Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2017

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

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.)
- [X] 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:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/1990

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)

SOUTHERN OHIO MEDICAL CENTER

1805 27TH STREET
PORTSMOUTH, OH 45662

2b Employer Identification Number (EIN)
31-0678022

2c Plan Sponsor's telephone number
740-356-8118

2d Business code (see instructions)
622000

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.	10/03/2018	VICKI A. NOEL
	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

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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**	3568
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)**	2675
a(2) Total number of active participants at the end of the plan year	**6a(2)**	2784
b Retired or separated participants receiving benefits	**6b**	124
c Other retired or separated participants entitled to future benefits	**6c**	902
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	3810
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f Total. Add lines **6d** and **6e**.	**6f**	3810
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	3499
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	164
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2E 2F 2G 2L 3H

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

9a Plan funding arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	Trust
(4)	[ ]	General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)	[X]	Insurance
(2)	[ ]	Code section 412(e)(3) insurance contracts
(3)	[X]	Trust
(4)	[ ]	General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1)	[X]	**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)	[X]		**H** (Financial Information)
(2)	[ ]		**I** (Financial Information – Small Plan)
(3)	[X]	2	**A** (Insurance Information)
(4)	[X]		**C** (Service Provider Information)
(5)	[X]		**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

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN OHIO MEDICAL CENTER

D Employer Identification Number (EIN)
31-0678022

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.

1 Coverage Information:

(a) Name of insurance carrier
GREAT-WEST LIFE & ANNUITY 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
84-0467907	7692	85605-01	3218	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	(b) Total amount of fees paid

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

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

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

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

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

(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	13894682
5	Current value of plan's interest under this contract in separate accounts at year end	5	43551396

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 ANNUITY CONTRACT

b	Balance at the end of the previous year			7b	13059602
c	Additions: (1) Contributions deposited during the year	7c(1)	1034747		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	406975		
	(4) Transferred from separate account	7c(4)	2202657		
	(5) Other (specify below)	7c(5)	79898		
	▶ LOAN PAYMENTS				
	(6) Total additions			7c(6)	3724277
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	16783879
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	1213211		
	(2) Administration charge made by carrier	7e(2)	1022		
	(3) Transferred to separate account	7e(3)	1674964		
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	2889197
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	13894682

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**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

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN OHIO MEDICAL CENTER

D Employer Identification Number (EIN)
31-0678022

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.

1 Coverage Information:

(a) Name of insurance carrier
GREAT WEST RETIREMENT SERVICES

(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
84-0467907	7692	93346-01	0	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	**(b)** Total amount of fees paid

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

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

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

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

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

(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	0
5	Current value of plan's interest under this contract in separate accounts at year end	5	0

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 ANNUITY CONTRACT

b	Balance at the end of the previous year			7b	339391
c	Additions: (1) Contributions deposited during the year	7c(1)	4841		
	(2) Dividends and credits	7c(2)	0		
	(3) Interest credited during the year	7c(3)	2200		
	(4) Transferred from separate account	7c(4)	0		
	(5) Other (specify below) ▶	7c(5)	0		
	(6) Total additions			7c(6)	7041
d	Total of balance and additions (add lines **7b** and **7c(6)**)			7d	346432
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	0		
	(2) Administration charge made by carrier	7e(2)	0		
	(3) Transferred to separate account	7e(3)	346432		
	(4) Other (specify below) ▶	7e(4)	0		
	(5) Total deductions			7e(5)	346432
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**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 C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN OHIO MEDICAL CENTER

D Employer Identification Number (EIN)
31-0678022

Part I Service Provider Information (see instructions)

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

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

(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)

ADVISED ASSET GROUP

8515 EAST ORCHARD ROAD
GREENWOOD VILLAGE, CO 80111

(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?
28	INVESTMENT MANAGEMENT	120526	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [ ]

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

GREAT WEST LIFE AND ANNUITY

8515 EAST ORCHARD ROAD
GREENWOOD VILLAGE, CO 80111

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
64	RECORDKEEPER	97481	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [X] No [ ]

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

AON CONSULTING

1900 16TH STREET
#100
DENVER, CO 80202

(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?
27	BROKER	43708	Yes [X] No [ ]	Yes [ ] No [X]	0	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)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

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
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

B Three-digit plan number (PN) ▶ 002

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
SOUTHERN OHIO MEDICAL CENTER

