

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 1.5em; font-weight: bold;">2017</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>	
A This return/report is for:	☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) ____
B This return/report is:	☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)

Part II	Basic Plan Information—enter all requested information				
1a Name of plan <u>THE SUMMIT HEALTH & REHAB SERVICES, INC. 401(K) PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>08/01/2003</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>08/01/2003</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>08/01/2003</u>					
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>THE SUMMIT HEALTH & REHAB SERVICES, INC.</u> <u>4109 HIGHWAY 98 W. PO BOX 579</u> <u>SUMMIT, MS 39666-0579</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>64-0946151</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>601-276-3905</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>621340</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>64-0946151</u>	2c Plan Sponsor's telephone number <u>601-276-3905</u>	2d Business code (see instructions) <u>621340</u>	
2b Employer Identification Number (EIN) <u>64-0946151</u>					
2c Plan Sponsor's telephone number <u>601-276-3905</u>					
2d Business code (see instructions) <u>621340</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.	07/16/2018	CHUCK E. LAMBERT
	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

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

Form 5500 (2017)
v. 170203

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 278
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	
a(1) Total number of active participants at the beginning of the plan year	6a(1) 197
a(2) Total number of active participants at the end of the plan year	6a(2) 174
b Retired or separated participants receiving benefits	6b 1
c Other retired or separated participants entitled to future benefits	6c 93
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 268
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e	6f 268
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 212
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h 31
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7

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

2E 2F 2G 2J 2K 2S 2T 3D 3H

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

9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1)** ☒ **R** (Retirement Plan Information)
- (2)** ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3)** ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- (1)** ☒ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☐ 0 **A** (Insurance Information)
- (4)** ☒ **C** (Service Provider Information)
- (5)** ☐ **D** (DFE/Participating Plan Information)
- (6)** ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 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 _____

<div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>	OMB No. 1210-0110
		2017
		This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017		
A Name of plan THE SUMMIT HEALTH & REHAB SERVICES, INC. 401(K) PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 THE SUMMIT HEALTH & REHAB SERVICES, INC.	D Employer Identification Number (EIN) 64-0946151	

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
CAPITAL RESEARCH & MANAGEMENT CO.
95-1411037

(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)

GRANTHAM POOLE

64-0903390

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	AUDITOR	8460	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CAPITAL RESEARCH & MANAGEMENT CO.

95-1411037

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
64 52 60 62 25 49 72	RECORDKEEPER	1505	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>		
A Name of plan <u>THE SUMMIT HEALTH & REHAB SERVICES, INC. 401(K) PLAN</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>THE SUMMIT HEALTH & REHAB SERVICES, INC.</u>	D Employer Identification Number (EIN) <u>64-0946151</u>	

Part I	Asset and Liability Statement		
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	0	0
(2) Participant contributions	1b(2)	0	0
(3) Other	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	288854	55181
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	0	0
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	1821246	2504760
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	0	0

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	2110100	2559941

Liabilities

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

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	2110100	2559941
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Part II Income and Expense Statement

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

Income

a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	36591	
(B) Participants	2a(1)(B)	215901	
(C) Others (including rollovers)	2a(1)(C)	0	
(2) Noncash contributions	2a(2)	0	
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		252492
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	0	
(B) U.S. Government securities	2b(1)(B)	0	
(C) Corporate debt instruments.....	2b(1)(C)	0	
(D) Loans (other than to participants)	2b(1)(D)	0	
(E) Participant loans.....	2b(1)(E)	0	
(F) Other	2b(1)(F)	0	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Dividends: (A) Preferred stock	2b(2)(A)	0	
(B) Common stock	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	91241	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		91241
(3) Rents.....	2b(3)		0
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)	0	
(B) Other	2b(5)(B)	0	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(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)		314599
c Other income	2c		173
d Total income. Add all income amounts in column (b) and enter total.....	2d		658505

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	198699	
(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)		198699
f Corrective distributions (see instructions)	2f		0
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)	9965	
(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)		9965
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		208664

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		449841
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

☒ Yes ☐ No

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

(1) Name: GRANTHAM, POOLE

(2) EIN: 64-0903390

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		25555
4b		X	

		Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		100000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☒ No
 If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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.)

