

|                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br>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).<br><br><p style="text-align: center;">▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p> | OMB Nos. 1210-0110<br>1210-0089<br><br><div style="text-align: center; font-size: 1.5em; font-weight: bold;">2019</div><br><br><b>This Form is Open to Public Inspection</b> |
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|                                                                                                          |                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part I</b>                                                                                            | <b>Annual Report Identification Information</b>                                                                                                                                                                                                                                                                                            |
| For calendar plan year 2019 or fiscal plan year beginning <u>01/01/2019</u> and ending <u>12/31/2019</u> |                                                                                                                                                                                                                                                                                                                                            |
| <b>A</b> This return/report is for:                                                                      | <input type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)<br><input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ |
| <b>B</b> This return/report is:                                                                          | <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report<br><input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)                                                                                                      |
| <b>C</b> If the plan is a collectively-bargained plan, check here. . . . .                               | <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |
| <b>D</b> Check box if filing under:                                                                      | <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program<br><input type="checkbox"/> special extension (enter description)                                                                                                                                     |

|                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------|--|
| <b>Part II</b>                                                                                                                                                                                                                                                                                                                                                                  | <b>Basic Plan Information</b> —enter all requested information                                                                                                                                                                                                                                                                              |                                                                     |                                                                  |                                                             |  |
| <b>1a</b> Name of plan<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>                                                                                                                                                                                                                                                                                         | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2"><b>1c</b> Effective date of plan<br/><u>07/01/1967</u></td> </tr> </table>                             | <b>1b</b> Three-digit plan number (PN) ▶                            | <u>001</u>                                                       | <b>1c</b> Effective date of plan<br><u>07/01/1967</u>       |  |
| <b>1b</b> Three-digit plan number (PN) ▶                                                                                                                                                                                                                                                                                                                                        | <u>001</u>                                                                                                                                                                                                                                                                                                                                  |                                                                     |                                                                  |                                                             |  |
| <b>1c</b> Effective date of plan<br><u>07/01/1967</u>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u><br><br><u>1341 CLARK STREET</u><br><u>CAMBRIDGE, OH 43725</u> | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><b>2b</b> Employer Identification Number (EIN)<br/><u>31-4391798</u></td> </tr> <tr> <td><b>2c</b> Plan Sponsor's telephone number<br/><u>740-439-8179</u></td> </tr> <tr> <td><b>2d</b> Business code (see instructions)<br/><u>622000</u></td> </tr> </table> | <b>2b</b> Employer Identification Number (EIN)<br><u>31-4391798</u> | <b>2c</b> Plan Sponsor's telephone number<br><u>740-439-8179</u> | <b>2d</b> Business code (see instructions)<br><u>622000</u> |  |
| <b>2b</b> Employer Identification Number (EIN)<br><u>31-4391798</u>                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
| <b>2c</b> Plan Sponsor's telephone number<br><u>740-439-8179</u>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                  |                                                             |  |
| <b>2d</b> Business code (see instructions)<br><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.

|                  |                                                   |            |                                                              |
|------------------|---------------------------------------------------|------------|--------------------------------------------------------------|
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 10/14/2020 | JONATHAN KELLY                                               |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. |            |                                                              |
|                  | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. |            |                                                              |
|                  | 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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>3b</b> Administrator's EIN<br><br><b>3c</b> Administrator's telephone number<br><br><div style="background-color: #cccccc; height: 40px; width: 100%;"></div> |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                                |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>5</b> 730                                                                                                                                                     |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><br><b>b</b> Retired or separated participants receiving benefits.....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><br><b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ..... | <b>6a(1)</b> 248<br><b>6a(2)</b> 202<br><b>6b</b> 376<br><b>6c</b> 106<br><b>6d</b> 684<br><b>6e</b> 26<br><b>6f</b> 710<br><b>6g</b><br><b>6h</b> 0             |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>7</b>                                                                                                                                                         |

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

1A 1I

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

|                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>9a</b> Plan funding arrangement (check all that apply)<br><b>(1)</b> <input type="checkbox"/> Insurance<br><b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br><b>(3)</b> <input checked="" type="checkbox"/> Trust<br><b>(4)</b> <input type="checkbox"/> General assets of the sponsor | <b>9b</b> Plan benefit arrangement (check all that apply)<br><b>(1)</b> <input type="checkbox"/> Insurance<br><b>(2)</b> <input type="checkbox"/> Code section 412(e)(3) insurance contracts<br><b>(3)</b> <input checked="" type="checkbox"/> Trust<br><b>(4)</b> <input type="checkbox"/> 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 \_\_\_\_\_

|                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                    |                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| <b>SCHEDULE SB</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Single-Employer Defined Benefit Plan</b><br><b>Actuarial Information</b><br><br>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).<br><br><b>► File as an attachment to Form 5500 or 5500-SF.</b> | <small>OMB No. 1210-0110</small><br><br><b>2019</b><br><br><b>This Form is Open to Public Inspection</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|

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

► **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.

|                                                                                                                                                         |                                                                    |            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|
| <b>A</b> Name of plan<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>                                                                  | <b>B</b> Three-digit plan number (PN) ►                            | <u>001</u> |
|                                                                                                                                                         |                                                                    |            |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u>                            | <b>D</b> Employer Identification Number (EIN)<br><u>31-4391798</u> |            |
|                                                                                                                                                         |                                                                    |            |
| <b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B               |                                                                    |            |
| <b>F</b> Prior year plan size: <input type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input checked="" type="checkbox"/> More than 500 |                                                                    |            |

|               |                                                                                                                                                                                                                |                            |                           |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|
| <b>Part I</b> | <b>Basic Information</b>                                                                                                                                                                                       |                            |                           |
| <b>1</b>      | Enter the valuation date:                      Month <u>01</u> Day <u>01</u> Year <u>2019</u>                                                                                                                  |                            |                           |
| <b>2</b>      | Assets:                                                                                                                                                                                                        |                            |                           |
|               | <b>a</b> Market value .....                                                                                                                                                                                    | <b>2a</b>                  | <u>48419054</u>           |
|               | <b>b</b> Actuarial value .....                                                                                                                                                                                 | <b>2b</b>                  | <u>50532086</u>           |
| <b>3</b>      | Funding target/participant count breakdown                                                                                                                                                                     | (1) Number of participants | (2) Vested Funding Target |
|               | <b>a</b> For retired participants and beneficiaries receiving payment.....                                                                                                                                     | <u>382</u>                 | <u>40720923</u>           |
|               | <b>b</b> For terminated vested participants.....                                                                                                                                                               | <u>100</u>                 | <u>3992263</u>            |
|               | <b>c</b> For active participants .....                                                                                                                                                                         | <u>248</u>                 | <u>13248550</u>           |
|               | <b>d</b> Total.....                                                                                                                                                                                            | <u>730</u>                 | <u>57961736</u>           |
| <b>4</b>      | If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>                                                                                                   |                            |                           |
|               | <b>a</b> Funding target disregarding prescribed at-risk assumptions .....                                                                                                                                      | <b>4a</b>                  |                           |
|               | <b>b</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..... | <b>4b</b>                  |                           |
| <b>5</b>      | Effective interest rate .....                                                                                                                                                                                  | <b>5</b>                   | <u>5.49</u> %             |
| <b>6</b>      | Target normal cost.....                                                                                                                                                                                        | <b>6</b>                   | <u>635590</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.

|                      |                                                                  |                                        |
|----------------------|------------------------------------------------------------------|----------------------------------------|
| <b>SIGN<br/>HERE</b> |                                                                  |                                        |
|                      | Signature of actuary                                             | <u>09/23/2020</u>                      |
|                      | <u>JASON C. WELLS</u>                                            | Date<br><u>20-07067</u>                |
|                      | Type or print name of actuary                                    | Most recent enrollment number          |
|                      | <u>AON CONSULTING, INC.</u>                                      | <u>614-436-8100</u>                    |
|                      | Firm name                                                        | Telephone number (including area code) |
|                      | <u>445 HUTCHINSON AVE, SUITE 900<br/>COLUMBUS, OH 43235-8619</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 ☐

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

**Schedule SB (Form 5500) 2019  
v. 190130**

| Part II Beginning of Year Carryover and Prefunding Balances                                                                                                          |                       |                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------|
|                                                                                                                                                                      | (a) Carryover balance | (b) Prefunding balance |
| <b>7</b> Balance at beginning of prior year after applicable adjustments (line 13 from prior year) .....                                                             | 0                     | 837423                 |
| <b>8</b> Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....                                                          | 0                     | 0                      |
| <b>9</b> Amount remaining (line 7 minus line 8) .....                                                                                                                | 0                     | 837423                 |
| <b>10</b> Interest on line 9 using prior year's actual return of <u>-4.07</u> % .....                                                                                | 0                     | -34083                 |
| <b>11</b> Prior year's excess contributions to be added to prefunding balance:                                                                                       |                       |                        |
| <b>a</b> Present value of excess contributions (line 38a from prior year) .....                                                                                      |                       | 3021                   |
| <b>b(1)</b> 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>5.66</u> % ..... |                       | 171                    |
| <b>b(2)</b> Interest on line 38b from prior year Schedule SB, using prior year's actual return .....                                                                 |                       | 0                      |
| <b>c</b> Total available at beginning of current plan year to add to prefunding balance .....                                                                        |                       | 3192                   |
| <b>d</b> Portion of (c) to be added to prefunding balance .....                                                                                                      |                       | 3192                   |
| <b>12</b> Other reductions in balances due to elections or deemed elections .....                                                                                    | 0                     | 0                      |
| <b>13</b> Balance at beginning of current year (line 9 + line 10 + line 11d – line 12) .....                                                                         | 0                     | 806532                 |