D Employer Identification Number (EIN)
31-0678022

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)

a Name of MTIA, CCT, PSA, or 103-12 IE: FUTUREFUNDS SERIES ACCOUNT II

b Name of sponsor of entity listed in (a): GREAT-WEST LIFE AND ANNUITY INSURANCE COMPANY

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)
84-0467907-003	P	43551396

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)

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

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 01/01/2017 and ending 12/31/2017

A Name of plan
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN OHIO MEDICAL CENTER

D Employer Identification Number (EIN)
31-0678022

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	0	0
(2) Participant contributions	1b(2)	0	0
(3) Other	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	0	0
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	1212369	1273600
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	53493035	43551396
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	16635908	40845799
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	13398992	13894683
(15) Other	1c(15)	0	0

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)	0	0
	(2) Employer real property	1d(2)	0	0
e	Buildings and other property used in plan operation	1e	0	0
f	Total assets (add all amounts in lines 1a through 1e)	1f	84740304	99565478
	Liabilities			
g	Benefit claims payable	1g	0	0
h	Operating payables	1h		
i	Acquisition indebtedness	1i	0	0
j	Other liabilities	1j	0	0
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	84740304	99565478

Part II Income and Expense Statement

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

	Income		(a) Amount	(b) Total
a	**Contributions:**			
	(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	2377682	
	(B) Participants	2a(1)(B)	5049127	
	(C) Others (including rollovers)	2a(1)(C)	802651	
	(2) Noncash contributions	2a(2)	0	
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		8229460
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	0	
	(B) U.S. Government securities	2b(1)(B)	0	
	(C) Corporate debt instruments	2b(1)(C)	0	
	(D) Loans (other than to participants)	2b(1)(D)	0	
	(E) Participant loans	2b(1)(E)	66295	
	(F) Other	2b(1)(F)	385100	
	(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		451395
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)	0	
	(B) Common stock	2b(2)(B)	0	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	1232931	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		1232931
	(3) Rents	2b(3)		0
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	0	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	0	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)	0	
	(B) Other	2b(5)(B)	0	
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		5950233
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		3410324
c Other income	2c		111195
d Total income. Add all **income** amounts in column (b) and enter total	2d		19385538
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	4262461	
(2) To insurance carriers for the provision of benefits	2e(2)	0	
(3) Other	2e(3)	0	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		4262461
f Corrective distributions (see instructions)	2f		0
g Certain deemed distributions of participant loans (see instructions)	2g		36188
h Interest expense	2h		0
i Administrative expenses: (1) Professional fees	2i(1)	0	
(2) Contract administrator fees	2i(2)	97481	
(3) Investment advisory and management fees	2i(3)	164234	
(4) Other	2i(4)	0	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		261715
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		4560364
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		14825174
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)** [X] Disclaimer **(4)** [ ] Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [X] Yes [ ] No

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

(1) Name: PLANTE & MORAN LLP **(2)** EIN: 38-1357951

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
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.)	4a		X	
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.)	4b		X	

			Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		1000000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X	
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m	X		
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n	X		

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

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

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

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

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2017

This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017

A Name of plan
SOUTHERN OHIO MEDICAL CENTER RETIREMENT SAVINGS PROGRAM

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN OHIO MEDICAL CENTER

D Employer Identification Number (EIN)
31-0678022

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** 0

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): 20-3691708

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**

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): _____

---

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):

Southern Ohio Medical Center Retirement Savings Program

Financial Report

December 31, 2017

Southern Ohio Medical Center Retirement Savings Program

Contents

Independent Auditor's Report	1-2
Statement of Net Assets Available for Benefits	3
Statement of Changes in Net Assets Available for Benefits	4
Notes to Financial Statements	5-9
Schedule of Assets Held at End of Year	10-11

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Independent Auditor's Report

To the Plan Administrator
Southern Ohio Medical Center
Retirement Savings Program

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Southern Ohio Medical Center Retirement Savings Program (the "Plan"), which comprise the statement 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 summarized in Note 3, which was certified by Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC (collectively, the "Trustee"), except for comparing such information with the related information included in the financial statements. We have been informed by the plan administrator that the Trustee holds the Plan's investment assets and participant notes receivable and executes related transactions. The plan administrator has obtained a certification from the Trustee as of December 31, 2017 and 2016 and for the year ended December 31, 2017 that the information provided to the plan administrator is complete and accurate.

Disclaimer of Opinion

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

Other Matter

The supplemental schedule of assets held at end of year as of 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.

