

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>MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN</u>	1b	Three-digit plan number (PN) ► <u>007</u>
		1c	Effective date of plan <u>07/01/2007</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>MARIETTA MEMORIAL HOSPITAL</u> <u>401 MATTHEW ST.</u> <u>MARIETTA, OH 45750</u>	2b	Employer Identification Number (EIN) <u>31-4379509</u>
		2c	Plan Sponsor's telephone number <u>740-374-1725</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.	10/16/2017	DEEANN GEHLAUF
	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 <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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 1257
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) 1048 6a(2) 1032 6b 30 6c 126 6d 1188 6e 1 6f 1189 6g 1189 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: 2A 2E 2F 2G 2T 3D 3H b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☒ <u>1</u> A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☐ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 A (Form 5500) Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110
		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 MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN	B Three-digit plan number (PN) ► 007
C Plan sponsor's name as shown on line 2a of Form 5500 MARIETTA MEMORIAL HOSPITAL	D Employer Identification Number (EIN) 31-4379509

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

(a) Name of insurance carrier

NATIONWIDE LIFE INSURANCE COMPANY COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
31-4156830	66869	194-84048	1189	01/01/2016	12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid 806	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

TRUSTMONT FINANCIAL GROUP, INC
200 BUSH RUN RD STE A
GREENSBURG, PA 15601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
806			4

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end **4** 376064**5** Current value of plan's interest under this contract in separate accounts at year end..... **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier**6b****c** Premiums due but unpaid at the end of the year**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount**6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year**7b**

297641

c Additions: (1) Contributions deposited during the year**7c(1)**

48211

(2) Dividends and credits.....

7c(2)

0

(3) Interest credited during the year.....

7c(3)

8200

(4) Transferred from separate account

7c(4)

36558

(5) Other (specify below)

7c(5)

29748

▶ TRANSFER FROM OUTSIDE NW-PRINCIPAL

(6) Total additions

7c(6)

122717

d Total of balance and additions (add lines **7b** and **7c(6)**)**7d**

420358

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

7e(1)

41693

(2) Administration charge made by carrier.....

7e(2)

1510

(3) Transferred to separate account

7e(3)

533

(4) Other (specify below)

7e(4)

(5) Total deductions

7e(5)

43736

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**).....**7f**

376622

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Part IV Provision of Information

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

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

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

<div>A</div> <div>Name of plan</div> <div>MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN</div>	<div>B</div> <div>Three-digit plan number (PN)</div> <div>▶</div> <div>007</div>
<div>C</div> <div>Plan sponsor's name as shown on line 2a of Form 5500</div> <div>MARIETTA MEMORIAL HOSPITAL</div>	<div>D</div> <div>Employer Identification Number (EIN)</div> <div>31-4379509</div>

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	
TRUSTMONT ADVISORY GROUP, INC	200 BRUSH RUN ROAD, STE A GREENSBURG, PA 15601

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

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

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

NILES LANKFORD GROUP, INC.

1500 NORTH OAK DRIVE
PLYMOUTH, IN 46563-3431

(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?
49 50 64 99	TPA	34846	Yes ☒ No ☐	Yes ☐ No ☒	2815	Yes ☐ No ☒

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

NATIONWIDE

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 26 49 52 59 60 63 64 99	SERVICE PROVIDER	21548	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NATIONWIDE	15 49 52 64	0
(d) Enter name and EIN (address) of source of indirect compensation NATIONWIDE LIFE INSURANCE COMPANY ONE NATIONWIDE PLAZA COLUMBUS, OH 43215	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. ANNUITY RATE ADJUSTMENT (SEE ATTACHEMENT)	
(a) Enter service provider name as it appears on line 2 NILES LANKFORD GROUP, INC.	(b) Service Codes (see instructions) 49 64 99	(c) Enter amount of indirect compensation 2815
(d) Enter name and EIN (address) of source of indirect compensation 1500 NORTH OAK DRIVE PLYMOUTH, IN 46563-3431	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. ADVISOR/SERVICE PROVIDER FEE AND ADMIN SERVICES FEE/OVERRIDE	
(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
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(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) <small>Internal Revenue Service</small> <small>Department of Labor</small> <small>Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 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 MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN	B Three-digit plan number (PN) ►	007
C Plan sponsor's name as shown on line 2a of Form 5500 MARIETTA MEMORIAL HOSPITAL	D Employer Identification Number (EIN) 31-4379509	

