

|                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br><br>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).<br><br><b>► Complete all entries in accordance with the instructions to the Form 5500.</b> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2016</b><br><br><b>This Form is Open to Public Inspection</b> |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Annual Report Identification Information</b><br>For calendar plan year 2016 or fiscal plan year beginning <u>01/01/2016</u> and ending <u>12/31/2016</u> |
| <b>A</b> This return/report is for: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> a multiemployer plan         </div> <div> <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)         </div> </div> <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> a single-employer plan         </div> <div> <input type="checkbox"/> a DFE (specify) ____         </div> </div> |                                                                                                                                                             |
| <b>B</b> This return/report is: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> the first return/report         </div> <div> <input type="checkbox"/> the final return/report         </div> </div> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> an amended return/report         </div> <div> <input type="checkbox"/> a short plan year return/report (less than 12 months)         </div> </div>                                                                                                         |                                                                                                                                                             |
| <b>C</b> If the plan is a collectively-bargained plan, check here. .... <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                             |
| <b>D</b> Check box if filing under: <div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> Form 5558         </div> <div> <input type="checkbox"/> automatic extension         </div> <div> <input type="checkbox"/> the DFVC program         </div> </div> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> special extension (enter description)         </div> </div>                                                                                                                                    |                                                                                                                                                             |

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                |                                                                     |            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------|------------|
| <b>Part II</b>                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Basic Plan Information</b> —enter all requested information |                                                                     |            |
| <b>1a</b> Name of plan<br><u>LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN</u>                                                                                                                                                                                                                                                                                                                                       |                                                                | <b>1b</b> Three-digit plan number (PN) ►                            | <u>001</u> |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                | <b>1c</b> Effective date of plan<br><u>01/01/2004</u>               |            |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br><br><u>LAKE HOSPITAL SYSTEM INC.</u><br><u>LAKE HEALTH</u><br><br><u>ATTN CRAIG GHIDOTTI</u><br><u>7590 AUBURN ROAD</u><br><u>CONCORD TOWNSHIP, OH 44077</u> |                                                                | <b>2b</b> Employer Identification Number (EIN)<br><u>34-1425870</u> |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                | <b>2c</b> Plan Sponsor's telephone number<br><u>440-354-1646</u>    |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                | <b>2d</b> Business code (see instructions)<br><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 | CRAIG GHIDOTTI                                               |
|                                                                                                                                                                                                                                                                           | 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)<br><u>AMERICAN UNITED LIFE INSURANCE CO.</u><br><u>AMERICAN UNITED LIFE INSURANCE CO.</u><br><u>ONE AMERICAN SQUARE, PO BOX 368</u><br><u>INDIANAPOLIS, IN 46206-0368</u> |                                                   |            | Preparer's telephone number<br><br><u>800-261-9618</u>       |
|                                                                                                                                                                                                                                                                           |                                                   |            |                                                              |

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

Form 5500 (2016)  
v. 160205

|                                                                                                                                                                                                                   |                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                          | <b>3b</b> Administrator's EIN              |
|                                                                                                                                                                                                                   | <b>3c</b> Administrator's telephone number |
|                                                                                                                                                                                                                   |                                            |
| <b>4</b> 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:<br><b>a</b> Sponsor's name | <b>4b</b> EIN<br><b>4c</b> PN              |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                           | <b>5</b> 4379                              |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).                  |                                            |
| <b>a(1)</b> Total number of active participants at the beginning of the plan year.....                                                                                                                            | <b>6a(1)</b> 2760                          |
| <b>a(2)</b> Total number of active participants at the end of the plan year .....                                                                                                                                 | <b>6a(2)</b> 2803                          |
| <b>b</b> Retired or separated participants receiving benefits.....                                                                                                                                                | <b>6b</b> 2                                |
| <b>c</b> Other retired or separated participants entitled to future benefits .....                                                                                                                                | <b>6c</b> 1554                             |
| <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....                                                                                                                                       | <b>6d</b> 4359                             |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....                                                                                                        | <b>6e</b> 11                               |
| <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....                                                                                                                                                           | <b>6f</b> 4370                             |
| <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....                                                                   | <b>6g</b> 3468                             |
| <b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....                                                                       | <b>6h</b> 37                               |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....                                                                               | <b>7</b>                                   |

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

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

|                                                                                |                                                                                |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <b>9a</b> Plan funding arrangement (check all that apply)                      | <b>9b</b> Plan benefit arrangement (check all that apply)                      |
| <b>(1)</b> <input checked="" type="checkbox"/> Insurance                       | <b>(1)</b> <input type="checkbox"/> Insurance                                  |
| <b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts | <b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| <b>(3)</b> <input type="checkbox"/> Trust                                      | <b>(3)</b> <input checked="" type="checkbox"/> Trust                           |
| <b>(4)</b> <input type="checkbox"/> General assets of the sponsor              | <b>(4)</b> <input type="checkbox"/> 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)

|                                                                                                                                                                       |                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <b>a Pension Schedules</b>                                                                                                                                            | <b>b General Schedules</b>                                                                   |
| <b>(1)</b> <input checked="" type="checkbox"/> <b>R</b> (Retirement Plan Information)                                                                                 | <b>(1)</b> <input checked="" type="checkbox"/> <b>H</b> (Financial Information)              |
| <b>(2)</b> <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | <b>(2)</b> <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)            |
| <b>(3)</b> <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary                               | <b>(3)</b> <input checked="" type="checkbox"/> <u>1</u> <b>A</b> (Insurance Information)     |
|                                                                                                                                                                       | <b>(4)</b> <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)       |
|                                                                                                                                                                       | <b>(5)</b> <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) |
|                                                                                                                                                                       | <b>(6)</b> <input type="checkbox"/> <b>G</b> (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 \_\_\_\_\_

|                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                           |                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>SCHEDULE A</b><br><b>(Form 5500)</b><br>Department of the Treasury<br>Internal Revenue Service<br>Department of Labor<br>Employee Benefits Security Administration<br>Pension Benefit Guaranty Corporation | <b>Insurance Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b><br><br>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | OMB No. 1210-0110<br><br><b>2016</b><br><br><b>This Form is Open to Public Inspection</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|

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

|                                                                                            |                                                             |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>A</b> Name of plan<br>LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN            | <b>B</b> Three-digit plan number (PN) ▶ 001                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>LAKE HOSPITAL SYSTEM INC. | <b>D</b> Employer Identification Number (EIN)<br>34-1425870 |

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

**1** Coverage Information:

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

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
|            |               |                                       |                                                                             | (f) From                | (g) To     |
| 35-0145825 | 60895         | G74645                                | 3468                                                                        | 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 | (b) Total amount of fees paid |
|                                      |                               |

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

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

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

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

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

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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** 31460180**5** Current value of plan's interest under this contract in separate accounts at year end..... **5** 121028180**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier .....**6b****c** Premiums due but unpaid at the end of the year .....**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....**6d**

Specify nature of costs ▶

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee  
(3) ☐ guaranteed investment (4) ☒ other ▶ GROUP ANNUITY CONTRACT**b** Balance at the end of the previous year ..... **7b** 27963444**c** Additions: (1) Contributions deposited during the year ..... **7c(1)** 901670(2) Dividends and credits..... **7c(2)** 0(3) Interest credited during the year..... **7c(3)** 1174344(4) Transferred from separate account..... **7c(4)** 4671495(5) Other (specify below)..... **7c(5)** 221088

▶ LOAN REPAYMENT

(6) Total additions ..... **7c(6)** 6968597**d** Total of balance and additions (add lines **7b** and **7c(6)**). ..... **7d** 34932041**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)** 2385826(2) Administration charge made by carrier..... **7e(2)** 19412(3) Transferred to separate account..... **7e(3)** 814753(4) Other (specify below)..... **7e(4)** 251870

▶ LOANS ISSUED

(5) Total deductions ..... **7e(5)** 3471861**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 31460180