Praxity MEMBER GLOBAL ALLIANCE OF INDEPENDENT FIRMS

To the Plan Administrator
Southern Ohio Medical Center
Retirement Savings Program

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

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

Plante & Moran, PLLC

Columbus, Ohio
September 19, 2018

Southern Ohio Medical Center Retirement Savings Program

Statement of Net Assets Available for Benefits

December 31, 2017 and 2016

	2017	2016
Assets		
Participant-directed investments at fair value:		
Mutual funds	$ 40,845,212	$ 16,635,907
Pooled separate accounts	43,551,984	53,493,027
Total participant-directed investments at fair value	84,397,196	70,128,934
Fully benefit-responsive investment contracts at contract value	13,894,682	13,398,992
Total participant-directed investments	98,291,878	83,527,926
Contributions receivable	660,782	615,316
Participant notes receivable	1,273,600	1,326,429
Net Assets Available for Benefits	**$ 100,226,260**	**$ 85,469,671**

See notes to financial statements.

Southern Ohio Medical Center Retirement Savings Program

Statement of Changes in Net Assets Available for Benefits

Year Ended December 31, 2017

Additions to Net Assets	
Contributions:	
Employee	$ 5,052,241
Employer	2,430,706
Rollovers	802,909
Total contributions	8,285,856
Investment income:	
Interest and dividends	1,680,896
Net realized and unrealized gains on investments:	
Mutual funds	3,448,364
Pooled separate accounts	5,872,661
Net realized and unrealized gains	9,321,025
Total investment income	11,001,921
Interest from participant notes receivable	70,280
Total additions to net assets	19,358,057
Deductions from Net Assets	
Benefits paid directly to participants or beneficiaries	4,339,753
Administrative expenses	261,715
Total deductions from net assets	4,601,468
Net Increase	14,756,589
Net Assets Available for Benefits	
Beginning of year	85,469,671
End of year	**$ 100,226,260**

See notes to financial statements.

Note 1 - Plan Description

The following description of Southern Ohio Medical Center Retirement Savings Program (the "Plan") provides only general information. Participants should refer to the plan agreement for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution plan covering all eligible employees of Southern Ohio Medical Center, SOMC Medical Care Foundation, and any affiliate of Southern Ohio Medical Center (collectively, the "Organization") who are 18 or older. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

The Plan provides for employee contributions up to maximum tax-deferred limitations established by the Internal Revenue Code. Participants may also make contributions to the Plan in the form of a rollover of funds from another qualified plan.

The Plan provides for employer matching contributions of 100 percent of participant contributions, not to exceed 2 percent of the employee's eligible compensation.

Participant Accounts

Each participant's account is credited with the participant's contributions and allocations of the Organization's contributions and plan earnings and charged with an allocation of administrative expenses. Allocations are based on participants' compensation or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account. Participants may direct the investments of their account balances into various investment options offered by the Plan.

Participant Notes Receivable

Participants may borrow from their accounts subject to certain maximum and minimum amounts, as prescribed in the Plan and in the Internal Revenue Code. Participant notes receivable are collateralized by the participant's account balance and bear interest at a market rate.

Vesting

Participants are immediately 100 percent vested in employee deferral and rollover contributions and any income or loss thereon. Vesting in the Organization's contribution portion of their accounts, plus actual earnings thereon, is based on years of service. Participants vest in contributions made by the Organization from their date of hire to year three and are 100 percent vested after three years of service.

Benefit Payments

Distributions are payable upon retirement, death, disability, or termination of employment in the form of a lump-sum amount or a monthly retirement benefit for life, which may continue to a spouse or other beneficiary upon the employee's death.

Forfeitures

If a participant is not fully vested on his or her termination date, the nonvested amount of the account is forfeited. Forfeitures are used to reduce administrative fees and to reduce future organization contributions. At December 31, 2017 and 2016, forfeited account balances totaled $169,822 and $79,846, respectively.

Note 1 - Plan Description (Continued)

Party-in-interest Transactions

Certain plan assets are investment funds managed by Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC. Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC are the trustees of the Plan; therefore, these transactions qualify as party-in-interest transactions, as defined under ERISA guidelines.

Termination

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

Note 2 - Summary of Significant Accounting Policies

Investment Valuation

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

The pooled separate accounts are valued at net asset value per share (NAV) of the funds, which is based on the fair value of the funds' underlying assets. There are no redemption restrictions or unfunded commitments on these investments. All other investments are valued based on quoted market prices. See Note 5 for additional information.

