

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 <u>01/01/2017</u> and ending <u>12/31/2017</u>	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
	☒ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ an amended return/report ☐ the final return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☒ Form 5558 ☐ special extension (enter description) ☐ automatic extension ☐ the DFVC program

Part II	Basic Plan Information —enter all requested information		
1a	Name of plan <u>SALEM COMMUNITY HOSPITAL RETIREMENT PLAN</u>	1b	Three-digit plan number (PN) ▶ <u>001</u>
		1c	Effective date of plan <u>09/01/1970</u>
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>SALEM COMMUNITY HOSPITAL</u> <u>SALEM REGIONAL MEDICAL CENTER</u> <u>1995 E STATE ST</u> <u>SALEM, OH 44460-2423</u>	2b	Employer Identification Number (EIN) <u>34-1041385</u>
		2c	Plan Sponsor's telephone number <u>330-332-7214</u>
		2d	Business code (see instructions) <u>622000</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/02/2018	BARBARA HIRST
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/02/2018	MICHAEL GIANGARDELLA
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017)
v. 170203

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
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	5 744
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) 604
a(2) Total number of active participants at the end of the plan year	6a(2) 557
b Retired or separated participants receiving benefits	6b 64
c Other retired or separated participants entitled to future benefits	6c 78
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 699
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 3
f Total. Add lines 6d and 6e	6f 702
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h 7
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:

1A

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

9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
---	---

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code _____

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	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

▶ **Round off amounts to nearest dollar.**
▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>SALEM COMMUNITY HOSPITAL RETIREMENT PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>SALEM COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>34-1041385</u>

E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☐ 100 or fewer ☐ 101-500 ☒ More than 500
---	---

Part I	Basic Information
---------------	--------------------------

1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2017</u>			
2 Assets:			
a Market value	2a	<u>42900501</u>	
b Actuarial value	2b	<u>42900501</u>	
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	<u>55</u>	<u>10058396</u>	<u>10058396</u>
b For terminated vested participants	<u>85</u>	<u>3004418</u>	<u>3004418</u>
c For active participants	<u>604</u>	<u>31472090</u>	<u>31678910</u>
d Total	<u>744</u>	<u>44534904</u>	<u>44741724</u>
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... ☐			
a Funding target disregarding prescribed at-risk assumptions	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b		
5 Effective interest rate	5	<u>6.03 %</u>	
6 Target normal cost	6	<u>2065240</u>	

Statement by Enrolled Actuary
To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE		
Signature of actuary	<u>10/01/2018</u>	Date
<u>CHAD M GREENWALT</u>	<u>17-07020</u>	Most recent enrollment number
Type or print name of actuary	<u>216-937-4000</u>	Telephone number (including area code)
<u>TOWERS WATSON DELAWARE INC.</u>		
Firm name		
<u>1001 LAKESIDE AVENUE, SUITE 1500</u> <u>CLEVELAND, OH 44114-1172</u>		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	4106330	5796184
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	4106330	5796184
10 Interest on line 9 using prior year's actual return of <u>10.80</u> %	443484	625988
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		414129
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.15</u> %		25469
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance		439598
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	3864865	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	684949	6422172

Part III Funding Percentages

14 Funding target attainment percentage	14	80.00%
15 Adjusted funding target attainment percentage	15	85.73%
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	94.79%
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
10/16/2017	374998	0	04/10/2018	250000	0
11/07/2017	250000	0	05/09/2018	250000	0
12/12/2017	250000	0	06/05/2018	250000	0
01/09/2018	250000	0	07/10/2018	291667	0
02/06/2018	250000	0	08/07/2018	291667	0
03/06/2018	250000	0	08/30/2018	291667	0
Totals ▶			18(b)	3249999	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	3025427

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☒ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.16 %	2nd segment: 5.72 %	3rd segment: 6.48 %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 4
22 Weighted average retirement age.....				22 63
23 Mortality table(s) (see instructions)	☐ Prescribed - combined	☒ Prescribed - separate	☐ Substitute	

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment	☒ Yes ☐ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.....	☐ Yes ☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	☒ Yes ☐ No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	2065240	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment.....	8948344	1469425	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33).....	34	3534665	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....	684949	746783	1431732
36 Additional cash requirement (line 34 minus line 35)	36	2102933	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	3025427	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	922494	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	922494	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years.....	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:				
a Schedule elected	☐ 2 plus 7 years	☐ 15 years		
b Eligible plan year(s) for which the election in line 41a was made	☐ 2008	☐ 2009	☐ 2010	☐ 2011
42 Amount of acceleration adjustment	42	0		
43 Excess installment acceleration amount to be carried over to future plan years	43	0		

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		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 SALEM COMMUNITY HOSPITAL RETIREMENT PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 SALEM COMMUNITY HOSPITAL	D Employer Identification Number (EIN) 34-1041385	

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
(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
(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

(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

(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

(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

(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)

EATON VANCE ATLANTA SMID CAP A

01-0553859

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

EMERALD BANKING FINANCE

23-2882135

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

FUNDAMENTAL INVESTORS A

22-1557722

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

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

GATEWAY TRUST INDEX PLUS

31-0921083

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

INTERMEDIATE BOND FUND OF AMERICA

95-6873999

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

LOOMIS STRATEGIC INCOME

04-3268670

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

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

LOOMIS SAYLES STRATEGIC ALPHA

27-3598296

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

LORD ABBETT BOND DEBENTURE

13-2669319

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

LORD ABBETT VALUE OPTIONS

20-3767040

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

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

NEW PERSPECTIVE FUND

95-2817150

(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?
72			Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

SELIGMAN COMMUNICATIONS

13-3154449

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

SHORT TERM BOND FUND OF AMERICA

20-5302406

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

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

THORNBURG INVESTMENT INCOME BUILDER

37-1448048

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

LINDE HANSON CONTRARIAN FUND

45-4289243

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

NATIXIS OAKMARK INTERNATIONAL

27-3598377

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

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

NEW WORLD FUND

95-4727424

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

LORD ABBETT SHORT DURATION INCOME A

13-3731507

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

EMERALD GROWTH FUND

23-2696899

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

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

CATALYST DYNAMIC ALPHA FUND

45-3837720

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

NATIXIS OAKMARK FUND A

01-1999069

(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?
72	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

FARMERS TRUST COMPANY

34-1853512

(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?
	CONTRACT ADMINISTRATOR	21340	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☒

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

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

AMERICAN INFLATION LINKED BOND FUND

45-5527780

(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?
	INVESTMENT PROVIDER		Yes ☒ No ☐	Yes ☒ No ☐		Yes ☒ No ☐

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

TOWERS WATSON

53-0181241

(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?
11	ACTUARIAL	107745	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☒

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

HACK,STEER AND ASSOCIATES

20-5607042

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	ACCOUNTING	6643	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☒

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

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

HUNTER AND ASSOCIATES

25-1681448

(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?
71	SECURITIES BROKERAGE	12863	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

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

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

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

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
HUNTER AND ASSOCIATES	63	
(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.	
EATON VANCE ATLANTA CAPITAL 01-0553859	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
EMERALD BANKING AND FINANCE 23-2882135	35 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
FUNDAMENTAL INVESTORS 22-1557722	25 BASIS POINTS OF INVESTMENT	

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
HUNTER AND ASSOCIATES	63	
(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.	
GATEWAY INDEX PLUS 31-0921083	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
INTERMEDIATE BOND FUND OF AMERICA 95-6873999	27 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
LOOMIS SAYLES STRATEGIC INCOME 04-3268670	25 BASIS POINTS OF INVESTMENT	

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
HUNTER AND ASSOCIATES	63	
(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.	
LOOMIS SAYLES STRATEGIC ALPHA 27-3598296	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
LORD ABBOTT BOND DEBENTURE 13-2669319	20 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
LORD ABBOTT VALUE OPPORTUNITY FUND 20-3767040	25 BASIS POINTS OF INVESTMENT	

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
HUNTER AND ASSOCIATES	63	
(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.	
NEW PERSPECTIVE FUND 95-2817150	24 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
SELIGMAN COMMUNICATIONS FUND 13-3154449	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
SHORT TERM BOND FUND OF AMERICA 20-5302406	30 BASIS POINTS OF INVESTMENT	

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
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
THORNBURG INCOME BUILDER 54-1473607	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
LINDE HANSON CONTRARIAN FUND 45-4289243	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
NATIXIS OAKMARK INTERNATIONAL 27-3598377	25 BASIS POINTS OF INVESTMENT	

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
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation		
NEW WORLD FUND 95-4727424	24 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2		
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation		
LORD ABBOTT SHORT DURATION 13-3731507	20 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2		
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation		
EMERALD GROWTH FUND A 23-2696899	35 BASIS POINTS OF INVESTMENT	

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
HUNTER AND ASSOCIATES	63	
(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.	
CATALYST DYNAMIC ALPHAFUND 45-3837720	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(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.	
NATIXIS OAKMARK FUND A 04-1990692	25 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
HUNTER AND ASSOCIATES	63	
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN INFLATION LINKED BOND FUND 45-5527780	30 BASIS POINTS OF INVESTMENT	

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
ISHARES	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	20 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
EATON VANCE LARGE CAP VALUE	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	119 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
EMERALD BANKLNG AND FINANCE FUND	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	141 BASIS POINTS OF INVESTMENT	