**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:

|                                                                                                                                                    |                 |                 |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|---|
| <b>a</b> Premiums: (1) Amount received .....                                                                                                       | <b>9a(1)</b>    |                 |   |
| (2) Increase (decrease) in amount due but unpaid .....                                                                                             | <b>9a(2)</b>    |                 |   |
| (3) Increase (decrease) in unearned premium reserve .....                                                                                          | <b>9a(3)</b>    |                 |   |
| (4) Earned ((1) + (2) - (3)) .....                                                                                                                 |                 | <b>9a(4)</b>    | 0 |
| <b>b</b> Benefit charges (1) Claims paid .....                                                                                                     | <b>9b(1)</b>    |                 |   |
| (2) Increase (decrease) in claim reserves .....                                                                                                    | <b>9b(2)</b>    |                 |   |
| (3) Incurred claims (add (1) and (2)) .....                                                                                                        |                 | <b>9b(3)</b>    | 0 |
| (4) Claims charged .....                                                                                                                           |                 | <b>9b(4)</b>    |   |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                      |                 |                 |   |
| (A) Commissions .....                                                                                                                              | <b>9c(1)(A)</b> |                 |   |
| (B) Administrative service or other fees .....                                                                                                     | <b>9c(1)(B)</b> |                 |   |
| (C) Other specific acquisition costs .....                                                                                                         | <b>9c(1)(C)</b> |                 |   |
| (D) Other expenses .....                                                                                                                           | <b>9c(1)(D)</b> |                 |   |
| (E) Taxes .....                                                                                                                                    | <b>9c(1)(E)</b> |                 |   |
| (F) Charges for risks or other contingencies .....                                                                                                 | <b>9c(1)(F)</b> |                 |   |
| (G) Other retention charges .....                                                                                                                  | <b>9c(1)(G)</b> |                 |   |
| (H) Total retention .....                                                                                                                          |                 | <b>9c(1)(H)</b> | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |   |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....                                |                 | <b>9d(1)</b>    |   |
| (2) Claim reserves .....                                                                                                                           |                 | <b>9d(2)</b>    |   |
| (3) Other reserves .....                                                                                                                           |                 | <b>9d(3)</b>    |   |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....                                           |                 | <b>9e</b>       |   |

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> |  |
| <b>b</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. ....<br>Specify nature of costs. | <b>10b</b> |  |

**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. ▶

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                              |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>2016</b>                                    |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>This Form is Open to Public Inspection.</b> |

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

|                                                                                                   |                                                                    |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>A</b> Name of plan<br><b>LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN</b>            | <b>B</b> Three-digit plan number (PN) ▶ <b>001</b>                 |
|                                                                                                   |                                                                    |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>LAKE HOSPITAL SYSTEM INC.</b> | <b>D</b> Employer Identification Number (EIN)<br><b>34-1425870</b> |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <b>Part I</b> | <b>Service Provider Information (see instructions)</b> |
|---------------|--------------------------------------------------------|

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>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation<br><b>AMERICAN UNITED LIFE INSURANCE CO</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|

**35-0145825**

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

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

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

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

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

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

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

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

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

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

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**(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)

AMERICAN UNITED LIFE INSURANCE CO

35-0145825

| <b>(b)</b><br>Service Code(s)       | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 15 50 64 37<br>52 59 60 63<br>66 67 | NONE                                                                                                     | 25982                                                                         | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                         | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                   | 71047                                                                                                                                                                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                 |

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

GLOBAL RETIREMENT PARTNERS

47-1411118

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 28 52                         | NONE                                                                                                     | 0                                                                             | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                         | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                   | 85000                                                                                                                                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                 |

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

RSM US LLP

1001 LAKESIDE AVE  
200 NORTH POINT TOWER  
CLEVELAND, OH 44114-1152

42-0714325

| <b>(b)</b><br>Service Code(s) | <b>(c)</b><br>Relationship to employer, employee organization, or person known to be a party-in-interest | <b>(d)</b><br>Enter direct compensation paid by the plan. If none, enter -0-. | <b>(e)</b><br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | <b>(f)</b><br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | <b>(g)</b><br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | <b>(h)</b><br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| 10 50                         | NONE                                                                                                     | 18060                                                                         | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                         | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                              |                                                                                                                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/>                                            |

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

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

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

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

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

**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<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 66 67                                                                                                                                                              | 71047                                     |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| AMERICAN UNITED LIFE INSURANCE CO<br><br>35-0145825                 | ASSET CHARGE                                                                                                                                                       |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| ALLIANZ GLOBAL INVESTORS<br><br>13-3538489                          | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| AMERICAN CENTURY INVESTMENTS<br><br>20-2036524                      | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| AMERICAN FUNDS<br><br>95-1411037                                    | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| CALVERT INVESTMENTS<br><br>52-6228948                               | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| COLUMBIA MGMT INVESTMENT ADVISORS<br><br>13-3180631                 | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| DEUTSCHE<br><br>13-3241232                                          | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| FIDELITY INVESTMENTS<br><br>04-2270522                              | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| FRANKLIN TEMPLETON INVESTMENTS<br><br>94-3382187                    | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2                                                                     | (b) Service Codes<br>(see instructions)                                                                                                                                                                          | (c) Enter amount of indirect compensation |
|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                                                                           | 63 60 52 59                                                                                                                                                                                                      | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation<br><br>GOLDMAN SACHS ASSET MANAGEMENT<br><br>13-4166989 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><br>REVENUE SHARING FORMULA - SEE ATTACHED |                                           |
| (a) Enter service provider name as it appears on line 2                                                                     | (b) Service Codes<br>(see instructions)                                                                                                                                                                          | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                                                                           | 63 60 52 59                                                                                                                                                                                                      | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation<br><br>INVESCO<br><br>74-1881364                        | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><br>REVENUE SHARING FORMULA - SEE ATTACHED |                                           |
| (a) Enter service provider name as it appears on line 2                                                                     | (b) Service Codes<br>(see instructions)                                                                                                                                                                          | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                                                                           | 63 60 52 59                                                                                                                                                                                                      | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation<br><br>JANUS CAPITAL GROUP INC<br><br>75-3019319        | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><br>REVENUE SHARING FORMULA - SEE ATTACHED |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| LORD ABBETT FUNDS<br><br>13-5620131                                 | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| MANNING & NAPIER FUND INC.<br><br>16-0995736                        | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| OPPENHEIMER FUNDS INC.<br><br>13-2527171                            | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2                                                          | (b) Service Codes<br>(see instructions)                                                                                                                                                                          | (c) Enter amount of indirect compensation |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                                                                | 63 60 52 59                                                                                                                                                                                                      | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation<br><br>PIMCO<br><br>06-1349805               | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><br>REVENUE SHARING FORMULA - SEE ATTACHED |                                           |
| (a) Enter service provider name as it appears on line 2                                                          | (b) Service Codes<br>(see instructions)                                                                                                                                                                          | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                                                                | 63 60 52 59                                                                                                                                                                                                      | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation<br><br>PIONEER INVESTMENTS<br><br>13-1961193 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><br>REVENUE SHARING FORMULA - SEE ATTACHED |                                           |
| (a) Enter service provider name as it appears on line 2                                                          | (b) Service Codes<br>(see instructions)                                                                                                                                                                          | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                                                                | 63 60 52 59                                                                                                                                                                                                      | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation<br><br>RIDGEWORTH<br><br>58-1604573          | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br><br>REVENUE SHARING FORMULA - SEE ATTACHED |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| RUSSELL INVESTMENT COMPANY<br><br>91-1175092                        | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| STATE STREET INSTITUTIONAL TRUST<br><br>04-2456637                  | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| T ROWE PRICE<br><br>52-1184650                                      | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| THORNBURG INVESTMENT MANAGEMENT<br><br>85-0301299                   | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNITED LIFE INSURANCE CO                                   | 63 60 52 59                                                                                                                                                        | 0                                         |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |                                           |
| TIAA-CREF<br><br>13-3760073                                         | REVENUE SHARING FORMULA - SEE ATTACHED                                                                                                                             |                                           |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes<br>(see instructions)                                                                                                                            | (c) Enter amount of indirect compensation |
| AMERICAN UNTIED LIFE INSURANCE CO                                   | 28 52                                                                                                                                                              | 85000                                     |
| (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. |                                           |
| GLOBAL RETIREMENT<br><br>47-1411118                                 | ADVISORS                                                                                                                                                           |                                           |

**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)

|                    |                                                            |                     |              |
|--------------------|------------------------------------------------------------|---------------------|--------------|
| <b>a</b> Name:     | RSM US LLP                                                 | <b>b</b> EIN:       | 42-0714325   |
| <b>c</b> Position: | AUDITOR                                                    |                     |              |
| <b>d</b> Address:  | 1001 LAKESIDE AVENUE E<br>SUITE 200<br>CLEVELAND, OH 44114 | <b>e</b> Telephone: | 216-622-1030 |