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

Participant Notes Receivable

Participant notes receivable are recorded at unpaid principal balances plus any accrued interest. Participant notes receivable are written off when deemed uncollectible.

Administrative Expenses

Various administrative costs are paid by the Organization.

Benefit Payments

Benefits are recorded when paid.

Use of Estimates

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

Note 2 - Summary of Significant Accounting Policies (Continued)

Risks and Uncertainties

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

Subsequent Events

The financial statements and related disclosures include evaluation of events up through and including September 19, 2018, which is the date the financial statements were available to be issued.

Note 3 - Unaudited Information

Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC (collectively the "Trustee") hold the Plan's investments and participant notes receivable and execute all related transactions. The investment and participant notes receivable balances and related income and losses included in the accompanying financial statements and supplemental schedule of assets held at end of year are based solely on information certified by the Trustee.

Note 4 - Tax Status

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

Note 5 - Fair Value Measurements

Accounting standards require that certain assets and liabilities be reported at fair value in the financial statements and provide a framework for establishing that fair value. The framework for determining fair value is based on a hierarchy that prioritizes the valuation techniques and inputs used to measure fair value.

The following tables present information about the Plan’s assets measured at fair value on a recurring basis at December 31, 2017 and 2016.

Level 1

Fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the Plan has the ability to access.

Level 2

Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets, quoted prices for identical or similar assets in markets that are not active, and inputs other than quoted prices that are observable for the asset.

Level 3

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset. These Level 3 fair value measurements are based primarily on management’s own estimates using pricing models, discounted cash flow methodologies, or similar techniques taking into account the characteristics of the asset.

Note 5 - Fair Value Measurements (Continued)

In instances whereby inputs used to measure fair value fall into different levels of the fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The Plan's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset.

	Assets Measured at Fair Value on a Recurring Basis at December 31, 2017	
	Investments (at Fair Value)	Level 1
Mutual funds	$ 40,845,212	$ 40,845,212
Investments measured at NAV - Pooled separate accounts:		
Asset allocation funds (1)	26,061,704	
International equities funds (2)	3,569,955	
Small- and mid-cap funds (3)	1,607,374	
Large-cap funds (3)	8,473,978	
Bond funds and other (4)	3,838,973	
Total investments at fair value	$ 84,397,196	

	Assets Measured at Fair Value on a Recurring Basis at December 31, 2016	
	Investments (at Fair Value)	Level 1
Mutual funds	$ 16,635,907	$ 16,635,907
Investments measured at NAV - Pooled separate accounts:		
Asset allocation funds (1)	21,639,832	
International equities funds (2)	4,735,478	
Small- and mid-cap funds (3)	4,681,759	
Large-cap funds (3)	9,659,193	
Bond funds and other (4)	12,776,765	
Total investments at fair value	$ 70,128,934	

(1) This class represents investments in actively managed pooled separate accounts with investments in both equity and debt securities. The investments may include common stock, corporate bonds, and U.S. and non-U.S. municipal securities.

(2) This class represents investments in actively managed pooled separate accounts that invest primarily in foreign equity securities, which may include common stocks, options, and futures.

(3) This class represents investments in actively managed pooled separate accounts with investments in both equity and debt securities. The investments may include common stock, corporate bonds, non-U.S. municipal securities, interest rate swaps, options, and futures.

(4) This class invests primarily in fixed-income securities, including, but not limited to, bonds, notes, or other investments, such as government securities, commercial paper, certificates of deposit, master notes, or variable amount notes, with the objective of providing high current income consistent with the preservation of capital and the maintenance of liquidity.

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

The Plan's policy is to recognize transfers between levels of the fair value hierarchy as of the actual date of the event of change in circumstances that caused the transfer.

Note 6 - Investment Contracts

The Plan has benefit-responsive investment contracts with Great-West Life & Annuity Insurance Company (Great West), namely Great-West Daily Interest Guarantee Fund (in 1989) and Great-West Guaranteed Certificate Funds (in 1984). Great West maintains plan contributions in a general account. The account is credited with earnings on the underlying investments and charged for participant withdrawals and administrative expenses. The investment contract issuer is contractually obligated to repay principal and a specified interest rate that is guaranteed to the Plan.

There are no reserves against contract value for credit risk of the contract issuer or otherwise. The crediting interest rate is based on a formula agreed upon with the issuer, but may not be less than 4 percent on Great-West Daily Interest Guarantee Fund and may not be less than 3 percent on Great-West Guaranteed Certificate Funds. Such interest rates are reviewed on a quarterly basis for resetting.

