

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 2019 This Form is Open to Public Inspection
---	---	--

Part I	Annual Report Identification Information
For calendar plan year 2019 or fiscal plan year beginning <u>01/01/2019</u> and ending <u>12/31/2019</u>	
A This return/report is for:	☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B This return/report is:	☐ the first return/report ☐ the final return/report ☒ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN & TRUST</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>05/01/2016</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>05/01/2016</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>05/01/2016</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>FRATERNAL HEALTH CARE LLC</u> <u>1601 WEST 117TH ST</u> <u>CLEVELAND, OH 44102</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>75-3230424</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>216-251-2559</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>541990</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>75-3230424</u>	2c Plan Sponsor's telephone number <u>216-251-2559</u>	2d Business code (see instructions) <u>541990</u>	
2b Employer Identification Number (EIN) <u>75-3230424</u>					
2c Plan Sponsor's telephone number <u>216-251-2559</u>					
2d Business code (see instructions) <u>541990</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.	08/04/2020	MERCEDES PEREZ
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2019)
v. 190130

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	5 139
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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6a(1) 132 6a(2) 123 6b 0 6c 12 6d 135 6e 0 6f 135 6g 43 6h 0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2E 2F 2G 2J 2K 2T 3D b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	

9a Plan funding arrangement (check all that apply) (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)** ☐ 0 **A** (Insurance Information)
- (4)** ☒ **C** (Service Provider Information)
- (5)** ☐ **D** (DFE/Participating Plan Information)
- (6)** ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2019 Form M-1 annual report. If the plan was not required to file the 2019 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 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
		2019
		This Form is Open to Public Inspection.

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019		
A Name of plan FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN & TRUST	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 FRATERNAL HEALTH CARE LLC	D Employer Identification Number (EIN) 75-3230424	

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	
PAYCHEX SECURITIES CORPORATION	225 KENNETH DRIVE ROCHESTER, NY 14623
16-1486352	

(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)

PAYCHEX, INC.

911 PANORAMA TRAIL S
ROCHESTER, NY 14625

16-1124166

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	RECORDKEEPER	6236	Yes ☐ No ☒	Yes ☐ No ☒		Yes ☐ No ☒

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

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

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE 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 2019 This Form is Open to Public Inspection
For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019		
A Name of plan FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN & TRUST	B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 FRATERNAL HEALTH CARE LLC	D Employer Identification Number (EIN) 75-3230424	

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	0	
b	Receivables (less allowance for doubtful accounts):			
	(1) Employer contributions.....	1b(1)	0	0
	(2) Participant contributions.....	1b(2)	0	0
	(3) Other.....	1b(3)	0	0
c	General investments:			
	(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	8593	0
	(2) U.S. Government securities	1c(2)	0	
	(3) Corporate debt instruments (other than employer securities):			
	(A) Preferred	1c(3)(A)	0	
	(B) All other.....	1c(3)(B)	0	
	(4) Corporate stocks (other than employer securities):			
	(A) Preferred	1c(4)(A)	0	
	(B) Common.....	1c(4)(B)	0	
	(5) Partnership/joint venture interests	1c(5)	0	
	(6) Real estate (other than employer real property).....	1c(6)	0	
	(7) Loans (other than to participants)	1c(7)	0	
	(8) Participant loans.....	1c(8)	189	0
	(9) Value of interest in common/collective trusts	1c(9)	0	0
	(10) Value of interest in pooled separate accounts	1c(10)	0	0
	(11) Value of interest in master trust investment accounts	1c(11)	0	0
	(12) Value of interest in 103-12 investment entities.....	1c(12)	0	0
	(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	76650	9717
	(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
	(15) Other.....	1c(15)	0	0

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities	1d(1) 0	
(2)	Employer real property	1d(2) 0	
e	Buildings and other property used in plan operation	1e 0	
f	Total assets (add all amounts in lines 1a through 1e)	1f 85432	9717
Liabilities			
g	Benefit claims payable	1g 0	
h	Operating payables	1h 0	
i	Acquisition indebtedness	1i 0	
j	Other liabilities	1j 0	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k 0	0
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l 85432	9717

