

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 24pt; font-weight: bold;">2017</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>	
A This return/report is for:	☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) ____
B This return/report is:	☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;">007</td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/1993</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	007	1c Effective date of plan <u>01/01/1993</u>	
1b Three-digit plan number (PN) ▶	007				
1c Effective date of plan <u>01/01/1993</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>LICKING MEMORIAL HEALTH SYSTEMS</u> <u>1320 WEST MAIN STREET</u> <u>NEWARK, OH 43055-1822</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>31-1096218</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>220-564-4528</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>622000</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>31-1096218</u>	2c Plan Sponsor's telephone number <u>220-564-4528</u>	2d Business code (see instructions) <u>622000</u>	
2b Employer Identification Number (EIN) <u>31-1096218</u>					
2c Plan Sponsor's telephone number <u>220-564-4528</u>					
2d Business code (see instructions) <u>622000</u>					

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/01/2018	CYNTHIA WEBSTER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017)
v. 170203

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 952
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) 809
a(2) Total number of active participants at the end of the plan year	6a(2) 1017
b Retired or separated participants receiving benefits	6b 17
c Other retired or separated participants entitled to future benefits	6c 170
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 1204
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 1
f Total. Add lines 6d and 6e	6f 1205
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 1150
h Number of participants who 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

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

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 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017	
A Name of plan LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN	B Three-digit plan number (PN) ▶ 007
C Plan sponsor's name as shown on line 2a of Form 5500 LICKING MEMORIAL HEALTH SYSTEMS	D Employer Identification Number (EIN) 31-1096218

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 HARTFORD 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
06-0974148	88072	750057	1017	01/01/2017	12/31/2017

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 1050	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KESTRA INVESTMENT SERVICES LLC 1250 S CAPITAL OF TEXAS HWY STE II125 WEST LAKE HILLS, TX 78746
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1050			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	817640
5 Current value of plan's interest under this contract in separate accounts at year end	5	407378

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. Specify nature of costs ▶	6d	

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 VARIABLE ANNUITY

b Balance at the end of the previous year	7b	813960
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c Additions: (1) Contributions deposited during the year	7c(1)		
	7c(2)		
	7c(3)	24168	
	7c(4)		
	7c(5)	887	

▶ ADDITIONS

(6) Total additions	7c(6)	25055
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d Total of balance and additions (add lines 7b and 7c(6))	7d	839015
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	21196	
	7e(2)	179	
	7e(3)		
	7e(4)		

(5) Total deductions	7e(5)	21375
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	817640
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Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

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 2017 This Form is Open to Public Inspection
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For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017		
A Name of plan LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN	B Three-digit plan number (PN) ▶	007
C Plan sponsor's name as shown on line 2a of Form 5500 LICKING MEMORIAL HEALTH SYSTEMS	D Employer Identification Number (EIN) 31-1096218	

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 HARTFORD 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
06-0974148	88072	750072	1017	01/01/2017	12/31/2017

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 603	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid KESTRA INVESTMENT SERVICES LLC 1250 S CAPITAL OF TEXAS HWY STE II125 WEST LAKE HILLS, TX 78746
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
603	0		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	193740
5 Current value of plan's interest under this contract in separate accounts at year end	5	326171

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. Specify nature of costs ▶	6d	

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 VARIABLE ANNUITY

b Balance at the end of the previous year	7b	243528
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c Additions: (1) Contributions deposited during the year	7c(1)	0	
(2) Dividends and credits	7c(2)		
(3) Interest credited during the year	7c(3)	6318	
(4) Transferred from separate account	7c(4)	0	
(5) Other (specify below)	7c(5)	2338	

▶ ADDITIONS

(6) Total additions	7c(6)	8656
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d Total of balance and additions (add lines 7b and 7c(6))	7d	252184
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e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	58335	
(2) Administration charge made by carrier	7e(2)	109	
(3) Transferred to separate account	7e(3)	0	
(4) Other (specify below)	7e(4)	0	

(5) Total deductions	7e(5)	58444
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f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	193740
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Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017		
A Name of plan LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN	B Three-digit plan number (PN) ▶	007
C Plan sponsor's name as shown on line 2a of Form 5500 LICKING MEMORIAL HEALTH SYSTEMS	D Employer Identification Number (EIN) 31-1096218	

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
THE VANGUARD GROUP, INC.
23-1945930

(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)

THE VANGUARD GROUP, INC.