| Part III Funding Percentages                                                                                                                                               |           |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------|
| <b>14</b> Funding target attainment percentage .....                                                                                                                       | <b>14</b> | 85.79 % |
| <b>15</b> Adjusted funding target attainment percentage .....                                                                                                              | <b>15</b> | 85.79 % |
| <b>16</b> Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement ..... | <b>16</b> | 88.83 % |
| <b>17</b> If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage .....                                        | <b>17</b> | %       |

| Part IV Contributions and Liquidity Shortfalls                                           |                                   |                                 |                          |                                   |                                 |
|------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------|--------------------------|-----------------------------------|---------------------------------|
| <b>18</b> Contributions made to the plan for the plan year by employer(s) and employees: |                                   |                                 |                          |                                   |                                 |
| (a) Date<br>(MM-DD-YYYY)                                                                 | (b) Amount paid by<br>employer(s) | (c) Amount paid by<br>employees | (a) Date<br>(MM-DD-YYYY) | (b) Amount paid by<br>employer(s) | (c) Amount paid by<br>employees |
| 04/12/2019                                                                               | 401116                            | 0                               |                          |                                   |                                 |
| 07/12/2019                                                                               | 401116                            | 0                               |                          |                                   |                                 |
| 10/11/2019                                                                               | 401116                            | 0                               |                          |                                   |                                 |
| 01/13/2020                                                                               | 401116                            | 0                               |                          |                                   |                                 |
| 02/14/2020                                                                               | 431856                            | 0                               |                          |                                   |                                 |
|                                                                                          |                                   |                                 | <b>Totals ►</b>          | <b>18(b)</b>                      | 2036320                         |
|                                                                                          |                                   |                                 |                          | <b>18(c)</b>                      | 0                               |

|                                                                                                                                                                                       |            |         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---------|
| <b>19</b> Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:                                                  |            |         |
| <b>a</b> Contributions allocated toward unpaid minimum required contributions from prior years .....                                                                                  | <b>19a</b> | 0       |
| <b>b</b> Contributions made to avoid restrictions adjusted to valuation date .....                                                                                                    | <b>19b</b> | 0       |
| <b>c</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date .....                                                               | <b>19c</b> | 1956391 |
| <b>20</b> Quarterly contributions and liquidity shortfalls:                                                                                                                           |            |         |
| <b>a</b> Did the plan have a "funding shortfall" for the prior year? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                              |            |         |
| <b>b</b> If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |            |         |
| <b>c</b> 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 |
| 0                                                                                                                                                                                     | 0          | 0       |
|                                                                                                                                                                                       |            | (4) 4th |
|                                                                                                                                                                                       |            | 0       |

**Part V Assumptions Used to Determine Funding Target and Target Normal Cost****21** Discount rate:**a** Segment rates:1st segment:  
3.74 %2nd segment:  
5.35 %3rd segment:  
6.11 %☐ N/A, full yield curve used**b** Applicable month (enter code) .....**21b**

4

**22** Weighted average retirement age .....**22**

62

**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** 635590**b** Excess assets, if applicable, but not greater than line 31a ..... **31b** 0**32** Amortization installments:**a** Net shortfall amortization installment ..... Outstanding Balance 8236182 Installment 2127222**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** 2762812

|                                                                        | Carryover balance | Prefunding balance | Total balance |
|------------------------------------------------------------------------|-------------------|--------------------|---------------|
| <b>35</b> Balances elected for use to offset funding requirement ..... | 0                 | 806421             | 806421        |

**36** Additional cash requirement (line 34 minus line 35) ..... **36** 1956391**37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) ..... **37** 1956391**38** Present value of excess contributions for current year (see instructions)**a** Total (excess, if any, of line 37 over line 36) ..... **38a** 0**b** Portion included in line 38a attributable to use of prefunding and funding standard carryover balances ..... **38b** 0**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

|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             |                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| <div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> | OMB No. 1210-0110                       |
|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                             | 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<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN                            | B Three-digit plan number (PN) ▶                     | 001 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER | D Employer Identification Number (EIN)<br>31-4391798 |     |

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

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

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

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

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

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

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

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

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**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)

AON HEWITT INVESTMENT

27-2436452

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 27 50 51               | NONE                                                                                              | 117931                                                                 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

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

AON CONSULTING

23-2293237

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 11 50                  | NONE                                                                                              | 56555                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

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

PNC BANK

222 DELAWARE AVENUE  
WILMINGTON, DE 19899

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 21 50                  | NONE                                                                                              | 50216                                                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                            | 0                                                                                                                                                                               | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                          |

**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)

BLUE AND COMPANY LLC

35-1178661

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 10 50                  | NONE                                                                                              | 12000                                                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                       |                                                                                                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

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

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

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

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

**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<br>(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<br>(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<br>(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)

|                    |                                                             |                     |              |
|--------------------|-------------------------------------------------------------|---------------------|--------------|
| <b>a</b> Name:     | BLUE AND COMPANY LLC                                        | <b>b</b> EIN:       | 35-1178661   |
| <b>c</b> Position: | ACCOUNTANT                                                  |                     |              |
| <b>d</b> Address:  | 9200 WORTHINGTON ROAD<br>SUITE 200<br>WESTERVILLE, OH 43082 | <b>e</b> Telephone: | 614-885-2583 |

Explanation: DURING OUR NORMAL RFP PROCESS, WE REVIEWED THE QUALITY AND VALUE OF SEVERAL ACCOUNTING FIRMS AND DECIDED TO SWITCH TO NEW ACCOUNTING FIRM.

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                    |  |                     |  |
|--------------------|--|---------------------|--|
| <b>a</b> Name:     |  | <b>b</b> EIN:       |  |
| <b>c</b> Position: |  |                     |  |
| <b>d</b> Address:  |  | <b>e</b> Telephone: |  |

Explanation:

|                                                                                                                                                                                                               |                                                                                                                                                                                                                              |                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>SCHEDULE D</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small> | <b>DFE/Participating Plan Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><div style="text-align: center; font-size: 1.2em; font-weight: bold;">2019</div><br><br><b>This Form is Open to Public Inspection.</b> |
| For calendar plan year 2019 or fiscal plan year beginning <span style="color: blue;">01/01/2019</span> and ending <span style="color: blue;">12/31/2019</span>                                                |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>A</b> Name of plan<br><span style="color: blue;">SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</span>                                                                                             |                                                                                                                                                                                                                              | <b>B</b> Three-digit plan number (PN) <span style="color: blue;">►</span> <span style="color: blue;">001</span>                                                 |
| <b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500<br><span style="color: blue;">SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</span>                                                           |                                                                                                                                                                                                                              | <b>D</b> Employer Identification Number (EIN)<br><span style="color: blue;">31-4391798</span>                                                                   |
| <b>Part I</b> <b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b><br>(Complete as many entries as needed to report all interests in DFEs)                |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AHGT MID DURATION LONG CREDIT FUND</span>                                                                                           |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-013</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">787849</span>                    |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AON GROUP TRUST HIGH YIELD BOND</span>                                                                                              |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-004</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">4270346</span>                   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AGT US SMALL MID CAP ACTIVE EQ</span>                                                                                               |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-002</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">1720723</span>                   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AGT NON US ACTIVE EQ</span>                                                                                                         |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-003</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">4363759</span>                   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AGT US LARGE CAP PASSIVE EQ</span>                                                                                                  |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-006</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">2947782</span>                   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AON GROUP TRUST GLOBAL EQUITY</span>                                                                                                |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-011</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">4743090</span>                   |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <span style="color: blue;">AGT ACWI EX US PASSIVE EQUITY</span>                                                                                                |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>b</b> Name of sponsor of entity listed in (a): <span style="color: blue;">AON HEWITT INVESTMENT CONSULTANT, INC.</span>                                                                                    |                                                                                                                                                                                                                              |                                                                                                                                                                 |
| <b>c</b> EIN-PN <span style="color: blue;">27-2436452-010</span>                                                                                                                                              | <b>d</b> Entity code <span style="color: blue;">C</span>                                                                                                                                                                     | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <span style="color: blue;">2656588</span>                   |

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AHGT GLOBAL REAL ESTATE FUND**

**b** Name of sponsor of entity listed in (a): **AON HEWITT INVESTMENT CONSULTANT, INC.**

|                                       |                               |                                                                                                                    |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN <b>27-2436452-005</b> | <b>d</b> Entity code <b>C</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>3012580</b> |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AON GROUP TRUST US LARGE CAP ACT EQ**

**b** Name of sponsor of entity listed in (a): **AON HEWITT INVESTMENT CONSULTANT, INC.**

|                                       |                               |                                                                                                                    |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN <b>27-2436452-001</b> | <b>d</b> Entity code <b>C</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>2851914</b> |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AGT US LONG FIXED ACTIVE CREDIT**

**b** Name of sponsor of entity listed in (a): **AON HEWITT INVESTMENT CONSULTANT, INC.**

|                                       |                               |                                                                                                                     |
|---------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN <b>27-2436452-007</b> | <b>d</b> Entity code <b>C</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>11854884</b> |
|---------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AGT 20 YEAR US TREASURY**

**b** Name of sponsor of entity listed in (a): **AON HEWITT INVESTMENT CONSULTANT, INC.**

|                                       |                               |                                                                                                                   |
|---------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN <b>27-2436452-012</b> | <b>d</b> Entity code <b>C</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>385349</b> |
|---------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **AHGT US LONG GOV BOND**

**b** Name of sponsor of entity listed in (a): **AON HEWITT INVESTMENT CONSULTANT, INC.**

|                                       |                               |                                                                                                                    |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN <b>27-2436452-015</b> | <b>d</b> Entity code <b>C</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>5735914</b> |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **SSGA INT US GOV BD**