Explanation: CONTRACT EXPIRED

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                                                                                                                                                                           |                                                                                                                                                                                                                              |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>SCHEDULE D</b><br><b>(Form 5500)</b><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration | <b>DFE/Participating Plan Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110                              |
|                                                                                                                                                                           |                                                                                                                                                                                                                              | <b>2016</b>                                    |
|                                                                                                                                                                           |                                                                                                                                                                                                                              | <b>This Form is Open to Public Inspection.</b> |

|                                                                                                          |                                                                    |            |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| For calendar plan year 2016 or fiscal plan year beginning <b>01/01/2016</b> and ending <b>12/31/2016</b> |                                                                    |            |
| <b>A</b> Name of plan<br><b>LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN</b>                   | <b>B</b> Three-digit plan number (PN) <b>►</b>                     | <b>001</b> |
|                                                                                                          |                                                                    |            |
| <b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500<br><b>LAKE HOSPITAL SYSTEM INC.</b> | <b>D</b> Employer Identification Number (EIN)<br><b>34-1425870</b> |            |

|               |                                                                                                                                                                                  |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b> | <b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b><br>(Complete as many entries as needed to report all interests in DFEs) |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                            |                               |                                                                                                                      |
|--------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <b>SEPARATE ACCOUNT II</b>                  |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a): <b>AMERICAN UNITED LIFE INSURANCE CO</b> |                               |                                                                                                                      |
| <b>c</b> EIN-PN <b>35-0145825-000</b>                                                      | <b>d</b> Entity code <b>P</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>121028180</b> |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:                                             |                               |                                                                                                                      |
| <b>b</b> Name of sponsor of entity listed in (a):                                          |                               |                                                                                                                      |
| <b>c</b> EIN-PN                                                                            | <b>d</b> Entity code          | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)                  |

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

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

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

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

|                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                              |                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br><small>Internal Revenue Service</small><br><small>Department of Labor</small><br><small>Employee Benefits Security Administration</small><br><small>Pension Benefit Guaranty Corporation</small> | <b>Financial Information</b><br><br>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).<br><br><b>► File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2016</b><br><br><b>This Form is Open to Public Inspection</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|

|                                                                                                          |                                                                    |            |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| For calendar plan year 2016 or fiscal plan year beginning <u>01/01/2016</u> and ending <u>12/31/2016</u> |                                                                    |            |
| <b>A</b> Name of plan<br><u>LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN</u>                   | <b>B</b> Three-digit plan number (PN) ►                            | <u>001</u> |
|                                                                                                          |                                                                    |            |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>LAKE HOSPITAL SYSTEM INC.</u>        | <b>D</b> Employer Identification Number (EIN)<br><u>34-1425870</u> |            |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**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 |
|---------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash .....                                                     | <b>1a</b>       | 0                     | 0               |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                      |                 |                       |                 |
| <b>(1)</b> Employer contributions.....                                                            | <b>1b(1)</b>    | 0                     | 0               |
| <b>(2)</b> Participant contributions .....                                                        | <b>1b(2)</b>    | 0                     | 0               |
| <b>(3)</b> Other.....                                                                             | <b>1b(3)</b>    | 0                     | 0               |
| <b>c</b> General investments:                                                                     |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit).....   | <b>1c(1)</b>    | 0                     | 0               |
| <b>(2)</b> U.S. Government securities .....                                                       | <b>1c(2)</b>    | 0                     | 0               |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                           |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(3)(A)</b> | 0                     | 0               |
| <b>(B)</b> All other.....                                                                         | <b>1c(3)(B)</b> | 0                     | 0               |
| <b>(4)</b> Corporate stocks (other than employer securities):                                     |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                        | <b>1c(4)(A)</b> | 0                     | 0               |
| <b>(B)</b> Common.....                                                                            | <b>1c(4)(B)</b> | 0                     | 0               |
| <b>(5)</b> Partnership/joint venture interests .....                                              | <b>1c(5)</b>    | 0                     | 0               |
| <b>(6)</b> Real estate (other than employer real property).....                                   | <b>1c(6)</b>    | 0                     | 0               |
| <b>(7)</b> Loans (other than to participants) .....                                               | <b>1c(7)</b>    | 0                     | 0               |
| <b>(8)</b> Participant loans.....                                                                 | <b>1c(8)</b>    | 3548273               | 3415031         |
| <b>(9)</b> Value of interest in common/collective trusts .....                                    | <b>1c(9)</b>    | 0                     | 0               |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                   | <b>1c(10)</b>   | 0                     | 0               |
| <b>(11)</b> Value of interest in master trust investment accounts .....                           | <b>1c(11)</b>   | 0                     | 0               |
| <b>(12)</b> Value of interest in 103-12 investment entities.....                                  | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds).....        | <b>1c(13)</b>   | 115502948             | 121028180       |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts)..... | <b>1c(14)</b>   | 27963444              | 31460180        |
| <b>(15)</b> Other .....                                                                           | <b>1c(15)</b>   | 0                     | 0               |

**1d** Employer-related investments:

|                                                                      |              | (a) Beginning of Year | (b) End of Year |
|----------------------------------------------------------------------|--------------|-----------------------|-----------------|
| (1) Employer securities .....                                        | <b>1d(1)</b> | 0                     | 0               |
| (2) Employer real property .....                                     | <b>1d(2)</b> | 0                     | 0               |
| <b>e</b> Buildings and other property used in plan operation .....   | <b>1e</b>    | 0                     | 0               |
| <b>f</b> Total assets (add all amounts in lines 1a through 1e) ..... | <b>1f</b>    | 147014665             | 155903391       |

**Liabilities**

|                                                                           |           |   |   |
|---------------------------------------------------------------------------|-----------|---|---|
| <b>g</b> Benefit claims payable .....                                     | <b>1g</b> | 0 | 0 |
| <b>h</b> Operating payables .....                                         | <b>1h</b> | 0 | 0 |
| <b>i</b> Acquisition indebtedness .....                                   | <b>1i</b> | 0 | 0 |
| <b>j</b> Other liabilities .....                                          | <b>1j</b> | 0 | 0 |
| <b>k</b> Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b> | 0 | 0 |

**Net Assets**

|                                                           |           |           |           |
|-----------------------------------------------------------|-----------|-----------|-----------|
| <b>l</b> Net assets (subtract line 1k from line 1f) ..... | <b>1l</b> | 147014665 | 155903391 |
|-----------------------------------------------------------|-----------|-----------|-----------|

**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 |
|------------------------------------------------------------------------------------------------------------|-----------------|------------|-----------|
| <b>a Contributions:</b>                                                                                    |                 |            |           |
| (1) Received or receivable in cash from: <b>(A)</b> Employers .....                                        | <b>2a(1)(A)</b> | 2060368    |           |
| <b>(B)</b> Participants .....                                                                              | <b>2a(1)(B)</b> | 6498161    |           |
| <b>(C)</b> Others (including rollovers) .....                                                              | <b>2a(1)(C)</b> | 202950     |           |
| (2) Noncash contributions .....                                                                            | <b>2a(2)</b>    | 0          | 8761479   |
| (3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    |            |           |
| <b>b Earnings on investments:</b>                                                                          |                 |            |           |
| (1) Interest:                                                                                              |                 |            |           |
| <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....       | <b>2b(1)(A)</b> | 0          |           |
| <b>(B)</b> U.S. Government securities .....                                                                | <b>2b(1)(B)</b> | 0          |           |
| <b>(C)</b> Corporate debt instruments .....                                                                | <b>2b(1)(C)</b> | 0          |           |
| <b>(D)</b> Loans (other than to participants) .....                                                        | <b>2b(1)(D)</b> | 0          |           |
| <b>(E)</b> Participant loans .....                                                                         | <b>2b(1)(E)</b> | 166365     |           |
| <b>(F)</b> Other .....                                                                                     | <b>2b(1)(F)</b> | 1174344    |           |
| <b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                              | <b>2b(1)(G)</b> |            | 1340709   |
| (2) Dividends: <b>(A)</b> Preferred stock .....                                                            | <b>2b(2)(A)</b> | 0          |           |
| <b>(B)</b> Common stock .....                                                                              | <b>2b(2)(B)</b> | 0          |           |
| <b>(C)</b> Registered investment company shares (e.g. mutual funds) .....                                  | <b>2b(2)(C)</b> | 0          |           |
| <b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....                  | <b>2b(2)(D)</b> |            | 0         |
| (3) Rents .....                                                                                            | <b>2b(3)</b>    |            | 0         |
| (4) Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....                                 | <b>2b(4)(A)</b> | 0          |           |
| <b>(B)</b> Aggregate carrying amount (see instructions) .....                                              | <b>2b(4)(B)</b> | 0          |           |
| <b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....                  | <b>2b(4)(C)</b> |            | 0         |
| (5) Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate .....                         | <b>2b(5)(A)</b> | 0          |           |
| <b>(B)</b> Other .....                                                                                     | <b>2b(5)(B)</b> | 0          |           |
| <b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....         | <b>2b(5)(C)</b> |            | 0         |

|                                                                                                |        | (a) Amount | (b) Total |
|------------------------------------------------------------------------------------------------|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts .....                             | 2b(6)  |            | 0         |
| (7) Net investment gain (loss) from pooled separate accounts .....                             | 2b(7)  |            | 0         |
| (8) Net investment gain (loss) from master trust investment accounts .....                     | 2b(8)  |            | 0         |
| (9) Net investment gain (loss) from 103-12 investment entities .....                           | 2b(9)  |            | 0         |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)..... | 2b(10) |            | 8829012   |
| c Other income.....                                                                            | 2c     |            |           |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total.....               | 2d     |            | 18931200  |

