

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2016 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information		
For calendar plan year 2016 or fiscal plan year beginning <u>10/01/2016</u> and ending <u>09/30/2017</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>OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN</u>	1b	Three-digit plan number (PN) ▶ <u>001</u>
		1c	Effective date of plan <u>10/01/1991</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>OHIO HEARTLAND COMMUNITY ACTION COMMISSION</u> <u>PO BOX 779</u> <u>MARION, OH 43301</u>	2b	Employer Identification Number (EIN) <u>34-0978820</u>
		2c	Plan Sponsor's telephone number <u>740-387-1039</u>
		2d	Business code (see instructions) <u>611000</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.	07/17/2018	ANDREW J DEVANY
	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) <u>AMERICAN UNITED LIFE INSURANCE CO.</u> <u>AMERICAN UNITED LIFE INSURANCE CO.</u> <u>ONE AMERICAN SQUARE, PO BOX 368</u> <u>INDIANAPOLIS, IN 46206-0368</u>			Preparer's telephone number <u>800-261-9618</u>

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

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
5 Total number of participants at the beginning of the plan year	5 543
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) 513
a(2) Total number of active participants at the end of the plan year	6a(2) 206
b Retired or separated participants receiving benefits.....	6b 0
c Other retired or separated participants entitled to future benefits	6c 18
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 224
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e	6f 224
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 195
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h 0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2F 2G 2L 2T 3D	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2016 This Form is Open to Public Inspection
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For calendar plan year 2016 or fiscal plan year beginning **10/01/2016** and ending **09/30/2017**

A Name of plan OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN	B Three-digit plan number (PN) ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO HEARTLAND COMMUNITY ACTION COMMISSION	D Employer Identification Number (EIN) 34-0978820

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

(a) Name of insurance carrier

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	G76577	195	10/01/2016	09/30/2017

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
5061	0

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

EXECUTIVE INS AGCY INC
130 SPRINGSIDE DRIVE STE 300
AKRON, OH 44333

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5061	0 N/A		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end	4	14946
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	1267698

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** 0

c Additions: (1) Contributions deposited during the year	7c(1)	4294
(2) Dividends and credits.....	7c(2)	0
(3) Interest credited during the year.....	7c(3)	144
(4) Transferred from separate account.....	7c(4)	12955
(5) Other (specify below).....	7c(5)	17596

▶ **LOAN REPAYMENT TRANSFER FROM OUTSIDE SOURCE**(6) Total additions **7c(6)** 34989**d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 34989**e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1038
(2) Administration charge made by carrier.....	7e(2)	712
(3) Transferred to separate account.....	7e(3)	15660
(4) Other (specify below).....	7e(4)	2633

▶ **LOANS ISSUED**(5) Total deductions **7e(5)** 20043**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 14946

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500. ► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2016 This Form is Open to Public Inspection
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For calendar plan year 2016 or fiscal plan year beginning **10/01/2016** and ending **09/30/2017**

A Name of plan OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO HEARTLAND COMMUNITY ACTION COMMISSION	D Employer Identification Number (EIN) 34-0978820	

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

(a) Name of insurance carrier

METROPOLITAN 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
13-5581829	65978	1095002	282	10/01/2016	09/30/2017

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
446	0

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

METLIFE SECURITIES, INC
1095 AVENUE OF THE AMERICAS
NEW YORK, NY 10036

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
446	0	N/A	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end **4** 649948**5** Current value of plan's interest under this contract in separate accounts at year end..... **5** 390646**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 DEFERRED ANNUITIES**b** Balance at the end of the previous year **7b** 698068**c** Additions: (1) Contributions deposited during the year **7c(1)** 0
(2) Dividends and credits..... **7c(2)** 0
(3) Interest credited during the year..... **7c(3)** 20073
(4) Transferred from separate account **7c(4)** 0
(5) Other (specify below) **7c(5)** 0
▶(6) Total additions **7c(6)** 20073**d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 718141**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 64068
(2) Administration charge made by carrier..... **7e(2)** 2091
(3) Transferred to separate account..... **7e(3)** 2034
(4) Other (specify below) **7e(4)** 0
▶(5) Total deductions **7e(5)** 68193**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 649948

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Part IV Provision of Information

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

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

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

For calendar plan year 2016 or fiscal plan year beginning **10/01/2016** and ending **09/30/2017**