**b** Name of sponsor of entity listed in (a): **STATE STREET BANK AND TRUST COMPANY**

|                                       |                               |                                                                                                                    |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN <b>04-0025081-143</b> | <b>d</b> Entity code <b>C</b> | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>4194144</b> |
|---------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

|                 |                      |                                                                                                     |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|
| <b>c</b> EIN-PN | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
|-----------------|----------------------|-----------------------------------------------------------------------------------------------------|

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

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

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

|                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                            |                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <div>SCHEDULE G<br/>(Form 5500)<br/><br/>Department of Treasury<br/>Internal Revenue Service<br/><br/><br/>Department of Labor<br/>Employee Benefits Security Administration</div> | <div>Financial Transaction Schedules</div> <div>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).</div> <div>► File as an attachment to Form 5500.</div> | <div>OMB No. 1210-0110</div> <div>2019</div> <div>This Form is Open to Public Inspection.</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|

|                                                                                                     |                                                      |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019          |                                                      |
| A Name of plan<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN                            | B Three-digit plan number (PN) ► 001                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER | D Employer Identification Number (EIN)<br>31-4391798 |

|        |                                                                                                                                                                                                                                                                                                                                                                      |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part I | <b>Schedule of Loans or Fixed Income Obligations in Default or Classified as Uncollectible</b><br>Complete as many entries as needed to report all loans or fixed income obligations in default or classified as uncollectible. Check box (a) if obligor is known to be a party in interest. Attach Overdue Loan Explanation for each loan listed. See Instructions. |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                          |                                     |                                                                                                                                                                                                                      |
|--------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (a)                      | (b) Identity and address of obligor | (c) Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |
| <input type="checkbox"/> |                                     |                                                                                                                                                                                                                      |

|                             | Amount received during reporting year |              |                                   | Amount overdue |              |
|-----------------------------|---------------------------------------|--------------|-----------------------------------|----------------|--------------|
| (d) Original amount of loan | (e) Principal                         | (f) Interest | (g) Unpaid balance at end of year | (h) Principal  | (i) Interest |
|                             |                                       |              |                                   |                |              |

|                          |                                     |                                                                                                                                                                                                                      |
|--------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (a)                      | (b) Identity and address of obligor | (c) Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |
| <input type="checkbox"/> |                                     |                                                                                                                                                                                                                      |

|                             | Amount received during reporting year |              |                                   | Amount overdue |              |
|-----------------------------|---------------------------------------|--------------|-----------------------------------|----------------|--------------|
| (d) Original amount of loan | (e) Principal                         | (f) Interest | (g) Unpaid balance at end of year | (h) Principal  | (i) Interest |
|                             |                                       |              |                                   |                |              |

|                          |                                     |                                                                                                                                                                                                                      |
|--------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (a)                      | (b) Identity and address of obligor | (c) Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |
| <input type="checkbox"/> |                                     |                                                                                                                                                                                                                      |

|                             | Amount received during reporting year |              |                                   | Amount overdue |              |
|-----------------------------|---------------------------------------|--------------|-----------------------------------|----------------|--------------|
| (d) Original amount of loan | (e) Principal                         | (f) Interest | (g) Unpaid balance at end of year | (h) Principal  | (i) Interest |
|                             |                                       |              |                                   |                |              |

|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|------------------------------------|--------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------|
| <b>(a)</b>                         | <b>(b)</b> Identity and address of obligor |                                       | <b>(c)</b> Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |                      |                     |
| <input type="checkbox"/>           |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|                                    |                                            | Amount received during reporting year |                                                                                                                                                                                                                             | Amount overdue       |                     |
| <b>(d)</b> Original amount of loan | <b>(e)</b> Principal                       | <b>(f)</b> Interest                   | <b>(g)</b> Unpaid balance at end of year                                                                                                                                                                                    | <b>(h)</b> Principal | <b>(i)</b> Interest |
|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |

  

|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|------------------------------------|--------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------|
| <b>(a)</b>                         | <b>(b)</b> Identity and address of obligor |                                       | <b>(c)</b> Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |                      |                     |
| <input type="checkbox"/>           |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|                                    |                                            | Amount received during reporting year |                                                                                                                                                                                                                             | Amount overdue       |                     |
| <b>(d)</b> Original amount of loan | <b>(e)</b> Principal                       | <b>(f)</b> Interest                   | <b>(g)</b> Unpaid balance at end of year                                                                                                                                                                                    | <b>(h)</b> Principal | <b>(i)</b> Interest |
|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |

  

|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|------------------------------------|--------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------|
| <b>(a)</b>                         | <b>(b)</b> Identity and address of obligor |                                       | <b>(c)</b> Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |                      |                     |
| <input type="checkbox"/>           |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|                                    |                                            | Amount received during reporting year |                                                                                                                                                                                                                             | Amount overdue       |                     |
| <b>(d)</b> Original amount of loan | <b>(e)</b> Principal                       | <b>(f)</b> Interest                   | <b>(g)</b> Unpaid balance at end of year                                                                                                                                                                                    | <b>(h)</b> Principal | <b>(i)</b> Interest |
|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |

  

|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|------------------------------------|--------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------|
| <b>(a)</b>                         | <b>(b)</b> Identity and address of obligor |                                       | <b>(c)</b> Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |                      |                     |
| <input type="checkbox"/>           |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|                                    |                                            | Amount received during reporting year |                                                                                                                                                                                                                             | Amount overdue       |                     |
| <b>(d)</b> Original amount of loan | <b>(e)</b> Principal                       | <b>(f)</b> Interest                   | <b>(g)</b> Unpaid balance at end of year                                                                                                                                                                                    | <b>(h)</b> Principal | <b>(i)</b> Interest |
|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |

  

|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|------------------------------------|--------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------|
| <b>(a)</b>                         | <b>(b)</b> Identity and address of obligor |                                       | <b>(c)</b> Detailed description of loan including dates of making and maturity, interest rate, the type and value of collateral, any renegotiation of the loan and the terms of the renegotiation, and other material items |                      |                     |
| <input type="checkbox"/>           |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |
|                                    |                                            | Amount received during reporting year |                                                                                                                                                                                                                             | Amount overdue       |                     |
| <b>(d)</b> Original amount of loan | <b>(e)</b> Principal                       | <b>(f)</b> Interest                   | <b>(g)</b> Unpaid balance at end of year                                                                                                                                                                                    | <b>(h)</b> Principal | <b>(i)</b> Interest |
|                                    |                                            |                                       |                                                                                                                                                                                                                             |                      |                     |

**Part II Schedule of Leases in Default or Classified as Uncollectible**

Complete as many entries as needed to report all leases in default or classified as uncollectible. Check box (a) if lessor or lessee is known to be a party in interest. Attach Overdue Lease Explanation for each lease listed. (See instructions)

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

  

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

  

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

  

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

  

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

  

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

  

| (a)                      | (b) Identity of lessor/lessee      | (c) Relationship to plan, employer, employee organization, or other party-in-interest | (d) Terms and description (type of property, location and date it was purchased, terms regarding rent, taxes, insurance, repairs, expenses, renewal options, date property was leased) |                  |                       |  |
|--------------------------|------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------|--|
| <input type="checkbox"/> |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |
| (e) Original cost        | (f) Current value at time of lease | (g) Gross rental receipts during the plan year                                        | (h) Expenses paid during the plan year                                                                                                                                                 | (i) Net receipts | (j) Amount in arrears |  |
|                          |                                    |                                                                                       |                                                                                                                                                                                        |                  |                       |  |

Complete as many entries as needed to report all nonexempt transactions. **Caution:** If a nonexempt prohibited transaction occurred with respect to a disqualified person, file Form 5330 with the IRS to pay the excise tax on the transaction.

|                                |                                                                |                                                                                                             |                   |                            |                                            |
|--------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------|----------------------------|--------------------------------------------|
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
| SE OH REG MED CTR              | PLAN SPONSOR                                                   | EXPENSES WERE REIMBURSED TO THE PLAN SPONSOR IN A TIMELINE OUTSIDE OF WHAT IS PRESCRIBED BY REGULATION.     |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                | 586370                                                                                                      |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (a) Identity of party involved | (b) Relationship to plan, employer, or other party-in-interest | (c) Description of transaction including maturity date, rate of interest, collateral, par or maturity value |                   |                            | (d) Purchase price                         |
|                                |                                                                |                                                                                                             |                   |                            |                                            |
| (e) Selling price              | (f) Lease rental                                               | (g) Transaction expenses                                                                                    | (h) Cost of asset | (i) Current value of asset | (j) Net gain (or loss) on each transaction |
|                                |                                                                |                                                                                                             |                   |                            |                                            |

|                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                              |                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Financial Information</b><br><br>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).<br><br><b>► File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2019</b><br><br><b>This Form is Open to Public Inspection</b> |
| For calendar plan year 2019 or fiscal plan year beginning <u>01/01/2019</u> and ending <u>12/31/2019</u>                                                                                                                                                                 |                                                                                                                                                                                                                                                                              |                                                                                           |
| <b>A</b> Name of plan<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>                                                                                                                                                                                   |                                                                                                                                                                                                                                                                              | <b>B</b> Three-digit plan number (PN) <u>001</u>                                          |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u>                                                                                                                                                        |                                                                                                                                                                                                                                                                              | <b>D</b> Employer Identification Number (EIN)<br><u>31-4391798</u>                        |