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection.
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For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan <u>THE SUMMIT HEALTH & REHAB SERVICES, INC. 401(K) PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>THE SUMMIT HEALTH & REHAB SERVICES, INC.</u>	D Employer Identification Number (EIN) <u>64-0946151</u>

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

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions	1	<u>0</u>
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>20-3691658</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	

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

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

Part III	Amendments
-----------------	-------------------

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

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

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

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

Schedule R (Form 5500) 2017
v. 170203

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- a** Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%
- b** Provide the average duration of the combined investment-grade and high-yield debt:
☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more
- c** What duration measure was used to calculate line 19(b)?
☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

**SUMMIT HEALTH & REHAB
SERVICES, INC.
401(k) PLAN**

**AUDITED FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION
DECEMBER 31, 2017 AND 2016**

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INDEPENDENT AUDITORS' REPORT

The Administrative Committee
Summit Health & Rehab Services, Inc.
401(k) Plan

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Summit Health & Rehab Services, Inc. 401(k) Plan, which comprise the statements of net assets available for benefits as of December 31, 2017 and 2016, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Notes 4 and 5, which was certified by Capital Bank and Trust Company, the trustee of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedule of assets (held at end of year). We have been informed by the Plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The Plan administrator has obtained a certification from the trustee as of and for the years ended December 31, 2017 and 2016, that the information provided to the Plan administrator by the trustee is complete and accurate.

Disclaimer of Opinion



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

Subsequent Event

As discussed in Note 3 to the financial statements, during 2018 the Summit Health & Rehab Services, Inc. 401(k) Plan will be merged with the HealthPro Rehabilitation 401(k) Plan. Our opinion is not modified with respect to that matter.

Other Matter

The supplemental schedule of delinquent participant contributions and schedule of assets (held at end of year) as of and for the year ended December 31, 2017 are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 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 matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

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

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

Graham Poole PCC

Ridgeland, Mississippi
June 14, 2018

SUMMIT HEALTH & REHAB SERVICES, INC. 401(k) PLAN
Statements of Net Assets Available for Benefits
December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u>
Assets:		
Investments at fair value - mutual funds	\$ 2,559,941	\$ 2,110,100
Receivables		
Employer contributions	-	1,540
Participant contributions	-	8,380
Total Receivables	<u>-</u>	<u>9,920</u>
Total Assets	<u>2,559,941</u>	<u>2,120,020</u>
Net Assets Available for Benefits	<u><u>\$ 2,559,941</u></u>	<u><u>\$ 2,120,020</u></u>

SUMMIT HEALTH & REHAB SERVICES , INC. 401(K) PLAN
Statements of Changes in Net Assets Available for Benefits
Years Ended December 31, 2017 and 2016

Additions

	<u>2017</u>	<u>2016</u>
Investment income		
Net appreciation in fair value of investments	\$ 314,599	\$ 41,156
Interest and dividends	91,241	59,763
Other Income	6	142
Total Investment Income	<u>405,846</u>	<u>101,061</u>
Contributions		
Employer	35,218	36,062
Participants	207,521	209,041
Total Contributions	<u>242,739</u>	<u>245,103</u>
Total Additions	<u>648,585</u>	<u>346,164</u>

Deductions

Benefits paid to participants	200,199	262,953
Administrative expenses	8,465	3,951
Total Deductions	<u>208,664</u>	<u>266,904</u>
Net Increase	439,921	79,260

Net Assets Available for Benefits:

Beginning of year	<u>2,120,020</u>	<u>2,040,760</u>
End of Year	<u>\$ 2,559,941</u>	<u>\$ 2,120,020</u>

SUMMIT HEALTH & REHAB SERVICES, INC.
401(k) PLAN
Notes to Financial Statements
December 31, 2017 and 2016

NOTE 1 DESCRIPTION OF PLAN

The following brief description of Summit Health & Rehab Services, Inc. 401(k) Plan (the Plan) is provided for general information purposes only. Participants should refer to the Plan agreement for more complete information.

General

The Plan is a 401(k) Profit Sharing Plan covering all employees of Summit Health & Rehab Services, Inc. and related entities (the Employer) who have one year or more of service with a minimum of 1,000 hours of service, and are age twenty-one or older. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Summit Health & Rehab Services, Inc. is the Plan's Sponsor.