A Name of plan OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN	B Three-digit plan number (PN) ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO HEARTLAND COMMUNITY ACTION COMMISSION	D Employer Identification Number (EIN) 34-0978820

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 AMERICAN UNITED LIFE INSURANCE CO 35-0145825
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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation METROPOLITAN LIFE INSURANCE CO 13-5581829

(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

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) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50 64 37 52 59 60 63 66 67	NONE	5785	Yes ☒ No ☐	Yes ☐ No ☒	5238	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 ☐

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
AMERICAN UNITED LIFE INSURANCE CO	66 67	5238
(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 35-0145825	ASSET CHARGE	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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 20-2036524	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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 95-1411037	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 (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	0
(d) Enter name and EIN (address) of source of indirect compensation COLUMBIA MGMT INVESTMENT ADVISORS 13-3180631	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2 AMERICAN UNITED LIFE INSURANCE CO	(b) Service Codes (see instructions) 52 59 60 63	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation FEDERATED 25-1111467	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2 AMERICAN UNITED LIFE INSURANCE CO	(b) Service Codes (see instructions) 52 59 60 63	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation FIRST AMERICAN FUNDS 41-2003732	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. 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 (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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.	
JANUS CAPITAL GROUP INC 75-3019319	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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.	
MFS INVESTMENT MANAGEMENT 04-3169826	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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. 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 (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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.	
PIMCO 06-1349805	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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.	
PIONEER INVESTMENTS 13-1961193	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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.	
PNC 27-0640560	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 (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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 04-2456637	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN UNITED LIFE INSURANCE CO	52 59 60 63	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 85-0301299	REVENUE SHARING FORMULA - SEE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

a Name:	RD CONLEY & COMPANY	b EIN:	31-1705260
c Position:	AUDITOR		
d Address:	4030 MT. CARMEL-TOBASCO RD STE 125 CINCINNATI, OH 45255	e Telephone:	513-528-0105

Explanation: MERGED WITH ANOTHER FIRM

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 D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2016 This Form is Open to Public Inspection.
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For calendar plan year 2016 or fiscal plan year beginning 10/01/2016 and ending 09/30/2017

A Name of plan <u>OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%; padding: 5px;"> B Three-digit plan number (PN) ► </td> <td style="width:20%; padding: 5px; text-align: center;"> <u>001</u> </td> </tr> <tr style="background-color: #f2f2f2;"> <td colspan="2" style="height: 20px;"></td> </tr> </table>	B Three-digit plan number (PN) ►	<u>001</u>		
B Three-digit plan number (PN) ►	<u>001</u>				
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>OHIO HEARTLAND COMMUNITY ACTION COMMISSION</u>	D Employer Identification Number (EIN) <u>34-0978820</u>				

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
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a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT II

b Name of sponsor of entity listed in (a): AMERICAN UNITED LIFE INSURANCE CO

c EIN-PN <u>35-0145825-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1267698</u>
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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)
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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)
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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)
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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)
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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)
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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)
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For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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
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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

SCHEDULE H (Form 5500) Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2016 This Form is Open to Public Inspection
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For calendar plan year 2016 or fiscal plan year beginning <u>10/01/2016</u> and ending <u>09/30/2017</u>		
A Name of plan <u>OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B 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>OHIO HEARTLAND COMMUNITY ACTION COMMISSION</u>	D Employer Identification Number (EIN) <u>34-0978820</u>	

Part I	Asset and Liability Statement
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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)	0	0
(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)	11059	15187
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities.....	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	1383258	1658344
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	698068	664894
(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	2092385	2338425

Liabilities

g Benefit claims payable	1g	0	0
h Operating payables	1h	0	0
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	2092385	2338425
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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)	119767	
(B) Participants.....	2a(1)(B)	82215	
(C) Others (including rollovers)	2a(1)(C)	154963	
(2) Noncash contributions	2a(2)	0	356945
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		
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)	365	
(F) Other	2b(1)(F)	144	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		509
(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)	0	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(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)		183109
c Other income.....	2c		0
d Total income. Add all income amounts in column (b) and enter total.....	2d		540563

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	290391	
(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)		290391
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)	6687	
(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)		6687
j Total expenses. Add all expense amounts in column (b) and enter total	2j		297078