| Part I Asset and Liability Statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                 |                       |                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------|-----------------|
| <b>1</b> 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. <b>Round off amounts to the nearest dollar.</b> MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions. |                 |                       |                 |
| Assets                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                 | (a) Beginning of Year | (b) End of Year |
| <b>a</b> Total noninterest-bearing cash .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>1a</b>       |                       |                 |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                 |                       |                 |
| <b>(1)</b> Employer contributions.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>1b(1)</b>    | 360000                | 832972          |
| <b>(2)</b> Participant contributions.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>1b(2)</b>    |                       |                 |
| <b>(3)</b> Other.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>1b(3)</b>    | 2552                  | 778             |
| <b>c</b> General investments:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit).....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>1c(1)</b>    |                       |                 |
| <b>(2)</b> U.S. Government securities .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |                       |                 |
| <b>(A)</b> Preferred .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property).....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>1c(8)</b>    |                       |                 |
| <b>(9)</b> Value of interest in common/collective trusts .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>1c(9)</b>    | 42099307              | 49524922        |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>1c(10)</b>   |                       |                 |
| <b>(11)</b> Value of interest in master trust investment accounts .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds).....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>1c(13)</b>   | 1528014               | 16921           |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts).....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>1c(14)</b>   |                       |                 |
| <b>(15)</b> Other.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>1c(15)</b>   | 4494425               | 4677811         |

|                    |                                                                  | (a) Beginning of Year | (b) End of Year   |
|--------------------|------------------------------------------------------------------|-----------------------|-------------------|
| <b>1d</b>          | Employer-related investments:                                    |                       |                   |
| (1)                | Employer securities .....                                        | <b>1d(1)</b>          |                   |
| (2)                | Employer real property .....                                     | <b>1d(2)</b>          |                   |
| <b>e</b>           | Buildings and other property used in plan operation .....        | <b>1e</b>             |                   |
| <b>f</b>           | Total assets (add all amounts in lines 1a through 1e) .....      | <b>1f</b>             | 48484298 55053404 |
| <b>Liabilities</b> |                                                                  |                       |                   |
| <b>g</b>           | Benefit claims payable .....                                     | <b>1g</b>             |                   |
| <b>h</b>           | Operating payables .....                                         | <b>1h</b>             | 64485 0           |
| <b>i</b>           | Acquisition indebtedness .....                                   | <b>1i</b>             |                   |
| <b>j</b>           | Other liabilities .....                                          | <b>1j</b>             |                   |
| <b>k</b>           | Total liabilities (add all amounts in lines 1g through 1j) ..... | <b>1k</b>             | 64485 0           |
| <b>Net Assets</b>  |                                                                  |                       |                   |
| <b>l</b>           | Net assets (subtract line 1k from line 1f) .....                 | <b>1l</b>             | 48419813 55053404 |

**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 |
|----------|--------------------------------------------------------------------------------------------------------|-----------------|-----------|
| <b>a</b> | <b>Contributions:</b>                                                                                  |                 |           |
| (1)      | Received or receivable in cash from: <b>(A)</b> Employers .....                                        | <b>2a(1)(A)</b> | 2036320   |
|          | <b>(B)</b> Participants .....                                                                          | <b>2a(1)(B)</b> |           |
|          | <b>(C)</b> Others (including rollovers) .....                                                          | <b>2a(1)(C)</b> |           |
| (2)      | Noncash contributions .....                                                                            | <b>2a(2)</b>    |           |
| (3)      | Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    | 2036320   |
| <b>b</b> | <b>Earnings on investments:</b>                                                                        |                 |           |
| (1)      | Interest:                                                                                              |                 |           |
|          | <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....   | <b>2b(1)(A)</b> |           |
|          | <b>(B)</b> U.S. Government securities .....                                                            | <b>2b(1)(B)</b> |           |
|          | <b>(C)</b> Corporate debt instruments .....                                                            | <b>2b(1)(C)</b> |           |
|          | <b>(D)</b> Loans (other than to participants) .....                                                    | <b>2b(1)(D)</b> |           |
|          | <b>(E)</b> Participant loans .....                                                                     | <b>2b(1)(E)</b> |           |
|          | <b>(F)</b> Other .....                                                                                 | <b>2b(1)(F)</b> |           |
|          | <b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                          | <b>2b(1)(G)</b> | 0         |
| (2)      | Dividends: <b>(A)</b> Preferred stock .....                                                            | <b>2b(2)(A)</b> |           |
|          | <b>(B)</b> Common stock .....                                                                          | <b>2b(2)(B)</b> |           |
|          | <b>(C)</b> Registered investment company shares (e.g. mutual funds) .....                              | <b>2b(2)(C)</b> | 203886    |
|          | <b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....              | <b>2b(2)(D)</b> | 203886    |
| (3)      | Rents .....                                                                                            | <b>2b(3)</b>    |           |
| (4)      | Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....                                 | <b>2b(4)(A)</b> |           |
|          | <b>(B)</b> Aggregate carrying amount (see instructions) .....                                          | <b>2b(4)(B)</b> |           |
|          | <b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....              | <b>2b(4)(C)</b> | 0         |
| (5)      | Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate .....                         | <b>2b(5)(A)</b> |           |
|          | <b>(B)</b> Other .....                                                                                 | <b>2b(5)(B)</b> |           |
|          | <b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....     | <b>2b(5)(C)</b> | 0         |

|                                                                                                 |        | (a) Amount | (b) Total |
|-------------------------------------------------------------------------------------------------|--------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts .....                              | 2b(6)  |            | 4461986   |
| (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) |            | 4337016   |
| c Other income .....                                                                            | 2c     |            | 13325     |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total .....               | 2d     |            | 11052533  |

**Expenses**

|                                                                                      |       |         |         |
|--------------------------------------------------------------------------------------|-------|---------|---------|
| e Benefit payment and payments to provide benefits:                                  |       |         |         |
| (1) Directly to participants or beneficiaries, including direct rollovers .....      | 2e(1) | 3728910 |         |
| (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) |         | 3728910 |
| 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) | 68555   |         |
| (2) Contract administrator fees .....                                                | 2i(2) | 50216   |         |
| (3) Investment advisory and management fees .....                                    | 2i(3) | 117931  |         |
| (4) Other .....                                                                      | 2i(4) | 453330  |         |
| (5) Total administrative expenses. Add lines 2i(1) through (4) .....                 | 2i(5) |         | 690032  |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total ..... | 2j    |         | 4418942 |

**Net Income and Reconciliation**

|                                                          |       |  |         |
|----------------------------------------------------------|-------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d ..... | 2k    |  | 6633591 |
| 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: **PLANTE & MORAN, PLLC**

(2) EIN: **38-1357951**

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

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

**Part IV Compliance Questions**

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

During the plan year:

**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 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----|----|--------|
| <b>c</b> 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.) .....                                          | <b>4c</b> |     | X  |        |
| <b>d</b> 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.).....                                | <b>4d</b> | X   |    | 586370 |
| <b>e</b> Was this plan covered by a fidelity bond? .....                                                                                                                                                                      | <b>4e</b> | X   |    | 500000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....                                                                                       | <b>4f</b> |     | X  |        |
| <b>g</b> 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?.....                                                     | <b>4g</b> |     | X  |        |
| <b>h</b> 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?.....                                           | <b>4h</b> |     | X  |        |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) .....                                                                | <b>4i</b> | X   |    |        |
| <b>j</b> 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.) ..... | <b>4j</b> | X   |    |        |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....                                                           | <b>4k</b> |     | X  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan?.....                                                                                                                                             | <b>4l</b> |     | X  |        |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....                                                                                                  | <b>4m</b> |     |    |        |
| <b>n</b> 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. ....                                      | <b>4n</b> |     |    |        |

**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 4234245. (See instructions.)

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>SCHEDULE R</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Retirement Plan Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2019</b><br><br><b>This Form is Open to Public Inspection.</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|

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

|                                                                                                                   |                                                                    |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>A</b> Name of plan<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN</u>                            | <b>B</b> Three-digit plan number (PN) ▶ <u>001</u>                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><u>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER</u> | <b>D</b> Employer Identification Number (EIN)<br><u>31-4391798</u> |

|               |                      |
|---------------|----------------------|
| <b>Part I</b> | <b>Distributions</b> |
|---------------|----------------------|

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

|                                                                                                                                                                                                                                                                    |          |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|
| <b>1</b> Total value of distributions paid in property other than in cash or the forms of property specified in the instructions .....                                                                                                                             | <b>1</b> | <u>0</u> |
| <b>2</b> 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):<br><br>EIN(s): <u>31-0966785</u> |          |          |
| Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.                                                                                                                                                                                                   |          |          |
| <b>3</b> Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year .....                                                                                                                                   | <b>3</b> | <u>4</u> |

|                |                                                                                                                                                                               |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part II</b> | <b>Funding Information</b> (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.) |
|----------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                             |                              |                             |                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|-----------------------------------------|
| <b>4</b> Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)? .....                                                                                                                                                                                                                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input checked="" type="checkbox"/> N/A |
| If the plan is a defined benefit plan, go to line 8.                                                                                                                                                                                                                                                                                                        |                              |                             |                                         |
| <b>5</b> 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 _____<br>If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule. |                              |                             |                                         |
| <b>6 a</b> Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived) .....                                                                                                                                                                                                              | <b>6a</b>                    |                             |                                         |
| <b>b</b> Enter the amount contributed by the employer to the plan for this plan year .....                                                                                                                                                                                                                                                                  | <b>6b</b>                    |                             |                                         |
| <b>c</b> 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) .....                                                                                                                                                                                                            | <b>6c</b>                    |                             |                                         |
| If you completed line 6c, skip lines 8 and 9.                                                                                                                                                                                                                                                                                                               |                              |                             |                                         |
| <b>7</b> Will the minimum funding amount reported on line 6c be met by the funding deadline? .....                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A            |
| <b>8</b> 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? .....                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input checked="" type="checkbox"/> N/A |

|                 |                   |
|-----------------|-------------------|
| <b>Part III</b> | <b>Amendments</b> |
|-----------------|-------------------|

|                                                                                                                                                                                                                             |                                   |                                   |                               |                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|----------------------------------------|
| <b>9</b> 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 ..... | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease | <input type="checkbox"/> Both | <input checked="" type="checkbox"/> No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------|-------------------------------|----------------------------------------|

|                |                                                                                                                                                   |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Part IV</b> | <b>ESOPs</b> (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. |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                              |                              |                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| <b>10</b> Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? .....                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>11 a</b> Does the ESOP hold any preferred stock? .....                                                                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>b</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.) ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>12</b> Does the ESOP hold any stock that is not readily tradable on an established securities market? .....                                                                               | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 \_\_\_\_\_

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# Southeastern Ohio Regional Medical Center Pension Plan

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**Financial Report  
December 31, 2019**

## **Southeastern Ohio Regional Medical Center Pension Plan**

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## **Independent Auditor's Report**

To the Plan Administrator  
Southeastern Ohio Regional Medical  
Center Pension Plan

### **Report on the Financial Statements**

We were engaged to audit the accompanying financial statements of Southeastern Ohio Regional Medical Center Pension Plan (the "Plan"), which comprise the statement of net assets available for benefits as of December 31, 2019 and the related statement of changes in net assets available for benefits for the year 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 2019 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 on the 2019 Financial Statements* paragraph, however, we were not able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the 2019 financial statements.