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)	563256	335564
(2) Participant contributions	1b(2)		
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	16420	25510
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other.....	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common.....	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property).....	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans.....	1c(8)		
(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)	3182321	4534467
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	297641	376622
(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	4059638	5272163

Liabilities

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

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	4059638	5272163
---	-----------	---------	---------

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)	1238030	
(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)		1238030
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	8200	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		8200
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		360382
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		1606612

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	336064	
(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)		336064
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)		
(2) Contract administrator fees.....	2i(2)		
(3) Investment advisory and management fees.....	2i(3)	58023	
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		58023
j Total expenses. Add all expense amounts in column (b) and enter total	2j		394087

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		1212525
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 & CO., LLC

(2) EIN: 35-1178661

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

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

Part IV Compliance Questions

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

During the plan year:

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		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			
o 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 (See instructions.)

Part V Trust Information

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

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under 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.
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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 <u>MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN</u>	B Three-digit plan number (PN) ▶ <u>007</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>MARIETTA MEMORIAL HOSPITAL</u>	D Employer Identification Number (EIN) <u>31-4379509</u>

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions	1	
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>31-4156830</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	

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

Part III	Amendments
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9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box.....	☐ Increase	☐ Decrease	☐ Both	☐ No
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Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
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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
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18	If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment	☐
19	If the total number of participants is 1,000 or more, complete lines (a) through (c)	
	a Enter the percentage of plan assets held as: Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%	
	b Provide the average duration of the combined investment-grade and high-yield debt: ☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more	
	c What duration measure was used to calculate line 19(b)? ☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____	

Part VII	IRS Compliance Questions
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20a Is the plan a 401(k) plan? 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 / / .	

MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN

**FINANCIAL STATEMENTS AND
SUPPLEMENTAL SCHEDULE**

DECEMBER 31, 2016 AND 2015

CPAs / ADVISORS



MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN

TABLE OF CONTENTS DECEMBER 31, 2016 AND 2015

Report of Independent Auditors	1
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Financial Statements

Statements of Net Assets Available for Benefits	3
Statement of Changes in Net Assets Available for Benefits	4
Notes to Financial Statements	5

Supplemental Schedule (December 31, 2016) *

Schedule H Part IV Line 4i – Schedule of Assets Held at End of Year	12
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* Other schedules required by the Department of Labor's Rules and Regulations for Reporting and Disclosures under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.



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REPORT OF INDEPENDENT AUDITORS

Board of Directors
Memorial Health System
Marietta, Ohio

Report on Financial Statements

We were engaged to audit the financial statements of the Marietta Health System Hospitals Defined Contribution Plan (the Plan), which comprise the statements of net assets available for benefits as of December 31, 2016 and 2015, and the related statement of changes in net assets available for benefits for the year ended December 31, 2016, 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 conducting the audits in accordance with auditing standards generally accepted in the United States of America. Because of the matter described in the *Basis for Disclaimer of Opinion* paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion.

Basis for Disclaimer of Opinion

As permitted by 29 CFR Section 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 4, which was certified by Nationwide Financial Services, Inc., the trustee of the plan, except for comparing the information with the related information included in the financial statements. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2016 and 2015, that the information provided to the plan administrator by the trustee is complete and accurate.