Certain events limit the ability of the Plan to transact at contract value with the insurance company. Such events include the following: (i) amendments to the plan documents (including complete or partial plan termination or merger with another plan), (ii) changes to the Plan's prohibition on competing investment options or deletion of equity wash provision, (iii) bankruptcy of the plan sponsor or other plan sponsor events (e.g., divestitures or spinoffs of a subsidiary) that cause a significant withdrawal from the Plan, or (iv) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under ERISA. The plan administrator believes that the occurrence of any such events, which would limit the Plan's ability to transact at contract value with participants, is not probable. There are no events that allow the issuer to terminate the contract and that require the plan sponsor to settle an amount different than contract value paid either within 90 days or over time.

As described in Note 2, because the contracts are fully benefit responsive, contract value is the relevant measurement attribute for that portion of the net assets attributable to the investment contracts. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investments at contract value.

Note 7 - Reconciliation of the Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements at December 31, 2017 and 2016 to Form 5500:

	2017	2016
Net assets available for benefits per the financial statements	$ 100,226,260	$ 85,469,671
Contributions receivable	(660,782)	(615,316)
Other	-	(114,051)
Net assets available for benefits per Form 5500	$ 99,565,478	$ 84,740,304

The following is a reconciliation of net increase in net assets available for benefits per the financial statements for the year ended December 31, 2017 to Form 5500:

Net increase in net assets available for benefits per the financial statements	$ 14,756,589
Change in contributions receivable	(45,466)
Other	114,051
Net increase in net assets available for benefits per Form 5500	$ 14,825,174

Southern Ohio Medical Center Retirement Savings Program

Schedule of Assets Held at End of Year

Form 5500, Schedule H, Line 4i
EIN 31-0678022, Plan No. 002
December 31, 2017

(a)(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
Great-West Life & Annuity Insurance Company and Great-West Trust Company, LLC	Mutual funds:		
	Artisan Mid Cap Value Fund	*	$ 2,635,554
	Fidelity Spartan 500 Index Fund	*	7,302,222
	Harbor International Fund	*	1,595,826
	Vanguard Index Trust - Extended Market Portfolio	*	3,945,767
	DFA Inflation-Protected Securities	*	2,023,366
	Diamond Hill Large Cap I	*	3,641,486
	Federated Instl High Yield Bond Instl	*	1,127,728
	Frontier Phocas Small Cap Value Instl	*	1,600,405
	Meridian Small Cap Growth Institutional	*	952,711
	Primecap Odyssey Growth	*	2,353,476
	Principal Global Real Estate SEC Instl	*	1,284,029
	Vanguard FTSE All-world Ex-US Index Inv	*	2,567,053
	Vanguard Target Retirement 2015 Inv	*	416
	Vanguard Target Retirement 2020 Inv	*	976,430
	Vanguard Target Retirement 2025 Inv	*	120,307
	Vanguard Target Retirement 2030 Inv	*	4,278
	Vanguard Target Retirement 2035 Inv	*	197,931
	Vanguard Target Retirement 2040 Inv	*	149,615
	Vanguard Target Retirement 2045 Inv	*	40,234
	Vanguard Target Retirement 2050 Inv	*	24,588
	Vanguard Target Retirement 2055 Inv	*	98,005
	Vanguard Target Retirement 2060 Inv	*	44,283
	Vanguard Target Retirement Income Inv	*	238,364
	PIMCO Total Return Admin	*	7,921,138
			40,845,212
	Pooled separate accounts:		
	Alger American Midcap Growth Portfolio	*	1,355,525
	American Funds Growth Fund R3	*	261,734
	Artisan International Fund	*	503,200
	Columbia Mid Cap Value Fund R	*	64,042
	Davis New York Venture Fund R	*	384,403
	Fidelity VIP Growth Portfolio	*	7,782
	Fidelity VIP II Contrafund	*	7,813,876
	Great-West Aggressive Profile Portfolio	*	3,207,664
	Great-West Bond Index Fund	*	3,420
	Great-West Conservative Profile Portfolio	*	11,704,279
	Great-West S&P Smallcap 600 Index Fund	*	3,601
	Great-West Loomis Sayles Bond Fund	*	317,967
	Great-West MFS International Value Portfolio	*	3,006,002
	Great-West Moderate Profile Portfolio	*	5,701,273
	Great-West Moderately Aggressive Profile Portfolio	*	4,236,733
	Great-West Moderately Conservative Profile	*	1,211,755
	Great-West Money Market Portfolio	*	2,416,188
	Great-West T. Rowe Price Equity/Income Fund	*	6,183
	Great-West T. Rowe Price Midcap Growth Fund	*	7,469
	PIMCO Total Return Admin	*	914,250
	Putnam High Yield Advantage R	*	17,326
	Putnam International Capital OPP R	*	60,753
	Ridgeworth Small Cap Growth Stock I	*	5,556
	Royce Total Return K	*	91,361
	Invesco American Value	*	79,820
	Forfeitures: maximum money market portfolio	*	169,822
			43,551,984