23-1945930

(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 25 37 52	NONE	52373	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☐

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

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

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information <p style="text-align: center;">This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p style="text-align: center;">▶ File as an attachment to Form 5500.</p>	<small>OMB No. 1210-0110</small> <hr/> <p style="text-align: center; font-size: 1.2em;">2017</p> <hr/> <p style="text-align: center;">This Form is Open to Public Inspection.</p>
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For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan <u>LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN</u>	B Three-digit plan number (PN) ▶	<u>007</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>LICKING MEMORIAL HEALTH SYSTEMS</u>	D Employer Identification Number (EIN) <u>31-1096218</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 DC 11

b Name of sponsor of entity listed in (a): HARTFORD LIFE INSURANCE COMPANY

c EIN-PN <u>06-0974148-000</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>733549</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)
-----------------	----------------------	---

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)
-----------------	----------------------	---

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):

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

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

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

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

SCHEDULE H (Form 5500) Department of the Treasury 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
		2017
		This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>		
A Name of plan <u>LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN</u>	B Three-digit plan number (PN) ►	<u>007</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>LICKING MEMORIAL HEALTH SYSTEMS</u>	D Employer Identification Number (EIN) <u>31-1096218</u>	

Part I	Asset and Liability Statement
---------------	--------------------------------------

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)	<u>829</u>	
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities.....	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other.....	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)	<u>420289</u>	<u>540025</u>
(9) Value of interest in common/collective trusts.....	1c(9)		
(10) Value of interest in pooled separate accounts.....	1c(10)	<u>610460</u>	<u>733549</u>
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	<u>42487689</u>	<u>51924295</u>
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	<u>1057488</u>	<u>1011381</u>
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities	1d(1)	
(2)	Employer real property	1d(2)	
e	Buildings and other property used in plan operation	1e	
f	Total assets (add all amounts in lines 1a through 1e)	1f	44576755 54209250
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	
i	Acquisition indebtedness	1i	
j	Other liabilities	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	0 0
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	44576755 54209250

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.

		(a) Amount	(b) Total
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers	2a(1)(A)	
	(B) Participants	2a(1)(B)	4236005
	(C) Others (including rollovers)	2a(1)(C)	1016558
(2)	Noncash contributions	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	5252563
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	
	(B) U.S. Government securities	2b(1)(B)	
	(C) Corporate debt instruments	2b(1)(C)	
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E)	22943
	(F) Other	2b(1)(F)	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	22943
(2)	Dividends: (A) Preferred stock	2b(2)(A)	
	(B) Common stock	2b(2)(B)	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	1275583
	(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	1275583
(3)	Rents	2b(3)	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	0
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		140577
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		5881900
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		12573566

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	2889095	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		2889095
f Corrective distributions (see instructions)	2f		71
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	51905	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		51905
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		2941071

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		9632495
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

☒ Yes ☐ No

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

(1) Name: MCM CPAS & ADVISORS LLP

(2) EIN: 27-1235638

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.)		X	
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.)		X	
4d		X	
e Was this plan covered by a fidelity bond?	X		1000000
4e	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
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?		X	
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?		X	
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.)	X		
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.)		X	
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?		X	
4k		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
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			