**Expenses**

|                                                                                      |       |         |          |
|--------------------------------------------------------------------------------------|-------|---------|----------|
| e Benefit payment and payments to provide benefits:                                  |       |         |          |
| (1) Directly to participants or beneficiaries, including direct rollovers .....      | 2e(1) | 9816158 |          |
| (2) To insurance carriers for the provision of benefits .....                        | 2e(2) | 0       |          |
| (3) Other .....                                                                      | 2e(3) | 0       |          |
| (4) Total benefit payments. Add lines 2e(1) through (3).....                         | 2e(4) |         | 9816158  |
| f Corrective distributions (see instructions) .....                                  | 2f    |         | 195324   |
| g Certain deemed distributions of participant loans (see instructions) .....         | 2g    |         | 0        |
| h Interest expense .....                                                             | 2h    |         | 0        |
| i Administrative expenses: (1) Professional fees.....                                | 2i(1) | 0       |          |
| (2) Contract administrator fees.....                                                 | 2i(2) | 30992   |          |
| (3) Investment advisory and management fees.....                                     | 2i(3) | 0       |          |
| (4) Other .....                                                                      | 2i(4) | 0       |          |
| (5) Total administrative expenses. Add lines 2i(1) through (4).....                  | 2i(5) |         | 30992    |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total ..... | 2j    |         | 10042474 |

**Net Income and Reconciliation**

|                                                          |       |  |         |
|----------------------------------------------------------|-------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d ..... | 2k    |  | 8888726 |
| l Transfers of assets:                                   |       |  |         |
| (1) To this plan.....                                    | 2l(1) |  | 0       |
| (2) From this plan.....                                  | 2l(2) |  | 0       |

**Part III Accountant's Opinion**

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

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

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

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

☒ Yes ☐ No

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

(1) Name: PLANTE MORAN

(2) EIN: 38-1357951

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

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

**Part IV Compliance Questions**

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

During the plan year:

**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   |    | 1867   |
| 4b |     | X  |        |

|                                                                                                                                                                                                                               |           | Yes | No | Amount |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|----|--------|
| <b>c</b> 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.) .....                                          | <b>4c</b> |     | X  |        |
| <b>d</b> 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.) .....                               | <b>4d</b> |     | X  |        |
| <b>e</b> Was this plan covered by a fidelity bond? .....                                                                                                                                                                      | <b>4e</b> | X   |    | 500000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                       | <b>4f</b> |     | X  |        |
| <b>g</b> 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? .....                                                    | <b>4g</b> |     | X  |        |
| <b>h</b> 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? .....                                          | <b>4h</b> |     | X  |        |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) .....                                                                | <b>4i</b> | X   |    |        |
| <b>j</b> 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.) ..... | <b>4j</b> |     | X  |        |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....                                                           | <b>4k</b> |     | X  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan? .....                                                                                                                                            | <b>4l</b> |     | X  |        |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....                                                                                                  | <b>4m</b> |     | X  |        |
| <b>n</b> 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. ....                                      | <b>4n</b> |     |    |        |
| <b>o</b> Defined Benefit Plan or Money Purchase Pension Plan Only:<br>Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service? .....                           | <b>4o</b> |     |    |        |

**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

|                                        |                                                     |
|----------------------------------------|-----------------------------------------------------|
| <b>6a</b> Name of trust                | <b>6b</b> Trust's EIN                               |
| <b>6c</b> Name of trustee or custodian | <b>6d</b> Trustee's or custodian's telephone number |

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>SCHEDULE R</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Retirement Plan Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2016</b><br><br><b>This Form is Open to Public Inspection.</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|

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

|                                                                                                   |                                                                    |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>A</b> Name of plan<br><u>LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN</u>            | <b>B</b> Three-digit plan number (PN) ▶<br><u>001</u>              |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>LAKE HOSPITAL SYSTEM INC.</u> | <b>D</b> Employer Identification Number (EIN)<br><u>34-1425870</u> |

|               |                      |
|---------------|----------------------|
| <b>Part I</b> | <b>Distributions</b> |
|---------------|----------------------|

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

|                                                                                                                                                                                                                                                                    |          |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| <b>1</b> Total value of distributions paid in property other than in cash or the forms of property specified in the instructions .....                                                                                                                             | <b>1</b> | <u>0</u> |
| <b>2</b> 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):<br><br>EIN(s): <u>35-0145825</u> |          |          |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.                                                                                                                                                                                                   |          |          |
| <b>3</b> Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year .....                                                                                                                                   | <b>3</b> |          |

|                |                                                                                                                                                                               |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part II</b> | <b>Funding Information</b> (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.) |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                             |                              |                             |                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------|
| <b>4</b> Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? .....                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8.                                                                                                                                                                                                                                                                                                        |                              |                             |                              |
| <b>5</b> 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 _____<br>If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. |                              |                             |                              |
| <b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....                                                                                                                                                                                                              | <b>6a</b>                    |                             |                              |
| <b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                                                                                                                                  | <b>6b</b>                    |                             |                              |
| <b>c</b> 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) .....                                                                                                                                                                                                            | <b>6c</b>                    |                             |                              |
| If you completed line 6c, skip lines 8 and 9.                                                                                                                                                                                                                                                                                                               |                              |                             |                              |
| <b>7</b> Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| <b>8</b> 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? .....                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |

|                 |                   |
|-----------------|-------------------|
| <b>Part III</b> | <b>Amendments</b> |
|-----------------|-------------------|

|                                                                                                                                                                                                                            |                                   |                                   |                               |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|
| <b>9</b> 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..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input type="checkbox"/> No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|-----------------------------|

|                |                                                                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part IV</b> | <b>ESOPs</b> (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. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                              |                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>10</b> Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? .....                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>11 a</b> Does the ESOP hold any preferred stock? .....                                                                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>b</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.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12</b> Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> 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): \_\_\_\_\_

|           |                                                                                                                                                                                                                                                      |            |  |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| <b>14</b> | Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:                                                                                                                    |            |  |
|           | <b>a</b> The current year .....                                                                                                                                                                                                                      | <b>14a</b> |  |
|           | <b>b</b> The plan year immediately preceding the current plan year .....                                                                                                                                                                             | <b>14b</b> |  |
|           | <b>c</b> The second preceding plan year .....                                                                                                                                                                                                        | <b>14c</b> |  |
| <b>15</b> | 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:                                                                         |            |  |
|           | <b>a</b> The corresponding number for the plan year immediately preceding the current plan year .....                                                                                                                                                | <b>15a</b> |  |
|           | <b>b</b> The corresponding number for the second preceding plan year .....                                                                                                                                                                           | <b>15b</b> |  |
| <b>16</b> | Information with respect to any employers who withdrew from the plan during the preceding plan year:                                                                                                                                                 |            |  |
|           | <b>a</b> Enter the number of employers who withdrew during the preceding plan year .....                                                                                                                                                             | <b>16a</b> |  |
|           | <b>b</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 .....                                                                               | <b>16b</b> |  |
| <b>17</b> | 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. .... <input type="checkbox"/> |            |  |

|                |                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------|
| <b>Part VI</b> | <b>Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans</b> |
|----------------|---------------------------------------------------------------------------------------------------|