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) 9510	
	(B) Participants	2a(1)(B) 45303	
	(C) Others (including rollovers)	2a(1)(C) 0	
(2)	Noncash contributions	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)	54813
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A) 158	
	(B) U.S. Government securities	2b(1)(B)	
	(C) Corporate debt instruments	2b(1)(C)	
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E) 67	
	(F) Other	2b(1)(F)	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)	225
(2)	Dividends: (A) Preferred stock	2b(2)(A)	
	(B) Common stock	2b(2)(B)	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C) 2985	
	(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)	2985
(3)	Rents	2b(3)	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	0
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		0
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		13991
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		72014

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	138946	
(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)		138946
f Corrective distributions (see instructions)	2f		1416
g Certain deemed distributions of participant loans (see instructions)	2g		0
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	6770	
(3) Investment advisory and management fees	2i(3)	597	
(4) Other	2i(4)	0	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		7367
j Total expenses. Add all expense amounts in column (b) and enter total	2j		147729

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-75715
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) ☐ Unmodified (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: **TRAMER,SHORE&ZWICK,CPAS**

(2) EIN: **34-1736265**

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

	Yes	No	Amount
4a		X	
4b		X	

	Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
4d		X	
e Was this plan covered by a fidelity bond?	X		20000
4e	X		20000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)		X	
4j		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
4k		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	
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 2019 This Form is Open to Public Inspection.
---	---	--

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan <u>FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN & TRUST</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>FRATERNAL HEALTH CARE LLC</u>	D Employer Identification Number (EIN) <u>75-3230424</u>

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

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions	1	
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>16-1470238</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	

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

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

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

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

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

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

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

Schedule R (Form 5500) 2019
v. 190130

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

b The plan year immediately preceding the current plan year

c The second preceding plan year

14a**14b****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

b The corresponding number for the second preceding plan year

15a**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

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

16a**16b**

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

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

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

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

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

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

- b** Provide the average duration of the combined investment-grade and high-yield debt:

☐ 0-3 years ☐ 3-6 years ☐ 6-9 years ☐ 9-12 years ☐ 12-15 years ☐ 15-18 years ☐ 18-21 years ☐ 21 years or more

- c** What duration measure was used to calculate line 19(b)?

☐ Effective duration ☐ Macaulay duration ☐ Modified duration ☐ Other (specify): _____

- 20 PBGC missed contribution reporting requirements.** If this is a multiemployer plan or a single-employer plan that is not covered by PBGC, skip line 20.

- a** Is the amount of unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 greater than zero? ☐ Yes ☐ No

- b** If line 20a is "Yes," has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

☐ Yes.

☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.

☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.

☐ No. Other. Provide explanation _____

FRATERNAL HEALTH CARE LLC 401(K) PLAN
FINANCIAL STATEMENTS
YEARS ENDED DECEMBER 31, 2019 AND 2018

Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2019 and 2018

Financial Statements:

Independent Auditors' Report.....	1
Statement of Net Assets Available for Benefits.....	3
Statement of Changes in Net Assets Available for Benefits.....	4
Notes to the Financial Statements.....	5

Supplemental Schedules:

Schedule of Assets (Held at End of Year)	10
--	----

INDEPENDENT AUDITORS' REPORT

To The Administrative Committee of
Fraternal Health Care LLC 401(k) Plan

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Fraternal Health Care LLC 401(k) Plan, which comprise the statements of net assets available for benefits as of December 31, 2019 and 2018, 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.

Auditors' 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 3, which was certified by Mid Atlantic 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, 2019 and 2018, 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.