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		243485
l Transfers of assets:			
(1) To this plan.....	2l(1)		2555
(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: **BHM CPA GROUP INC**

(2) EIN: **31-1413363**

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

	Yes	No	Amount
4a		X	
4b		X	

		Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		250000
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		
o Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	4o			

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

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

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

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? ☐ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part V Trust Information

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

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2016 This Form is Open to Public Inspection.
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For calendar plan year 2016 or fiscal plan year beginning 10/01/2016 and ending 09/30/2017

A Name of plan <u>OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B 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>OHIO HEARTLAND COMMUNITY ACTION COMMISSION</u>	D Employer Identification Number (EIN) <u>34-0978820</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>13-5581829</u> <u>35-0145825</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) 2016
v. 160205

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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



bhm cpa group, inc.
CERTIFIED PUBLIC ACCOUNTANTS

**SECTION 403(B) RETIREMENT PLAN FOR
OHIO HEARTLAND COMMUNITY ACTION COMMISSION**

FINANCIAL STATEMENTS

FOR THE YEAR ENDED SEPTEMBER 30, 2017 and 2016

TOGETHER WITH INDEPENDENT AUDITOR'S REPORT

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bhm cpa group, inc.
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Administrative Committee of the
Section 403(b) Retirement Plan for Ohio
Heartland Community Action Commission
Marion, Ohio

Report on the Financial Statements

We have been engaged to audit the accompanying financial statements of the Administrative Committee of the Section 403(b) Retirement Plan for Ohio Heartland Community Action Commission (the Plan), which comprise the statements of net assets available for benefits – modified cash basis, as of September 30, 2017 and 2016, and the related statement of changes in net assets available for benefits – modified cash basis for the years then ended, and the related notes to 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 the modified cash basis of accounting described in the notes to the financial statements; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible for 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 our 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 (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 investment information summarized in the notes to financial statements, which was certified by Ascensus Trust Company and the MetLife Insurance Company of Connecticut for the year ended September 30, 2016 and American United Life Insurance Company and the MetLife Insurance Company of Connecticut for the year ended September 30, 2017, the custodians of the Plan, except for comparing the information with the related information included in the financial statements. We have been informed by the plan administrator that the American United Life Insurance Company and MetLife Insurance Company of Connecticut held the Plan's investment assets and executed investment transactions from October 1, 2016

to September 30, 2017 and Ascensus Trust Company and MetLife Insurance of Connecticut held the Plan's investment assets and executed investment transactions from October 1, 2015 to September 30, 2016. The plan administrator has obtained certifications from the custodians as of and for the years ended September 30, 2017 and 2016, that the information provided to the plan administrator by the custodian 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.

Basis of Accounting

We draw attention to the Notes to Financial Statements, which describes the basis of accounting. The financial statements were prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America.

Other Matter

The supplemental schedule of assets held at year end is required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA and is presented for the purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedule.

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

The form and content of the information included in the financial statements and supplemental schedule, other than that derived from the information certified by the custodian, 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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

BHM CPA Group, Inc.

BHM CPA Group, Inc.
Columbus, Ohio

July 12, 2018

FINANCIAL STATEMENTS

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**STATEMENT OF IN NET ASSETS AVAILABLE FOR BENEFITS -
MODIFIED CASH BASIS**

SEPTEMBER 30, 2017 AND 2016

ASSETS	2017	2016
Investment at contract value:		
Insurance company general account	\$ 649,948	\$ 698,068
Investments at fair value:		
Registered investment companies	<u>1,673,290</u>	<u>1,383,258</u>
Total investments	<u>2,323,238</u>	<u>2,081,326</u>
Receivables:		
Notes receivable from participants:	<u>20,232</u>	<u>11,059</u>
TOTAL ASSETS	<u>2,343,470</u>	<u>2,092,385</u>
LIABILITIES	<u>-</u>	<u>-</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 2,343,470</u></u>	<u><u>\$ 2,092,385</u></u>

The accompanying notes to financial statements
are an integral part of these financial statements.