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
FUNDAMENTAL INVESTORS	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	60 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
GATEWAY INDEX PLUS	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	94 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
INTERNATIONAL BOND FUND OF AMERICA	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	61 BASIS POINTS OF INVESTMENT	

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
LOOMIS SAYLES STRATEGIC INCOME	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	96 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
LOOMIS SAYLES STRATEGIC ALPHA	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	105 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
LORD ABBOTT BOND DEBENTURE	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	81 BASIS POINTS OF INVESTMENT	

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
LORFD ABBOTT VALUE OPPORTUNITY	72	
(d) Enter name and EIN (address) of source of indirect compensation		
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	115 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2		
NEW PERSPECTIVE FUND	72	
(d) Enter name and EIN (address) of source of indirect compensation		
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	75 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2		
SELIGMAN COMMUNICATIONS	72	
(d) Enter name and EIN (address) of source of indirect compensation		
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	124 BASIS POINTS OF INVESTMENT	

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
SHORT TERM BOND FUND OF AMERICA	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	64 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
THORNBURG INCOME BUILDER	72	
(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.	
SALEM COMMUNITY HOSPITAL 34-1041385	119 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
LINDE HANSON CONTRARION FUND	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	140 BASIS PINTS OF INVESTMENT	

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
NATIXIS OAKMARK INTERNATIONAL	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	132 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NEW WORLD FUND	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	104 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
LORD ABBETT SHORT DURATION	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	59 BASIS POINTS OF INVESTMENT	

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
EMERALD GROWTH FUND A	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	103 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CATALYST DYNAMIC ALPHA FUND	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	135 BASIS POINTS OF INVESTMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AMERICAN INFLATION LINKED BOND FUND	72	
(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.	
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	73 BASIS POINTS OF INVESTMENT	

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
NATIXIS OAKMARK FUND A	72	

(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.
SALEM COMMUNITY HOSPITAL RETIREMENT 34-1041385	118 BASIS POINTS OF INVESTMENT

(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 H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2017 This Form is Open to Public Inspection
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>		
A Name of plan <u>SALEM COMMUNITY HOSPITAL RETIREMENT PLAN</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SALEM COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>34-1041385</u>	

Part I	Asset and Liability Statement		(a) Beginning of Year	(b) End of Year
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	Total noninterest-bearing cash	1a		
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions	1b(1)		
	(2) Participant contributions	1b(2)		
	(3) Other.....	1b(3)	28357	26500
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	473564	611430
	(2) U.S. Government securities.....	1c(2)		
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)		
	(B) All other.....	1c(3)(B)	425209	426613
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)		
	(B) Common	1c(4)(B)	7896922	7885711
	(5) Partnership/joint venture interests	1c(5)		
	(6) Real estate (other than employer real property)	1c(6)		
	(7) Loans (other than to participants)	1c(7)		
	(8) Participant loans	1c(8)		
	(9) Value of interest in common/collective trusts.....	1c(9)		
	(10) Value of interest in pooled separate accounts.....	1c(10)		
	(11) Value of interest in master trust investment accounts	1c(11)		
	(12) Value of interest in 103-12 investment entities	1c(12)		
	(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	32240894	34713082
	(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
	(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities	1d(1)	
(2)	Employer real property	1d(2)	
e	Buildings and other property used in plan operation	1e	
f	Total assets (add all amounts in lines 1a through 1e)	1f	41064946 43663336
Liabilities			
g	Benefit claims payable	1g	
h	Operating payables	1h	9838 5847
i	Acquisition indebtedness	1i	
j	Other liabilities	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	9838 5847
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	41055108 43657489

Part II Income and Expense Statement

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

		(a) Amount	(b) Total
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers	2a(1)(A)	2750004
	(B) Participants	2a(1)(B)	
	(C) Others (including rollovers)	2a(1)(C)	
(2)	Noncash contributions	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	2750004
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	
	(B) U.S. Government securities	2b(1)(B)	2985
	(C) Corporate debt instruments	2b(1)(C)	19705
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E)	
	(F) Other	2b(1)(F)	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	22690
(2)	Dividends: (A) Preferred stock	2b(2)(A)	
	(B) Common stock	2b(2)(B)	204478
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	
	(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	204478
(3)	Rents	2b(3)	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	9475767
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	8593349
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	882418
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	3305777
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	3305777

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)		961643
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		8127010

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	4952987	
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		4952987
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees	2i(1)	114388	
(2) Contract administrator fees	2i(2)	21270	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)	435984	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		571642
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		5524629

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		2602381
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

☒ Yes ☐ No

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

(1) Name: HACK, STEER & COMPANY, LLC

(2) EIN: 20-5607042

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

	Yes	No	Amount
4a		X	
4b		X	

		Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		500000
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 SALEM COMMUNITY HOSPITAL RETIREMENT PLAN		B Three-digit plan number (PN) ▶ 001
C Plan sponsor's name as shown on line 2a of Form 5500 SALEM COMMUNITY HOSPITAL		D Employer Identification Number (EIN) 34-1041385
Part I	Distributions	
All references to distributions relate only to payments of benefits during the plan year.		
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions		1
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 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 30
Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)	
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? ☐ Yes ☒ No ☐ N/A If the plan is a defined benefit plan, go to line 8.		
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month Day Year If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived)		6a
b Enter the amount contributed by the employer to the plan for this plan year		6b
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)		6c
If you completed line 6c, skip lines 8 and 9.		
7 Will the minimum funding amount reported on line 6c be met by the funding deadline? ☐ Yes ☐ No ☐ N/A		
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ☐ Yes ☐ No ☒ N/A		
Part III	Amendments	
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box. ☒ Increase ☐ Decrease ☐ Both ☐ No		
Part IV	ESOPs (see instructions). If this is not a plan described under section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.	
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ☐ Yes ☐ No		
11 a Does the ESOP hold any preferred stock? ☐ Yes ☐ No		
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) ☐ Yes ☐ No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market? ☐ Yes ☐ No		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.		
Schedule R (Form 5500) 2017 v. 170203		

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- a** Enter the percentage of plan assets held as:

Stock: 68.8% Investment-Grade Debt: 31.0% High-Yield Debt: _____% Real Estate: _____% Other: 0.2%

- 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):

FINANCIAL STATEMENTS
AND SUPPLEMENTAL SCHEDULES

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

--- o o O o o ---

C O N T E N T S

	<u>P A G E</u>
Independent Auditor's Report -----	1-2
Statements of Net Assets Available for Benefits -----	3
Statements of Changes in Net Assets Available for Benefits -----	4
Notes to Financial Statements -----	5-12
Supplemental Schedules:	
Schedule H, Part IV, Item 4i - Schedule of Assets Held for Investment Purposes -----	13-14
Schedule H, Part IV, Item 4j - Schedule of Reportable Transactions -----	15

--- o o O o o ---



HACK, STEER & COMPANY, LLC

314 E. 2nd Street

Salem, Ohio 44460

(330) 337-8713

Fax (330) 337-3127

INDEPENDENT AUDITOR'S REPORT

Retirement Plan Trustees
The Salem Community Hospital Retirement Plan
Salem, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of The Salem Community Hospital Retirement Plan, which comprise the statements of net assets available for benefits as of December 31, 2017 and 2016, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

Basis for Disclaimer of Opinion

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

Disclaimer of Opinion

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

INDEPENDENT AUDITOR'S REPORT (CONTINUED)

Other Matter

The supplemental schedules of schedule H, Part IV, Item 4i - schedule of assets held for investment purposes and schedule H, Part IV, Item 4j - schedule of reportable transactions for the year ended December 31, 2017, are required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for the purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedule referred to above.

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

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



Hack, Steer & Company, LLC
Certified Public Accountants
Salem, Ohio
September 26, 2018

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u>
<u>ASSETS</u>		
Cash	\$ 611,430	\$ 473,564
Investments, at fair value (notes C and G):		
Mutual funds:		
Bond	14,043,508	14,553,245
Stock	20,669,574	17,687,649
Common stocks	7,885,711	7,896,922
Corporate bonds	426,613	425,209
TOTAL INVESTMENTS	<u>43,025,406</u>	<u>40,563,025</u>
Accrued interest receivable	26,500	28,357
TOTAL ASSETS	<u>43,663,336</u>	<u>41,064,946</u>
<u>LIABILITIES</u>		
Accounts payable	<u>5,847</u>	<u>9,838</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 43,657,489</u></u>	<u><u>\$ 41,055,108</u></u>

See accompanying notes to financial statements

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

	<u>2017</u>	<u>2016</u>
<u>ADDITIONS TO NET ASSETS</u>		
Investment income (note G):		
Net appreciation (depreciation) in fair value of investments	\$ 3,305,777	\$ (753,528)
Realized gain on sale	882,418	4,824,875
Interest and dividends	1,188,811	1,824,611
	<u>5,377,006</u>	<u>5,895,958</u>
Investment expenses	21,270	30,280
	<u>5,355,736</u>	<u>5,865,678</u>
Contributions:		
Employer	2,750,004	2,250,006
TOTAL ADDITIONS TO NET ASSETS	<u>8,105,740</u>	<u>8,115,684</u>
<u>DEDUCTIONS FROM NET ASSETS</u>		
Benefits paid to participants	4,952,987	7,694,621
Administrative expenses	114,388	145,815
PBGC insurance	435,984	426,104
Purchases of annuity contracts	0	20,569,961
TOTAL DEDUCTIONS FROM NET ASSETS	<u>5,503,359</u>	<u>28,836,501</u>
NET INCREASE (DECREASE)	2,602,381	(20,720,817)
<u>NET ASSETS AVAILABLE FOR BENEFITS</u>		
Beginning of year	<u>41,055,108</u>	<u>61,775,925</u>
End of year	<u>\$ 43,657,489</u>	<u>\$ 41,055,108</u>

See accompanying notes to financial statements

NOTES TO FINANCIAL STATEMENTS

THE SALEM COMMUNITY HOSPITAL RETIREMENT PLAN

December 31, 2017 and 2016

NOTE A - DESCRIPTION OF PLAN

The following description of The Salem Community Hospital Retirement Plan ("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 benefit pension plan providing retirement and death benefits to all permissible employees. The Plan sponsor is The Salem Community Hospital (Company) and is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan includes all eligible full-time employees of the Company as of January 1, 2014. The Retirement Plan Trust Committee (Committee), which is a committee of the board of directors of the Company is responsible for oversight of the Plan. The Committee determines the appropriateness of the Plan's investment offerings and monitors investment performance.