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

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

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

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

<div>SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Retirement Plan Information</div> <div>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).</div> <div>▶ File as an attachment to Form 5500.</div>	<div>OMB No. 1210-0110</div> <div>2017</div> <div>This Form is Open to Public Inspection.</div>
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017		
A Name of plan LICKING MEMORIAL HEALTH SYSTEMS TAX DEFERRED 403(B) PLAN		B Three-digit plan number (PN) ▶ 007
C Plan sponsor's name as shown on line 2a of Form 5500 LICKING MEMORIAL HEALTH SYSTEMS		D Employer Identification Number (EIN) 31-1096218
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
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): 23-2186884		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year		3
Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)	
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ☐ Yes ☐ No ☐ N/A If the plan is a defined benefit plan, go to line 8.		
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month Day Year If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)		6a
b Enter the amount contributed by the employer to the plan for this plan year		6b
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)		6c
If you completed line 6c, skip lines 8 and 9.		
7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ☐ Yes ☐ No ☐ N/A		
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ☐ Yes ☐ No ☐ N/A		
Part III	Amendments	
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. ☐ Increase ☐ Decrease ☐ Both ☐ No		
Part IV	ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.	
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ☐ Yes ☐ No		
11 a Does the ESOP hold any preferred stock? ☐ Yes ☐ No		
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ☐ Yes ☐ No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ☐ Yes ☐ No		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.		
Schedule R (Form 5500) 2017 v. 170203		

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Independent Auditor's Report

To Plan administrator

Licking Memorial Health Systems Tax Deferred 403(b) Plan

We were engaged to audit the accompanying financial statements of Licking Memorial Health Systems Tax Deferred 403(b) Plan (the "Plan") which comprise the statements of net assets available for benefits as of December 31, 2017 and 2016, and the related statement of changes in net assets available for benefits for the year ended December 31, 2017, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the 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 information in Note C, which was certified by Vanguard Fiduciary Trust Company, the trustee of the Plan and Hartford Life Insurance Company, the custodian of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the Plan administrator that both the trustee and custodian each hold a portion of the Plan's investment assets and execute investment transactions. The Plan administrator has obtained certifications from the trustee and custodian as of December 31, 2017 and 2016 and for the year ended December 31, 2017, that the information provided to the Plan administrator by the trustee and custodian is complete and accurate.

Kentucky
Indiana
Ohio

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Independent Auditor's Report (Continued)

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.

Report on Supplementary Information

The supplemental Schedule of Assets (Held at End of Year) at December 31, 2017 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 this 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 trustee and 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.

A handwritten signature in black ink that reads "MCM CPAs & Advisors LLP". The signature is stylized, with the "MCM" being particularly prominent and the rest of the text following in a cursive-like script.

Louisville, Kentucky
September 6, 2018

**Licking Memorial Health Systems
Tax Deferred 403(b) Plan**

Financial Statements

December 31, 2017 and 2016

Licking Memorial Health Systems Tax Deferred 403(b) Plan

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December 31, 2017 and 2016

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Independent Auditor's Report

To Plan administrator

Licking Memorial Health Systems Tax Deferred 403(b) Plan

We were engaged to audit the accompanying financial statements of Licking Memorial Health Systems Tax Deferred 403(b) Plan (the "Plan") which comprise the statements of net assets available for benefits as of December 31, 2017 and 2016, and the related statement of changes in net assets available for benefits for the year ended December 31, 2017, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the 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 information in Note C, which was certified by Vanguard Fiduciary Trust Company, the trustee of the Plan and Hartford Life Insurance Company, the custodian of the Plan, except for comparing such information with the related information included in the financial statements. We have been informed by the Plan administrator that both the trustee and custodian each hold a portion of the Plan's investment assets and execute investment transactions. The Plan administrator has obtained certifications from the trustee and custodian as of December 31, 2017 and 2016 and for the year ended December 31, 2017, that the information provided to the Plan administrator by the trustee and custodian is complete and accurate.

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Independent Auditor's Report (Continued)

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.

Report on Supplementary Information

The supplemental Schedule of Assets (Held at End of Year) at December 31, 2017 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 this 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 trustee and 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.

A handwritten signature in black ink that reads "MCM CPAs & Advisors LLP". The signature is stylized, with the "MCM" being particularly prominent and the rest of the text following in a cursive-like script.