Southern Ohio Medical Center Retirement Savings Program

Schedule of Assets Held at End of Year (Continued)

Form 5500, Schedule H, Line 4i
EIN 31-0678022, Plan No. 002
December 31, 2017

(a)(b) Identity of Issuer	(c) Description of Investment	(d) Cost	(e) Current Value
	Investment contracts:		
	Great-West Guaranteed Certificate Fund - 84 months	*	$ 7,067,172
	Great-West Guaranteed Certificate Fund - 36 months	*	6,224,474
	Great-West guaranteed Certificate Fund - 60 months	*	455,872
	Great-West Daily Interest Guarantee Fund	*	147,164
			13,894,682
Participants	Participant notes receivable - Interest ranging from 5.25 to 11.50 percent	-	1,273,600
	Total		**$ 99,565,478**

* Cost information not required

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Southern Ohio Medical Center ERTSA Plan
01-JAN-17 to 31-DEC-17

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
1MX5R			2,964,842.19	3,207,663.64
1MX1R			11,413,801.36	11,704,278.55
1MX4R			3,995,559.81	4,236,733.33
1MX2R			1,166,564.30	1,211,755.39
1MX3R			5,426,515.69	5,701,273.49
1VTINX			231,051.17	238,363.69
1VTXVX			428.15	415.71
1VTWNX			914,610.24	976,430.24
1VTTVX			117,123.01	120,307.25
1VTHRX			4,209.02	4,277.73
1VTTHX			189,752.04	197,930.98
1VFORX			142,683.22	149,615.47
1VTIVX			39,027.37	40,233.67
1VFIFX			24,209.16	24,587.81
1VFFVX			91,702.24	98,004.64
1VTTSX			42,582.02	44,283.37
1AI			345,182.94	503,200.12
1IEF			2,314,269.90	3,006,002.46
1HR-INT			1,492,761.74	1,595,826.08
1POSIX			1,211,611.32	1,284,028.78
1PIO			36,524.96	60,753.17
1VFWIX			2,348,882.66	2,567,052.86
1FPSVX			1,610,603.34	1,600,404.76
1MR2			1,508.97	3,601.17
1MSGRX			831,461.39	952,711.33
1SSG			3,993.41	5,553.28
1RTK			70,645.17	91,361.22
1AAM			717,938.58	1,355,524.65
1ARTQX			2,603,232.23	2,635,554.20
1CVR			41,130.80	64,041.53
1TMC			3,017.91	7,469.06
1VAV			68,205.97	79,820.48
1EXTMKT			3,145,678.64	3,945,767.22
1AFG			180,556.83	261,733.58
1DVR			186,039.72	384,402.84
1DHLRX			3,374,306.16	3,641,486.40
1FVG			3,017.98	7,781.50
1FCF			3,795,898.99	7,813,876.27
1TEI			3,017.98	6,183.42
1POGRX			2,116,494.16	2,353,476.12
1FUSEX			5,668,386.73	7,302,221.89
1DIPSX			2,033,672.41	2,023,366.48
1FIHBX			1,126,643.75	1,127,727.80
1BI			3,384.25	3,420.43
1CBF			232,331.49	317,966.90
1PI-TRT			7,833,757.00	7,921,137.81
1PTR			741,679.72	914,250.27
1PHA			15,585.00	17,326.25
1GCF 36	02-JAN-2018	3.000	553,178.80	605,628.91
1GCF 36	31-MAR-2018	3.000	364,212.35	396,593.83
1GCF 36	30-JUN-2018	3.000	407,901.22	440,052.99

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Southern Ohio Medical Center ERTSA Plan
01-JAN-17 to 31-DEC-17