Frozen Plan:

The Company has amended the Plan to incorporate a "soft freeze". Effective January 1, 2014, newly hired employees are no longer eligible for The Salem Community Hospital Retirement Plan. Participants already in the Plan continue to accrue benefits and benefits increase with the growth in participant's wages. After January 1, 2014, newly hired employees are eligible for the Salem Community Hospital 403(b) plan.

Funding Policy:

The Plan's funding policy is for the Company to contribute an amount which will meet or exceed the annual ERISA minimum funding requirement. Company contributions for the years ended December 31, 2017, and 2016 were \$2,750,004 and \$2,250,006 respectively. The Company's contributions for 2017 and 2016 exceeded the minimum funding requirements of ERISA.

Although it has not expressed any intention to do so, the Company 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 ERISA.

Pension Benefits:

The Plan provides for regular retirement benefits for participants with five or more years of vesting service upon reaching age 65 and has provisions for disability; early retirement; survivor; and other benefits, each of which reduces the regular benefit by an amount stated in the Plan or determined by the Plan's actuary. Participants may elect to receive their benefits as a life annuity payable monthly from retirement or may elect to receive optional forms of payment of actuarial equivalent amounts. The Plan permits early retirement beginning at age 55.

Death Benefits:

Benefits are payable upon the death of (a) a nonretired participant who has completed five years of vesting service or (b) a terminated vested participant, prior to the commencement of benefits, provided that the participant had elected surviving spouse coverage.

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Date of Management's Review:

The Plan has evaluated subsequent events through September 26, 2018, which is the date the financial statements were available to be issued. The Committee is in the process of freezing the defined benefit plan effective December 31, 2018 and replacing it with a safe harbor defined contribution plan with an employer matching formula. Details are currently being determined.

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 and disclosures. Accordingly, actual results may differ from those estimates.

Basis of Accounting:

The financial statements of the Plan are prepared on the accrual basis of accounting.

Investment Valuation and Income Recognition:

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note C for a discussion of fair value measurements.

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

Payment of Benefits:

Benefit payments to participants are recorded upon distribution.

Administrative Expenses

The Plan's expenses are paid either by the Plan or the Company, as provided by the Plan document. Expenses that are paid directly by the Company are excluded from these financial statements. Certain expenses incurred in connection with the general administration of the Plan that are paid by the Plan are recorded as deductions in the accompanying statement of changes in net assets available for benefits. In addition, certain investment related expenses are included in net appreciation of fair value of investments presented in the accompanying statement of changes in net assets available for benefits.

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

NOTE C – FAIR VALUE MEASUREMENTS

The Plan's investments are reported at fair value in the accompanying statement of net assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. The Committee determines the Plan's valuation policies utilizing information provided by the investment advisors, custodians and insurance company. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to measure the fair value of certain financial instruments could result in a different fair value at the reporting date.

The fair value measurement accounting literature establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: Level 1 inputs consist of unadjusted quoted prices in active markets for identical assets and have the highest priority; Level 2 inputs consist of observable inputs other than quoted prices for identical assets; and Level 3 inputs are unobservable and have the lowest priority. The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. Level 3 inputs would be used only when Level 1 or Level 2 inputs are not available.

Level 1 Fair Value Measurements

The fair values of investments are based on the closing price reported in the active market where the individual securities are traded, when available.

Level 2 Fair Value Measurements

The fair values of investments for which quoted market price are not available are valued using a market approach on yields currently available on comparable securities of issuers with similar credit ratings.

Level 3 Fair Value Measurements

For those assets with fair value measured using Level 3 inputs, the Board of Trustees determines the fair value measurement policies and procedures in consultation with the Plan's investment advisors, custodians and insurance company. Those policies and procedures are reassessed at least annually to determine if the current valuation techniques are still appropriate. At that time, the unobservable inputs used in the fair value measurements are evaluated and adjusted, as necessary, based on current market conditions and other third-party information.

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

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

NOTE C – FAIR VALUE MEASUREMENTS (CONTINUED)

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

Common stocks: Valued at the closing price reported on the New York Stock Exchange.

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

U.S. government securities: Valued at the closing price reported in the active market in which the individual security is traded.

Corporate bonds: Certain corporate bonds are valued at the closing price reported in the active market in which the bond is traded. Other corporate bonds are valued based on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for identical or similar bonds, the bond is valued under a discounted cash flows approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may be observable, such as credit and liquidity risks.

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

The Plan administrator determines the fair value measurement policies and procedures, subject to oversight by the Organization's employee benefit committee. Those policies and procedures are reassessed at least annually to determine if the current valuation techniques are still appropriate.

The level within the fair value hierarchy of the Plan's investments is as follows:

Fair Value Measurements at December 31:

	<u>2017</u>	<u>2016</u>
Quoted Prices in Active Markets for Identical Assets (Level 1)	\$ 42,598,793	\$ 40,137,816
Significant Other Observable Inputs (Level 2)	426,613	425,209
Significant Other Unobservable Inputs (Level 3)	<u>0</u>	<u>0</u>
TOTAL	<u>\$ 43,025,406</u>	<u>\$ 40,563,025</u>

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

NOTE D - ACTUARIAL PRESENT VALUE OF ACCUMULATED PLAN BENEFITS

Accumulated Plan benefits are those future periodic payments, including lump-sum distributions that are attributable under the Plan's provisions to the service employees have rendered. Accumulated Plan benefits include benefits expected to be paid to (a) retired or terminated employees or their beneficiaries, (b) beneficiaries of employees who have died, and (c) present employees or their beneficiaries. Benefits under the Plan are accumulated based on employees' compensation during each year of credited service. The accumulated Plan benefits for active employees will equal the accumulation, with interest, of the annual benefit accruals as of the benefit information date. Benefits payable under all circumstances - retirement, death, disability, and termination of employment - are included, to the extent they are deemed attributable to employee service rendered to the valuation date. Benefits to be provided via annuity contracts excluded from Plan assets are excluded from accumulated Plan benefits. The actuarial present value of accumulated Plan benefits is determined by an actuary from Willis Towers Watson PLC and is that amount that results from applying assumptions to adjust the accumulated Plan benefits to reflect the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment. The significant actuarial assumptions used in the valuations as of December 31, 2017 and 2016 are presented in note I. The foregoing actuarial assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of accumulated Plan benefits. The computations of the actuarial present value of accumulated Plan benefits were made as of January 1, 2017 and 2016. Had the valuations been performed as of December 31, there would be no material differences.

NOTE E - PLAN TERMINATION

In the event the Plan terminates, the net assets of the Plan will be allocated, as prescribed by ERISA and its related regulations, generally to provide the following benefits in the order indicated:

1. Benefits attributable to employee contributions.
2. Annuity benefits that former employees or their beneficiaries have been receiving for at least three years, or that employees eligible to retire for that three-year period would have been receiving if they had retired with benefits in the normal form of annuity under the Plan. The priority amount is limited to the lowest benefit that was payable (or would have been payable) during those three years. The amount is further limited to the lowest benefit that would be payable under Plan provisions in effect at any time during the five years preceding Plan termination.
3. Other vested benefits insured by the Pension Benefit Guaranty Corporation (PBGC) (a U.S. government agency) up to the applicable limitations (discussed subsequently).
4. All other vested benefits (that is, vested benefits not insured by the PBGC).
5. All nonvested benefits.

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

THE SALEM COMMUNITY HOSPITAL RETIREMENT PLAN

December 31, 2017 and 2016

NOTE E - PLAN TERMINATION (CONTINUED)

Certain benefits under the Plan are insured by the PBGC if the Plan terminates. Generally, the PBGC guarantees most vested normal age retirement benefits, early retirement benefits, and certain disability and survivor's pensions. However, the PBGC does not guarantee all types of benefits under the Plan, and the amount of benefit protection is subject to certain limitations. Vested benefits under the Plan are guaranteed at the level in effect on the date of the Plan's termination. However, a statutory ceiling exists, which is adjusted periodically, on the amount of an individual's monthly benefit that the PBGC guarantees. For Plan terminations occurring during 2017 that ceiling is \$5,369 per month. That ceiling applies to those pensioners who elect to receive their benefits in the form of a single-life annuity and are at least 65 years old at the time of the retirement of Plan termination (whichever comes later). For younger annuitants or for those who elect to receive their benefits in some form more valuable than a single-life annuity, the corresponding ceilings are actuarially adjusted downward.