Other Matter

The supplemental Schedule H, Line 4i - Schedule of Assets Held for Investment at End of Year as of December 31, 2019, are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

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

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



Cleveland, Ohio
July 30, 2020

FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2019 and 2018

	<u>2019</u>	<u>2018</u>
ASSETS		
Investments:		
Investments, at Fair Value	\$ 9,722	\$ 85,243
Receivables:		
Notes Receivable - Participant Loans	<u>-</u>	<u>189</u>
Total Receivables	<u>-</u>	<u>189</u>
TOTAL ASSETS	<u>9,722</u>	<u>85,432</u>
LIABILITIES	<u>-</u>	<u>-</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 9,722</u></u>	<u><u>\$ 85,432</u></u>

FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years Ended December 31, 2019 and 2018

	<u>2019</u>	<u>2018</u>
ADDITIONS		
Additions to Net Assets Attributed to:		
Investment Income:		
Interest	\$ 158	\$ 10
Dividends	2,985	4,037
Net (Depreciation) Appreciation in Fair Value of Mutual Fund Investments	<u>13,991</u>	<u>(8,829)</u>
	17,134	(4,782)
Interest Income on Notes Receivable from Participants	67	22
Contributions:		
Participants	45,303	30,708
Employer	<u>9,510</u>	<u>6,271</u>
	54,813	36,979
 TOTAL ADDITIONS	 72,014	 32,219
DEDUCTIONS		
Benefits Paid to Participants	140,362	9,963
Administrative Expenses	<u>7,362</u>	<u>1,218</u>
 TOTAL DEDUCTIONS	 <u>147,724</u>	 <u>11,181</u>
 NET (DECREASE) INCREASE	 (75,710)	 21,038
NET ASSETS AVAILABLE FOR PLAN BENEFITS		
Beginning of Year	<u>85,432</u>	<u>64,394</u>
End of Year	<u><u>\$ 9,722</u></u>	<u><u>\$ 85,432</u></u>

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2019 and 2018**

NOTE 1 - DESCRIPTION OF PLAN

The following description of the Fraternal Health Care LLC 401(k) Plan ("the Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General: The Plan is a defined contribution plan covering all full-time employees of Fraternal Health Care LLC (referred to as "the Company"), who have twelve months of service and are age twenty-one or older. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions: Each year, participants may contribute a percentage of pretax annual compensation, not to exceed the limits of Internal Revenue Code Sections 401(k), 402, 404, and 415. Participants who have attained age fifty (50) before the end of the plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Plan currently offers various mutual funds as options.

The Company contributes a matching contribution equal to 25% of eligible employees' elective deferral, not to exceed 4% of the compensation earned, determined based on each payroll period. All contributions to the Plan are made in the form of cash contributions.

Participant Accounts: Each participant's account is credited with the participant's contributions and allocations of (a) the Company's contributions and (b) Plan earnings (losses), and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting: Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in the Company's contribution portion of their accounts is based on years of continuous service. A participant is 20% vested in the Plan after two years of service. For each year of service thereafter, the vesting percentage increases by 20% until the participant is 100% vested after completing 6 years of credited service.

Notes Receivable from Participants: Participants may borrow from their fund accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their vested account balance. The loans are secured by the balances in the participants' account and bear interest at prime plus 1%. Principal and interest is paid through payroll deductions. During the years ended December 31, 2019 and 2018, interest income of \$67 and \$22 was received on participant loans.

Payment of Benefits: Upon termination of service due to death, disability, or retirement, a participant will generally receive a lump-sum amount equal to the value of the participant's vested interest in his or her account. Upon termination of service, other than due to death, disability, or retirement, a participant with an account balance under \$1,000 will automatically receive a payout equal to the value of the participant's vested interest.

Forfeited Accounts: At December 31, 2019 and 2018, forfeited accounts totaled \$-0-. The forfeiture account will be used to reduce future employer contributions.

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017**

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Date of Management's Review: Subsequent events were evaluated through July 30, 2020, which is the date the financial statements were available to be issued.

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

Notes Receivable from Participants: Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Delinquent participant loans are reclassified as distributions based on the terms of the Plan document.

Investment Valuation and Income Recognition: The Plan 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 4 for discussion on 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.

Operating Expenses: Expenses, including the accounting fee for year-end bookkeeping, audit preparation and Form 5500 preparation are paid by the Company.