|           |                                                                                                                                                                                                                                                                                                                                                                                                      |                          |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| <b>18</b> | 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 .....                         | <input type="checkbox"/> |
| <b>19</b> | If the total number of participants is 1,000 or more, complete lines (a) through (c)                                                                                                                                                                                                                                                                                                                 |                          |
|           | <b>a</b> Enter the percentage of plan assets held as:<br>Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%                                                                                                                                                                                                                                       |                          |
|           | <b>b</b> Provide the average duration of the combined investment-grade and high-yield debt:<br><input type="checkbox"/> 0-3 years <input type="checkbox"/> 3-6 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> 9-12 years <input type="checkbox"/> 12-15 years <input type="checkbox"/> 15-18 years <input type="checkbox"/> 18-21 years <input type="checkbox"/> 21 years or more |                          |
|           | <b>c</b> What duration measure was used to calculate line 19(b)?<br><input type="checkbox"/> Effective duration <input type="checkbox"/> Macaulay duration <input type="checkbox"/> Modified duration <input type="checkbox"/> Other (specify): _____                                                                                                                                                |                          |

|                 |                                 |
|-----------------|---------------------------------|
| <b>Part VII</b> | <b>IRS Compliance Questions</b> |
|-----------------|---------------------------------|

|                                                                                                                                                                                                                             |                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>20a</b> Is the plan a 401(k) plan? If "No," skip b .....                                                                                                                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                          |
| <b>20b</b> How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply: .....                                                        | <input type="checkbox"/> Design-based safe harbor <input type="checkbox"/> "Prior year" ADP test<br><input type="checkbox"/> "Current year" ADP test <input type="checkbox"/> N/A |
| <b>21a</b> What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply: .....                                                                            | <input type="checkbox"/> Ratio percentage test <input type="checkbox"/> Average benefit test <input type="checkbox"/> N/A                                                         |
| <b>21b</b> 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? ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                          |
| <b>22a</b> 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   .      |                                                                                                                                                                                   |
| <b>22b</b> 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   /   /   .                                     |                                                                                                                                                                                   |

# **Lake Hospital System Inc. 403(b) Retirement Savings Plan**

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**Financial Report  
December 31, 2016**

# **Lake Hospital System Inc. 403b Retirement Savings Plan**

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## **Contents**

|                                                                  |                   |
|------------------------------------------------------------------|-------------------|
| <b>Report Letter</b>                                             | <b>I-3</b>        |
| <b>Statement of Net Assets Available for Benefits</b>            | <b>4</b>          |
| <b>Statement of Changes in Net Assets Available for Benefits</b> | <b>5</b>          |
| <b>Notes to Financial Statements</b>                             | <b>6-12</b>       |
| <b>Schedule of Assets Held at End of Year</b>                    | <b>Schedule I</b> |
| <b>Schedule of Delinquent Participant Contributions</b>          | <b>Schedule 2</b> |

## Independent Auditor's Report

To the Plan Administrator  
Lake Hospital System Inc. 403(b) Retirement Savings Plan

### **Report on the Financial Statements**

We were engaged to audit the accompanying financial statements of Lake Hospital System Inc. 403(b) Retirement Savings Plan (the "Plan"), which comprise the statement of net assets available for benefits as of December 31, 2016 and the related statement of changes in net assets available for benefits for the year then ended, and the related notes to the financial statements.

### ***Management's Responsibility for the Financial Statements***

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

### ***Auditor's Responsibility***

Our responsibility is to express an opinion on these financial statements based on conducting the audit in accordance with auditing standards generally accepted in the United States of America. Because of the matters described in the *Basis for Disclaimer of Opinion* paragraphs, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the 2016 financial statements.

### ***Basis for Disclaimer of Opinion***

As permitted by 29 CFR 2520.103-8 of the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA), the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by American United Life Insurance Company (AUL) (the "Custodian"), except for comparing such information with the related information included in the 2016 financial statements. We have been informed by the plan administrator that the Custodian holds the Plan's participant notes receivable and certain investment assets and executes certain related transactions. The plan administrator has obtained a certification from the Custodian as of and for the year ended December 31, 2016 that the information provided to the plan administrator by the Custodian is complete and accurate.

To the Plan Administrator  
Lake Hospital System Inc. 403(b) Retirement Savings Plan

***Basis for Disclaimer of Opinion (Continued)***

As described in Note 4, the Plan has excluded from investments in the accompanying statement of net assets available for benefits certain annuity and custodial accounts issued to current and former employees prior to January 1, 2009, as permitted by the Department of Labor's (DOL) Field Assistance Bulletin No. 2009-02, *Annual Reporting Requirements for 403(b) Plans*. The investment income and distributions related to such accounts have also been excluded in the accompanying statement of changes in net assets available for benefits. The amount of these excluded annuity and custodial accounts and the related income and distributions are not determinable. Accounting principles generally accepted in the United States of America require that these accounts and the related income and distributions be included in the accompanying financial statements. The Plan has not maintained sufficient accounting records and supporting documents relating to these annuity and custodial accounts issued to current and former employees prior to January 1, 2009. Accordingly, we were unable to apply auditing procedures sufficiently to determine the extent to which the financial statements may have been affected by these conditions.

***Disclaimer of Opinion***

Because of the significance of the matters described in the *Basis for Disclaimer of Opinion* paragraphs, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the 2016 financial statements. Accordingly, we do not express an opinion on the 2016 financial statements.

***Other Matter***

The supplemental schedule of assets held at end of year and the schedule of delinquent participant contributions as of December 31, 2016 are required by the DOL's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA) and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matters described in the *Basis for Disclaimer of Opinion* paragraphs, we do not express an opinion on the supplemental schedules.

***Report on Prior Year Financial Statements***

The financial statements of Lake Hospital System Inc. 403(b) Retirement Savings Plan as of December 31, 2015 were audited by other auditors whose report, dated October 12, 2016, disclaimed an opinion as permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA and as permitted by the Department of Labor's Field Assistance Bulletin No. 2009-02, *Annual Reporting Requirements for 403(b) Plans*.

To the Plan Administrator  
Lake Hospital System Inc. 403(b) Retirement Savings Plan

**Report on Form and Content in Compliance with DOL Rules and Regulations for 2016  
Financial Statements**

Because of the significance of the matters described in the *Basis for Disclaimer of Opinion* paragraphs, we have not been able to obtain sufficient appropriate evidence to provide a basis for an audit opinion on the 2016 financial statements. Accordingly, we do not express an opinion on the supplemental schedules.

*Plante & Moreau, PLLC*

Columbus, Ohio  
October 10, 2017

# **Lake Hospital System Inc. 403b Retirement Savings Plan**

## **Statement of Net Assets Available for Benefits**

|                                                                | December 31,<br>2016  | December 31,<br>2015  |
|----------------------------------------------------------------|-----------------------|-----------------------|
| <b>Assets</b>                                                  |                       |                       |
| Investments at fair value - Pooled separate accounts           | \$ 121,028,180        | \$ 115,502,948        |
| Investments at contract value - Unallocated insurance contract | 31,460,180            | 27,963,444            |
| Total investments                                              | 152,488,360           | 143,466,392           |
| Participant notes receivable                                   | 3,415,031             | 3,558,494             |
| <b>Net Assets Available for Benefits</b>                       | <b>\$ 155,903,391</b> | <b>\$ 147,024,886</b> |

# **Lake Hospital System Inc. 403b Retirement Savings Plan**

## **Statement of Changes in Net Assets Available for Benefits Year Ended December 31, 2016**

### **Additions to Net Assets**

#### Contributions:

|           |                |
|-----------|----------------|
| Employee  | \$ 6,498,193   |
| Employer  | 1,973,536      |
| Rollovers | <u>197,862</u> |

Total contributions 8,669,591

#### Investment income:

|                                                  |                  |
|--------------------------------------------------|------------------|
| Interest and dividends                           | 1,173,626        |
| Net realized and unrealized gains on investments | <u>8,824,413</u> |

Total investment income 9,998,039

Interest from participant notes receivable 166,311

Total additions 18,833,941

### **Deductions from Net Assets**

|                                                         |               |
|---------------------------------------------------------|---------------|
| Benefits paid directly to participants or beneficiaries | 9,905,147     |
| Administrative expenses                                 | <u>50,289</u> |

Total deductions 9,955,436

**Net Increase** 8,878,505

### **Net Assets Available for Benefits**

|                   |                              |
|-------------------|------------------------------|
| Beginning of year | <u>147,024,886</u>           |
| End of year       | <u><u>\$ 155,903,391</u></u> |

# Lake Hospital System Inc. 403b Retirement Savings Plan

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## Notes to Financial Statements December 31, 2016 and 2015

### Note 1 - Plan Description

The following description of Lake Hospital System Inc. 403b Retirement Savings Plan (the "Plan") provides only general information. Participants should refer to the plan agreement for a more complete description of the Plan's provisions.