Whether all participants receive their benefits should the Plan terminate at some future time will depend on the sufficiency, at that time, of the Plan's net assets to provide for accumulated benefit obligations and may also depend on the financial condition of the Plan sponsor and the level of benefits guaranteed by the PBGC.

NOTE F - TAX STATUS

The Internal Revenue Service has determined and informed the Company by a letter dated September 22, 2017, that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). The Plan administrator and the Plan's tax counsel believe that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC and therefore believe that the Plan is qualified and the related trust is tax-exempt.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan to recognize a tax liability (or asset) if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2017, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any periods in progress. The Plan administrator believes it is no longer subject to income tax examinations for periods prior to 2015.

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

NOTE G – INFORMATION PREPARED AND CERTIFIED BY TRUSTEE

The following information included in the accompanying financial statements and supplemental schedules was obtained from data that has been prepared and certified to be complete and accurate by the trustee.

	<u>2017</u>	<u>2016</u>
Investments, at fair value:		
Mutual funds - Bond	\$ 14,043,508	\$ 14,553,245
Money funds - Stock	20,669,574	17,687,649
Common stocks	7,885,711	7,896,922
Corporate bonds	426,613	425,209
Investment income:		
Realized gain on sale	\$ 882,418	\$ 4,824,875
Interest and dividends	1,188,811	1,824,611

During 2017 and 2016, the Plan's investments appreciated (depreciated) in value by \$3,305,777 and (\$753,528) respectively as follows:

	<u>2017</u>	<u>2016</u>
Corporate bonds	\$ 1,404	\$ 1,664
Mutual funds - Bond	180,210	784,954
Mutual funds - Stock	2,623,808	(223,258)
Common stocks	<u>500,355</u>	<u>(1,316,888)</u>
NET APPRECIATION (DEPRECIATION) IN FAIR VALUE	<u>\$ 3,305,777</u>	<u>\$ (753,528)</u>

NOTE H - RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and those changes could materially affect the amounts reported in the statement of net assets available for benefits.

Plan contributions are made and the actuarial present value of accumulated Plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

December 31, 2017 and 2016

NOTE I – ACTUARIAL PRESENT VALUE OF ACCUMULATED PLAN BENEFITS

The actuarial present value of accumulated Plan benefits as of the beginning of the year are as follows:

	<u>As of January, 1</u>	
	<u>2017</u>	<u>2016</u>
Actuarial present value of accumulated Plan benefits:		
Vested benefits:		
Participants currently receiving payments	\$9,437,691	\$24,363,508
Other participants	<u>34,666,192</u>	<u>35,482,706</u>
	44,103,883	59,846,214
Nonvested benefits	<u>217,765</u>	<u>222,388</u>
TOTAL ACTUARIAL PRESENT VALUE OF ACCUMULATED PLAN BENEFITS	<u>\$44,321,648</u>	<u>\$60,068,602</u>

The change in the actuarial present value of the accumulated Plan benefits during 2017 consisted of the following:

Accumulated Plan benefits - January 1, 2016	\$ 60,068,602
Benefits accumulated	1,547,866
Actuarial gains and (losses)	6,502,629
Increase for interest due to the decrease in the discount period	3,751,859
Actual benefits paid	(28,264,582)
Assumption changes	<u>715,274</u>
Accumulated Plan benefits - January 1, 2017	<u>\$ 44,321,648</u>

The significant actuarial assumptions used in the valuations as of January 1, 2017 and 2016 include:

	<u>2017</u>	<u>2016</u>
Interest discount rate	7.00% per annum	7.00% per annum
Current year PPA effective interest rate	6.03% per annum	6.15% per annum
Actuarial cost method	Projected Unit Credit	Projected Unit credit
Mortality basis	The RP-2014 Mortality tables projected back to 2006 without adjustments, generationally using scale MP-2016 for annuitants and non-annuitants	The RP-2014 Mortality tables projected back to 2006 without adjustments generationally using scale MP-2015 for annuitants and non-annuitants
Retirement	Age 65, decrementing to age 55	Age 65, decrementing to age 55
Salary scale	2.25% per annum	3.00% per annum

SCHEDULE H, PART IV, ITEM 4i - SCHEDULE OF ASSETS
HELD FOR INVESTMENT PURPOSES

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

EIN: 34-1041385
PLAN NUMBER: 001

December 31, 2017

(a)	(b) IDENTITY OF ISSUE, BORROWER OR SIMILAR PARTY	(c) DESCRIPTION OF INVESTMENT INCLUDING MATURITY DATE, RATE OF INTEREST, PAR OR MATURITY VALUE, NUMBER OF SHARES	(d) COST	(e) CURRENT VALUE
Corporate Bonds:				
	Advance Auto Parts Inc	\$250,000, 4.500% due 01/15/2022	\$ 248,125	\$ 261,988
	Briggs & Stratton Corp	\$150,000, 6.875% due 12/15/2020	153,938	164,625
	Total Corporate Bonds		<u>\$ 402,063</u>	<u>\$ 426,613</u>
Mutual Funds:				
	Bond:			
	American inflation Linked Bond Fund	314,612 units	\$ 2,990,191	\$ 3,045,448
	Intermediate Bond Fund America A	79,835 units	1,067,206	1,063,403
	iShares Lehman TIPS Bond	5,000 shares	565,371	570,400
	Loomis Sayles Strategic Alpha Fund A	172,646 units	1,787,795	1,710,923
	Loomis Sayles Strategic Income Fund A	188,754 units	2,698,786	2,744,484
	Lord Abbett Bond Debenture Fund A	222,195 units	1,786,298	1,833,105
	Lord Abbett Short Duration Income Fund A	300,058 units	1,315,641	1,275,248
	Short Term Bond Fund of America A	181,868 units	1,830,820	1,800,497
	Total Mutual Funds - Bond		<u>\$ 14,042,108</u>	<u>\$ 14,043,508</u>
	Stock:			
	Catalyst Dynamic Alpha fund A	29,172 units	500,000	640,898
	Columbia Seligman Comm & Info Fund A	22,322 units	906,443	1,579,930
	Eaton Vance Atlanta Capital SMID Cap Fd A	44,219 units	627,571	1,348,692
	Emerald Banking & Finance Fund A	31,383 units	662,973	1,425,103
	Emerald Growth Fund	25,951 units	499,038	686,404
	Fundamental Investors A	35,229 units	1,352,303	2,191,588
	Gateway Trust Index Plus Fund A	32,721 units	848,231	1,095,187
	Linde Hansen Contrarion Value FD CL A	131,709 units	1,337,832	1,812,312
	Lord Abbott Value Opportunities Fund A	61,477 units	788,428	1,235,068
	Natixis Oakmark International Fund A	94,456 units	1,054,939	1,471,631
	Natixis Oakmark Fund A	25,630 units	516,573	633,565
	New Perspective Fund A	35,463 units	815,358	1,530,583
	New World Fund A	32,256 units	1,040,046	2,158,564
	Thornburg Invt Income Builder Fund A	130,358 units	2,116,437	2,860,049
	Total Mutual Funds - Stock		<u>\$ 13,066,172</u>	<u>\$ 20,669,574</u>

SCHEDULE H, PART IV, ITEM 4i - SCHEDULE OF ASSETS
HELD FOR INVESTMENT PURPOSES (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

EIN: 34-1041385
PLAN NUMBER: 001

December 31, 2017

(a)	(b) IDENTITY OF ISSUE, BORROWER OR SIMILAR PARTY	(c) DESCRIPTION OF INVESTMENT INCLUDING MATURITY DATE, RATE OF INTEREST, PAR OR MATURITY VALUE, NUMBER OF SHARES	(d) COST	(e) CURRENT VALUE
	Common Stocks:			
	Alleghany corp	400 shares	\$ 177,892	\$ 238,436
	Apple Inc	2,500 shares	43,864	423,075
	Chevron Corp.	4,000 shares	165,402	500,760
	Cognizant	3,000 shares	153,757	213,060
	Consumers Bancorp	30,000 shares	472,200	645,000
	Eaton Vance Corp	10,000 shares	25,840	563,900
	Franco Nevada corp.	4,000 shares	228,314	319,800
	Hain Celestial Group	4,000 shares	159,412	169,560
	JM Smucker	2,500 shares	305,146	310,600
	Marathon Petroleum Corp	8,000 shares	71,166	527,840
	National Fuel Gas Corp.	4,000 shares	71,944	219,640
	Northwest Natural Gas	4,000 shares	141,460	238,600
	Suntrust Banks	8,000 shares	202,102	516,720
	Thermo Fisher Scientific Inc	2,000 shares	90,663	379,760
	TJX Companies Inc	5,000 shares	261,944	382,300
	United Parcel Service	1,600 shares	182,864	190,640
	United Technologies Corp	2,000 shares	215,338	255,140
	Vodafone	10,000 shares	371,435	319,000
	Welltower. Inc	4,000 shares	254,177	255,080
	Weyerhaeuser Co	10,000 shares	310,985	352,600
	Wiley John&Sons Inc	10,000 shares	389,275	657,500
	W.P.Carey Inc	3,000 shares	190,112	206,700
	Total Common Stocks		<u>4,485,292</u>	<u>7,885,711</u>
	Total Investments		<u>\$ 31,995,635</u>	<u>\$ 43,025,406</u>

* Denotes party-in-interest; there are no parties-in-interest

SCHEDULE H, PART IV, ITEM 4j - SCHEDULE OF
REPORTABLE TRANSACTIONS

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

EIN: 34-1041385
PLAN NUMBER: 001

December 31, 2017

(a)	(b) DESCRIPTION OF ASSET	(c) PURCHASES	(d) SALE PROCEEDS	(g)	(i) NET GAIN/(LOSS)
				COST OF ASSETS SOLD	
	Federal Prime Obligations Fund #117	\$ 2,477,127	\$ 1,865,697	\$ 1,865,697	\$ 0
	Federal Government Obligations Fund #5	3,664,077	4,137,641	4,137,641	0

Columns not included are not applicable.