Louisville, Kentucky
September 6, 2018

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Statements of Net Assets Available for Benefits
December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u>
Assets		
Investments, at fair value	\$ 52,657,844	\$ 43,098,149
Investments, at contract value	1,011,381	1,057,488
Receivables:		
Participant contributions	-	829
Notes receivable from participants	<u>540,025</u>	<u>420,289</u>
	<u>540,025</u>	<u>421,118</u>
Net Assets Available for Benefits	<u><u>\$ 54,209,250</u></u>	<u><u>\$ 44,576,755</u></u>

See accompanying notes.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Statement of Changes in Net Assets Available for Benefits
Year Ended December 31, 2017

Additions to Net Assets Attributed to:

Investment income:

Net appreciation in fair value of investments	\$ 6,022,477
Interest and dividends	1,275,583

7,298,060

Interest income on notes receivable from participants	22,943
---	--------

Contributions:

Participant	4,236,005
Rollover	1,016,394
Other	164

5,252,563

Total Additions 12,573,566

Deductions from Net Assets Attributed to:

Benefit payments to participants	2,889,166
Administrative expenses	51,905

Total Deductions 2,941,071

Net Increase 9,632,495

Net Assets Available for Benefits:

Beginning of Year 44,576,755

End of Year \$ 54,209,250

See accompanying notes.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Notes to the Financial Statements
December 31, 2017 and 2016

Note A - Description of Plan

The following description of the Licking Memorial Health Systems Tax Deferred 403(b) Plan (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

1. General: The Plan is a defined contribution plan under Section 403(b) of the Internal Revenue Code (the "IRC") covering substantially all employees of Licking Memorial Health Systems (the "Plan Sponsor"). The Plan was established to provide employees with a systematic means of saving and investing for the future. All permissible employees of the Plan Sponsor, as defined in accordance with the universal availability standards, are eligible to enroll in the Plan on their date of hire. Deferrals begin upon enrollment. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").
2. Plan Contributions: Each year, participants may elect to contribute up to 75% of their eligible compensation, subject to certain limitations prescribed by the IRC and other limitations specified in the Plan. Participants also are permitted to make rollover contributions to the Plan from a qualified plan, annuity contract, or individual retirement account or annuity in accordance with the Plan Document.
3. Participant Accounts: Individual accounts are maintained for each Plan participant. Each participant's account is credited with the participant's contributions and Plan gains or losses. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.
4. Vesting: Participants are immediately vested in all contributions plus actual earnings thereon.
5. Investment Options: Upon enrollment in the Plan, participants may direct the investment of their accounts into various investment options offered by the Plan. They may change their investment options among those investments offered by the Plan at any time during the Plan year.
6. Notes Receivable from Participants: Participants may borrow from their account balances with interest charged at a rate equal to a reasonable interest rate commensurate with current interest rates charged for loans made under similar circumstances by persons in the business of lending money, which remains in effect for the duration of the loan. Loan terms range from 1 to 5 years or up to 15 years for the purchase of a primary residence. The minimum loan is \$1,000 and the maximum loan is the lesser of \$50,000 less the highest outstanding loan balance during the one-year period prior to the new loan application date, or 50% of the participant's account balance less any current outstanding loan balance. The loans are secured by the balance in the participants' account. Principal and interest are paid ratably through payroll deductions. Participants may only take out one loan during any 12 month period and may only have one loan outstanding at any time.
7. Payment of Benefits: Upon retirement, disability or death, a participant or beneficiary receives the entire amount credited to the participant's account in either a lump sum or, at the participant's election, in annual installments or an annuity contract. Upon termination, other than by retirement, disability, or death, a participant becomes eligible to receive the current value of the participant's vested account in a lump sum. Hardship distributions are permitted under the Plan if certain conditions are satisfied.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Notes to the Financial Statements (Continued)
December 31, 2017 and 2016

Note B - Summary of Significant Accounting Policies

1. Basis of Accounting: The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with principles generally accepted in the United States of America ("U.S. GAAP"). The Accounting Standards Codification ("ASC") as produced by the Financial Accounting Standards Board ("FASB") is the sole source of authoritative U.S. GAAP.
2. Use of Estimates: The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and the disclosure of contingent assets and liabilities. Actual results could differ from those estimates.
3. Investment Valuation and Income Recognition: The Plan's investments are stated at fair value (except for fully benefit-responsive investment contracts, which are reported at contract value). Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