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
1GCF 36	30-SEP-2018	3.000	297,141.63	318,073.35
1GCF 36	31-DEC-2018	3.000	706,156.55	741,410.92
1GCF 36	31-MAR-2019	3.000	336,967.68	355,134.30
1GCF 36	30-JUN-2019	3.000	421,996.32	441,864.94
1GCF 36	30-SEP-2019	3.000	527,972.70	548,489.61
1GCF 36	31-DEC-2019	3.000	409,402.22	422,213.40
1GCF 36	31-MAR-2020	3.000	474,216.53	486,348.91
1GCF 36	30-JUN-2020	3.000	598,201.69	607,593.92
1GCF 36	30-SEP-2020	3.000	564,241.44	569,078.20
1GCF 36	31-DEC-2020	3.000	290,219.79	291,990.85
1GCF 60	02-JAN-2018	3.000	13,211.31	15,346.45
1GCF 60	31-MAR-2018	3.000	10,443.82	12,034.90
1GCF 60	30-JUN-2018	3.000	13,687.92	15,666.15
1GCF 60	30-SEP-2018	3.000	21,769.21	24,701.00
1GCF 60	31-DEC-2018	3.000	25,549.84	28,789.09
1GCF 60	31-MAR-2019	3.000	11,271.34	12,610.36
1GCF 60	30-JUN-2019	3.000	14,856.19	16,507.87
1GCF 60	30-SEP-2019	3.000	14,526.64	16,010.81
1GCF 60	31-DEC-2019	3.000	13,251.65	14,497.63
1GCF 60	31-MAR-2020	3.000	44,759.55	48,758.65
1GCF 60	30-JUN-2020	3.000	18,387.21	19,825.95
1GCF 60	30-SEP-2020	3.000	16,134.33	17,260.29
1GCF 60	31-DEC-2020	3.000	15,788.82	16,768.51
1GCF 60	31-MAR-2021	3.000	17,883.03	18,866.43
1GCF 60	30-JUN-2021	3.000	69,744.69	73,054.39
1GCF 60	30-SEP-2021	3.000	18,955.73	19,695.78
1GCF 60	31-DEC-2021	3.000	22,865.52	23,580.29
1GCF 60	31-MAR-2022	3.000	19,756.35	20,229.09
1GCF 60	30-JUN-2022	3.000	18,993.11	19,294.17
1GCF 60	30-SEP-2022	3.000	18,718.56	18,882.92
1GCF 60	31-DEC-2022	3.000	3,478.45	3,491.47
1GCF 84	02-JAN-2018	3.750	428.98	441.53
1GCF 84	02-JAN-2018	3.000	177,425.93	220,029.42
1GCF 84	31-MAR-2018	3.000	146,967.43	179,914.37
1GCF 84	30-JUN-2018	3.000	237,925.93	289,025.57
1GCF 84	30-JUN-2018	3.700	1,097.04	1,128.72
1GCF 84	30-SEP-2018	3.000	155,935.65	187,977.14
1GCF 84	31-DEC-2018	3.000	193,665.97	231,637.32
1GCF 84	31-DEC-2018	3.500	1,110.71	1,141.06
1GCF 84	31-MAR-2019	3.000	177,647.44	211,408.97
1GCF 84	30-JUN-2019	3.000	194,053.20	228,453.40
1GCF 84	30-SEP-2019	3.000	181,602.53	212,299.39
1GCF 84	31-DEC-2019	3.000	203,420.93	235,992.94
1GCF 84	31-MAR-2020	3.000	183,555.76	211,459.76
1GCF 84	30-JUN-2020	3.000	265,727.27	296,927.42
1GCF 84	30-SEP-2020	3.000	227,740.90	258,412.91
1GCF 84	31-DEC-2020	3.000	255,336.40	287,612.02
1GCF 84	31-MAR-2021	3.000	186,720.62	208,741.28
1GCF 84	30-JUN-2021	3.000	249,598.52	277,055.55
1GCF 84	30-SEP-2021	3.000	325,904.33	358,898.90
1GCF 84	31-DEC-2021	3.000	333,202.15	365,523.61

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Southern Ohio Medical Center ERTSA Plan
01-JAN-17 to 31-DEC-17