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS -
MODIFIED CASH BASIS**

FOR THE YEARS ENDED SEPTEMBER 30, 2017 AND 2016

ADDITIONS	2017	2016
Additions to net assets attributed to:		
Investment income:		
Net appreciation in fair value of investments		
Registered investment companies	\$ 183,109	\$ 150,671
Interest	509	507
	<u>183,618</u>	<u>151,178</u>
Contributions:		
Employer's contributions	119,767	138,195
Employee's contributions	82,215	58,490
Contributions from rollovers	154,963	5,284
	<u>356,945</u>	<u>201,969</u>
TOTAL ADDITIONS	<u>540,563</u>	<u>353,147</u>
DEDUCTIONS		
Deductions to net assets attributed to:		
Administrative expenses	4,132	15,692
Benefits paid to participants	285,346	373,916
TOTAL DEDUCTIONS	<u>289,478</u>	<u>389,608</u>
NET INCREASE/DECREASE	251,085	(36,461)
NET ASSETS AVAILABLE FOR PLAN BENEFITS		
Beginning of year	<u>2,092,385</u>	<u>2,128,846</u>
End of year	<u>\$ 2,343,470</u>	<u>\$ 2,092,385</u>

The accompanying notes to financial statements
are an integral part of these financial statements.

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 2017 AND 2016**

(1) DESCRIPTION OF PLAN

The following brief description of the Section 403(b) Retirement Plan for Ohio Heartland Community Action Commission (the Plan) provides only general information. Participants should refer to the summary plan description and plan document for a more complete description of the Plan's provisions.

A. General

The Plan is a defined contribution plan covering certain employees of Ohio Heartland Community Action Commission (the Organization). The Plan is subject to the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The purpose of the Plan is to provide eligible employees a qualified plan which meets the requirements of Section 403(b) of the Internal Revenue Code of 1986.

B. Contributions and Participant Accounts

Participants may contribute an elective percentage of their compensation annually, subject to certain limitations as defined by the Plan. Contributions in excess of allowable amounts are refunded to the participants. The Organization matches 3% of the employee deferrals. The Organization contributed approximately \$135,451 and \$130,638 for the years ended September 30, 2017 and 2016 respectively.

Each participant's account is charged or credited with (a) the participant's contributions, (b) the Organization's contribution, (c) the Plan's investment earnings or losses and (d) certain Plan administration costs not covered by the Organization.

C. Benefit Payments

Upon termination of service due to death, disability or retirement, a participant, or his or her beneficiary, may elect to receive an amount equal to the value of the participant's vested account balance. The payment is in the form of a lump-sum distribution or annuity.

D. Vesting

Participants are 100% vested after two years in contributions made by the Organization.

(2) SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying financial statements have been prepared using the Plan's modified cash method (basis) of accounting. This method utilizes a modified cash approach whereby cash receipts and disbursements are recorded in the period received or made, respectively. Investments are recorded at fair value where unrealized gain/loss is recorded as income/loss.

Estimates

The preparation of financial statements in conformity with modified cash basis of accounting requires the Plan's management to make estimates and assumptions that affect the accompanying financial statements and disclosures. Accordingly, actual results may differ from those estimates.

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 2017 AND 2016**

Administrative Expenses

Certain administrative expenses of the Plan are paid and/or incurred by the Organization.

Payment of Benefits

Benefits are recorded when paid.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair value except for its investment in the trustee's common collective trust which is valued at contract value. Shares of mutual funds are valued on quoted market prices obtained by the trustee. Participant loans are valued at cost less an allowance for bad debts if deemed necessary. Purchases and sales of securities are recorded on a trade-date basis. Interest and dividends are recorded on the date of receipt

(3) FAIR VALUE MEASUREMENTS

The Plan's investments are reported at fair value in the accompanying statement of net assets available for benefits-modified cash basis. The following table presents fair value measurement information for investments:

<u>FAIR MEASUREMENTS AT REPORTING DATE USING:</u>				
		UNADJUSTED QUOTED MARKET PRICES	SIGNIFICANT OTHER OBSERVABLE INPUTS	SIGNIFICANT UNOBSERVABLE INPUTS
	<u>FAIR VALUE</u>	<u>(LEVEL 1)</u>	<u>(LEVEL 2)</u>	<u>(LEVEL 3)</u>
SEPTEMBER 30, 2017				
Registered investment companies	\$ 1,673,290	\$ 1,673,290	\$ -	\$ -
Ins company general acct	649,948	-	-	649,948
TOTAL	\$ 2,323,238	\$ 1,673,290	\$ -	\$ 649,948
SEPTEMBER 30, 2016				
Registered investment companies	\$ 1,383,258	\$ 1,383,258	\$ -	\$ -
Ins company general acct	698,068	-	-	698,068
TOTAL	\$ 2,081,326	\$ 1,383,258	\$ -	\$ 698,068