**General** - The Plan is a defined contribution plan covering substantially all employees of Lake Hospital System, Inc. (d.b.a. Lake Health) (the "System"). Employees become participants in the elective deferral portion of the Plan on their first day of employment with the System. Employees are eligible for the System's discretionary matching and nonelective contributions on January 1 or July 1 after they have completed one year of service. One year of service is defined as having 1,000 hours of service during the first anniversary of the participant, or the 12-month plan year that is coincidental with a calendar year. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

**Contributions** - Each year, participants may contribute up to the maximum percentage of pretax annual compensation, as defined by the Plan. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan. Participants who attained age 50 before the end of the plan year were eligible to contribute additional catch-up contributions. The System may contribute, at its discretion, a matching contribution equal to a uniform percentage of the amount of a participant's salary reduction which percentage will be determined each year by the System. The discretionary matching contribution for 2016 was 50 percent of employee deferrals up to 6 percent of compensation. Additional amounts may be contributed at the discretion of the System's board of directors. No additional amounts were contributed at the discretion of the board of directors for 2016. Contributions are subject to limitations contained in Section 402(g) of the Internal Revenue Code.

During 2012, the System identified certain employee deferrals and participant loan repayments were remitted to the Plan after the Department of Labor's (DOL) required timeframe during plan years 2007-2012. The System remitted the late employee deferrals and participant loan repayments identified related to 2007-2012 during 2012. In addition, a contribution of the lost earnings was made in 2012.

During 2016, the DOL completed a comprehensive review of all participant contributions remitted to the Plan beginning January 1, 2011 through December 31, 2015 in order to identify delinquent participant contributions. As a result of the review, additional late contributions and participant loan repayments of \$3,742 related to 2012 were identified and remitted during 2016 according to the DOL's guidance. The System also remitted approximately \$1,575 in lost earnings during 2016 to remedy the prohibited transactions identified during this review.

# Lake Hospital System Inc. 403b Retirement Savings Plan

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## Notes to Financial Statements December 31, 2016 and 2015

### Note 1 - Plan Description (Continued)

**Participant Accounts** - American United Life Insurance Company (AUL) maintains individual accounts for each participant for the deposit of contributions and earnings thereon. Earnings on plan assets are distributed based upon the participant's pro-rata share of the total account balances.

Allocations are based on participant's compensation or account balances, as defined in the plan agreement. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

**Vesting** - Participants are immediately 100 percent vested in employee salary and rollover contributions and any income or loss thereon. Vesting in the System's contribution portion of their accounts, plus actual earnings thereon, is based on years of continuous service. A participant is 100 percent vested after six years of credited service, as defined by the Plan. Employees hired prior to January 1, 2004, who became participants, are 100 percent vested after two years of credited service, as defined by the Plan.

**Participant Notes Receivable** - Participants may borrow from their accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50 percent of their account balances, whichever is less. The notes receivable are secured by the balance in the participant's account and bear interest at rates commensurate with local prevailing rates as determined periodically by the System. Principal and interest are paid ratably through biweekly payroll deductions.

**Forfeitures** - If a participant is not fully vested on his or her termination date, the nonvested amount of the account is forfeited. Forfeitures are used to pay plan expenses and to reduce future employer contributions.

**Benefit Payments** - On termination of service due to death, disability, or retirement, a participant may elect to receive an amount equal to the value of the participant's vested interest in his or her account in either a lump-sum amount, or in annual installments over a 10 year period. For termination of service due to other reasons, a participant may receive the value of the vested interest in his or her account as a lump-sum distribution. The System may distribute to participants up to 100 percent of their elective deferral account balances in the event of a hardship if participants satisfy certain requirements that demonstrate immediate and heavy financial need.

**Party-in-interest Transactions** - Certain plan assets are in investment funds managed by American United Life Insurance Company (AUL) or its affiliates. AUL is the custodian of the Plan; therefore, these transactions qualify as party-in-interest transactions as defined under ERISA guidelines.

# **Lake Hospital System Inc. 403b Retirement Savings Plan**

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## **Notes to Financial Statements December 31, 2016 and 2015**

### **Note 1 - Plan Description (Continued)**

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

### **Note 2 - Summary of Significant Accounting Policies**

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

The pooled separate accounts are valued at net asset value per share (NAV) (or its equivalent) of the funds, which is based on the fair value of the funds' underlying assets.

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

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

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

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

**Benefit Payments** - Benefits are recorded when paid.

**Administrative Expenses** - Various administrative costs are paid by the System or the Plan, at the discretion of the System.

# **Lake Hospital System Inc. 403b Retirement Savings Plan**

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## **Notes to Financial Statements December 31, 2016 and 2015**

### **Note 2 - Summary of Significant Accounting Policies (Continued)**

**Subsequent Events** - The financial statements and related disclosures include evaluation of events up through and including October 10, 2017, which is the date the financial statements were available to be issued.

### **Note 3 - Unaudited Information**

American United Life Insurance Company (AUL) (the "Custodian") holds certain of the Plan's investments and participant notes receivable and executes related transactions. The investment and participant notes receivable balances and related income and losses included in the accompanying financial statements and supplemental schedule of assets held at end of year are based solely on information certified by the Custodian.

The Plan has excluded certain assets from the statement of net assets available for benefits at December 31, 2016 and 2015 (See Note 4).

### **Note 4 - Excluded Investments**

The Plan has excluded from investments in the accompanying statement of net assets available for benefits as of December 31, 2016 and 2015 and the statement of changes in net assets available for benefits for the year ended December 31, 2016 certain annuity and custodial accounts issued to current and former employees prior to January 1, 2009 as permitted by the Department of Labor's Field Assistance Bulletin No. 2009-02, *Annual Reporting Requirements for 403(b) Plans*. The investment income and distributions related to such accounts have also been excluded in the accompanying statement of changes in net assets available for benefits. The amount of these excluded annuity and custodial accounts and the related income and distributions is not determinable. Accounting principles generally accepted in the United States of America require that these accounts and the related income and distributions be included in the accompanying financial statements.

### **Note 5 - Tax Status**

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

# **Lake Hospital System Inc. 403b Retirement Savings Plan**

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## **Notes to Financial Statements December 31, 2016 and 2015**

### **Note 6 - Unallocated Insurance Contract**

The Plan has a benefit-responsive unallocated insurance contract with AUL. AUL maintains the contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The investment contracts issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan. There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer and has a 4 percent minimum guarantee.

Interest rates are established and declared for new contributions that will be received in a calendar quarter. The rate is based on the return AUL expects on new investments made by it and held with the AUL general account. When establishing interest credit rates for these contracts, AUL considers past general account investments, adjusted for portfolio turnover and withdrawals for benefit payments. The crediting rate will always equal or exceed the contractually guaranteed rate.

Certain events limit the ability of the Plan to transact at contract value with the insurance company. Such events include the following: (i) amendments to the plan documents (including complete or partial plan termination or merger with another plan); (ii) changes to the plan's prohibition on competing investment options or deletion of equity wash provision; (iii) bankruptcy of the plan sponsor or other plan sponsor events (e.g. divestitures or spinoffs of a subsidiary), which cause a significant withdrawal from the Plan; or (iv) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The plan administrator believe that the occurrence of any such events, which would limit the Plan's ability to transact at contract value with participants, is not probable of occurring. There are no events that allow the issuer to terminate the contract and which require the plan sponsor to settle an amount different than contract value paid.

Liquidation of the entire contract may cause a one-time adjustment to the aggregate contract value, resulting in a fair value different from the contract value. This total liquidation is a contingent event, which cannot be initiated by the plan participants and can only be initiated by the plan trustee upon termination of the Plan or complete termination of the contract.

### **Note 7 - Fair Value Measurements**

The following tables present information about the included plan assets measured at fair value on a recurring basis at December 31, 2016 and 2015. The Plan has excluded certain assets from the statement of net assets available for benefits at December 31, 2016 and 2015 (See Note 4).