Board of Directors
Memorial Health System
Marietta, Ohio

Disclaimer of Opinion

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

Other Matter

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

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

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

Blue & Co., LLC

Columbus, Ohio
October 12, 2017

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

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

	2016	2015
Investment at Fair Value		
Investment contract	\$ 376,065	\$ 295,325
Money market fund	25,510	16,420
Mutual funds	4,534,467	3,182,321
Total investments	<u>4,936,042</u>	<u>3,494,066</u>
 Employer contribution receivable	 <u>335,564</u>	 <u>563,256</u>
 Net assets available for benefits	 <u><u>\$ 5,271,606</u></u>	 <u><u>\$ 4,057,322</u></u>

See accompanying notes to financial statements.

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEAR ENDED DECEMBER 31, 2016

	<u>2016</u>
Additions	
Employer contributions	\$ 1,238,030
Net appreciation in fair value of investments	362,141
Interest and dividends	<u>8,200</u>
Total additions	1,608,371
Deductions	
Benefit payments	336,064
Administrative expenses	<u>58,023</u>
Total deductions	<u>394,087</u>
 Net increase	 1,214,284
Net assets available for benefits	
Beginning of year	<u>4,057,322</u>
End of year	<u><u>\$ 5,271,606</u></u>

See accompanying notes to financial statements.

MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2016 AND 2015

1. DESCRIPTION OF THE PLAN

The following is a general description of the Memorial Health System Hospitals Defined Contribution Plan (the "Plan"). Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution plan covering employees of Marietta Health System and Selby General Hospital (the "Plan Sponsors"). The Plan was formed on July 1, 2007, but Plan participants were first eligible for the Plan on January 1, 2009, as there was a two year waiting period before entering into the Plan. The plan was restated effective July 1, 2016. To be eligible to participate in the Plan, employees must complete one year of service, have attained age 21 and not be eligible for Marietta Memorial Hospital Defined Retirement Plan. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

For each plan year, the Plan Sponsors make a contribution for each eligible employee based on the years of service. For eligible participants with 2 to 4 years of service, the Plan Sponsors shall contribute 2% of compensation. For eligible participants with more than 4 years and up to 14 years of service, the Plan Sponsors shall contribute 3% of compensation. For eligible participants with more than 15 years of service, the Plan Sponsors shall contribute 4% of compensation. Participants direct the investment of contributions into various investment options offered by the plan. Employee contributions are not permitted to the Plan.

Participants Accounts

Each participant's account is credited with allocations of (a) the Plan Sponsors' contribution and, (b) Plan earnings, and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting

Participants are fully vested upon entering the plan.

Administrative Expenses

The Plan Sponsors absorb significant operating expenses of the Plan.

MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

Payment of Benefits

Upon termination of service due to death, disability, or retirement, a participant may elect to receive a lump-sum or certain annuities as provided by the Plan document. Normal retirement age is 65. Provisions exist for early, deferred, and disability retirements.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

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

Use of Estimates

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

Investment Valuation and Income Recognition

The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 3 for discussion of fair value measurements.

Purchases and sale 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. Net depreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Payment of Benefits

Benefits are recorded when paid.

Subsequent Events

The Plan has evaluated subsequent events through October 12, 2017, the date the financial statements were available to be issued.

MEMORIAL HEALTH SYSTEM HOSPITALS

DEFINED CONTRIBUTION PLAN

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2016 AND 2015

3. FAIR VALUE OF FINANCIAL INSTRUMENTS

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 as of December 31, 2016 and 2015:

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.

Mutual funds: Valued at the daily closing price 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.

MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2016 AND 2015

Investment contracts: Guaranteed investment contracts are valued at fair value by the insurance company by discounting the related cash flows based on current yields of similar instruments with comparable durations considering the creditworthiness of the issuer. Since the participants transact at contract value, fair value is determined annually for financial statement reporting purposes only. In determining the reasonableness of the methodology, the Board of Directors evaluates a variety of factors including review of existing contracts, economic conditions, industry and market developments, and overall credit ratings. Certain unobservable inputs are assessed through review of contract terms (for example, duration or payout date) while others are substantiated utilizing available market data (for example, swap curve rate).