Statement of Financial Accounting Standards No. 157, *Fair Value Measurements*, 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 and have the highest priority, Level 2 inputs consist of observable inputs other than quoted prices for identical assets, and 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. Level 2 inputs are

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 2017 AND 2016**

the second most reliable evidence of fair value, and Level 3 inputs were used only when Level 1 or Level 2 inputs were not available.

Level 1 Fair Value Measurement

The fair value of mutual funds is based on quoted net asset values of the shares held by the Plan at year –end.

Level 2 Fair Value Measurement

None disclosed.

Level 3 Fair Value Measurement

The fair value of the common collective trust represents the participants’ principal plus accrued interest at year-end.

(4) INVESTMENTS REPRESENTING 5% OR MORE OF NET ASSETS AVAILABLE FOR BENEFIT

The Plan provides for investments in various securities. Investment securities, in general, are exposed to various risks, such as but not limited to, interest rate risks, credit risks, and overall market volatility. Furthermore, due to the level of risks associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the statement of net assets available for benefits.

	September 30,	
	<u>2017</u>	<u>2016</u>
Insurance Company General Account	\$ 649,948	\$ 698,068
Amerfds 2015 Trgt Date Ret R3	251,063	-
Amerfds 2020 Trgt Date Ret R3	179,320	-
Met Life Stock Index Portfolio	106,124	129,620
Fidelity Adv Freedom 2015 FD	-	212,911

5) TAX STATUS

The Internal Revenue Service does not have an approval program for 403(b) documents. However, management and the trustee of the Plan believe that the Plan is in full compliance with the applicable requirements of the IRC for the years ended September 30, 2017 and 2016.

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 2017 AND 2016**

(6) PLAN TERMINATION

Although it has not expressed any interest to do so, the Organization has the right, under the Plan trust Agreement, to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

(7) INFORMATION CERTIFIED BY THE PLAN'S TRUSTEES

All investment balances and transactions contained in the statements of net assets available for benefits and the statement of changes in net assets available for benefits contains information certified by MetLife Insurance Company of Connecticut and American United Life Insurance Company. No auditing procedures were performed on the information provided, except to confirm participant loans and to compare other certified information to the related information in the financial statements and in the notes to financial statements.

(8) RELATED PARTY TRANSACTIONS

Certain Plan investments are shares of mutual funds managed by MetLife Insurance Company of Connecticut and American United Life Insurance Company. MetLife Insurance Company of Connecticut and American Life Insurance Company are the trustees as defined by the Plan and, therefore, these transactions qualify as party-in-interest transactions.

**(9) RECONCILIATION OF FINANCIAL STATEMENTS TO SCHEDULE H OF FORM
5500**

Differences between the financial statements and schedule H for the years ending September 30, 2017 and 2016 are as follows:

	September 30,	
	<u>2017</u>	<u>2016</u>
Net assets available of benefits per the financial statements	\$ 2,343,470	\$ 2,092,385
Notes receivable from participants	<u>(5,045)</u>	<u>-</u>
		-
Net assets available of benefits per schedule H to the Form 5500	<u><u>\$ 2,338,425</u></u>	<u><u>\$ 2,092,385</u></u>

(10) FORFEITED ACCOUNTS

During the year ended September 30, 2017, employer contributions were reduced by \$15,684 from utilization of forfeited non-vested accounts.

**SECTION 403(B) RETIREMENT PLAN FOR OHIO HEARTLAND
COMMUNITY ACTION COMMISSION**

**NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 2017 AND 2016**

(11) SUBSEQUENT EVENTS

Subsequent events were evaluated through July 12, 2018 which was the date the financial statements were available to be issued.