Use of Estimates: The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires the Plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

NOTE 3 - INFORMATION PREPARED AND CERTIFIED BY CUSTODIANS

Certain information related to investments and notes receivable from participants disclosed in the accompanying financial statements and supplemental schedule, including investments and notes receivable from participants held at December 31, 2019 and 2018, and net appreciation in fair value of investments, interest and dividends for the years ended December 31, 2019 and 2018, were obtained or derived from information supplied to the plan administrator and certified as complete and accurate by Mid Atlantic Trust Company (the trustee of the Plan).

NOTE 4 – FAIR VALUE MEASUREMENTS

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. 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.

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017**

NOTE 4 – FAIR VALUE MEASUREMENTS (continued)

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 are significant observables other than quoted prices in active markets, 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. There were no plan assets requiring the use of Level 2 or 3 inputs for the periods presented.

Level 1 Fair Value Measurements: The fair value of mutual funds is based on quoted net asset values of the shares held by the Plan at year-end. The mutual funds held by the Plan are open-end funds registered with the U.S. Securities and Exchange Commission. The funds must publish their daily net asset value and transact at that price. The mutual funds held by the Plan are considered to be actively traded.

The following tables set forth, by level within the fair value hierarchy, the Plan's investments at fair value as of December 31, 2019 and 2018:

	Fair Value	Fair Value Measurements at the End of the Reporting Period Using: Level 1
Mutual Funds:		
Large-Cap Funds	\$ 5,348	\$ 5,348
Mid-Cap Funds	2,215	2,215
Bond Funds	1,493	1,493
Small-Cap Funds	366	366
Target Date Funds	285	285
International Funds	15	15
Total investments at fair value-2019	<u>\$ 9,722</u>	<u>\$ 9,722</u>

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017**

NOTE 4 – FAIR VALUE MEASUREMENTS (continued)

	Fair Value	Fair Value Measurements at the End of the Reporting Period Using: Level 1
Mutual Funds:		
Large-Cap Funds	\$ 36,113	\$ 36,113
Bond Funds	22,031	22,031
Small-Cap Funds	13,708	13,708
Money Market	8,593	8,593
Mid-Cap Funds	3,333	3,333
Target Date Funds	1,141	1,141
International Funds	324	324
Total investments at fair value-2018	<u>\$ 85,243</u>	<u>\$ 85,243</u>

Gains and losses included in changes in net assets available for benefits for the years ended December 31, 2019 and 2018, are included in net appreciation/(depreciation) in fair value of investments. Net appreciation/(depreciation) is as follows:

Description	2019	2018
Registered Investment Companies	\$ 13,991	\$ (8,829)
Total	\$ 13,991	\$ (8,829)

NOTE 5 – 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 that such changes could materially affect participants' account balances and the amounts reported in the statements of net assets available for benefits.

The Plan's assets include investments in mutual funds, which are subject to potential volatility in the underlying investment markets. This volatility has the potential to have a severe impact on the values of such investments, and it is at least reasonably possible that this could occur in the near term.

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017**

NOTE 6 - PLAN TERMINATION

The Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. On December 10, 2019, a resolution by management was enacted to terminate the plan and participants became 100% vested in their accounts. Most participant accounts have been liquidated based on the participants personal election to treat the distribution by the end of 2019 with the remaining liquidated in 2020.

NOTE 7 – TAX STATUS

The Internal Revenue Service has ruled that the prototype plan, sponsored by Paychex Inc. and used as the basis for this Plan, is in compliance with applicable sections of the Internal Revenue Code. The Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Plan's financial statements. Due to the infancy of The Plan, The Plan is open to income tax examinations for the 2017-2019 plan years.