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2016:

	Level 1	Level 2	Level 3	Total
Investment contracts	\$ -	\$ -	\$ 376,065	\$ 376,065
Money market fund	-	25,510	-	25,510
Mutual funds	4,534,467	-	-	4,534,467
Total assets at fair value	<u>\$ 4,534,467</u>	<u>\$ 25,510</u>	<u>\$ 376,065</u>	<u>\$ 4,936,042</u>

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2015:

	Level 1	Level 2	Level 3	Total
Investment contracts	\$ -	\$ -	\$ 295,325	\$ 295,325
Money market fund	-	16,420	-	16,420
Mutual funds	3,182,321	-	-	3,182,321
Total assets at fair value	<u>\$ 3,182,321</u>	<u>\$ 16,420</u>	<u>\$ 295,325</u>	<u>\$ 3,494,066</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. There were no transfers between hierarchy levels during 2016 or 2015.

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2016 AND 2015

Changes in Fair Value of Level 3 Assets and Related Gains and Losses

The following table sets forth the Plan's assets that are carried at fair value on a recurring basis, classified within Level 3 of the valuation hierarchy for the year ended December 31, 2016:

	2016
Beginning balance	\$ 295,325
Contributions, net exchanges	113,984
Interest income	8,200
Sales, repayments settlements net	(41,444)
Ending balance	<u>\$ 376,065</u>

4. INVESTMENTS

All of the Plan's investments are maintained by Nationwide Financial Services, Inc. (the Trustee) whereby all contributions are remitted to the Trustee and invested. The plan administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, as permitted under such election, the plan administrator has obtained a certification from the Trustee of the Plan that all the information provided by them is complete and accurate. Information included in the accompanying financial statements as to investments, interest income, net appreciation in investments and all information in the supplemental schedule is presented in reliance solely upon this certification.

The Plan has entered into a non-benefit-responsive investment contract with Nationwide Financial Services Inc. Nationwide Financial Services, Inc. maintains the investments in a general non allocated fixed account. This account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The contract is included in the financial statements at fair value which reported to the Plan by Nationwide Financial Services, Inc. The contract's average yield was 2.40% for 2016 and 2015, and the crediting interest rate as of December 31, 2016 and 2015 was 2.40%. Crediting interest rates are determined daily by dividing earned income for the day by the new contract value.

MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2016 AND 2015

5. INCOME TAX STATUS

The Internal Revenue Service has determined and informed the Plan Sponsors by a letter dated March 31, 2014 that the prototype Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code. Although the Plan has been restated since the date of the letter, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the requirements of the Code and, therefore, believe that the Plan is qualified and that the related trust is tax-exempt.

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by various federal and state taxing authorities. Management has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2016 and 2015, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the accompanying financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes it is no longer subject to income tax examinations for years prior to 2013.

6. TRANSACTIONS WITH PARTIES-IN-INTEREST

Certain Plan investments are shares of mutual funds managed by Nationwide Financial Services. Nationwide Financial Services is the trustee as defined by the Plan, and, therefore, these transactions qualify as party-in-interest transactions.

Parties-in-interest are defined under Department of Labor regulations as any fiduciary of the Plan, any party rendering services to the Plan, the Employers and certain others. Investment management fees are paid to the trustee. Niles Lankford Group, Inc. is the Plan's third party administrator. Blue & Co., LLC is the independent auditor for the Plan. The aforementioned parties generally receive payment from the Plan Sponsors.

7. 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 values of investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statement of net assets available for benefits.

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2016 AND 2015

8. PLAN TERMINATION

Although it has not expressed any intent to do so, the Plan Sponsors have the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 SCHEDULE H

The following schedule reconciles amounts in the 2016 and 2015 Statement of Net Assets Available for Benefits and the 2016 Statement of Changes in Net Assets Available for Benefits to amounts on the Form 5500 Schedule H. The differences are due to the financial statements being reported at fair market value and the Form 5500 Schedule H being reported at contract value.