SUPPLEMENTAL INFORMATION

**SECTION 403(b) RETIREMENT PLAN FOR
OHIO HEARTLAND COMMUNITY ACTION COMMISSION
EIN 34-0978820
ATTACHMENT 5500 SCHEDULE H LINE C (8)(9)(13)**

(a)	(b)	(c)	(d)	(e)
Identify of issue borrower	Description of	Investment	Cost	Current Value
lessor or similar party				
* MetLife	Insurance Company General Account		\$ 649,948	649,948
Participant Loan	Prevailing interest 0 to 15 years		15,187	15,187
* MetLife	American Funds Balanced Allocation Portfolio		**	3,058
	American Funds Bond Fund		**	410
	American Funds Global Small Capitalization Fund		**	1,694
	American Funds Growth Fund		**	6,049
	American Funds Growth-Income Fund		**	18,746
	Barclays Capital Aggregate Bond Index		**	4,955
	Frontier Mid Cap Growth Portfolio		**	14,033
	BlackRock Bond Income Portfolio		**	7,858
	WMC Balanced Portfolio		**	56,225
	WMC Large Cap Research		**	40,967
	BlackRock Large Cap Value Portfolio		**	606
	Invesco Mid Cap Value Portfolio		**	2,321
	MetLife Asset Allocation 100		**	9,029
	MetLife Asset Allocation 20		**	28,096
	MetLife Asset Allocation 40		**	560
	MetLife Mid Cap Stock Index Portfolio		**	6,441
	MetLife Asset Allocation 60		**	811
	MetLife Asset Allocation 80		**	34,058
	MetLife Stock Index Portfolio		**	784
	MFS Value Portfolio		**	106,124
	Morgan Stanley EAFE Index Portfolio		**	441
	Morgan Stanley Mid Cap Growth Portfolio		**	1,236
	Neuberger Berman Genesis Portfolio		**	40,860
	Russell 2000 Index Portfolio		**	770
	Western Asset Mgt Strategic Bond Opp Port		**	2,733
	Western Asset Mgt US Gov		**	24
	WMC Core Equity Opp		**	1,070
				686

**SECTION 403(b) RETIREMENT PLAN FOR
OHIO HEARTLAND COMMUNITY ACTION COMMISSION
EIN 34-0978820
ATTACHMENT 5500 SCHEDULE H, PART IV, LINE 4(i)-SCHEDULE
OF ASSETS (HELD AT YEAR-END)**

(a)	(b)	(c)	(d)	(e)
	Identify of issue borrower lessor or similar party	Description of Investment	Cost	Current Value
*	American United Life	AM Century Emerging Mkt	**	135
		Am Century Midcap Val A	**	79
		Am Century Small Comp A	**	46,267
		Amerfds 2015 Trgt Date Ret R3	**	251,063
		Amerfds 2020 Trgt Date Ret R3	**	179,320
		Amerfds 2025 Trgt Date Ret R3	**	30,769
		Amerfds 2030 Trgt Date Ret R3	**	80,309
		Amerfds 2035 Trgt Date Ret R3	**	89,046
		Amerfds 2040 Trgt Date Ret R3	**	96,985
		Amerfds 2045 Trgt Date Ret R3	**	89,051
		Amerfds 2050 Trgt Date Ret R3	**	81,608
		Amerfds 2055 Trgt Date Ret R3	**	1,283
		Amerfds 2060 Trgt Date Ret R3	**	490
		Amerfds American Balanced R3	**	60,674
		Amerfds New Perspective R3	**	16,728
		Amerfds Washington Mutual R3	**	391
		American United Fixed Account	**	14,946
		Columbia Us Gov Mortgage A	**	8,729
		Federated High Yield Svc	**	255
		Jan Hen Enterprises S	**	24,736
		Jan Hen Us Mgd Volatility S	**	41,989
		MFS Intl New Discovery R2	**	12,595
		Nuveen Smcap Val R3	**	180
		Oppenheimer Intl Grth a	**	14,438
		Oppenheimer Tot Ret Bond Y	**	35,525
		Pimco Real Return R	**	17,282
		Pioneer Fdamental Grth A	**	391
		Pioneer Strat Inc a	**	14,380
		Pnc International Equity A	**	10,329
		Pnc Multi Fact Smllcap Core A	**	186
		State Street Equity 500 Indx	**	185
		Thornburg Ltd-Term Inc R3	**	62,300

* Party-in-interest

** Not applicable for participant-directed investments

Schedule C Attachment for Line Item 3(e)