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE
1GCF 84	31-MAR-2022	3.000	195,028.44	211,623.63
1GCF 84	30-JUN-2022	3.000	210,099.63	226,376.95
1GCF 84	30-SEP-2022	3.000	223,544.10	239,027.93
1GCF 84	31-DEC-2022	3.000	299,441.04	317,888.81
1GCF 84	31-MAR-2023	3.000	251,675.81	265,293.48
1GCF 84	30-JUN-2023	3.000	216,477.37	226,491.50
1GCF 84	30-SEP-2023	3.000	243,168.17	252,601.88
1GCF 84	31-DEC-2023	3.000	226,870.35	233,946.48
1GCF 84	31-MAR-2024	3.000	246,466.07	252,301.16
1GCF 84	30-JUN-2024	3.000	261,457.98	265,603.93
1GCF 84	30-SEP-2024	3.000	253,107.34	255,261.42
1GCF 84	31-DEC-2024	3.000	56,460.48	56,673.35
1DIGF		4.000	43,592.38	147,164.00
1MMF			2,365,796.28	2,416,188.49
			86,094,178.41	**98,122,055.91**
PARTICIPANT LOANS	VARIOUS	5.250-11.500	1,273,112.63	1,273,600.45
FORFEITURES			169,064.63	169,821.85

Attachment to Form 5500, Schedule H, Part 4, Item I
EIN # 310678022

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Southern Ohio Medical Center ERTSA Plan
01-JAN-17 to 31-DEC-17

INVESTMENT OPTION	MATURITY DATE	INTEREST RATE	COST OF ASSETS	CURRENT VALUE

LEGEND

INVESTMENT OPTION:

1MX5R	Great-West Aggressive Profile Fund Inv
1MX4R	Great-West Mod Aggr Profile Fund Inv
1MX3R	Great-West Moderate Profile Fund Inv
1VTXVX	Vanguard Target Retirement 2015 Inv
1VTTVX	Vanguard Target Retirement 2025 Inv
1VTTHX	Vanguard Target Retirement 2035 Inv
1VTIVX	Vanguard Target Retirement 2045 Inv
1VFFVX	Vanguard Target Retirement 2055 Inv
1AI	Artisan International Fund
1HR-INT	Harbor International Instl
1PIO	Putnam International Capital Opp R
1FPSVX	Frontier Phocas Small Cap Value Instl
1MSGRX	Meridian Small Cap Growth Institutional
1RTK	Royce Total Return K
1ARTQX	Artisan Mid Cap Value Investor
1TMC	Great-West T Rowe Price MidCap Gr Fund I
1EXTMKT	Vanguard Index Trust-Ext. Market Port
1DVR	Davis New York Venture Fund - R
1FVG	Fidelity VIP Growth Portfolio
1TEI	Great-West T. Rowe Price Eq Inc Fund I
1FUSEX	Fidelity 500 Index Inv
1FIHBX	Federated Instl High Yield Bond Instl
1CBF	Great-West Loomis Sayles Bond Fund Inv
1PTR	PIMCO Total Return Admin
1GCF 36	Great-West Guaranteed Certificate Fund
1GCF 84	Great-West Guaranteed Certificate Fund
1MMF	Great-West Government Money Mkt Fund Inv
1MX1R	Great-West Conservative Profile Fund Inv
1MX2R	Great-West Mod Cons Profile Fund Inv
1VTINX	Vanguard Target Retirement Income Inv
1VTWNX	Vanguard Target Retirement 2020 Inv
1VTHRX	Vanguard Target Retirement 2030 Inv
1VFORX	Vanguard Target Retirement 2040 Inv
1VFIFX	Vanguard Target Retirement 2050 Inv
1VTTSX	Vanguard Target Retirement 2060 Inv
1IEF	Great-West MFS Intl Value Fund Inv
1POSIX	Principal Global Real Estate Sec Instl
1VFWIX	Vanguard FTSE All-World ex-US Index Inv
1MR2	Great-West S&P SmallCap 600 Index Fund I
1SSG	RidgeWorth Small Cap Growth Stock - I
1AAM	Alger Mid Cap Growth I-2
1CVR	Columbia Mid Cap Value Fund R
1VAV	Invesco American Value R
1AFG	American Funds Growth Fund R3
1DHLRX	Diamond Hill Large Cap I
1FCF	Fidelity VIP II ContraFund
1POGRX	PRIMECAP Odyssey Growth
1DIPSX	DFA Inflation-Protected Securities I
1BI	Great-West Bond Index Fund I
1PI-TRT	PIMCO Total Return Admin
1PHA	Putnam High Yield R
1GCF 60	Great-West Guaranteed Certificate Fund
1DIGF	Great-West Daily Interest Guarantee Fund

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