	<u>2016</u>	<u>2015</u>
Net assets available for benefits per Schedule H of Form 5500	\$ 5,272,163	\$ 4,059,638
Adjustment from contract value to fair value for non-fully benefit responsive investment contracts	<u>(557)</u>	<u>(2,316)</u>
Net assets available for benefits per financial statements	<u>\$ 5,271,606</u>	<u>\$ 4,057,322</u>
Net investment gain from registered investment companies per Schedule H of Form 5500	\$ 360,382	
Change in contract value to fair value for non-fully benefit responsive investment contracts	<u>1,759</u>	
Net investment loss from registered investment companies per financial statements	<u>\$ 362,141</u>	

Supplemental Schedule

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

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

EIN: 31-4379509

PN: 007

(a)	(b)	(c)	(d)	(e)
Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value	
Investment contract:				
* Fixed Account	Guaranteed Investment Contract	**	\$	376,065
Money market fund:				
* NW Mny Mkt Inst	Money Market Fund	**		25,510
Mutual funds:				
Abrden Gbl Eq A	Registered Investment Company	**		2,582
AmCent Sht Dr Infl Prt Bd	Registered Investment Company	**		2,035
BlkRk Eq Dvd Inv A	Registered Investment Company	**		355
BlkRk Hi Yld Bd Inv A	Registered Investment Company	**		2,602
BlkRk LgCap Val Inv A	Registered Investment Company	**		542
BlkRk Strat Inc Oppr Inv A	Registered Investment Company	**		1,445
Clvrt Gbl Enrgy Soltns A	Registered Investment Company	**		3,448
Col Sel LgCap Gr R5	Registered Investment Company	**		2,979
DFA Emrg Mkt Cor Inst	Registered Investment Company	**		1,563
DFA Intmd Govt Fixed Income Inst	Registered Investment Company	**		476
DFA US LgCcap Val Inst	Registered Investment Company	**		2,347
Fid Adv Freedom 2025 A	Registered Investment Company	**		1,154
Fid Adv Freedom 2035 A	Registered Investment Company	**		1,602
Fid Adv Freedom 2055 A	Registered Investment Company	**		2,643
Fid Adv Infl Prtct Bd A	Registered Investment Company	**		481
FnklnTmP Gbl Bd A	Registered Investment Company	**		1,772
Harbor Intl Inst	Registered Investment Company	**		2,815
Invsco Gold Prec Mtls Inv	Registered Investment Company	**		2,497
Jns Bal I	Registered Investment Company	**		1,272
Jns Prkns MdCap Val I	Registered Investment Company	**		1,847
JPM Eq Inc A	Registered Investment Company	**		2,427
JPM SmCap Val A	Registered Investment Company	**		737
Loomis Bd Adm	Registered Investment Company	**		1,157
MFS Util R1	Registered Investment Company	**		2,306
MnSty Ttl Rtn Bd I	Registered Investment Company	**		3,944
Natixis Loomis Gr A	Registered Investment Company	**		909
* NW Bd Indx Instl	Registered Investment Company	**		12,493
* NW Dest 2060 Instl	Registered Investment Company	**		7,815
* NW Intl Indx Inst	Registered Investment Company	**		134,013

See accompanying report of independent auditors on pages 1 and 2.