SUPPLEMENTAL SCHEDULES

FRATERNAL HEALTH CARE LLC 401(K) PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR) FORM 5500, SCHEDULE H, ITEM 4i

EIN: 75-3230424 PLAN: #001

December 31, 2019

(a)	(b) Identity of Issue, Borrower, or Similar Party	(c) Description of Investment Including Maturity Date, Reate of Interest, Collateral, Par, or	(d) Cost	(e) Current Value
Investments				
Registered Investment Companies				
	American Funds Mortgage Fund	Interest in registered investment company	**	115
	American Funds Washington Mutual Investors	Interest in registered investment company	**	4,317
	Franklin Small-Mid Cap Growth	Interest in registered investment company	**	4
	Fidelity Advisor Stock Select Mid Cap	Interest in registered investment company	**	2,211
	American Funds New World	Interest in registered investment company	**	8
	Voya Intermediate Bond Fund	Interest in registered investment company	**	1,378
	Columbia Large Cap Enhanced Core Fund	Interest in registered investment company	**	100
	MFS International New Discovery Fund	Interest in registered investment company	**	7
	MFS Lifetime 2030	Interest in registered investment company	**	285
	Nuveen Small Cap Value Fund	Interest in registered investment company	**	366
	JPMorgan Intrepid Growth Fund	Interest in registered investment company	**	931
	Total Registered Investment Companies			<u>9,722</u>
	TOTAL INVESTMENTS PER FINANCIAL STATEMENTS			9,722
*	Notes Receivable from Participants			<u>-</u>
	TOTAL INVESTMENTS PER 5500			<u><u>\$ 9,722</u></u>

* Denotes a party-in-interest to the Plan.

** Cost information not required for participant-directed investments.

FRATERNAL HEALTH CARE LLC 401(K) PLAN
FINANCIAL STATEMENTS
YEARS ENDED DECEMBER 31, 2019 AND 2018

Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2019 and 2018

Financial Statements:

Independent Auditors' Report.....	1
Statement of Net Assets Available for Benefits.....	3
Statement of Changes in Net Assets Available for Benefits.....	4
Notes to the Financial Statements.....	5

Supplemental Schedules:

Schedule of Assets (Held at End of Year)	10
--	----

INDEPENDENT AUDITORS' REPORT

To The Administrative Committee of
Fraternal Health Care LLC 401(k) Plan

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Fraternal Health Care LLC 401(k) Plan, which comprise the statements of net assets available for benefits as of December 31, 2019 and 2018, 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.

Auditors' 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 3, which was certified by Mid Atlantic 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, 2019 and 2018, 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.

Other Matter

The supplemental Schedule H, Line 4i - Schedule of Assets Held for Investment at End of Year as of December 31, 2019, are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

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

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



Cleveland, Ohio
July 30, 2020

FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2019 and 2018

	<u>2019</u>	<u>2018</u>
ASSETS		
Investments:		
Investments, at Fair Value	\$ 9,722	\$ 85,243
Receivables:		
Notes Receivable - Participant Loans	<u>-</u>	<u>189</u>
Total Receivables	<u>-</u>	<u>189</u>
TOTAL ASSETS	<u>9,722</u>	<u>85,432</u>
LIABILITIES	<u>-</u>	<u>-</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 9,722</u></u>	<u><u>\$ 85,432</u></u>

FRATERNAL HEALTH CARE LLC 401(K) PROFIT SHARING PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years Ended December 31, 2019 and 2018

	<u>2019</u>	<u>2018</u>
ADDITIONS		
Additions to Net Assets Attributed to:		
Investment Income:		
Interest	\$ 158	\$ 10
Dividends	2,985	4,037
Net (Depreciation) Appreciation in Fair Value of Mutual Fund Investments	<u>13,991</u>	<u>(8,829)</u>
	17,134	(4,782)
Interest Income on Notes Receivable from Participants	67	22
Contributions:		
Participants	45,303	30,708
Employer	<u>9,510</u>	<u>6,271</u>
	54,813	36,979
TOTAL ADDITIONS	72,014	32,219
DEDUCTIONS		
Benefits Paid to Participants	140,362	9,963
Administrative Expenses	<u>7,362</u>	<u>1,218</u>
TOTAL DEDUCTIONS	<u>147,724</u>	<u>11,181</u>
NET (DECREASE) INCREASE	(75,710)	21,038
NET ASSETS AVAILABLE FOR PLAN BENEFITS		
Beginning of Year	<u>85,432</u>	<u>64,394</u>
End of Year	<u><u>\$ 9,722</u></u>	<u><u>\$ 85,432</u></u>