# Lake Hospital System Inc. 403b Retirement Savings Plan

## Notes to Financial Statements December 31, 2016 and 2015

### Note 7 - Fair Value Measurements (Continued)

#### Assets Measured at Fair Value on a Recurring Basis at December 31, 2016

|                                 | Investments<br>(at Fair Value) |
|---------------------------------|--------------------------------|
| Investments measured at NAV:    |                                |
| Balanced investments (1)        | \$ 38,836,993                  |
| Equity investments (2)          | 73,528,968                     |
| Fixed-income investments (3)    | <u>8,662,219</u>               |
| Total investments at fair value | <u>\$ 121,028,180</u>          |

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

|                                 | Investments<br>(at Fair Value) |
|---------------------------------|--------------------------------|
| Investments measured at NAV:    |                                |
| Balanced investments (1)        | \$ 36,837,933                  |
| Equity investments (2)          | 70,679,709                     |
| Fixed-income investments (3)    | <u>7,985,306</u>               |
| Total investments at fair value | <u>\$ 115,502,948</u>          |

- (1) This class represents investments in actively managed pooled separate accounts with investments in both equity and debt securities. The investments may include common stock, corporate bonds, U.S. and non-U.S. municipal securities, interest rate swaps, options, and futures.
- (2) This class represents investments in actively managed pooled separate accounts that invest primarily in equity securities which may include common stocks, options, and futures.
- (3) This class represents investments in actively managed pooled separate accounts that invest in a variety of fixed income investments which may include corporate bonds, both U.S. and non-U.S. municipal securities, interest rate swaps, options, and futures.

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

# Lake Hospital System Inc. 403b Retirement Savings Plan

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## Notes to Financial Statements December 31, 2016 and 2015

### Note 8 - Reconciliation to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements at December 31, 2016 and 2015 to Form 5500:

|                                                                        | <u>2016</u>           | <u>2015</u>           |
|------------------------------------------------------------------------|-----------------------|-----------------------|
| Net assets available for benefits per the financial statements         | \$ 155,903,391        | \$ 147,024,886        |
| Deemed distribution loans excluded from participant loans on Form 5500 | <u>-</u>              | <u>(10,221)</u>       |
| Net assets available for benefits per Form 5500                        | <u>\$ 155,903,391</u> | <u>\$ 147,014,665</u> |

# Lake Hospital System Inc. 403b Retirement Savings Plan

## Schedule of Assets Held at End of Year Form 5500, Schedule H, Line 4i EIN 34-1425870, Plan No. 001 December 31, 2016

| (a)(b)<br>Identity of Issuer           | (c)<br>Description of Investment                      | (d)<br>Cost | (e)<br>Current Value |
|----------------------------------------|-------------------------------------------------------|-------------|----------------------|
| Pooled separate accounts:              |                                                       |             |                      |
| American United Life Insurance Company | American Century Investments One Choice In Retirement | *           | \$ 1,012,452         |
| American United Life Insurance Company | American Century Mid Cap Value Fund Investor Class    | *           | 10,306,276           |
| American United Life Insurance Company | American Century One Choice 2020 Inv                  | *           | 5,633,113            |
| American United Life Insurance Company | American Century One Choice 2025 Inv                  | *           | 1,972,839            |
| American United Life Insurance Company | American Century One Choice 2030 Inv                  | *           | 3,912,549            |
| American United Life Insurance Company | American Century One Choice 2035 Inv                  | *           | 1,863,549            |
| American United Life Insurance Company | American Century One Choice 2040 Inv                  | *           | 4,627,189            |
| American United Life Insurance Company | American Century One Choice 2045 Inv                  | *           | 795,841              |
| American United Life Insurance Company | American Century One Choice 2050 Inv                  | *           | 1,134,470            |
| American United Life Insurance Company | American Century One Choice 2055 Inv                  | *           | 516,009              |
| American United Life Insurance Company | American Century One Choice 2060 Inv                  | *           | 5,980                |
| American United Life Insurance Company | American Funds New World Fund Class R-4               | *           | 188,376              |
| American United Life Insurance Company | Columbia Mid Cap Index Fund Class A                   | *           | 253,381              |
| American United Life Insurance Company | Goldman Sachs Small Cap Value Fund Institutional      | *           | 5,016,272            |
| American United Life Insurance Company | Invesco Diversified Dividend Fund Investor Class      | *           | 9,605,593            |
| American United Life Insurance Company | Janus Aspen Balanced S                                | *           | 5,894,276            |
| American United Life Insurance Company | Lord Abbett High Yield Fund Class A                   | *           | 273,933              |
| American United Life Insurance Company | Manning & Napier Pro-Blend Conservative Strategy F    | *           | 1,349,751            |
| American United Life Insurance Company | Manning & Napier Pro-Blend Ext Term Strategy Fund     | *           | 2,921,189            |

# Lake Hospital System Inc. 403b Retirement Savings Plan

## Schedule of Assets Held at End of Year (Continued) Form 5500, Schedule H, Line 4i EIN 34-1425870, Plan No. 001 December 31, 2016

| (a)(b)<br>Identity of Issuer           | (c)<br>Description of Investment                                        | (d)<br>Cost | (e)<br>Current Value  |
|----------------------------------------|-------------------------------------------------------------------------|-------------|-----------------------|
| Pooled separate accounts (continued):  |                                                                         |             |                       |
| American United Life Insurance Company | Manning & Napier Pro-Blend Maximum Term Series Cla                      | *           | 1,228,585             |
| American United Life Insurance Company | Manning & Napier Pro-Blend Moderate Strategy Fund                       | *           | 5,969,201             |
| American United Life Insurance Company | Oppenheimer International Growth Fund Class Y                           | *           | 6,123,155             |
| American United Life Insurance Company | Pioneer Bond Fund Class Y                                               | *           | 8,248,043             |
| American United Life Insurance Company | State Street Equity 500 Index Fund Administrative                       | *           | 11,819,351            |
| American United Life Insurance Company | T. Rowe Price Growth Stock Fund Advisor Class                           | *           | 23,464,190            |
| American United Life Insurance Company | Templeton Global Bond Fund Class A                                      | *           | 140,243               |
| American United Life Insurance Company | Vanguard Vif Small Comp Growth Fund                                     | *           | 6,752,374             |
| American United Life Insurance Company | Unallocated insurance contract - AUL Fixed Account                      | *           | 31,460,180            |
| Participants                           | Participant notes receivable bearing interest at a rate of 5.00 percent | -           | 3,415,031             |
| Total                                  |                                                                         |             | <b>\$ 155,903,391</b> |

\* Cost information not required

# Lake Hospital System Inc. 403b Retirement Savings Plan

## Schedule of Delinquent Participant Contributions Form 5500, Schedule H, Line 4a EIN 34-1425870, Plan No. 001 Year Ended December 31, 20165

| Participant Contributions<br>Transferred Late to Plan              | Total that Constitute Nonexempt Prohibited<br>Transactions |                                            |                                                   | Total Fully<br>Corrected<br>Under VFCP<br>and PTE<br>2002-51 |
|--------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------|---------------------------------------------------|--------------------------------------------------------------|
| Check here if Late<br>Participant Loan<br>Repayments are included: | Contributions<br>Not<br>Corrected                          | Contributions<br>Corrected<br>Outside VFCP | Contributions<br>Pending<br>Correction in<br>VFCP |                                                              |
| <input checked="" type="checkbox"/>                                | \$ -                                                       | \$ 3,742                                   | \$ -                                              | \$ -                                                         |

## Schedule C Attachment for Line Item 3(e)

**Plan Name**      **G74645 LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN**

**Plan Number**    **001**                      **Plan Year End**    **12/31/2016**

**EIN**                      **34-1425870**

Revenue Sharing Formula:

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

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

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

| Investment Company           | Investment Portfolio           | Annual Percentage |
|------------------------------|--------------------------------|-------------------|
| ALLIANZ GLOBAL INVESTORS     | AllianzGI NFJ MidCap Val Adm   | 0.25              |
| AMERICAN CENTURY INVESTMENTS | AmerCent MidCap Val Inv        | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice In Ret Inv | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2015 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2020 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2025 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2030 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2035 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2040 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2045 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2050 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS | AmerCent One Choice 2055 Inv   | 0.35              |