* Denotes party-in-interest; there are no parties-in-interest

SCHEDULE SB ATTACHMENTS

Schedule SB, Part V Statement of Actuarial Assumptions/Methods

Economic Assumptions

Interest rate basis:

- | | |
|-----------------------|-----------------|
| ■ Applicable month | September |
| ■ Interest rate basis | 3-Segment Rates |

Interest rates:

- | | Reflecting
Corridors | Not Reflecting
Corridors |
|---------------------------|-------------------------|-----------------------------|
| ■ First segment rate | 4.16% | 1.52% |
| ■ Second segment rate | 5.72% | 3.80% |
| ■ Third segment rate | 6.48% | 4.79% |
| ■ Effective interest rate | 6.03% | 4.27% |

Annual rates of increase

- | | |
|-------------------------------------|----------------|
| ■ Compensation | 2.25% |
| ■ Future Social Security wage bases | Not applicable |
| ■ Statutory limits on compensation | 2.25% |

Plan-related expenses

The amount included this year for plan-related expenses is \$612,860.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Demographic Assumptions

Inclusion date The valuation date coincident with or next following the date on which the employee becomes a participant.

New or rehired employees It was assumed there will be no new or rehired employees.

Mortality

- **Funding** The prescribed mortality assumption under Section 430(h)(3)(A) of the Internal Revenue Code using static tables with separate mortality rates for annuitants and non-annuitants.

Termination The rates are which participants are assumed to leave the Hospital by age and union status are shown below:

Representative Termination Rates (per 100 employees)

Percentage assumed to leave during the year		
Attained Age	Non-Union Employees	Union Employees
20	18.6	14.0
25	13.6	10.2
30	10.1	7.6
35	7.9	5.9
40	6.5	4.9
45	5.5	4.1
50	4.5	3.4
55 and over	-	-

Disability None

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Retirement

The following rates have been utilized as the assumed incidence of retirement.

Attained Age	Rate
55	2%
56	2
57	2
58	2
59	5
60	5
61	5
62	20
63	10
64	10
65 and older	100%

Benefit commencement date:

- Preretirement death benefit The later of the death of the active participant or the date the participant would have attained age 65
- Deferred vested benefit The later of age 65 or termination of employment
- Retirement benefit Upon termination of employment

Form of payment

Union employees and former employees are assumed to elect the straight life form. 80% of non-union employees are assumed to elect a lump sum distribution at termination; the remaining 20% are assumed to elect the straight life annuity. The lump sum is assumed to be valued using the discount rate and unisex mortality under current regulations for 2017 distributions.

Percent married

For purposes of valuing the preretirement death benefit, 100% of eligible participants are assumed to have a beneficiary.

Spouse age

Male spouses are assumed to be 3 years older than female spouses.

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Plan Compensation/Salary

Non-Union Employees

Compensation assumed paid in the valuation year is the hourly rate of pay at the census date times the expected number of hours to be worked in the valuation year. Compensation prior to the census date is the actual paid amount.

Union Employees

Accruals are frozen as of December 31, 2008; therefore, no plan compensation is applicable after that date.

Methods

Valuation date

First day of plan year

Funding target

Present value of accrued benefits as required by regulations under IRC §430.

Target normal cost

Present value of benefits expected to accrue during the plan year plus plan-related expenses expected to be paid from plan assets during the plan year as required by regulations under IRC §430.

Actuarial value of assets

The actuarial value of assets is equal to the market value of assets as of the valuation date plus the discounted present value of contributions made after the valuation date for the prior plan year, discounted using the effective interest rate for the prior plan year.

Benefits not valued

None

Sources of Data and Other Information

The plan sponsor furnished participant data as of 1/1/2017. Information on assets, contributions and plan provisions was supplied by the plan sponsor. Data and other information were reviewed for reasonableness and consistency, but no audit was performed.

We are not aware of any errors or omissions in the data that would have a significant effect on the results of our calculations.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Assumptions Rationale - Significant Economic Assumptions

Discount rate The basis chosen was selected by the plan sponsor from among choices prescribed by law, all of which are based on observed market data over certain periods of time.

Lump sum conversion rate As required by IRC 430, lump sum benefits are valued using "annuity substitution", so that the interest rates assumed are effectively the same as described above for the discount rate.

Rates of increase in:

- **Compensation** Assumed compensation increases are based on plan sponsor expectations for near-term years and the effect that the assumed long-term CPI and NAW will have on compensation increases over the longer term.

The resulting salary increase assumption is 2.25%, which is a composite rate that reflects both current conditions and future expectations.

Assumptions Rationale - Significant Demographic Assumptions

Healthy Mortality Assumptions used for funding purposes are as prescribed by IRC §430(h).

Termination Termination rates were based on a published table for pension participants believed to have similar characteristics to the plan population.

Assumed termination rates differ by union status because of expected differences in union statuses.

Retirement Retirement rates are based on plan sponsor expectations for the future with periodic monitoring of observed gains and losses caused by retirement patterns different than assumed.

Form of payment The percentage of retiring and terminating participants assumed to take lump sums is based on expected experience.

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Percent married

Because the plan allows for non-spouse beneficiaries, 100% is assumed.

Source of Prescribed Methods

Funding methods

The methods used for funding purposes as described in Appendix A, including the method of determining plan assets, are “prescribed methods set by law”, as defined in the actuarial standards of practice (ASOPs). These methods are required by IRC §430, or were selected by the plan sponsor from a range of methods permitted by IRC §430.

Changes in Assumptions and Methods

Change in assumptions since prior valuation

- The segment interest rates used to calculate the funding target and target normal cost were updated to the current valuation date as required by IRC 430.
- The mortality table used to calculate the funding target and target normal cost was updated to include one additional year of projected mortality improvement, as required by IRC 430.
- Salary Scale and Statutory Limits on Compensation were changed from 3.00% in the prior year to 2.25%.

Change in methods since prior valuation

None

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 26 Schedule of Active Participant Data as of January 1, 2017

Attained Age	Years of Credited Service																			
	Under 1		1 to 4		5 to 9		10 to 14		15 to 19		20 to 24		25 to 29		30 to 34		35 to 39		40 & Over	
	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.
Under 25	0		7		0		0		0		0		0		0		0		0	
25 - 29	0		20		11		0		0		0		0		0		0		0	
30 - 34	0		13		17		8		0		0		0		0		0		0	
35 - 39	0		11		9		23		3		0		0		0		0		0	
40 - 44	0		7		11		16		25		4		0		0		0		0	
45 - 49	0		10		18		15		20		17		6		0		0		0	
50 - 54	0		9		13		24		21		14		17		1		0		0	
55 - 59	0		6		18		24		12		13		12		24		2		0	
60 - 64	0		7		9		19		13		0		13		10		32		0	
65 - 69	0		1		1		2		2		0		1		1		4		6	
70 & Over	0		1		1		0		0		0		0		0		0		0	

Plan Name: Salem Community Hospital Retirement Plan
 EIN / PN: 34-1041385/001
 Plan Sponsor: Salem Community Hospital
 Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 32
Schedule of Amortization Bases
as of January 1, 2017

Type of Base	Date Established	Initial Amount	Remaining Amortization Period (Years)	Outstanding Balance	Amortization Payment
1 Shortfall	01/01/2017	8,948,344	7	8,948,344	1,469,425
Total				8,948,344	1,469,425

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB – Statement by Enrolled Actuary

Plan Sponsor	Salem Community Hospital
EIN/PN	34-1041385/001
Plan Name	Salem Community Hospital Retirement Plan
Valuation Date	January 1, 2017
Enrolled Actuary	Chad M. Greenwalt
Enrollment Number	17-07020

The actuarial assumptions that are not mandated by IRC § 430 and regulations, represent the enrolled actuary's best estimate of anticipated experience under the plan, subject to the following conditions:

The actuarial valuation, on which the information in this Schedule SB is based, has been prepared in reliance upon the employee and financial data furnished by the plan administrator and the trustee. The enrolled actuary has not made a rigorous check of the accuracy of this information but has accepted it after reviewing it and concluding it is reasonable in relation to similar information furnished in previous years. The amounts of contributions and dates paid shown in Item 18 of Schedule SB were listed in reliance on information provided by the plan administrator and/or trustee.

SCHEDULE SB ATTACHMENTS

Schedule SB, Part V Summary of Plan Provisions

Plan Provisions

September 1, 1970; Amended and Restated effective January 1, 2016.