### ***Basis for Disclaimer of Opinion on the 2019 Financial Statements***

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 (ERISA), the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 3, which was certified by PNC Bank, N.A. (the "Trustee"), except for comparing such information with the related information included in the 2019 financial statements. We have been informed by the plan administrator that the Trustee holds the Plan's investment assets and executes related transactions, except for the investment in the limited partnership. The plan administrator has obtained a certification from the Trustee as of and for the year ended December 31, 2019 that the information provided to the plan administrator, other than the investment in the limited partnership, is complete and accurate.

### ***Disclaimer of Opinion on the 2019 Financial Statements***

Because of the significance of the matter described in the *Basis for Disclaimer of Opinion on the 2019 Financial Statements* paragraph, we have not been able to obtain sufficient appropriate audit evidence to provide a basis for an audit opinion on the 2019 financial statements. Accordingly, we do not express an opinion on the 2019 financial statements.

### ***Other Matter***

The supplemental schedules of assets held at end of year as of December 31, 2019 and reportable transactions and nonexempt transactions for the year ended December 31, 2019 are required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under ERISA 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 on the 2019 Financial Statements* paragraph, we do not express an opinion on these supplemental schedules.

To the Plan Administrator  
Southeastern Ohio Regional Medical  
Center Pension Plan

**Report on Prior Year Financial Statements**

The financial statements of the Plan as of and for the year ended December 31, 2018 were audited by other auditors, whose report dated October 15, 2019 expressed an unmodified opinion on those statements.

**Report on Form and Content in Compliance with DOL Rules and Regulations for 2019 Financial Statements**

The form and content of the information included in the 2019 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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

*Plante & Moreau, PLLC*

Columbus, Ohio  
October 8, 2020

## Southeastern Ohio Regional Medical Center Pension Plan

### Statement of Net Assets Available for Benefits

|                                          |    | December 31, 2019 and 2018 |                      |
|------------------------------------------|----|----------------------------|----------------------|
|                                          |    | 2019                       | 2018                 |
| <b>Assets</b>                            |    |                            |                      |
| Investments at fair value:               |    |                            |                      |
| Money market fund                        | \$ | 16,921                     | \$ 1,528,014         |
| Common collective trust funds            |    | 49,524,922                 | 42,099,307           |
| Investment in limited partnership        |    | 4,677,811                  | 4,494,425            |
| Total investments at fair value          |    | 54,219,654                 | 48,121,746           |
| Contributions receivable                 |    | 832,972                    | 360,000              |
| Accrued income                           |    | 778                        | 2,552                |
| Total assets                             |    | 55,053,404                 | 48,484,298           |
| <b>Liabilities - Accrued liabilities</b> |    | -                          | 64,485               |
| <b>Net Assets Available for Benefits</b> |    | <b>\$ 55,053,404</b>       | <b>\$ 48,419,813</b> |

## Southeastern Ohio Regional Medical Center Pension Plan

### Statement of Changes in Net Assets Available for Benefits

Years Ended December 31, 2019 and 2018

|                                                           | 2019                        | 2018                        |
|-----------------------------------------------------------|-----------------------------|-----------------------------|
| <b>Additions</b>                                          |                             |                             |
| Employer contributions                                    | \$ 2,036,320                | \$ 1,660,586                |
| Investment income (loss):                                 |                             |                             |
| Interest and dividends                                    | 217,211                     | 14,762                      |
| Net realized and unrealized gains (losses) on investments | 8,799,002                   | (2,105,088)                 |
| Total investment income (loss)                            | 9,016,213                   | (2,090,326)                 |
| Total additions - Net                                     | 11,052,533                  | (429,740)                   |
| <b>Deductions</b>                                         |                             |                             |
| Benefits paid directly to participants or beneficiaries   | 3,728,910                   | 3,485,317                   |
| Administrative expenses                                   | 690,032                     | 623,443                     |
| Total deductions                                          | 4,418,942                   | 4,108,760                   |
| <b>Net Increase (Decrease)</b>                            | 6,633,591                   | (4,538,500)                 |
| <b>Net Assets Available for Benefits</b>                  |                             |                             |
| Beginning of year                                         | 48,419,813                  | 52,958,313                  |
| End of year                                               | <u><u>\$ 55,053,404</u></u> | <u><u>\$ 48,419,813</u></u> |

## **Southeastern Ohio Regional Medical Center Pension Plan**

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### **Notes to Financial Statements**

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**December 31, 2019 and 2018**

#### **Note 1 - Plan Description**

The following description of Southeastern Ohio Regional Medical Center Pension 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 benefit plan covering all eligible employees of Southeastern Ohio Regional Medical Center (the "Medical Center"). The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Employees become participants in the Plan following completion of the eligibility requirements described in the Plan and are fully vested for normal retirement benefits after five years of service. The board of directors of the Medical Center resolved to freeze the Plan effective April 30, 2007. Accrued benefits for individual participants will not increase; however, service will continue to be credited for vesting and retirement purposes.

##### ***Pension Benefits***

Eligible employees with five or more years of service are entitled to normal annual pension benefits beginning at the participant's normal retirement age of 65, as described in the Plan. The individual pension benefit is equal to a percentage, as specified in the Plan, of the employee's final average monthly compensation multiplied by the employee's credited service, not to exceed 35 years. Special provisions for retirement at other than the normal retirement age are described in the plan agreement. Employees with at least 10 years of service may elect early retirement and receive the accrued normal retirement benefits at age 55 or a reduced monthly retirement benefit payable immediately in accordance with the plan agreement. Employees may elect to receive the value of their accumulated plan benefits as a lump-sum distribution upon retirement or termination or they may elect to receive their benefits as a life annuity payable monthly from retirement.

##### ***Payment of Benefits***

Upon retirement, death, or permanent disability, a participant's distribution will commence in the form of a one of the various annuity options, as selected by the participant. In certain instances, it may be paid in a lump sum.

##### ***Contributions***

All contributions to the Plan are made by the Medical Center. The Medical Center contributes such amounts, as determined on an actuarial basis, to provide the Plan with assets sufficient to meet the projected benefits to be paid to plan participants and to satisfy ERISA funding standards. Annual contributions meet the minimum funding requirements of ERISA. No participant contributions are permitted.

##### ***Party-in-interest Transactions***

Certain plan assets are in investment funds managed by PNC Bank, N.A. or its affiliates. PNC Bank, N.A. is the trustee of the Plan; therefore, these transactions qualify as party-in-interest transactions, as defined under ERISA guidelines.

Prohibited transactions with parties in interest were identified during 2019. These transactions, as defined in ERISA Section 3(14), totaled \$586,370 where the Plan reimbursed the plan sponsor in a timeline outside of what is allowed by regulations under that section.

#### **Note 2 - Summary of Significant Accounting Policies**

##### ***Investment Valuation***

The Plan's investments are stated at fair value.

**December 31, 2019 and 2018**

**Note 2 - Summary of Significant Accounting Policies (Continued)**

The common collective trust funds are valued at net asset value per share (NAV) (or its equivalent) of the funds, which is based on the fair value of the funds' underlying assets.

The investment in a limited partnership is valued at net asset value per share (NAV) (or its equivalent) of the fund based on audited financial statements of the fund, where available, with adjustments to account for partnership activity and other applicable valuation adjustments.

The money market fund is valued at fair value based on its outstanding balance.

See Note 5 for additional information.

***Benefit Payments***

Benefits are recorded when paid.

***Administrative Expenses***

Various administrative costs are paid by the Medical Center.

***Actuarial Present Value of Accumulated Plan Benefits***

Accumulated plan benefits are those future periodic payments that are attributable, under the Plan's provisions, to the service employees have rendered. These include benefits expected to be paid to:

- (a) Retired or terminated employees or their beneficiaries
- (b) Beneficiaries of employees who have died
- (c) Present employees or their beneficiaries

Benefits are calculated based on active employees' credited years of service multiplied by a specified percentage of their average monthly compensation plus a specified percentage of their average monthly compensation in excess of the Social Security Integration Level.

Benefits provided via annuity contracts are deducted from plan assets and from accumulated plan benefits.

***Actuarial Assumptions***

The actuarial present value of accumulated plan benefits is determined by an actuary and is the amount that results from applying actuarial assumptions to adjust the accumulated plan benefits to reflect the time value of money and probability of payment between the valuation date and the expected date of payment.