| Investment Company                | Investment Portfolio           | Annual Percentage |
|-----------------------------------|--------------------------------|-------------------|
| AMERICAN CENTURY INVESTMENTS      | AmerCent One Choice 2060 Inv   | 0.35              |
| AMERICAN CENTURY INVESTMENTS      | AmerCent AllocCon Inv          | 0.35              |
| AMERICAN CENTURY INVESTMENTS      | AmerCent SmCap Val Inv         | 0.35              |
| AMERICAN FUNDS                    | AmerFds New World R4           | 0.35              |
| CALVERT INVESTMENTS               | Calvert Inc A                  | 0.50              |
| COLUMBIA MGMT INVESTMENT ADVISORS | Columbia MidCap Indx A         | 0.25              |
| COLUMBIA MGMT INVESTMENT ADVISORS | Columbia SmCap Indx A          | 0.25              |
| DEUTSCHE                          | Deutsche Real Estate Secs S    | 0.25              |
| FIDELITY INVESTMENTS              | Fidelity VIP Grth Init         | 0.15              |
| FIDELITY INVESTMENTS              | Fidelity VIP Overseas Init     | 0.15              |
| FIDELITY INVESTMENTS              | Fidelity VIP Asset Mngr Init   | 0.15              |
| FRANKLIN TEMPLETON INVESTMENTS    | Templeton Global Bond A        | 0.40              |
| GOLDMAN SACHS ASSET MANAGEMENT    | GoldmanSachs MidCap Val Inst   | 0.10              |
| GOLDMAN SACHS ASSET MANAGEMENT    | GoldmanSachs SmCapVal Inst     | 0.10              |
| INVESCO                           | Invesco Diversified Div Inv    | 0.50              |
| JANUS CAPITAL GROUP, INC          | Janus Asp Balanced S           | 0.25              |
| JANUS CAPITAL GROUP, INC          | Perkins Small Cap Value S      | 0.50              |
| LORD ABBETT FUNDS                 | Lord Abbett High Yield R5      | 0.25              |
| LORD ABBETT FUNDS                 | Lord Abbett High Yield A       | 0.40              |
| MANNING & NAPIER FUND INC.        | Man&Nap Pro-Blend Conserv S    | 0.35              |
| MANNING & NAPIER FUND INC.        | Man&Nap Pro-Blend Ext Term S   | 0.35              |
| MANNING & NAPIER FUND INC.        | Man&Nap Pro-Blend Mod Term S   | 0.35              |
| MANNING & NAPIER FUND INC.        | Man&Nap Pro-Blend Maximum S    | 0.35              |
| OPPENHEIMER FUNDS INC.            | Oppenheimer Intl Growth Y      | 0.25              |
| PIMCO                             | PIMCO Total Return Adm         | 0.25              |
| PIONEER INVESTMENTS               | Pioneer Bond Y                 | 0.35              |
| PIONEER INVESTMENTS               | Pioneer Sel Mid Cap Grth VCT I | 0.25              |
| RIDGEWORTH                        | RidgeWorth Ceredex MCV Eqty I  | 0.35              |
| RUSSELL INVESTMENT COMPANY        | Russell LP In Ret Fd R1        | 0.20              |
| RUSSELL INVESTMENT COMPANY        | Russell LifePoints® 2010 Strat | 0.20              |
| RUSSELL INVESTMENT COMPANY        | Russell LP 2020 Strat Fd R1    | 0.20              |
| RUSSELL INVESTMENT COMPANY        | Russell LP 2030 Strat Fd R1    | 0.20              |

| Investment Company               | Investment Portfolio            | Annual Percentage |
|----------------------------------|---------------------------------|-------------------|
| RUSSELL INVESTMENT COMPANY       | Russell LP 2040 Strat Fd R1     | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP 2050 Strat Fd R1     | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP 2055 Strat R1        | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP 2015 Strat Fd R1     | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP 2025 Strat Fd R1     | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP 2035 Strat Fd R1     | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP 2045 Strat Fd R1     | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP Balanced R1          | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP Consv R1             | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell L.P. EqtyGrthStrat R1   | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP Grth Strat R1        | 0.20              |
| RUSSELL INVESTMENT COMPANY       | Russell LP Mod R1               | 0.20              |
| STATE STREET INSTITUTIONAL TRUST | State Street Equity 500 Idx Adm | 0.15              |
| T ROWE PRICE                     | TRowePrice MidCap Grth R        | 0.65              |
| T ROWE PRICE                     | TRowePrice Eqty Inc Ins         | 0.25              |
| T ROWE PRICE                     | TRowePrice Grth Stock Adv       | 0.40              |
| THORNBURG INVESTMENT MANAGEMENT  | Thornburg Intl Val R5           | 0.25              |
| THORNBURG INVESTMENT MANAGEMENT  | Thornburg Core Grth R5          | 0.25              |
| TIAA-CREF                        | TIAA-CREF Intl Eqty Indx R      | 0.25              |

Plan Type 3 403ER

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

Name of Plan: LAKE HOSPITAL SYSTEM INC. 403B RETIREMENT SAVINGS PLAN  
Employer Identification Number: 34-1425870  
For plan year (beginning/ending): 01-01-2016 TO 12-31-2016 Plan number: 001

| (a) | (b) Identity of issue, borrower, lessor, or similar party | (c) Description of investment including maturity date, rate of interest, collateral, par or maturity value | (d) Cost | (e) Current value |
|-----|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------|-------------------|
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT MIDCAP VAL INV MUTUAL FUND SHARES                                                                 | 0        | 10,306,276        |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2025 INV MUTUAL FUND SHARES                                                            | 0        | 1,972,839         |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2035 INV MUTUAL FUND SHARES                                                            | 0        | 1,863,549         |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2055 INV MUTUAL FUND SHARES                                                            | 0        | 516,009           |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2020 INV MUTUAL FUND SHARES                                                            | 0        | 5,633,114         |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2030 INV MUTUAL FUND SHARES                                                            | 0        | 3,912,549         |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2040 INV MUTUAL FUND SHARES                                                            | 0        | 4,627,189         |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2045 INV MUTUAL FUND SHARES                                                            | 0        | 795,841           |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2050 INV MUTUAL FUND SHARES                                                            | 0        | 1,134,470         |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE 2060 INV MUTUAL FUND SHARES                                                            | 0        | 5,980             |
|     | AMERICAN CENTURY INVESTMENTS                              | AMERCENT ONE CHOICE IN RET INV MUTUAL FUND SHARES                                                          | 0        | 1,012,452         |
|     | AMERICAN FUNDS                                            | AMERFDS NEW WORLD R4 MUTUAL FUND SHARES                                                                    | 0        | 188,376           |
| *   | AMERICAN UNITED LIFE INS CO                               | AUL FIXED ACCOUNT                                                                                          | 0        | 31,460,180        |
|     | COLUMBIA MGMT INVESTMENT ADVISORS                         | COLUMBIA MIDCAP INDX A MUTUAL FUND SHARES                                                                  | 0        | 253,381           |
|     | GOLDMAN SACHS ASSET MANAGEMENT                            | GOLDMANSACHS SMCAPVAL INST MUTUAL FUND SHARES                                                              | 0        | 5,016,272         |
|     | INVESCO                                                   | INVESCO DIVERSIFIED DIV INV MUTUAL FUND SHARES                                                             | 0        | 9,605,593         |
|     | JANUS CAPITAL GROUP INC                                   | JANUS ASP BALANCED S MUTUAL FUND SHARES                                                                    | 0        | 5,894,276         |
|     | PARTICIPANTS                                              | LOANS 5% TO 5%                                                                                             | 0        | 3,415,031         |
|     | LORD ABBETT FUNDS                                         | LORD ABBETT HIGH YIELD A MUTUAL FUND SHARES                                                                | 0        | 273,933           |
|     | MANNING & NAPIER FUND INC.                                | MAN&NAP PRO-BLEND MAXIMUM S MUTUAL FUND SHARES                                                             | 0        | 1,228,585         |
|     | MANNING & NAPIER FUND INC.                                | MAN&NAP PRO-BLEND CONSV S MUTUAL FUND SHARES                                                               | 0        | 1,349,751         |
|     | MANNING & NAPIER FUND INC.                                | MAN&NAP PRO-BLEND EXT TERM S MUTUAL FUND SHARES                                                            | 0        | 2,921,189         |
|     | MANNING & NAPIER FUND INC.                                | MAN&NAP PRO-BLEND MOD TERM S MUTUAL FUND SHARES                                                            | 0        | 5,969,201         |
|     | OPPENHEIMER FUNDS INC.                                    | OPPENHEIMER INTL GROWTH Y MUTUAL FUND SHARES                                                               | 0        | 6,123,154         |
|     | PIONEER INVESTMENTS                                       | PIONEER BOND Y MUTUAL FUND SHARES                                                                          | 0        | 8,248,043         |
|     | STATE STREET INSTITUTIONAL TRUST                          | STATE STREET EQUITY 500 IDX ADM MUTUAL FUND SHARES                                                         | 0        | 11,819,351        |
|     | FRANKLIN TEMPLETON INVESTMENTS                            | TEMPLETON GLOBAL BOND A MUTUAL FUND SHARES                                                                 | 0        | 140,243           |
|     | T ROWE PRICE                                              | TROWEPRIE GRTH STOCK ADV MUTUAL FUND SHARES                                                                | 0        | 23,464,190        |
|     | THE VANGUARD GROUP INC                                    | VANGUARD VIF SMALLCOMPGRTH INS MUTUAL FUND SHARES                                                          | 0        | 6,752,374         |