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

4. Notes Receivable from Participants: Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. No allowance for credit losses has been recorded as of December 31, 2017 and 2016.
5. Payment of Benefits: Benefit payments are recorded when paid.
6. Administrative Expenses: Administrative expenses of the Plan are paid by the Plan sponsor or Plan participants, as defined in the Plan agreement.
7. Investment Management Fees and Operating Expenses: Investment management fees and operating expenses charged to the Plan for investments in the various funds are deducted from income earned on a daily basis and are reflected as a component of net appreciation (depreciation) in fair values of investments.
8. Subsequent Events: Subsequent events for the Plan have been considered through the date of the Independent Auditor's Report, which represents the date the financial statements were available to be issued. See Note J.

Note C - Information Certified by the Plan's Trustee and Custodian

The Plan Administrator has elected the method of compliance permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Accordingly, Vanguard Fiduciary Trust Company ("Vanguard"), the trustee of the Plan and Hartford Life Insurance Company ("Hartford"), the custodian of the Plan, have certified to the completeness and accuracy of all investments and notes receivable from participants information reflected on the accompanying Statements of Net Assets Available for Benefits as of December 31, 2017 and 2016, the Schedule of Assets (Held at End of Year) at December 31, 2017, and the related investment income and interest income on notes receivable from participants information reflected in the Statement of Changes in Net Assets Available for Benefits for the year ended December 31, 2017.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Notes to the Financial Statements (Continued)
December 31, 2017 and 2016

Note D - Fair Value Measurements

FASB ASC 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

- Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.
- Level 2: Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.
- Level 3: Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2017 and 2016.

Mutual Funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value ("NAV") and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Sub-accounts of Separate Accounts of an Insurance Company: Valued at NAV of units held by the Plan at year end. The NAV is used as a practical expedient to estimate fair value and is based on the value of the underlying investment assets. This practical expedient is not used when it is determined to be probable that the sub-account will sell the investment for an amount different than the reported NAV. The sub-accounts are comprised, primarily, of mutual funds. The investment strategies of these sub-accounts are consistent with each of the strategies in the names of the sub-accounts. The investments are redeemable at the adjusted NAV under agreements with the insurance company. There are currently no redemption requirements or unfunded commitments on these investments.

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

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Notes to the Financial Statements (Continued)
December 31, 2017 and 2016

Note D - Fair Value Measurements (Continued)

The following table sets forth by level, within the fair value hierarchy, the Plan's assets measured at fair value on a recurring basis at December 31, 2017:

	Level 1	Level 2	Level 3	Total
Mutual Funds	\$ 51,924,295	\$ -	\$ -	\$ 51,924,295
Total Assets in the Fair Value Hierarchy	<u>\$ 51,924,295</u>	<u>\$ -</u>	<u>\$ -</u>	51,924,295
Investments Measured at NAV (a)				<u>733,549</u>
Investments at Fair Value				<u>\$ 52,657,844</u>

The following table sets forth by level, within the fair value hierarchy, the Plan's assets measured at fair value on a recurring basis at December 31, 2016:

	Level 1	Level 2	Level 3	Total
Mutual Funds	\$ 42,487,689	\$ -	\$ -	\$ 42,487,689
Total Assets in the Fair Value Hierarchy	<u>\$ 42,487,689</u>	<u>\$ -</u>	<u>\$ -</u>	42,487,689
Investments Measured at NAV (a)				<u>610,460</u>
Investments at Fair Value				<u>\$ 43,098,149</u>

- (a) In accordance with FASB guidance, investments measured at fair value using NAV as a practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the investments at fair value presented in the Statements of Net Assets Available for Benefits.