The significant actuarial assumptions used in the valuation of the Plan at January 1, 2019 are summarized as follows:

|                        |                                                                                  |
|------------------------|----------------------------------------------------------------------------------|
| Actuarial cost method  | Projected unit credit                                                            |
| Assumed rate of return | 6.25 percent per annum                                                           |
| Mortality basis        | Pri-2012 private retirement plans mortality table using projection scale MP-2019 |

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.

## Southeastern Ohio Regional Medical Center Pension Plan

### Notes to Financial Statements

December 31, 2019 and 2018

#### Note 2 - Summary of Significant Accounting Policies (Continued)

##### *Use of Estimates*

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

##### *Risks and Uncertainties*

Contributions to the Plan and the accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates, and employee demographics. Due to the changing nature of these assumptions, it is at least reasonably possible that changes in these assumptions will occur in the near term and, due to the uncertainties inherent in setting assumptions, that the effect of such changes could be material to the financial statements. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. 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 the financial statements.

##### *Subsequent Events*

The financial statements and related disclosures include evaluation of events up through and including October 8, 2020, which is the date the financial statements were available to be issued.

#### Note 3 - Unaudited Information

PNC Bank, N.A. (the "Trustee") holds the Plan's investments, other than the investment in limited partnership, and executes all related investment transactions. The investment balances and related investment results included in the accompanying financial statements, supplemental schedule of assets held at end of year, and supplemental schedule of reportable transactions, other than the investment in the limited partnership, are based solely on information certified by the Trustee.

The Plan's investment in the limited partnership totaling \$4,677,811 and \$4,494,425 at December 31, 2019 and 2018, respectively, and related investment income of \$183,386 and \$105,575 for the years ended December 31, 2019 and 2018, respectively, were not certified by the Trustee.

#### Note 4 - Accumulated Plan Benefits

The actuarial present value of accumulated plan benefits is determined by consulting actuaries. The calculation of the actuarial present value of accumulated plan benefits attributable to participants in the Plan, which was made as of January 1, 2019, the most recent actuarial valuation, is as follows:

Actuarial present value of accumulated plan benefits:

Vested benefits:

|                                                   |               |
|---------------------------------------------------|---------------|
| Participants currently receiving benefit payments | \$ 37,565,382 |
| Other vested participants                         | 14,856,622    |

|                       |            |
|-----------------------|------------|
| Total vested benefits | 52,422,004 |
|-----------------------|------------|

|                    |           |
|--------------------|-----------|
| Nonvested benefits | 1,115,411 |
|--------------------|-----------|

|                                                            |                      |
|------------------------------------------------------------|----------------------|
| Total actuarial present value of accumulated plan benefits | <u>\$ 53,537,415</u> |
|------------------------------------------------------------|----------------------|

## Southeastern Ohio Regional Medical Center Pension Plan

### Notes to Financial Statements

December 31, 2019 and 2018

#### Note 4 - Accumulated Plan Benefits (Continued)

A summary of significant changes in the actuarial present value of accumulated plan benefits from January 1, 2018 to January 1, 2019 is as follows:

|                                                                          |               |
|--------------------------------------------------------------------------|---------------|
| Actuarial present value of accumulated plan benefits - Beginning of year | \$ 54,125,318 |
| Increase (decrease) during the year attributable to:                     |               |
| Interest due to the decrease in the discount period                      | 3,275,567     |
| Benefits paid                                                            | (3,485,317)   |
| Changes in actuarial assumptions                                         | (442,052)     |
| Other                                                                    | 63,899        |
| Net decrease                                                             | (587,903)     |
| Actuarial present value of accumulated plan benefits - End of year       | \$ 53,537,415 |

The decrease in actuarial present value of accumulated plan benefits due to changes in actuarial assumptions relates to an increase in the discount rate from 3.72 percent to 4.25 percent and an update in the mortality tables from RP-2014 generational mortality table using projection scale MP-2017 to Pri-2012 private retirement plans mortality table using projection scale MP-2019.

#### Note 5 - Fair Value Measurements

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

##### Level 1

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

##### Level 2

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

##### Level 3

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset.

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

## Southeastern Ohio Regional Medical Center Pension Plan

### Notes to Financial Statements

December 31, 2019 and 2018

#### Note 5 - Fair Value Measurements (Continued)

|                                       |  | Assets Measured at Fair Value on<br>a Recurring Basis<br>at December 31, 2019 |           |
|---------------------------------------|--|-------------------------------------------------------------------------------|-----------|
|                                       |  | Investments<br>(at Fair Value)                                                | Level 2   |
| Money market fund                     |  | \$ 16,921                                                                     | \$ 16,921 |
| Investments measured at NAV:          |  |                                                                               |           |
| Common collective trust funds         |  | 49,524,922                                                                    |           |
| Investment in limited partnership (1) |  | 4,677,811                                                                     |           |
| Total investments at fair value       |  | <u>\$ 54,219,654</u>                                                          |           |

|                                       |  | Assets Measured at Fair Value on<br>a Recurring Basis<br>at December 31, 2018 |              |
|---------------------------------------|--|-------------------------------------------------------------------------------|--------------|
|                                       |  | Investments<br>(at Fair Value)                                                | Level 2      |
| Money market fund                     |  | \$ 1,528,014                                                                  | \$ 1,528,014 |
| Investments measured at NAV:          |  |                                                                               |              |
| Common collective trust funds         |  | 42,099,307                                                                    |              |
| Investment in limited partnership (1) |  | 4,494,425                                                                     |              |
| Total investments at fair value       |  | <u>\$ 48,121,746</u>                                                          |              |

- (1) This fund's investment objective is to generate consistent long-term capital appreciation with diversification of risk through the use of a multimanager, multistrategy global investment approach.

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

#### ***Investments in Entities that Calculate Net Asset Value per Share***

The Plan holds shares or interests in investment companies at year end whereby the fair value of the investment held is estimated based on the net asset value per share (or its equivalent) of the investment company.

At year end, the fair value, unfunded commitments, and redemption rules of those investments are as follows:

|                                   |    | December 31,<br>2019 | December 31,<br>2018 |                         |                                         |                             |
|-----------------------------------|----|----------------------|----------------------|-------------------------|-----------------------------------------|-----------------------------|
|                                   |    | Fair Value           | Fair Value           | Unfunded<br>Commitments | Redemption<br>Frequency, if<br>Eligible | Redemption<br>Notice Period |
| AON Liquid Alternatives Fund Ltd. | \$ | 4,677,811            | \$ 4,494,425         | \$ -                    | Monthly                                 | 10 days                     |

#### Note 6 - Tax Status

The Plan has received a determination letter from the Internal Revenue Service indicating that the Plan, as designed, is qualified for tax-exempt treatment under the applicable section of the Internal Revenue Code (IRC). Although the Plan has been amended since receiving the determination letter, management believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

**December 31, 2019 and 2018**

**Note 7 - Plan Termination**

Should the Plan terminate at some future time, its net assets generally will not be available on a pro rata basis to provide participants' benefits. Whether a particular participant's accumulated plan benefits will be paid depends on both the priority of those benefits and the level of benefits guaranteed by the Pension Benefit Guaranty Corporation (PBGC) at that time. Some benefits may be fully or partially provided for by the then-existing assets and the PBGC guarantee, while other benefits may not be provided for at all.

## Southeastern Ohio Regional Medical Center Pension Plan

### Schedule of Assets Held at End of Year

**Form 5500, Schedule H, Line 4i**  
**EIN 31-4391798, Plan No. 001**  
**December 31, 2019**

| (a)(b)<br>Identity of Issuer | (c)<br>Description of Investment                                      | (d)<br>Cost          | (e)<br>Current Value |
|------------------------------|-----------------------------------------------------------------------|----------------------|----------------------|
|                              | Common collective trust funds:                                        |                      |                      |
| AON Hewitt Group Trust       | AHGT Global Real Estate Fund                                          | \$ 2,614,829         | \$ 3,012,580         |
| AON Hewitt Group Trust       | AHGT US LG Gov BD                                                     | 5,383,667            | 5,735,914            |
| AON Hewitt Group Trust       | AGT ACWI EX US Passive Equity                                         | 2,470,043            | 2,656,588            |
| AON Hewitt Group Trust       | AON Group Trust Global Equity                                         | 4,054,251            | 4,743,090            |
| AON Hewitt Group Trust       | AON Group Trust High Yield Bond                                       | 3,896,982            | 4,270,346            |
| AON Hewitt Group Trust       | AON Group Trust US Large Cap Active Equity                            | 2,194,416            | 2,851,914            |
| AON Hewitt Group Trust       | AHGT Mid Duration Long Credit Fund                                    | 711,933              | 787,849              |
| AON Hewitt Group Trust       | AGT+20 Year US Treasury                                               | 302,339              | 385,349              |
| AON Hewitt Group Trust       | AGT US Large Cap Passive EQ                                           | 2,262,037            | 2,947,782            |
| AON Hewitt Group Trust       | AGT US Long Fixed Active Credit                                       | 11,554,917           | 11,854,884           |
| AON Hewitt Group Trust       | AGT Non US Active EQ                                                  | 3,966,986            | 4,363,759            |
| AON Hewitt Group Trust       | AGT US Small Mid Cap Active EQ                                        | 1,450,536            | 1,720,723            |
| AON Hewitt Group Trust       | AHGT SSGA Int US Gov BD                                               | 4,200,000            | 4,194,144            |
| PNC Bank, N.A.               | Money market fund - Federated Government Obligations SEL              | 16,921               | 16,921               |
| AON Hewitt Group Trust       | Investment in limited partnership - AON Liquid Alternatives Fund Ltd. | 4,600,000            | 4,677,811            |
|                              | Total                                                                 | <b>\$ 49,679,857</b> | <b>\$ 54,219,654</b> |

