SB Attachment (Form 5500)—2016 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	October 1, 2015
Plan Year / 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.

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

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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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.
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.

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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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:

- (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.

Schedule SB Attachment (Form 5500)—2016 Plan Year
Southeastern Ohio Regional Medical Center Pension Plan
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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.

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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	12/31/2016

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)

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Southeastern Ohio Regional Medical Center Pension Plan
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