Note E - Fully Benefit-Responsive Investment Contracts

The Plan holds fully benefit-responsive investment contracts with Hartford. Hartford maintains the contributions in general accounts. The accounts are credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The guaranteed investment contracts are included in the financial statements at contract value as reported to the Plan by Hartford. Because the guaranteed investment contracts are fully benefit-responsive, contract value is the relevant measurement attribute for that portion of the net assets available for benefits of a defined contribution plan attributable to the guaranteed investment contracts. Contract value represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expense. Participants pay ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value. The guaranteed investment contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed by the Plan. There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon by the issuer, but may not be less than 3% for contracts 750057 and 750072 over the life of the respective contracts. Such interest rates are reviewed on a quarterly basis for resetting.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Notes to the Financial Statements (Continued)
December 31, 2017 and 2016

Note E - Fully Benefit-Responsive Investment Contracts (Continued)

Certain events, such as premature termination of the contracts by the Plan or the termination of the Plan, would limit the Plan's ability to transact at contract value with the issuer. The Plan administrator believes the occurrence of such events that would also limit the Plan's ability to transact at contract value with Plan participants is not probable.

Note F - Related Party Transactions

Certain administrative services are provided by the Plan Sponsor at no cost to the Plan and certain administrative costs incurred by the Plan are paid by the Plan Sponsor.

Certain Plan investments are shares of mutual funds managed by Vanguard, and certain Plan investments are shares of sub-accounts of separate accounts of an insurance company and guaranteed investment contracts managed by Hartford. Vanguard is the trustee of the Plan and Hartford is the custodian of the Plan, therefore, these transactions qualify as party-in-interest.

Note G - Income Tax Status

The Plan has been designed to qualify under Section 403(b) of the IRC and is required to operate in conformity with the IRC to maintain its qualification. The Plan administrator believes the Plan is operating in compliance with the IRC and therefore believes the Plan is qualified and the related custodial accounts are tax-exempt.

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

Note H - Plan Termination

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

Note I - Risk and Uncertainties

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

Note J - Subsequent Events

Effective January 1, 2018, the Plan was amended to reflect certain changes in connection with retirement benefit restructuring, including (i) automatic enrollment of eligible employees in the Plan, and (ii) discretionary employer matching and nonelective contributions.

Supplemental Schedule

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Schedule of Assets (Held at End of Year)
Plan Sponsor EIN: 31-1096218 Plan Number: 007
December 31, 2017

(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	(e) Current Value
	Mutual Funds:		
	American Funds	EuroPacific Growth Class R-5	\$ 729,419
	Goldman Sachs	Small/Mid Cap Growth Fund: Inst'l Shr	196,267
	Hartford	Equity Income Fund; Class Y	166,431
	Hartford	Small Cap Growth Fund; Class Y	138,572
	JPMorgan	Small Cap Value Fund; Class R5	35,007
	JPMorgan	US Equity Fund; Class R5	259,418
	John Hancock	Disciplined Value Mid Cap Fund; Class I	147,594
	PIMCO	Diversified Income Fund; Institutional Class	248,184
	Lord Abbett	Short Duration Income Fund; Class I	217,741
	Metropolitan West	Total return Bond Fund; Class I Shares	392,194
	T. Rowe Price	Blue Chip Growth Fund	1,145,393
*	Vanguard	500 Index Fund Investor Shares	1,945,534
*	Vanguard	Inflation-Protected Securities Fund: Inv Shares	80,889
*	Vanguard	Federal Money Market Fund	1,344,723
*	Vanguard	Mid-Cap Index Fund Investor Shares	843,575
*	Vanguard	Small-Cap Index Fund Investor Shares	419,239
*	Vanguard	Target Retirement 2015 Fund	2,357,731
*	Vanguard	Target Retirement 2020 Fund	7,819,878
*	Vanguard	Target Retirement 2025 Fund	8,278,662
*	Vanguard	Target Retirement 2030 Fund	8,799,379
*	Vanguard	Target Retirement 2035 Fund	5,690,922
*	Vanguard	Target Retirement 2040 Fund	3,135,625
*	Vanguard	Target Retirement 2045 Fund	2,867,283
*	Vanguard	Target Retirement 2050 Fund	1,534,333
*	Vanguard	Target Retirement 2055 Fund	529,989
*	Vanguard	Target Retirement 2060 Fund	87,174
*	Vanguard	Target Retirement Income	2,420,960
	Virtus	Real Estate Securities Fund; Class I	92,179
			51,924,295
	Sub-accounts of Separate Accounts of an Insurance Company:		
*	Hartford Life Insurance Company	America Century - Equity Income	9,157
*	Hartford Life Insurance Company	Dreyfus - Intermediate Term Inc	10,621
*	Hartford Life Insurance Company	Franklin - Small-Mid Cap Growth	28,613
*	Hartford Life Insurance Company	Hartford Ultrashort Bond HLS	11,307
*	Hartford Life Insurance Company	Hardtford Global Growth HLS	4,157
*	Hartford Life Insurance Company	Hartford Balanced HLS	45,837
*	Hartford Life Insurance Company	Hartford Capital Appreciation HLS	110,735
*	Hartford Life Insurance Company	Hartford Dividend and Growth HLS	28,052
*	Hartford Life Insurance Company	Hartford Global Health HLS	65,536