Tax Status

The Plan obtained its latest determination letter on March 31, 2008, in which the Internal Revenue Service (IRS) stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code (IRC). The Plan administrator believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the IRC.

Accounting principles generally accepted in the United States of America (GAAP), require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2017 and 2016, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Employee Contributions

Eligible employees can defer up to 100% of their eligible compensation into the Plan, up to the maximum allowed by the Internal Revenue Code (IRC). Participants are allowed to make additional catch-up contributions to the Plan if they are 50 years of age or older as of the end of the Plan year. Additionally, participants are permitted to make rollover contributions to the Plan from individual retirement accounts.

Employer Contributions

At the discretion of the Employer, a contribution may be made as a percentage of the employee's eligible compensation, not to exceed the employee's allowable deferral contribution amount. Contributions are made to the Plan each pay period.

SUMMIT HEALTH & REHAB SERVICES, INC.
401(k) PLAN
Notes to Financial Statements
December 31, 2017 and 2016

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Participant Accounts

Each participant's account is credited with the participant's contributions, the Employer's contributions, and an allocation of investment income net of investment expenses. Expense allocations are determined as defined in the Plan document. Participants may direct their account balances into a variety of investment options offered by the Plan. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account balance.

Automatic Deferral

The Plan contains automatic deferral provisions whereby the Employer, as to each participant affected, will withhold as the automatic deferral amount, 2% from the participant's compensation each payroll period unless the participant makes a contrary election.

Vesting of Accounts

Participants are immediately 100% vested in their individual deferral contributions and earnings thereon. Participants are 100% vested in any employer discretionary contributions at the completion of a six-year vesting schedule.

Payment of Benefits

On termination of service due to death, disability, or retirement, a participant may elect to receive a lump-sum amount equal to, or a portion of, the value of the vested interest in his or her account. 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, or a rollover to another retirement account. Participants may also receive in-service distributions from their vested interest once they have attained age 59½. Benefits are recorded when paid.

Hardship Withdrawals

The Plan does not permit hardship withdrawals.

Participant Loans

The Plan does not permit participant loans.

Forfeited Accounts

Forfeitures may occur the last day of the Plan year in which the former participant incurs five consecutive 1-year breaks in service, or where the former participant receives the distribution of the entire vested portion of the participant's account. Forfeitures may be used to pay administrative expenses and then used to reduce Employer contributions, if any. Forfeited balances included in the Plan assets as of December 31, 2017 and 2016 were \$373 and \$2,856, respectively. During the years ended December 31, 2017 and 2016, forfeitures used to pay administrative fees or reduce Employer contributions totaled \$8,460 and \$3,016, respectively.

SUMMIT HEALTH & REHAB SERVICES, INC.
401(k) PLAN
Notes to Financial Statements
December 31, 2017 and 2016

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Terminated Participants

Plan participants include 65 terminated participants with vested balances of \$189,871 at December 31, 2017, and 53 terminated participants with vested balances of \$181,953 at December 31, 2016.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

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

Estimates

The preparation of financial statements in conformity with GAAP requires the Plan administrator to make estimates and assumptions that affect the reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair value. Quoted market prices are used to value investments. Shares of mutual funds are valued at quoted market prices which represent the net asset value of shares held by the Plan at year-end.

Purchases and sales of securities are recorded on a trade-date basis. Interests income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the plan's gains and losses on investments bought and sold as well as held during the year.

Expenses

Administrative expenses incurred by the Plan may be paid by the Plan unless paid by the Employer. Expenses paid by the Employer are excluded from these financial statements. Investment related expenses are included in net depreciation in fair value of investments.

Risk and Uncertainties

The Plan invests in a variety of investment funds. Investments in general are exposed to various risks, such as interest rate, credit, and overall volatility risk. Due to the level of risk associated with certain investments, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

SUMMIT HEALTH & REHAB SERVICES, INC.
401(k) PLAN
Notes to Financial Statements
December 31, 2017 and 2016

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Subsequent Events

Management has evaluated subsequent events through June 14, 2018 the date the financial statements were available to be issued. During March 2018, Summit Health and Rehab Services, Inc. announced the sale of the company and future merger of the Plan with the HealthPro Rehabilitation 401(k) Plan. (See Note 3)

NOTE 3 PLAN MERGER

During March 2018, Summit Health and Rehab Services, Inc. announced the sale of the company to HealthPro Heritage. The Summit Health & Rehab Services, Inc. 401(k) Plan will be merged with the HealthPro Rehabilitation 401(k) Plan. The Plan merger is expected to be completed by December 31, 2018.