Coverage and Participation	Each non-union employee of the Hospital becomes a participant on the first day of the month following attainment of age 21 and completion of one year of employment in which the employee worked at least 1,000 hours. Employees hired after January 1, 2014 are not eligible to become participants in the plan.
-----------------------------------	---

Definitions

Vesting service	One year is credited for each year of employment after age 18 in which the employee worked at least 1,000 hours.
------------------------	--

Credited Service	One year is credited for each year of participation in the Plan in which the employee worked at least 1,000 hours. Credited Service for Union participants was frozen as of December 31, 2008.
-------------------------	--

Normal retirement date (NRD)	The later of the covered employee's attainment of age 65, or the fifth anniversary of the date the covered employee commenced participation in the plan.
-------------------------------------	--

Annual pension benefit	For each year of Credited Service, employees accrue an annual benefit equal to 1.0% of annual compensation earned during such year, plus 0.6% of annual compensation above \$4,800 earned during such year. Effective January 1, 2009, Nurses receive no future accruals under this formula. Annual compensation is generally defined as W-2 pay excluding imputed income and severance amounts.
-------------------------------	--

Eligibility for Benefits

Normal retirement	Retirement on NRD
--------------------------	-------------------

Early retirement	Retirement before NRD and on or after attaining age 55
-------------------------	--

Postponed retirement	Retirement after NRD
-----------------------------	----------------------

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Deferred vested termination Termination for reasons other than death or retirement after completing five years of vesting service

Preretirement death benefit Death while eligible for normal, early, postponed, or deferred vested retirement benefits

Benefits Paid Upon the Following Events

Normal retirement The pension benefit determined as of NRD

Early retirement The monthly pension benefit determined as of the early retirement date, with reductions for commencement prior to age 65 as shown in the table excerpt below.

Retirement Age	Early Retirement Factor	
	Union	Non Union
62	.744	.790
60	.619	.650
55	.402	.450

Postponed retirement The monthly pension benefit determined as of the actual retirement date, recognizing pay and service after normal retirement age.

Deferred vested termination The accrued monthly pension commencing at age 65 or commencing as early as age 55 on an actuarially reduced basis. Participants may also elect a lump sum payment if made within 180 days of termination.

Preretirement death Benefits are payable upon the death of (a) a nonretired participant who has completed 5 years of Vesting Service or (b) a terminated vested participant, prior to the commencement of benefits.

A benefit is payable to a beneficiary, equal to what would have been payable had the participant retired (or, in the case of a vested terminated participant, had he elected to have his benefit commence) immediately prior to death (or, if later, age 55 for surviving spouse beneficiaries) with a 50% Joint and Survivor option in effect.

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Other Plan Provisions

Forms of payment

An employee may elect to receive his benefit on a straight-life or a reduced Joint and Survivor basis. Unless otherwise elected, any benefit payable under the Plan shall be paid:

- on an actuarially reduced 50% or 75% Joint and Survivor basis, or
- on a straight life basis otherwise.
- for non-union employees terminating after July 1, 2012, a lump sum option is available for six months after termination. The lump sum uses IRC Section 417(e) compliant rates and mortality with an August lookback month and annual stability period.
- If the participant elects and the spouse consents, benefits are paid in another actuarially equivalent optional form offered by the plan. Actuarial Equivalence is based on:
 - Participants under 55 – 417(e)
 - Participants 55 and over – 6%, Revenue Ruling 2001-62

Pension Increases

None

Plan participants' contributions

None

Limits on benefits and pay

All benefits and pay for any calendar year may not exceed the maximum limitations for that year as defined in the Internal Revenue Code. The plan provides for increasing the dollar limits automatically as such changes become effective. Increases in the dollar limits are assumed for determining pension cost.

Future Plan Changes

No future plan changes were recognized in determining minimum and maximum contributions.

Changes in Benefits Valued Since Prior Year

An annuity purchase and lump sum window were amended into the Plan during 2016. This valuation reflects the effects of those changes including a reduction in participants, their liabilities and plan assets.

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 24 Change in Actuarial Assumptions

Salary Scale and Statutory Limits on Compensation were changed from 3.00% in the prior year to 2.25%.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 22
Description of Weighted Average Retirement Age
as of January 1, 2017

See Appendix A for retirement rates. The average retirement age for Line 22 was calculated by creating a hypothetical life table with retirement as the only decrement, and then computing the average retirement age for the table.

Age of Retirement	Rates of Retirement	% Retiring	Weighted Ages
(A)	(B)	(C)	(A)*(C)
55	2.00%	2.00%	1.1000
56	2.00%	1.96%	1.0976
57	2.00%	1.92%	1.0949
58	2.00%	1.88%	1.0918
59	5.00%	4.61%	2.7210
60	5.00%	4.38%	2.6287
61	5.00%	4.16%	2.5389
62	20.00%	15.82%	9.8061
63	10.00%	6.33%	3.9857
64	10.00%	5.69%	3.6441
65	100.00%	51.24%	33.3091
Retirement Age			63

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	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

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>SALEM COMMUNITY HOSPITAL RETIREMENT PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>SALEM COMMUNITY HOSPITAL</u>	D Employer Identification Number (EIN) <u>34-1041385</u>
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☐ 100 or fewer ☐ 101-500 ☒ More than 500

Part I Basic Information

1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2017</u>			
2 Assets:			
a Market value	2a	<u>42900501</u>	
b Actuarial value	2b	<u>42900501</u>	
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	<u>55</u>	<u>10058396</u>	<u>10058396</u>
b For terminated vested participants	<u>85</u>	<u>3004418</u>	<u>3004418</u>
c For active participants	<u>604</u>	<u>31472090</u>	<u>31678910</u>
d Total	<u>744</u>	<u>44534904</u>	<u>44741724</u>
4 If the plan is in at-risk status, check the box and complete lines (a) and (b) ☐			
a Funding target disregarding prescribed at-risk assumptions	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor	4b		
5 Effective interest rate	5	<u>6.03 %</u>	
6 Target normal cost	6	<u>2065240</u>	

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	<u>CG</u>	<u>10/1/18</u>
	Signature of actuary	Date
<u>CHAD M GREENWALT</u>	Type or print name of actuary	<u>17-07020</u>
<u>TOWERS WATSON DELAWARE INC.</u>	Firm name	Most recent enrollment number
<u>1001 LAKESIDE AVENUE, SUITE 1500</u> <u>CLEVELAND, OH 44114-1172</u>	Address of the firm	<u>216-937-4000</u>
		Telephone number (including area code)

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

Schedule SB (Form 5500) 2017
v. 170203

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	4106330	5796184
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9	Amount remaining (line 7 minus line 8)	4106330	5796184
10	Interest on line 9 using prior year's actual return of <u>10.80</u> %	443484	625988
11	Prior year's excess contributions to be added to prefunding balance:		
	a Present value of excess contributions (line 38a from prior year)		414129
	b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.15</u> %		25469
	b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
	c Total available at beginning of current plan year to add to prefunding balance		439598
	d Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections	3864865	0
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	684949	6422172

Part III Funding Percentages			
14	Funding target attainment percentage	14	80.00%
15	Adjusted funding target attainment percentage	15	85.73%
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	94.79%
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.	17	%

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
10/16/2017	374998	0	04/10/2018	250000	0
11/07/2017	250000	0	05/09/2018	250000	0
12/12/2017	250000	0	06/05/2018	250000	0
01/09/2018	250000	0	07/10/2018	291667	0
02/06/2018	250000	0	08/07/2018	291667	0
03/06/2018	250000	0	08/30/2018	291667	0
Totals ▶			18(b)	3249999	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	3025427

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☒ Yes ☐ No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
0	0	0	0

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 4.16 %	2nd segment: 5.72 %	3rd segment: 6.48 %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 4
22 Weighted average retirement age				22 63
23 Mortality table(s) (see instructions) ☐ Prescribed - combined ☒ Prescribed - separate ☐ Substitute				

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	☒ Yes ☐ No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment	☐ Yes ☒ No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment	☒ Yes ☐ No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	2065240	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	8948344	1469425	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)	34	3534665	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement	684949	746783	1431732
36 Additional cash requirement (line 34 minus line 35)	36	2102933	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	3025427	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	922494	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	922494	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:			
a Schedule elected	☐ 2 plus 7 years ☐ 15 years		
b Eligible plan year(s) for which the election in line 41a was made	☐ 2008 ☐ 2009 ☐ 2010 ☐ 2011		
42 Amount of acceleration adjustment	42	0	
43 Excess installment acceleration amount to be carried over to future plan years	43	0	

SCHEDULE SB ATTACHMENTS

Schedule SB – Statement by Enrolled Actuary

Plan Sponsor	Salem Community Hospital
EIN/PN	34-1041385/001
Plan Name	Salem Community Hospital Retirement Plan
Valuation Date	January 1, 2017
Enrolled Actuary	Chad M. Greenwalt
Enrollment Number	17-07020

The actuarial assumptions that are not mandated by IRC § 430 and regulations, represent the enrolled actuary's best estimate of anticipated experience under the plan, subject to the following conditions:

The actuarial valuation, on which the information in this Schedule SB is based, has been prepared in reliance upon the employee and financial data furnished by the plan administrator and the trustee. The enrolled actuary has not made a rigorous check of the accuracy of this information but has accepted it after reviewing it and concluding it is reasonable in relation to similar information furnished in previous years. The amounts of contributions and dates paid shown in Item 18 of Schedule SB were listed in reliance on information provided by the plan administrator and/or trustee.