Plan Name **G76577 OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN**

Plan Number **001**

Plan Year End

9/30/2017

EIN

34-0978820

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
AMERICAN CENTURY INVESTMENTS	AmerCent MidCap Val A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent Emerging Mkt A	0.60
AMERICAN CENTURY INVESTMENTS	AmerCent Small Comp A	0.60
AMERICAN FUNDS	AmerFds American Balanced R3	0.65
AMERICAN FUNDS	AmerFds 2010 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2015 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2020 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2025 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2030 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2035 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2040 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2045 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2050 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2055 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds 2060 Trgt Date Ret R3	0.65
AMERICAN FUNDS	AmerFds New Perspective R3	0.65
AMERICAN FUNDS	AmerFds Washington Mutual R3	0.65
COLUMBIA MGMT INVESTMENT ADVISORS	Columbia US Gov Mortgage A	0.50
FEDERATED	Federated High Yield Svc	0.60

Investment Company	Investment Portfolio	Annual Percentage
FIRST AMERICAN FUNDS	Nuveen MidCap Indx R3	0.65
FIRST AMERICAN FUNDS	Nuveen SmCap Val R3	0.75
JANUS CAPITAL GROUP, INC	Jan Hen Enterprise S	0.50
JANUS CAPITAL GROUP, INC	Jan Hen US Mgd Volatility S	0.50
MFS INVESTMENT MANAGEMENT	MFS Intl New Discovery R2	0.65
OPPENHEIMER FUNDS INC.	Oppenheimer Tot Ret Bond Y	0.50
OPPENHEIMER FUNDS INC.	Oppenheimer Intl Grth A	0.50
PIMCO	PIMCO Real Return R	0.60
PIONEER INVESTMENTS	Pioneer Fdamental Grth A	0.60
PIONEER INVESTMENTS	Pioneer Strat Inc A	0.60
PNC	PNC International Equity A	0.60
PNC	PNC Multi Fact SmllCap Core A	0.60
STATE STREET INSTITUTIONAL TRUST	State Street Equity 500 Indx R	0.60
THORNBURG INVESTMENT MANAGEMENT	Thornburg Ltd-Term Inc R3	0.55

Plan Type 3 403ER

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

Name of Plan: OHIO HEARTLAND COMMUNITY ACTION COMMISSION 403B PLAN

Employer Identification Number: 34-0978820

For plan year (beginning/ending):