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

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

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PN: 007

(a)	(b)	(c)	(d)	(e)
	Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value
*	NW Dest 2010 Instl	Registered Investment Company	**	17,393
*	NW Dest 2015 Inst	Registered Investment Company	**	80,049
*	NW Dest 2020 Inst	Registered Investment Company	**	160,979
*	NW Dest 2025 Inst	Registered Investment Company	**	269,320
*	NW Dest 2030 Inst	Registered Investment Company	**	287,694
*	NW Dest 2035 Instl	Registered Investment Company	**	332,574
*	NW Dest 2040 Instl	Registered Investment Company	**	359,185
*	NW Dest 2045 Instl	Registered Investment Company	**	404,978
*	NW Dest 2050 Instl	Registered Investment Company	**	339,597
*	NW Dest 2055 Instl	Registered Investment Company	**	123,417
*	NW Inv Dest Aggr Instl	Registered Investment Company	**	187,848
*	NW Inv Dest Mod Instl	Registered Investment Company	**	11,666
*	NW Inv Dest Mod Cnsrv Instl	Registered Investment Company	**	21,569
*	NW MdCap Mkt Indx Inst	Registered Investment Company	**	12,800
*	NW SmCap Indx Instl	Registered Investment Company	**	38,405
*	NW S&P 500 Indx Instl	Registered Investment Company	**	544,523
	Okmrk Fd II	Registered Investment Company	**	1,878
	Opp Intl Growth Fd A	Registered Investment Company	**	2,835
	PIMCO AllAsst AllAthrity A	Registered Investment Company	**	1,419
	PIMCO Unconstrnd Bd A	Registered Investment Company	**	746
	Pioneer Bd A	Registered Investment Company	**	512
	Prudntl Gbl RealEst A	Registered Investment Company	**	2,004
	Prudntl Jnism Gr A	Registered Investment Company	**	914
	Prudntl Ttl Rtn Dbd A	Registered Investment Company	**	2,304
	RydexSGI Bio Adv	Registered Investment Company	**	3,378
	RydexSGI Elctrncs Adv	Registered Investment Company	**	3,401
	RydexSGI Fin Svc Adv	Registered Investment Company	**	2,293
	RydexSGI Util Adc	Registered Investment Company	**	2,288
	T Rowe Pr New Inc R	Registered Investment Company	**	517
	Vngrd 500 Index Fd AS	Registered Investment Company	**	2,943
	Vngrd Emrg Mkt Stk Indx Adlm	Registered Investment Company	**	3,495
	Vngrd Explr Adml	Registered Investment Company	**	1,210
	Vngrd Gr Indx Adml	Registered Investment Company	**	330,325
	Vngrd Hi Yld Corp Adml	Registered Investment Company	**	119,765
	Vngrd Infl Prtct Sec Adml	Registered Investment Company	**	2,990
	Vngrd Intl Explr Inv	Registered Investment Company	**	6,632
	Vngrd MdCap Gr Indx Adml	Registered Investment Company	**	86,194

See accompanying report of independent auditors on page 1 and 2.

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

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

EIN: 31-4379509

PN: 007

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Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value	
Vngrd MdCap Val Indx Adml	Registered Investment Company	**	153,185	
Vngrd REIT Indx Adml	Registered Investment Company	**	11,835	
Vngrd Sm Cap Indx Fd AS	Registered Investment Company	**	45,854	
Vngrd SmCap Val Indx Inv	Registered Investment Company	**	107,763	
Vngrd Ttl Intl Bd Idx Adml	Registered Investment Company	**	173,722	
Vngrd Ttl StkMkt Indx Fd AS	Registered Investment Company	**	9,139	
Vngrd Val Indx Adml	Registered Investment Company	**	55,770	
WFA Util Telcom A	Registered Investment Company	**	3,434	
Wlmntn Brd Mkt Bd A	Registered Investment Company	**	488	
Wlmntn Short Intmd Trm Bd A	Registered Investment Company	**	474	
WR Ivy Bd Y	Registered Investment Company	**	505	
	Total mutual funds		4,534,467	
	Total investments		\$ 4,936,042	

* Indicates parties-in-interest to the Plan.

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

See accompanying report of independent auditors on page 1 and 2.