SCHEDULE SB ATTACHMENTS

Schedule SB, Part V Summary of Plan Provisions

Plan Provisions

September 1, 1970; Amended and Restated effective January 1, 2016.

Coverage and Participation	Each non-union employee of the Hospital becomes a participant on the first day of the month following attainment of age 21 and completion of one year of employment in which the employee worked at least 1,000 hours. Employees hired after January 1, 2014 are not eligible to become participants in the plan.
-----------------------------------	---

Definitions

Vesting service	One year is credited for each year of employment after age 18 in which the employee worked at least 1,000 hours.
Credited Service	One year is credited for each year of participation in the Plan in which the employee worked at least 1,000 hours. Credited Service for Union participants was frozen as of December 31, 2008.
Normal retirement date (NRD)	The later of the covered employee's attainment of age 65, or the fifth anniversary of the date the covered employee commenced participation in the plan.
Annual pension benefit	For each year of Credited Service, employees accrue an annual benefit equal to 1.0% of annual compensation earned during such year, plus 0.6% of annual compensation above \$4,800 earned during such year. Effective January 1, 2009, Nurses receive no future accruals under this formula. Annual compensation is generally defined as W-2 pay excluding imputed income and severance amounts.

Eligibility for Benefits

Normal retirement	Retirement on NRD
Early retirement	Retirement before NRD and on or after attaining age 55
Postponed retirement	Retirement after NRD

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Deferred vested termination

Termination for reasons other than death or retirement after completing five years of vesting service

Preretirement death benefit

Death while eligible for normal, early, postponed, or deferred vested retirement benefits

Benefits Paid Upon the Following Events

Normal retirement

The pension benefit determined as of NRD

Early retirement

The monthly pension benefit determined as of the early retirement date, with reductions for commencement prior to age 65 as shown in the table excerpt below.

Retirement Age	Early Retirement Factor	
	Union	Non Union
62	.744	.790
60	.619	.650
55	.402	.450

Postponed retirement

The monthly pension benefit determined as of the actual retirement date, recognizing pay and service after normal retirement age.

Deferred vested termination

The accrued monthly pension commencing at age 65 or commencing as early as age 55 on an actuarially reduced basis. Participants may also elect a lump sum payment if made within 180 days of termination.

Preretirement death

Benefits are payable upon the death of (a) a nonretired participant who has completed 5 years of Vesting Service or (b) a terminated vested participant, prior to the commencement of benefits.

A benefit is payable to a beneficiary, equal to what would have been payable had the participant retired (or, in the case of a vested terminated participant, had he elected to have his benefit commence) immediately prior to death (or, if later, age 55 for surviving spouse beneficiaries) with a 50% Joint and Survivor option in effect.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Other Plan Provisions

Forms of payment

An employee may elect to receive his benefit on a straight-life or a reduced Joint and Survivor basis. Unless otherwise elected, any benefit payable under the Plan shall be paid:

- on an actuarially reduced 50% or 75% Joint and Survivor basis, or
- on a straight life basis otherwise.
- for non-union employees terminating after July 1, 2012, a lump sum option is available for six months after termination. The lump sum uses IRC Section 417(e) compliant rates and mortality with an August lookback month and annual stability period.
- If the participant elects and the spouse consents, benefits are paid in another actuarially equivalent optional form offered by the plan. Actuarial Equivalence is based on:
 - Participants under 55 – 417(e)
 - Participants 55 and over – 6%, Revenue Ruling 2001-62

Pension Increases

None

Plan participants' contributions

None

Limits on benefits and pay

All benefits and pay for any calendar year may not exceed the maximum limitations for that year as defined in the Internal Revenue Code. The plan provides for increasing the dollar limits automatically as such changes become effective. Increases in the dollar limits are assumed for determining pension cost.

Future Plan Changes

No future plan changes were recognized in determining minimum and maximum contributions.

Changes in Benefits Valued Since Prior Year

An annuity purchase and lump sum window were amended into the Plan during 2016. This valuation reflects the effects of those changes including a reduction in participants, their liabilities and plan assets.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Part V Statement of Actuarial Assumptions/Methods

Economic Assumptions

Interest rate basis:

■ Applicable month	September
■ Interest rate basis	3-Segment Rates

Interest rates:

	Reflecting Corridors	Not Reflecting Corridors
■ First segment rate	4.16%	1.52%
■ Second segment rate	5.72%	3.80%
■ Third segment rate	6.48%	4.79%
■ Effective interest rate	6.03%	4.27%

Annual rates of increase

■ Compensation	2.25%
■ Future Social Security wage bases	Not applicable
■ Statutory limits on compensation	2.25%

Plan-related expenses

The amount included this year for plan-related expenses is \$612,860.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Demographic Assumptions

Inclusion date The valuation date coincident with or next following the date on which the employee becomes a participant.

New or rehired employees It was assumed there will be no new or rehired employees.

Mortality

■ **Funding** The prescribed mortality assumption under Section 430(h)(3)(A) of the Internal Revenue Code using static tables with separate mortality rates for annuitants and non-annuitants.

Termination The rates at which participants are assumed to leave the Hospital by age and union status are shown below:

Representative Termination Rates (per 100 employees)

Percentage assumed to leave during the year		
Attained Age	Non-Union Employees	Union Employees
20	18.6	14.0
25	13.6	10.2
30	10.1	7.6
35	7.9	5.9
40	6.5	4.9
45	5.5	4.1
50	4.5	3.4
55 and over	-	-

Disability None

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Retirement

The following rates have been utilized as the assumed incidence of retirement.

Attained Age	Rate
55	2%
56	2
57	2
58	2
59	5
60	5
61	5
62	20
63	10
64	10
65 and older	100%

Benefit commencement date:

- Preretirement death benefit The later of the death of the active participant or the date the participant would have attained age 65
- Deferred vested benefit The later of age 65 or termination of employment
- Retirement benefit Upon termination of employment

Form of payment

Union employees and former employees are assumed to elect the straight life form. 80% of non-union employees are assumed to elect a lump sum distribution at termination; the remaining 20% are assumed to elect the straight life annuity. The lump sum is assumed to be valued using the discount rate and unisex mortality under current regulations for 2017 distributions.

Percent married

For purposes of valuing the preretirement death benefit, 100% of eligible participants are assumed to have a beneficiary.

Spouse age

Male spouses are assumed to be 3 years older than female spouses.

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Plan Compensation/Salary

Non-Union Employees

Compensation assumed paid in the valuation year is the hourly rate of pay at the census date times the expected number of hours to be worked in the valuation year. Compensation prior to the census date is the actual paid amount.

Union Employees

Accruals are frozen as of December 31, 2008; therefore, no plan compensation is applicable after that date.

Methods

Valuation date	First day of plan year
Funding target	Present value of accrued benefits as required by regulations under IRC §430.
Target normal cost	Present value of benefits expected to accrue during the plan year plus plan-related expenses expected to be paid from plan assets during the plan year as required by regulations under IRC §430.
Actuarial value of assets	The actuarial value of assets is equal to the market value of assets as of the valuation date plus the discounted present value of contributions made after the valuation date for the prior plan year, discounted using the effective interest rate for the prior plan year.
Benefits not valued	None

Sources of Data and Other Information

The plan sponsor furnished participant data as of 1/1/2017. Information on assets, contributions and plan provisions was supplied by the plan sponsor. Data and other information were reviewed for reasonableness and consistency, but no audit was performed.

We are not aware of any errors or omissions in the data that would have a significant effect on the results of our calculations.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Assumptions Rationale - Significant Economic Assumptions

Discount rate	The basis chosen was selected by the plan sponsor from among choices prescribed by law, all of which are based on observed market data over certain periods of time.
Lump sum conversion rate	As required by IRC 430, lump sum benefits are valued using "annuity substitution", so that the interest rates assumed are effectively the same as described above for the discount rate.
Rates of increase in:	
■ Compensation	Assumed compensation increases are based on plan sponsor expectations for near-term years and the effect that the assumed long-term CPI and NAW will have on compensation increases over the longer term. The resulting salary increase assumption is 2.25%, which is a composite rate that reflects both current conditions and future expectations.

Assumptions Rationale - Significant Demographic Assumptions

Healthy Mortality	Assumptions used for funding purposes are as prescribed by IRC §430(h).
Termination	Termination rates were based on a published table for pension participants believed to have similar characteristics to the plan population. Assumed termination rates differ by union status because of expected differences in union statuses.
Retirement	Retirement rates are based on plan sponsor expectations for the future with periodic monitoring of observed gains and losses caused by retirement patterns different than assumed.
Form of payment	The percentage of retiring and terminating participants assumed to take lump sums is based on expected experience.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Percent married

Because the plan allows for non-spouse beneficiaries, 100% is assumed.

Source of Prescribed Methods

Funding methods

The methods used for funding purposes as described in Appendix A, including the method of determining plan assets, are "prescribed methods set by law", as defined in the actuarial standards of practice (ASOPs). These methods are required by IRC §430, or were selected by the plan sponsor from a range of methods permitted by IRC §430.