NOTE 4 FAIR VALUE MEASUREMENTS

The Plan's investments are reported at fair value in the accompanying statements of net assets available for benefits. GAAP establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value.

This hierarchy consists of three broad levels:

Level 1 - inputs consist of unadjusted quoted prices in active markets for identical assets or liabilities.

Level 2 – inputs consist of significant observable inputs other than the prices quoted in active markets for identical assets or liabilities, such as quoted prices in active markets for similar assets or liabilities.

Level 3 – fair value measurements are based upon significant unobservable inputs.

Level 1 have the highest priority, while Level 3 inputs have the lowest priority. The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. No level 2 or 3 inputs were available or necessary for the Plan.

Level 1 Fair Value Measurements

The following table presents the fair value measurements of assets recognized in the accompanying statements of net assets available for benefits measured at fair value on a recurring basis at December 31, 2017 and 2016.

SUMMIT HEALTH & REHAB SERVICES, INC.
401(k) PLAN
Notes to Financial Statements
December 31, 2017 and 2016

NOTE 4 FAIR VALUE MEASUREMENTS (CONTINUED)

	<u>Fair Value</u>	<u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u>
<u>December 31, 2017</u>		
Mutual funds	<u>\$ 2,559,941</u>	<u>\$ 2,559,941</u>
<u>December 31, 2016</u>		
Mutual funds	<u>\$ 2,110,100</u>	<u>\$ 2,110,100</u>

The valuation methodologies and inputs used for assets are measured at fair value on a recurring basis and recognized in the accompanying statements of net assets available for benefits, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the years ended June 30, 2017 or 2016. The Plan had no liabilities measured at fair value on a recurring basis. Additionally, the Plan had no assets or liabilities measured at fair value on a nonrecurring basis.

Gains and losses (realized and unrealized) included in changes in net assets available for benefits for the year ended December 31, 2017 are reported in net appreciation in fair value of investments.

NOTE 5 INFORMATION CERTIFIED BY THE TRUSTEE (UNAUDITED)

The Plan administrator has elected the method of annual reporting compliance permitted by 29 CFR 2520.103-8 of the Department of Labor Rules and Regulations for Reporting and Disclosure under ERISA. The Plan trustee, Capital Bank & Trust Company/American Funds, has certified that the investments and related income reflected in the accompanying financial statements and supplemental information are complete and accurate.

The Plan's independent accountants did not perform auditing procedures with respect to this information, except for comparing such information to the related information included in the financial statements and supplemental information.

The following is a summary of the Plan's financial information included in the financial statements based on information certified by the Plan trustee:

- Investments as shown in the statements of net assets available for benefits as of December 31, 2017 and 2016
- Investment income as shown in the statements of changes in net assets available for benefits for the years ended December 31, 2017 and 2016
- Fair Value Measurement (Note 4)

SUMMIT HEALTH & REHAB SERVICES, INC.
401(k) PLAN
Notes to Financial Statements
December 31, 2017 and 2016

NOTE 6 RELATED-PARTY AND PARTY IN INTEREST TRANSACTIONS

Plan investments are interests in registered investment companies (mutual funds) managed by American Funds. American Funds and Capital Bank and Trust Company are trustees as defined by the Plan and, therefore, these transactions qualify as party in interest transactions. Fees incurred by the Plan for the investment management and other services are included in net appreciation in fair value of investments, as they are paid through revenue sharing rather than direct payments.

NOTE 7 NONEXEMPT TRANSACTIONS

During the year ended December 31, 2017 the Employer did not remit certain participant contributions to the Plan in a timely manner, as defined by ERISA. The late deposits totaled \$25,555. These contributions are considered non-exempt party-in-interest transactions. The lost earnings associated with the late deposits were \$16. The Employer has deposited the lost earnings associated with these late deposits to the affected participants' accounts.