# Southeastern Ohio Regional Medical Center Pension Plan

## Schedule of Reportable Transactions

Form 5500, Schedule H, Line 4j  
 EIN 31-4391798, Plan No. 001  
 Year Ended December 31, 2019

| (a)<br>Identity of Party Involved                                                                                    | (b)<br>Description of Asset        | (c)<br>Purchase Price | (d)<br>Selling Price | (g)<br>Cost of Asset | (h)<br>Current Value of Asset on Transaction Date | (i)<br>Net Gain |
|----------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------|----------------------|----------------------|---------------------------------------------------|-----------------|
| Category (i) - A single transaction that amounts to more than 5 percent of the beginning value of total plan assets: |                                    |                       |                      |                      |                                                   |                 |
| PNC Bank, N.A.                                                                                                       | AHGT Mid Duration Long Credit Fund | \$ 3,000,000          | \$ -                 | \$ 3,000,000         | \$ 3,000,000                                      | \$ -            |
| PNC Bank, N.A.                                                                                                       | AHGT Mid Duration Long Credit Fund | -                     | 10,500,000           | 9,882,419            | 10,500,000                                        | 617,581         |
| PNC Bank, N.A.                                                                                                       | AGT+20 Year US Treasury            | -                     | 3,000,000            | 2,218,400            | 3,000,000                                         | 781,600         |
| PNC Bank, N.A.                                                                                                       | AGT+20 Year US Treasury            | -                     | 4,500,000            | 3,296,729            | 4,500,000                                         | 1,203,271       |
| PNC Bank, N.A.                                                                                                       | AHGT US LG Gov BD                  | 3,000,000             | -                    | 3,000,000            | 3,000,000                                         | -               |
| PNC Bank, N.A.                                                                                                       | AGT US Long Fixed Active Credit    | -                     | 3,000,000            | 2,827,302            | 3,000,000                                         | 172,698         |
| PNC Bank, N.A.                                                                                                       | AGT US Long Fixed Active Credit    | 10,500,000            | -                    | 10,500,000           | 10,500,000                                        | -               |
| PNC Bank, N.A.                                                                                                       | AHGT SSGA Int US Gov BD            | 4,200,000             | -                    | 4,200,000            | 4,200,000                                         | -               |

Category (iii) - A series of transactions with respect to securities of the same issue that amount in the aggregate to more than 5 percent of the beginning value of the total plan assets:

|                |                                     |            |            |            |            |           |
|----------------|-------------------------------------|------------|------------|------------|------------|-----------|
| PNC Bank, N.A. | AHGT Mid Duration Long Credit Fund: |            |            |            |            |           |
|                | Purchases - 4                       | 6,500,000  | -          | 6,500,000  | 6,500,000  | -         |
|                | Sales - 1                           | -          | 10,500,000 | 9,882,419  | 10,500,000 | 617,581   |
| PNC Bank, N.A. | AGT+20 Year US Treasury:            |            |            |            |            |           |
|                | Purchases - 1                       | 300,000    | -          | 300,000    | 300,000    | -         |
|                | Sales - 4                           | -          | 10,500,000 | 8,250,381  | 10,500,000 | 2,249,619 |
| PNC Bank, N.A. | AHGT US LG Gov BD:                  |            |            |            |            |           |
|                | Purchases - 1                       | 3,000,000  | -          | 3,000,000  | 3,000,000  | -         |
|                | Sales - 2                           | -          | 2,300,000  | 2,047,333  | 2,300,000  | 252,667   |
| PNC Bank, N.A. | PNC Govt Money Market Fund:         |            |            |            |            |           |
|                | Purchases - 3                       | 1,036,820  | -          | 1,036,820  | 1,036,820  | -         |
|                | Sales - 8                           | -          | 2,564,834  | 2,564,834  | 2,564,834  | -         |
| PNC Bank, N.A. | AGT US Long Fixed Active Credit:    |            |            |            |            |           |
|                | Purchases - 3                       | 13,300,000 | -          | 13,300,000 | 13,300,000 | -         |
|                | Sales - 3                           | -          | 5,750,000  | 5,378,342  | 5,750,000  | 371,658   |
| PNC Bank, N.A. | AHGT SSGA Int US Gov BD -           |            |            |            |            |           |
|                | Purchases - 1                       | 4,200,000  | -          | 4,200,000  | 4,200,000  | -         |

There were no Category (ii) or (iv) reportable transactions during the year.

## Southeastern Ohio Regional Medical Center Pension Plan

### Schedule of Nonexempt Transactions

Form 5500, Schedule G, Part III  
EIN 31-4391798, Plan No. 001  
Year Ended December 31, 2019

|                                                                                                                                                                                                                         |                                   |                                                                                |                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------|
| (a) Identity of party involved<br>Southern Ohio Regional Medical Center                                                                                                                                                 |                                   | (b) Relationship to plan, employer, or other party-in-interest<br>Plan sponsor |                                                                   |
| (c) Description of transactions including maturity date, rate of interest, collateral, par or maturity value<br>Expenses were reimbursed to the plan sponsor in a timeline outside of what is prescribed by regulation. |                                   |                                                                                |                                                                   |
| (d) Purchase price<br>\$-                                                                                                                                                                                               | (e) Selling price<br>\$-          | (f) Lease rental/loan amount involved<br>\$-                                   | (g) Expenses incurred in connection with transaction<br>\$586,370 |
| (h) Cost of asset<br>\$-                                                                                                                                                                                                | (i) Current value of asset<br>\$- | (j) Net gain (loss) on each transaction<br>\$-                                 |                                                                   |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 26—Schedule of Active Participant Data as of January 1, 2019

| Attained Age | Number of Participants    |     |     |       |       |       |       |       |       |     |
|--------------|---------------------------|-----|-----|-------|-------|-------|-------|-------|-------|-----|
|              | Years of Credited Service |     |     |       |       |       |       |       |       |     |
|              | <1                        | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40+ |
| <25          |                           |     |     |       |       |       |       |       |       |     |
| 25-29        |                           |     |     |       |       |       |       |       |       |     |
| 30-34        | 1                         | 1   |     |       |       |       |       |       |       |     |
| 35-39        | 5                         | 23  | 6   |       |       |       |       |       |       |     |
| 40-44        | 1                         | 13  | 13  |       |       |       |       |       |       |     |
| 45-49        | 1                         | 10  | 15  | 15    | 5     |       |       |       |       |     |
| 50-54        | 1                         | 8   | 5   | 8     | 19    | 1     |       |       |       |     |
| 55-59        | 2                         | 6   | 6   | 5     | 7     | 12    |       |       |       |     |
| 60-64        | 4                         | 11  | 5   | 8     | 7     | 11    | 3     |       |       |     |
| 65-69        |                           | 3   | 1   | 2     |       | 1     | 1     | 1     |       |     |
| 70+          |                           |     |     | 1     |       |       |       |       |       |     |

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Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, Part V—Statement of Actuarial Assumptions/Methods

|                                             |                                                                                                                                                                           |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Interest Rates for Minimum Funding Purposes | Based on segment rates with a four-month lookback (as of September 2018), each adjusted as needed to fall within the 25-year average interest rate stabilization corridor |
| 1st Segment Rate                            | 3.74%                                                                                                                                                                     |
| 2nd Segment Rate                            | 5.35%                                                                                                                                                                     |
| 3rd Segment Rate                            | 6.11%                                                                                                                                                                     |
| Interest Rates for Maximum Tax Purposes     | Based on segment rates with a four-month lookback (as of September 2018), without regard to interest rate stabilization                                                   |
| 1st Segment Rate                            | 2.28%                                                                                                                                                                     |
| 2nd Segment Rate                            | 3.81%                                                                                                                                                                     |
| 3rd Segment Rate                            | 4.46%                                                                                                                                                                     |
| Retirement Age                              |                                                                                                                                                                           |
| Active Participants                         | See Table 1                                                                                                                                                               |
| Terminated Vested Participants              | Age 65                                                                                                                                                                    |
| Mortality Rates                             |                                                                                                                                                                           |
| Healthy and Disabled                        | 2019 static mortality table for annuitants and non-annuitants per §1.430(h)(3)-1(e)                                                                                       |
| Withdrawal Rates                            | See Table 2                                                                                                                                                               |
| Disability Rates                            | None                                                                                                                                                                      |
| Decrement Timing                            | Beginning of year decrements                                                                                                                                              |
| Surviving Spouse Benefit                    | It is assumed that 80% of males and 80% of females have an eligible spouse, and that males are three years older than their spouses.                                      |
| Benefit Limits                              | Projected benefits are limited by the current IRC section 415 maximum benefit of \$225,000.                                                                               |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Valuation of Plan Assets

Smoothed fair market value of assets over the current and prior two years, adjusted for contributions, benefit payments, administrative expenses, and expected earnings. The average value of assets calculated in this manner is further limited to not less than 90% nor more than 110% of fair market value.

A characteristic of this method is that the expected distribution of the value of plan assets is skewed toward understatement relative to the corresponding market values for expected long-term rates of return in excess of the third segment rate under IRC section 430(h)(2)(C)(iii).