Changes in Assumptions and Methods

Change in assumptions since prior valuation

- The segment interest rates used to calculate the funding target and target normal cost were updated to the current valuation date as required by IRC 430.
- The mortality table used to calculate the funding target and target normal cost was updated to include one additional year of projected mortality improvement, as required by IRC 430.
- Salary Scale and Statutory Limits on Compensation were changed from 3.00% in the prior year to 2.25%.

Change in methods since prior valuation

None

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 22
Description of Weighted Average Retirement Age
as of January 1, 2017

See Appendix A for retirement rates. The average retirement age for Line 22 was calculated by creating a hypothetical life table with retirement as the only decrement, and then computing the average retirement age for the table.

Age of Retirement	Rates of Retirement	% Retiring	Weighted Ages
(A)	(B)	(C)	(A)*(C)
55	2.00%	2.00%	1.1000
56	2.00%	1.96%	1.0976
57	2.00%	1.92%	1.0949
58	2.00%	1.88%	1.0918
59	5.00%	4.61%	2.7210
60	5.00%	4.38%	2.6287
61	5.00%	4.16%	2.5389
62	20.00%	15.82%	9.8061
63	10.00%	6.33%	3.9857
64	10.00%	5.69%	3.6441
65	100.00%	51.24%	33.3091

Retirement Age

63

Plan Name: Salem Community Hospital Retirement Plan
EIN / PN: 34-1041385/001
Plan Sponsor: Salem Community Hospital
Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 24 Change in Actuarial Assumptions

Salary Scale and Statutory Limits on Compensation were changed from 3.00% in the prior year to 2.25%.

Plan Name:	Salem Community Hospital Retirement Plan
EIN / PN:	34-1041385/001
Plan Sponsor:	Salem Community Hospital
Valuation Date	January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 26 Schedule of Active Participant Data as of January 1, 2017

Attained Age	Years of Credited Service															
	Under 1		1 to 4		5 to 9		10 to 14		15 to 19		20 to 24		25 to 29		30 to 34	
	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.
Under 25	0		7		0		0		0		0		0		0	
25 - 29	0		20		11		0		0		0		0		0	
30 - 34	0		13		17		8		0		0		0		0	
35 - 39	0		11		9		23		3		0		0		0	
40 - 44	0		7		11		16		25		4		0		0	
45 - 49	0		10		18		15		20		17		6		0	
50 - 54	0		9		13		24		21		14		17		1	
55 - 59	0		6		18		24		12		13		12		24	
60 - 64	0		7		9		19		13		0		13		10	
65 - 69	0		1		1		2		2		0		1		1	
70 & Over	0		1		1		0		0		0		0		0	

Plan Name: Salem Community Hospital Retirement Plan
 EIN / PN: 34-1041385/001
 Plan Sponsor: Salem Community Hospital
 Valuation Date: January 1, 2017

SCHEDULE SB ATTACHMENTS

Schedule SB, Line 32
Schedule of Amortization Bases
as of January 1, 2017

Type of Base	Date Established	Initial Amount	Remaining Amortization Period (Years)	Outstanding Balance	Amortization Payment
1 Shortfall	01/01/2017	8,948,344	7	8,948,344	1,469,425
Total				8,948,344	1,469,425

Plan Name:
EIN / PN:
Plan Sponsor:
Valuation Date

Salem Community Hospital Retirement Plan
34-1041385/001
Salem Community Hospital
January 1, 2017

SCHEDULE H, PART IV, ITEM 4i - SCHEDULE OF ASSETS
HELD FOR INVESTMENT PURPOSES

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

EIN: 34-1041385
PLAN NUMBER: 001

December 31, 2017

(a)	(b) IDENTITY OF ISSUE, BORROWER OR SIMILAR PARTY	(c) DESCRIPTION OF INVESTMENT INCLUDING MATURITY DATE, RATE OF INTEREST, PAR OR MATURITY VALUE, NUMBER OF SHARES	(d) COST	(e) CURRENT VALUE
Corporate Bonds:				
	Advance Auto Parts Inc	\$250,000, 4.500% due 01/15/2022	\$ 248,125	\$ 261,988
	Briggs & Stratton Corp	\$150,000, 6.875% due 12/15/2020	153,938	164,625
	Total Corporate Bonds		<u>\$ 402,063</u>	<u>\$ 426,613</u>
Mutual Funds:				
Bond:				
	American inflation Linked Bond Fund	314,612 units	\$ 2,990,191	\$ 3,045,448
	Intermediate Bond Fund America A	79,835 units	1,067,206	1,063,403
	iShares Lehman TIPS Bond	5,000 shares	565,371	570,400
	Loomis Sayles Strategic Alpha Fund A	172,646 units	1,787,795	1,710,923
	Loomis Sayles Strategic Income Fund A	188,754 units	2,698,786	2,744,484
	Lord Abbett Bond Debenture Fund A	222,195 units	1,786,298	1,833,105
	Lord Abbett Short Duration Income Fund A	300,058 units	1,315,641	1,275,248
	Short Term Bond Fund of America A	181,868 units	1,830,820	1,800,497
	Total Mutual Funds - Bond		<u>\$ 14,042,108</u>	<u>\$ 14,043,508</u>
Stock:				
	Catalyst Dynamic Alpha fund A	29,172 units	500,000	640,898
	Columbia Seligman Comm & Info Fund A	22,322 units	906,443	1,579,930
	Eaton Vance Atlanta Capital SMID Cap Fd A	44,219 units	627,571	1,348,692
	Emerald Banking & Finance Fund A	31,383 units	662,973	1,425,103
	Emerald Growth Fund	25,951 units	499,038	686,404
	Fundamental Investors A	35,229 units	1,352,303	2,191,588
	Gateway Trust Index Plus Fund A	32,721 units	848,231	1,095,187
	Linde Hansen Contrarion Value FD CL A	131,709 units	1,337,832	1,812,312
	Lord Abbott Value Opportunities Fund A	61,477 units	788,428	1,235,068
	Natixis Oakmark International Fund A	94,456 units	1,054,939	1,471,631
	Natixis Oakmark Fund A	25,630 units	516,573	633,565
	New Perspective Fund A	35,463 units	815,358	1,530,583
	New World Fund A	32,256 units	1,040,046	2,158,564
	Thornburg Invt Income Builder Fund A	130,358 units	2,116,437	2,860,049
	Total Mutual Funds - Stock		<u>\$ 13,066,172</u>	<u>\$ 20,669,574</u>

SCHEDULE H, PART IV, ITEM 4i - SCHEDULE OF ASSETS
HELD FOR INVESTMENT PURPOSES (CONTINUED)

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

EIN: 34-1041385
PLAN NUMBER: 001

December 31, 2017

(a)	(b) IDENTITY OF ISSUE, BORROWER OR SIMILAR PARTY	(c) DESCRIPTION OF INVESTMENT INCLUDING MATURITY DATE, RATE OF INTEREST, PAR OR MATURITY VALUE, NUMBER OF SHARES	(d) COST	(e) CURRENT VALUE
	Common Stocks:			
	Alleghany corp	400 shares	\$ 177,892	\$ 238,436
	Apple Inc	2,500 shares	43,864	423,075
	Chevron Corp.	4,000 shares	165,402	500,760
	Cognizant	3,000 shares	153,757	213,060
	Consumers Bancorp	30,000 shares	472,200	645,000
	Eaton Vance Corp	10,000 shares	25,840	563,900
	Franco Nevada corp.	4,000 shares	228,314	319,800
	Hain Celestial Group	4,000 shares	159,412	169,560
	JM Smucker	2,500 shares	305,146	310,600
	Marathon Petroleum Corp	8,000 shares	71,166	527,840
	National Fuel Gas Corp.	4,000 shares	71,944	219,640
	Northwest Natural Gas	4,000 shares	141,460	238,600
	Suntrust Banks	8,000 shares	202,102	516,720
	Thermo Fisher Scientific Inc	2,000 shares	90,663	379,760
	TJX Companies Inc	5,000 shares	261,944	382,300
	United Parcel Service	1,600 shares	182,864	190,640
	United Technologies Corp	2,000 shares	215,338	255,140
	Vodafone	10,000 shares	371,435	319,000
	Welltower. Inc	4,000 shares	254,177	255,080
	Weyerhaeuser Co	10,000 shares	310,985	352,600
	Wiley John&Sons Inc	10,000 shares	389,275	657,500
	W.P.Carey Inc	3,000 shares	190,112	206,700
	Total Common Stocks		<u>4,485,292</u>	<u>7,885,711</u>
	Total Investments		<u>\$ 31,995,635</u>	<u>\$ 43,025,406</u>

* Denotes party-in-interest; there are no parties-in-interest

SCHEDULE H, PART IV, ITEM 4j - SCHEDULE OF
REPORTABLE TRANSACTIONS

**THE SALEM COMMUNITY HOSPITAL
RETIREMENT PLAN**

EIN: 34-1041385
PLAN NUMBER: 001

December 31, 2017

(a)	(b) DESCRIPTION OF ASSET	(c) PURCHASES	(d) SALE PROCEEDS	(g) COST OF ASSETS SOLD	(i) NET GAIN/(LOSS)
	Federal Prime Obligations Fund #117	\$ 2,477,127	\$ 1,865,697	\$ 1,865,697	\$ 0
	Federal Government Obligations Fund #5	3,664,077	4,137,641	4,137,641	0

Columns not included are not applicable.

* Denotes party-in-interest; there are no parties-in-interest