NOTE 8 RECONCILIATION OF FINANCIAL STATEMENTS TO SCHEDULE H OF FORM 5500

The following is a reconciliation of Form 5500 Schedule H to the statement of changes in net assets available for benefits.

	Financial	Form 5500	
<u>Net Assets Available for Benefits</u>	<u>Statements</u>	<u>Schedule H</u>	<u>Differences</u>
Investments at fair value - mutual funds	\$ 2,559,941	\$ 2,504,760	\$ 55,181
Cash, interest bearing		55,181	(55,181)
Employer contributions receivable	-	-	-
Participants contributions receivable	-	-	-
Net Assets Available for Benefits	<u>\$ 2,559,941</u>	<u>\$ 2,559,941</u>	<u>\$ -</u>
	Financial	Form 5500	
<u>Changes in Net Assets Available</u>	<u>Statements</u>	<u>Schedule H</u>	<u>Differences</u>
<u>for Benefits</u>			
Net appreciation in fair value of investments	\$ 314,599	\$ 314,599	\$ -
Interest and dividends	91,241	91,241	-
Other income	6	173	(167)
Employer contributions	35,218	36,591	(1,373)
Participant contributions	207,521	215,901	(8,380)
Benefits paid to participants	(200,199)	(198,699)	(1,500)
Administrative expenses	(8,465)	(9,965)	1,500
Net Increase in Net Assets Available			
for Benefits	<u>\$ 439,921</u>	<u>\$ 449,841</u>	<u>\$ (9,920)</u>

Note: The net difference (\$9,920), is due to timing differences in recording prior year contribution receivables.

SUPPLEMENTARY INFORMATION

SUMMIT HEALTH & REHAB SERVICES, INC. 401(k) PLAN

Employer I.D. Number 64-0946151

Plan Number 001

Sch. H Line 4a - Schedule of Delinquent Participant Contributions

December 31, 2017

<u>Participant Contributions Transferred Late to Plan</u>	<u>Contributions Not Corrected</u>	<u>Contributions Corrected Outside VFCP</u>	<u>Contributions Pending Correction in VFCP</u>	<u>Total Fully Corrected Under VFCP and PTE 2002-51</u>
<u>\$ 25,555</u>	<u>\$ -</u>	<u>\$ 25,555</u>	<u>\$ -</u>	<u>\$ -</u>

SUMMIT HEALTH & REHAB SERVICES, INC. 401(K) PLAN
Employer I.D. Number 64-0946151
Plan Number 001
Sch. H 4i - Schedule of Assets (Held at End of Year)
December 31, 2017

(a)	(b) Issuer	Identity of Issue	(c) Description of Investment	(d) Cost**	(e) Current Value
*	American Funds	Growth Fund of America	Mutual Fund	**	\$ 315,610
*	American Funds	Income Fund of America	Mutual Fund	**	105,738
*	American Funds	New Perspective Fund	Mutual Fund	**	234,841
*	American Funds	Bond Fund of America	Mutual Fund	**	43,523
*	American Funds	American Balanced Fund	Mutual Fund	**	139,147
*	American Funds	New Economy Fund	Mutual Fund	**	92,674
*	American Funds	US Government Securities Fund	Mutual Fund	**	21,223
*	American Funds	Intermediate Bond Fund of America	Mutual Fund	**	4,961
*	American Funds	Capital World Growth & Income Fund	Mutual Fund	**	369,758
*	American Funds	Small Cap World Fund	Mutual Fund	**	84,855
*	American Funds	U.S. Govt. Money Market Fund	Mutual Fund	**	54,808
*	American Funds	Money Market Fund/Forfeitures	Mutual Fund	**	373
*	American Funds	International Growth & Income	Mutual Fund	**	199,352
*	Franklin	Natural Resources Fund	Mutual Fund	**	986
*	Franklin	Real Estate Securities	Mutual Fund	**	1,604
*	American Funds	2010 Target Date Fund	Mutual Fund	**	2,174
*	American Funds	2015 Target Date Fund	Mutual Fund	**	323
*	American Funds	2020 Target Date Fund	Mutual Fund	**	134,171
*	American Funds	2025 Target Date Fund	Mutual Fund	**	67,056
*	American Funds	2030 Target Date Fund	Mutual Fund	**	69,957
*	American Funds	2035 Target Date Fund	Mutual Fund	**	83,034
*	American Funds	2040 Target Date Fund	Mutual Fund	**	61,414
*	American Funds	2045 Target Date Fund	Mutual Fund	**	49,394
*	American Funds	2050 Target Date Fund	Mutual Fund	**	213,943
*	American Funds	2055 Target Date Fund	Mutual Fund	**	208,783
*	American Funds	2060 Target Date Fund	Mutual Fund	**	239
					<u>\$ 2,559,941</u>