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2019 and 2018**

NOTE 1 - DESCRIPTION OF PLAN

The following description of the Fraternal Health Care LLC 401(k) Plan ("the Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General: The Plan is a defined contribution plan covering all full-time employees of Fraternal Health Care LLC (referred to as "the Company"), who have twelve months of service and are age twenty-one or older. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions: Each year, participants may contribute a percentage of pretax annual compensation, not to exceed the limits of Internal Revenue Code Sections 401(k), 402, 404, and 415. Participants who have attained age fifty (50) before the end of the plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Plan currently offers various mutual funds as options.

The Company contributes a matching contribution equal to 25% of eligible employees' elective deferral, not to exceed 4% of the compensation earned, determined based on each payroll period. All contributions to the Plan are made in the form of cash contributions.

Participant Accounts: Each participant's account is credited with the participant's contributions and allocations of (a) the Company's contributions and (b) Plan earnings (losses), and charged with an allocation of administrative expenses. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting: Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in the Company's contribution portion of their accounts is based on years of continuous service. A participant is 20% vested in the Plan after two years of service. For each year of service thereafter, the vesting percentage increases by 20% until the participant is 100% vested after completing 6 years of credited service.

Notes Receivable from Participants: Participants may borrow from their fund accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their vested account balance. The loans are secured by the balances in the participants' account and bear interest at prime plus 1%. Principal and interest is paid through payroll deductions. During the years ended December 31, 2019 and 2018, interest income of \$67 and \$22 was received on participant loans.

Payment of Benefits: Upon termination of service due to death, disability, or retirement, a participant will generally receive a lump-sum amount equal to the value of the participant's vested interest in his or her account. Upon termination of service, other than due to death, disability, or retirement, a participant with an account balance under \$1,000 will automatically receive a payout equal to the value of the participant's vested interest.

Forfeited Accounts: At December 31, 2019 and 2018, forfeited accounts totaled \$-0-. The forfeiture account will be used to reduce future employer contributions.

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017**

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Date of Management's Review: Subsequent events were evaluated through July 30, 2020, which is the date the financial statements were available to be issued.

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

Notes Receivable from Participants: Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Delinquent participant loans are reclassified as distributions based on the terms of the Plan document.

Investment Valuation and Income Recognition: The Plan 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 4 for discussion on 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.

Operating Expenses: Expenses, including the accounting fee for year-end bookkeeping, audit preparation and Form 5500 preparation are paid by the Company.

Use of Estimates: The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires the Plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

NOTE 3 - INFORMATION PREPARED AND CERTIFIED BY CUSTODIANS

Certain information related to investments and notes receivable from participants disclosed in the accompanying financial statements and supplemental schedule, including investments and notes receivable from participants held at December 31, 2019 and 2018, and net appreciation in fair value of investments, interest and dividends for the years ended December 31, 2019 and 2018, were obtained or derived from information supplied to the plan administrator and certified as complete and accurate by Mid Atlantic Trust Company (the trustee of the Plan).

NOTE 4 – FAIR VALUE MEASUREMENTS

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. 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.

Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017

NOTE 4 – FAIR VALUE MEASUREMENTS (continued)

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 are significant observables other than quoted prices in active markets, 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. There were no plan assets requiring the use of Level 2 or 3 inputs for the periods presented.

Level 1 Fair Value Measurements: The fair value of mutual funds is based on quoted net asset values of the shares held by the Plan at year-end. The mutual funds held by the Plan are open-end funds registered with the U.S. Securities and Exchange Commission. The funds must publish their daily net asset value and transact at that price. The mutual funds held by the Plan are considered to be actively traded.