10-01-2016 TO 09-30-2017

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 EMERGING MKT A MUTUAL FUND SHARES	0	135
	AMERICAN CENTURY INVESTMENTS	AMERCENT MIDCAP VAL A MUTUAL FUND SHARES	0	79
	AMERICAN CENTURY INVESTMENTS	AMERCENT SMALL COMP A MUTUAL FUND SHARES	0	46,267
	AMERICAN FUNDS	AMERFDS 2015 TRGT DATE RET R3 MUTUAL FUND SHARES	0	251,063
	AMERICAN FUNDS	AMERFDS 2020 TRGT DATE RET R3 MUTUAL FUND SHARES	0	179,320
	AMERICAN FUNDS	AMERFDS 2025 TRGT DATE RET R3 MUTUAL FUND SHARES	0	30,769
	AMERICAN FUNDS	AMERFDS 2030 TRGT DATE RET R3 MUTUAL FUND SHARES	0	80,309
	AMERICAN FUNDS	AMERFDS 2035 TRGT DATE RET R3 MUTUAL FUND SHARES	0	89,046
	AMERICAN FUNDS	AMERFDS 2040 TRGT DATE RET R3 MUTUAL FUND SHARES	0	96,985
	AMERICAN FUNDS	AMERFDS 2045 TRGT DATE RET R3 MUTUAL FUND SHARES	0	89,051
	AMERICAN FUNDS	AMERFDS 2050 TRGT DATE RET R3 MUTUAL FUND SHARES	0	81,608
	AMERICAN FUNDS	AMERFDS 2055 TRGT DATE RET R3 MUTUAL FUND SHARES	0	1,283
	AMERICAN FUNDS	AMERFDS 2060 TRGT DATE RET R3 MUTUAL FUND SHARES	0	490
	AMERICAN FUNDS	AMERFDS AMERICAN BALANCED R3 MUTUAL FUND SHARES	0	60,674
	AMERICAN FUNDS	AMERFDS NEW PERSPECTIVE R3 MUTUAL FUND SHARES	0	16,728
	AMERICAN FUNDS	AMERFDS WASHINGTON MUTUAL R3 MUTUAL FUND SHARES	0	391
*	AMERICAN UNITED LIFE INS CO	AUL FIXED ACCOUNT	0	14,946
	COLUMBIA MGMT INVESTMENT ADVISORS	COLUMBIA US GOV MORTGAGE A MUTUAL FUND SHARES	0	8,729
	FEDERATED	FEDERATED HIGH YIELD SVC MUTUAL FUND SHARES	0	255
	JANUS CAPITAL GROUP INC	JAN HEN ENTERPRISE S MUTUAL FUND SHARES	0	24,736
	JANUS CAPITAL GROUP INC	JAN HEN US MGD VOLATILITY S MUTUAL FUND SHARES	0	41,989
	PARTICIPANTS	LOANS 4.25% TO 4.5%	0	15,187
	MFS INVESTMENT MANAGEMENT	MFS INTL NEW DISCOVERY R2 MUTUAL FUND SHARES	0	12,595
	FIRST AMERICAN FUNDS	NUVEEN SMCAP VAL R3 MUTUAL FUND SHARES	0	180
	OPPENHEIMER FUNDS INC.	OPPENHEIMER INTL GRTH A MUTUAL FUND SHARES	0	14,438
	OPPENHEIMER FUNDS INC.	OPPENHEIMER TOT RET BOND Y MUTUAL FUND SHARES	0	35,525
	PIMCO	PIMCO REAL RETURN R MUTUAL FUND SHARES	0	17,282
	PIONEER INVESTMENTS	PIONEER FDAMENTAL GRTH A MUTUAL FUND SHARES	0	391
	PIONEER INVESTMENTS	PIONEER STRAT INC A MUTUAL FUND SHARES	0	14,380
	PNC	PNC INTERNATIONAL EQUITY A MUTUAL FUND SHARES	0	10,329
	PNC	PNC MULTI FACT SMLLCAP CORE A MUTUAL FUND SHARES	0	186
	STATE STREET INSTITUTIONAL TRUST	STATE STREET EQUITY 500 INDX R MUTUAL FUND SHARES	0	185
	THORNBURG INVESTMENT MANAGEMENT	THORNBURG LTD-TERM INC R3 MUTUAL FUND SHARES	0	62,300
*	METLIFE	INSURANCE COMPNAY GENERAL ACCOUNT	649,948	649,948
*	METLIFE	AMERICAN FUNDS BALANCED ALLOCATION PORTFOLIO	0	3,058
*	METLIFE	AMERICAN FUNDS BOND FUND	0	410
*	METLIFE	AMERICAN FUNDS GLOBAL SMALL CAPITALIZATION FUND	0	1,694
*	METLIFE	AMERICAN FUNDS GROWTH FUND	0	6,049
*	METLIFE	AMERICAN FUNDS GROWTH-INCOME FUND	0	18,746

*	METLIFE	BARCLAYS CAPITAL AGGREGATE BOND INDEX	0	4,955
*	METLIFE	FRONTIER MID CAP GROWTH PORTFOLIO	0	14,033
*	METLIFE	BLACKROCK BOND INCOME PORTFOLIO	0	7,858
*	METLIFE	WMC BALANCED PORTFOLIO	0	56,225
*	METLIFE	WMC LARGE CAP RESEARCH	0	40,967
*	METLIFE	BLACKROCK LARGE CAP VALUE PORTFOLIO	0	606
*	METLIFE	INVESCO MID CAP VALUE	0	2,321
*	METLIFE	PORTFOLIO	0	9,029
*	METLIFE	METLIFE ASSET ALLOCATION 100	0	28,096
*	METLIFE	METLIFE ASSET ALLOCATION 20	0	560
*	METLIFE	METLIFE ASSET ALLOCATION 40	0	6,441
*	METLIFE	METLIFE MID CAP STOCK INDEX PORTFOLIO	0	811
*	METLIFE	METLIFE ASSET ALLOCATION 60	0	34,058
*	METLIFE	METLIFE ASSET ALLOCATION 80	0	784
*	METLIFE	METLIFE STOCK INDEX PORTFOLIO	0	106,124
*	METLIFE	MFS VALUE PORTFOLIO	0	441