Attachment to 2016 Form 5500
Schedule C, Line 2h - Formula Description

Plan Name: MEMORIAL HEALTH SYSTEM HOSPITALS DEFINED CONTRIBUTION PLAN
EIN: 31-4379509
Plan Sponsor's Name: MARIETTA MEMORIAL HOSPITAL
PN: 007

Payee Name: NATIONWIDE
ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

Formula: Net Rate of Return (ROR) on GIC = Gross ROR - Annuity Rate Adjustment

For the period of 1/1/2016 - 12/31/2016:

$$2.40\% = 3.86\% - 1.46\%$$

**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

SCHEDULE H PART IV LINE 4i - SCHEDULE OF ASSETS HELD AT END OF YEAR
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BlkRk Eq Dvd Inv A	Registered Investment Company	**		355
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BlkRk LgCap Val Inv A	Registered Investment Company	**		542
BlkRk Strat Inc Oppr Inv A	Registered Investment Company	**		1,445
Clvrt Gbl Enrgy Soltns A	Registered Investment Company	**		3,448
Col Sel LgCap Gr R5	Registered Investment Company	**		2,979
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DFA Intmd Govt Fixed Income Inst	Registered Investment Company	**		476
DFA US LgCcap Val Inst	Registered Investment Company	**		2,347
Fid Adv Freedom 2025 A	Registered Investment Company	**		1,154
Fid Adv Freedom 2035 A	Registered Investment Company	**		1,602
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Jns Prkns MdCap Val I	Registered Investment Company	**		1,847
JPM Eq Inc A	Registered Investment Company	**		2,427
JPM SmCap Val A	Registered Investment Company	**		737
Loomis Bd Adm	Registered Investment Company	**		1,157
MFS Util R1	Registered Investment Company	**		2,306
MnSty Ttl Rtn Bd I	Registered Investment Company	**		3,944
Natixis Loomis Gr A	Registered Investment Company	**		909
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DEFINED CONTRIBUTION PLAN**

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	PIMCO AllAsst AllAthrity A	Registered Investment Company	**	1,419
	PIMCO Unconstrnd Bd A	Registered Investment Company	**	746
	Pioneer Bd A	Registered Investment Company	**	512
	Prudntl Gbl RealEst A	Registered Investment Company	**	2,004
	Prudntl Jnism Gr A	Registered Investment Company	**	914
	Prudntl Ttl Rtn Dbd A	Registered Investment Company	**	2,304
	RydexSGI Bio Adv	Registered Investment Company	**	3,378
	RydexSGI Elctrnics Adv	Registered Investment Company	**	3,401
	RydexSGI Fin Svc Adv	Registered Investment Company	**	2,293
	RydexSGI Util Adc	Registered Investment Company	**	2,288
	T Rowe Pr New Inc R	Registered Investment Company	**	517
	Vngrd 500 Index Fd AS	Registered Investment Company	**	2,943
	Vngrd Emrg Mkt Stk Indx Adlm	Registered Investment Company	**	3,495
	Vngrd Explr Adml	Registered Investment Company	**	1,210
	Vngrd Gr Indx Adml	Registered Investment Company	**	330,325
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**MEMORIAL HEALTH SYSTEM HOSPITALS
DEFINED CONTRIBUTION PLAN**

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

EIN: 31-4379509

PN: 007

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Vngrd REIT Indx Adml	Registered Investment Company	**	11,835	
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Vngrd SmCap Val Indx Inv	Registered Investment Company	**	107,763	
Vngrd Ttl Intl Bd Idx Adml	Registered Investment Company	**	173,722	
Vngrd Ttl StkMkt Indx Fd AS	Registered Investment Company	**	9,139	
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Wlmntn Brd Mkt Bd A	Registered Investment Company	**	488	
Wlmntn Short Intmd Trm Bd A	Registered Investment Company	**	474	
WR Ivy Bd Y	Registered Investment Company	**	505	
	Total mutual funds		4,534,467	
	Total investments		\$ 4,936,042	

* Indicates parties-in-interest to the Plan.

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See accompanying report of independent auditors on page 1 and 2.