The following tables set forth, by level within the fair value hierarchy, the Plan's investments at fair value as of December 31, 2019 and 2018:

	Fair Value	Fair Value Measurements at the End of the Reporting Period Using: Level 1
Mutual Funds:		
Large-Cap Funds	\$ 5,348	\$ 5,348
Mid-Cap Funds	2,215	2,215
Bond Funds	1,493	1,493
Small-Cap Funds	366	366
Target Date Funds	285	285
International Funds	15	15
Total investments at fair value-2019	<u>\$ 9,722</u>	<u>\$ 9,722</u>

Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017

NOTE 4 – FAIR VALUE MEASUREMENTS (continued)

	Fair Value	Fair Value Measurements at the End of the Reporting Period Using: Level 1
Mutual Funds:		
Large-Cap Funds	\$ 36,113	\$ 36,113
Bond Funds	22,031	22,031
Small-Cap Funds	13,708	13,708
Money Market	8,593	8,593
Mid-Cap Funds	3,333	3,333
Target Date Funds	1,141	1,141
International Funds	324	324
Total investments at fair value-2018	<u>\$ 85,243</u>	<u>\$ 85,243</u>

Gains and losses included in changes in net assets available for benefits for the years ended December 31, 2019 and 2018, are included in net appreciation/(depreciation) in fair value of investments. Net appreciation/(depreciation) is as follows:

Description	2019	2018
Registered Investment Companies	\$ 13,991	\$ (8,829)
Total	\$ 13,991	\$ (8,829)

NOTE 5 – 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 that such changes could materially affect participants' account balances and the amounts reported in the statements of net assets available for benefits.

The Plan's assets include investments in mutual funds, which are subject to potential volatility in the underlying investment markets. This volatility has the potential to have a severe impact on the values of such investments, and it is at least reasonably possible that this could occur in the near term.

**Fraternal Health Care LLC 401(K) Plan
Financial Statements
Years Ended December 31, 2018 and 2017**

NOTE 6 - PLAN TERMINATION

The Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. On December 10, 2019, a resolution by management was enacted to terminate the plan and participants became 100% vested in their accounts. Most participant accounts have been liquidated based on the participants personal election to treat the distribution by the end of 2019 with the remaining liquidated in 2020.

NOTE 7 – TAX STATUS

The Internal Revenue Service has ruled that the prototype plan, sponsored by Paychex Inc. and used as the basis for this Plan, is in compliance with applicable sections of the Internal Revenue Code. The Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Plan's financial statements. Due to the infancy of The Plan, The Plan is open to income tax examinations for the 2017-2019 plan years.

SUPPLEMENTAL SCHEDULES

FRATERNAL HEALTH CARE LLC 401(K) PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR) FORM 5500, SCHEDULE H, ITEM 4i

EIN: 75-3230424 PLAN: #001

December 31, 2019

(a)	(b) Identity of Issue, Borrower, or Similar Party	(c) Description of Investment Including Maturity Date, Reate of Interest, Collateral, Par, or	(d) Cost	(e) Current Value
Investments				
Registered Investment Companies				
	American Funds Mortgage Fund	Interest in registered investment company	**	115
	American Funds Washington Mutual Investors	Interest in registered investment company	**	4,317
	Franklin Small-Mid Cap Growth	Interest in registered investment company	**	4
	Fidelity Advisor Stock Select Mid Cap	Interest in registered investment company	**	2,211
	American Funds New World	Interest in registered investment company	**	8
	Voya Intermediate Bond Fund	Interest in registered investment company	**	1,378
	Columbia Large Cap Enhanced Core Fund	Interest in registered investment company	**	100
	MFS International New Discovery Fund	Interest in registered investment company	**	7
	MFS Lifetime 2030	Interest in registered investment company	**	285
	Nuveen Small Cap Value Fund	Interest in registered investment company	**	366
	JPMorgan Intrepid Growth Fund	Interest in registered investment company	**	931
	Total Registered Investment Companies			<u>9,722</u>
	TOTAL INVESTMENTS PER FINANCIAL STATEMENTS			9,722
*	Notes Receivable from Participants			<u>-</u>
	TOTAL INVESTMENTS PER 5500			<u><u>\$ 9,722</u></u>

* Denotes a party-in-interest to the Plan.

** Cost information not required for participant-directed investments.