* Denotes Party in Interest

** Note: Column (d) is blank as all investments are participant directed

Name of Plan:

Employer Identification No.: ► 64-0946151

Plan year (beginning/ending):▶ 1/1/2017 - 12/31/2017 Plan number:▶ 001

[illegible]

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

The Summit Health & Rehab Services, Inc. 401(k) Plan
01-JAN-17 to 31-DEC-17

20-JAN-18 16:35:29

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
IRGABX			235,020.85	315,609.51
IRNGBX			66,059.51	92,673.57
IRNPBX			186,538.58	234,841.39
IRSLBX			62,485.47	84,855.26
IFNCRX			1,188.67	986.13
IRWIBX			296,692.13	369,757.46
IRIGBX			176,412.31	199,352.10
IFRRSX			1,285.66	1,604.37
IRIDBX			94,933.02	105,738.24
IRLBBX			116,103.16	139,146.74
IRBFBX			43,575.91	43,522.82
IRBOBX			5,010.31	4,960.60
IRGVBX			21,859.31	21,223.04
IRABXX			54,808.09	54,808.09
IRBATX			2,066.67	2,174.29
IRBJTX			304.78	323.46
IRBCTX			124,466.31	134,170.70
IRBDTX			58,457.11	67,055.99
IRBETX			60,323.81	69,956.99
IRBFTX			69,361.86	83,033.93
IRBKTX			48,720.09	61,414.16
IRBHTX			41,635.01	49,394.38
IRBITX			178,520.43	213,943.28
IRBMTX			177,225.20	208,782.52
IRBNTX			212.54	238.78
			2,123,266.79	2,559,567.80
FORFEITURES			372.95	372.95

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

GA

The Summit Health & Rehab Services, Inc. 401(k) Plan
01-JAN-17 to 31-DEC-17

20-JAN-18 16:35:29

INVESTMENT OPTION

MATURITY DATE

INTEREST RATE

COST OF ASSETS

CURRENT VALUE

LEGEND

INVESTMENT OPTION:

1RGABX American Funds Growth Fund of Amer R2
 1RNPBX American Funds New Perspective R2
 1FNCRX Franklin Natural Resources Fund Class C
 1RIGBX American Funds International Gr & Inc R2
 1RIDBX American Funds Income Fund of America R2
 1RFBFX American Funds Bond Fund of Amer R2
 1RGVBX American Funds US Government Sec R2
 1RBATX American Funds 2010 Target Date Fund R2
 1RBCTX American Funds 2020 Target Date Fund R2
 1RBETX American Funds 2030 Target Date Fund R2
 1RBKTX American Funds 2040 Target Date Fund R2
 1RBITX American Funds 2050 Target Date Fund R2
 1RBNTX American Funds 2060 Target Date Fund R2

1RNGBX American Funds New Economy R2
 1RSLBX American Funds SMALLCAP World R2
 1RWIBX American Funds Capital World G/I R2
 1FRRSX Franklin Real Estate Securities C
 1RLBBX American Funds American Balanced R2
 1RBOBX American Funds Interm Bd Fd of Amer R2
 1RABXX American Funds US Govt Money Market R2
 1RBJTX American Funds 2015 Target Date Fund R2
 1RBDTX American Funds 2025 Target Date Fund R2
 1RBFTX American Funds 2035 Target Date Fund R2
 1RBHTX American Funds 2045 Target Date Fund R2
 1RBMTX American Funds 2055 Target Date Fund R2

COST OF ASSETS: The original cost of the assets in each investment option as of the last day of the plan year

CURRENT VALUE: The value of all assets in each investment option as of the last day of the plan year