Continued

See accompanying independent auditor's report.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Schedule of Assets (Held at End of Year) (Continued)
Plan Sponsor EIN: 31-1096218 Plan Number: 007
December 31, 2017

(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	(e) Current Value
	Sub-accounts of Separate Accounts of an Insurance Company (Continued):		
*	Hartford Life Insurance Company	Hartford Stock HLS	7,943
*	Hartford Life Insurance Company	Hartford Total Return Bond HLS	14,969
*	Hartford Life Insurance Company	Hartford US Government Sec HLS	2,097
*	Hartford Life Insurance Company	HIMCO - VIT Index	22,814
*	Hartford Life Insurance Company	Invesco - American Franchise	44,276
*	Hartford Life Insurance Company	Invesco - Diversified Div	16,216
*	Hartford Life Insurance Company	Invesco - Technology	201
*	Hartford Life Insurance Company	Invesco - Small Cap Growth	25,160
*	Hartford Life Insurance Company	Invesco - VK VI Equity and Income	48,646
*	Hartford Life Insurance Company	Janus - Forty	33,093
*	Hartford Life Insurance Company	Janus - Overseas	20,137
*	Hartford Life Insurance Company	Janus - Global Research	94
*	Hartford Life Insurance Company	John Hancock - New Opportunities	1,768
*	Hartford Life Insurance Company	MASS - Investors Growth	16,424
*	Hartford Life Insurance Company	MFS - Core Equity	68
*	Hartford Life Insurance Company	MFS - High Income	13,772
*	Hartford Life Insurance Company	MFS - Mid-Cap Growth	438
*	Hartford Life Insurance Company	MFS - Utilities	62,599
*	Hartford Life Insurance Company	MFS - Value	188
*	Hartford Life Insurance Company	Mutual Shares - Mutual Shares	42,741
*	Hartford Life Insurance Company	Oppenheimer - Capital Appreciation	15,019
*	Hartford Life Insurance Company	Oppenheimer - Global	27,859
*	Hartford Life Insurance Company	Templeton - Foreign	3,012
			<u>733,549</u>
	Guaranteed Investment Contract:		
*	Hartford Life Insurance Company	General Account	1,011,381
*	Notes receivable from participants	Loans to participants, various maturities, interest rates ranging 4.25% to 5.25%	<u>540,025</u>
			<u><u>\$ 54,209,250</u></u>

* Represents a party-in-interest

Cost information (column (d)) not required due to Plan being participant-directed.

See accompanying independent auditor's report.

Licking Memorial Health Systems Tax Deferred 403(b) Plan
Schedule of Assets (Held at End of Year)
Plan Sponsor EIN: 31-1096218 Plan Number: 007
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Licking Memorial Health Systems Tax Deferred 403(b) Plan
Schedule of Assets (Held at End of Year) (Continued)
Plan Sponsor EIN: 31-1096218 Plan Number: 007
December 31, 2017

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