Expected Return on Assets

|                |       |
|----------------|-------|
| 2017 Plan Year | 6.25% |
| 2018 Plan Year | 6.25% |
| 2019 Plan Year | 6.25% |

Trust Expenses Included in Target Normal Cost

Based on prior year administrative expenses and current year PBGC Premium

Actuarial Method

Standard unit credit cost method

Valuation Date

January 1, 2019

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Table 1

**Retirement Rates**

| <b>Age</b> | <b>Standard</b> | <b>Rule of 89</b> |
|------------|-----------------|-------------------|
| 55         | 2.50%           | 7.50%             |
| 56         | 2.50%           | 7.50%             |
| 57         | 2.50%           | 7.50%             |
| 58         | 2.50%           | 7.50%             |
| 59         | 2.50%           | 7.50%             |
| 60         | 5.00%           | 15.00%            |
| 61         | 5.00%           | 15.00%            |
| 62         | 20.00%          | 60.00%            |
| 63         | 10.00%          | 30.00%            |
| 64         | 10.00%          | 30.00%            |
| 65         | 30.00%          | 90.00%            |
| 66         | 30.00%          | 90.00%            |
| 67         | 100.00%         | 100.00%           |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Table 2

**Withdrawal Rates**

| <b>Age</b> | <b>Rate</b> | <b>Age</b> | <b>Rate</b> |
|------------|-------------|------------|-------------|
| 15         | 9.9384%     | 45         | 6.3540%     |
| 16         | 9.9384%     | 46         | 6.0053%     |
| 17         | 9.9384%     | 47         | 5.6227%     |
| 18         | 9.9384%     | 48         | 5.2000%     |
| 19         | 9.9384%     | 49         | 4.7337%     |
| 20         | 9.9384%     | 50         | 4.2247%     |
| 21         | 9.8898%     | 51         | 3.6823%     |
| 22         | 9.8398%     | 52         | 3.1228%     |
| 23         | 9.7877%     | 53         | 2.5661%     |
| 24         | 9.7331%     | 54         | 2.0347%     |
| 25         | 9.6742%     | 55         | 1.5488%     |
| 26         | 9.6114%     | 56         | 1.1247%     |
| 27         | 9.5438%     | 57         | 0.7718%     |
| 28         | 9.4704%     | 58         | 0.4939%     |
| 29         | 9.3906%     | 59         | 0.2879%     |
| 30         | 9.3031%     | 60         | 0.1465%     |
| 31         | 9.2065%     | 61         | 0.0594%     |
| 32         | 9.1000%     | 62         | 0.0152%     |
| 33         | 8.9820%     | 63         | 0.0000%     |
| 34         | 8.8511%     | 64         | 0.0000%     |
| 35         | 8.7062%     |            |             |
| 36         | 8.5466%     |            |             |
| 37         | 8.3717%     |            |             |
| 38         | 8.1815%     |            |             |
| 39         | 7.9756%     |            |             |
| 40         | 7.7543%     |            |             |
| 41         | 7.5151%     |            |             |
| 42         | 7.2556%     |            |             |
| 43         | 6.9760%     |            |             |
| 44         | 6.6758%     |            |             |

|                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br>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).<br><br><b>Complete all entries in accordance with the instructions to the Form 5500.</b> | OMB Nos. 1210-0110<br>1210-0089<br><br><div style="font-size: 24pt; font-weight: bold; text-align: center;">2019</div><br><br><b>This Form is Open to Public Inspection</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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

|                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                        |                                                              |                                                           |                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------|--|
| <b>Part II Basic Plan Information—enter all requested information</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        |                                                              |                                                           |                                                      |  |
| <b>1a</b> Name of plan<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN                                                                                                                                                                                                                                                                              | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;">001</td> </tr> <tr> <td colspan="2"><b>1c</b> Effective date of plan<br/>07/01/1967</td> </tr> </table>                      | <b>1b</b> Three-digit plan number (PN) ▶                     | 001                                                       | <b>1c</b> Effective date of plan<br>07/01/1967       |  |
| <b>1b</b> Three-digit plan number (PN) ▶                                                                                                                                                                                                                                                                                                                      | 001                                                                                                                                                                                                                                                                                                                    |                                                              |                                                           |                                                      |  |
| <b>1c</b> Effective date of plan<br>07/01/1967                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                        |                                                              |                                                           |                                                      |  |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (If foreign, see instructions)<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER<br><br>1341 CLARK STREET<br><br>CAMBRIDGE OH 43725 | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td><b>2b</b> Employer Identification Number (EIN)<br/>31-4391798</td> </tr> <tr> <td><b>2c</b> Plan Sponsor's telephone number<br/>740-439-8179</td> </tr> <tr> <td><b>2d</b> Business code (see instructions)<br/>622000</td> </tr> </table> | <b>2b</b> Employer Identification Number (EIN)<br>31-4391798 | <b>2c</b> Plan Sponsor's telephone number<br>740-439-8179 | <b>2d</b> Business code (see instructions)<br>622000 |  |
| <b>2b</b> Employer Identification Number (EIN)<br>31-4391798                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                        |                                                              |                                                           |                                                      |  |
| <b>2c</b> Plan Sponsor's telephone number<br>740-439-8179                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                        |                                                              |                                                           |                                                      |  |
| <b>2d</b> Business code (see instructions)<br>622000                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                        |                                                              |                                                           |                                                      |  |

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

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

|              |                                    |            |                                                              |
|--------------|------------------------------------|------------|--------------------------------------------------------------|
| SIGN<br>HERE |                                    | 10/14/2020 | Jonathan Kelly                                               |
|              | Signature of plan administrator    | Date       | Enter name of individual signing as plan administrator       |
| SIGN<br>HERE |                                    |            |                                                              |
|              | Signature of employer/plan sponsor | Date       | Enter name of individual signing as employer or plan sponsor |
| SIGN<br>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

Form 5500 (2019)

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|                                                                                                                                                                                                                                                                                        |  |                                            |     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|-----|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                               |  | <b>3b</b> Administrator's EIN              |     |
|                                                                                                                                                                                                                                                                                        |  | <b>3c</b> Administrator's telephone number |     |
|                                                                                                                                                                                                                                                                                        |  |                                            |     |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name |  | <b>4b</b> EIN                              |     |
|                                                                                                                                                                                                                                                                                        |  | <b>4d</b> PN                               |     |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                |  | <b>5</b>                                   | 730 |
| <b>6</b> 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).                                                                                                                               |  |                                            |     |
| <b>a(1)</b> Total number of active participants at the beginning of the plan year .....                                                                                                                                                                                                |  | <b>6a(1)</b>                               | 248 |
| <b>a(2)</b> Total number of active participants at the end of the plan year .....                                                                                                                                                                                                      |  | <b>6a(2)</b>                               | 202 |
| <b>b</b> Retired or separated participants receiving benefits.....                                                                                                                                                                                                                     |  | <b>6b</b>                                  | 376 |
| <b>c</b> Other retired or separated participants entitled to future benefits .....                                                                                                                                                                                                     |  | <b>6c</b>                                  | 106 |
| <b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c.....                                                                                                                                                                                                                                    |  | <b>6d</b>                                  | 684 |
| <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....                                                                                                                                                                             |  | <b>6e</b>                                  | 26  |
| <b>f</b> Total. Add lines 6d and 6e.....                                                                                                                                                                                                                                               |  | <b>6f</b>                                  | 710 |
| <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....                                                                                                                                        |  | <b>6g</b>                                  |     |
| <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....                                                                                                                                             |  | <b>6h</b>                                  | 0   |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....                                                                                                                                                    |  | <b>7</b>                                   |     |
| <b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:<br>1A 1I                                                                                                                  |  |                                            |     |
| <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:                                                                                                                            |  |                                            |     |

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

Form 5500 (2019)

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**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 \_\_\_\_\_

|                         |                                                               |
|-------------------------|---------------------------------------------------------------|
| <b>Plan Name</b>        | <b>Southeastern Ohio Regional Medical Center Pension Plan</b> |
| <b>Plan Sponsor EIN</b> | <b>31-4391798</b>                                             |
| <b>ERISA Plan No.</b>   | <b>001</b>                                                    |
| <b>Plan Year End</b>    | <b>12/31/2019</b>                                             |

The required attachment noted below is included within the Accountant's Opinion attachment to the  
Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's  
Independent Qualified Public Accountant (IQPA).

| <b>Form/Schedule</b> | <b>Line Item</b> | <b>Description</b>                  |
|----------------------|------------------|-------------------------------------|
| 5500 Schedule H      | Line 4j          | Schedule of Reportable Transactions |

|                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <b>SCHEDULE SB</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Single-Employer Defined Benefit Plan</b><br><b>Actuarial Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500 or 5500-SF.</b> | OMB No. 1210-0110<br><br><b>2019</b><br><br><b>This Form is Open to Public Inspection</b> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|

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

▶ **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.

|                                                                                                                                           |                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>A</b> Name of plan<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER PENSION PLAN                                                           | <b>B</b> Three-digit plan number (PN) ▶ 001                                                                                                             |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF<br>SOUTHEASTERN OHIO REGIONAL MEDICAL CENTER                     | <b>D</b> Employer Identification Number (EIN)<br>31-4391798                                                                                             |
| <b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B | <b>F</b> Prior year plan size: <input type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input checked="" type="checkbox"/> More than 500 |

|                                                                                                                                                                                                                |                            |                           |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|--------------------------|
| <b>Part I Basic Information</b>                                                                                                                                                                                |                            |                           |                          |
| <b>1</b> Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2019</u>                                                                                                                              |                            |                           |                          |
| <b>2</b> Assets:                                                                                                                                                                                               |                            |                           |                          |
| <b>a</b> Market value.....                                                                                                                                                                                     | <b>2a</b>                  | 48,419,054                |                          |
| <b>b</b> Actuarial value.....                                                                                                                                                                                  | <b>2b</b>                  | 50,532,086                |                          |
| <b>3</b> Funding target/participant count breakdown                                                                                                                                                            | (1) Number of participants | (2) Vested Funding Target | (3) Total Funding Target |
| <b>a</b> For retired participants and beneficiaries receiving payment.....                                                                                                                                     | 382                        | 40,720,923                | 40,720,923               |
| <b>b</b> For terminated vested participants.....                                                                                                                                                               | 100                        | 3,992,263                 | 3,992,263                |
| <b>c</b> For active participants.....                                                                                                                                                                          | 248                        | 12,002,228                | 13,248,550               |
| <b>d</b> Total.....                                                                                                                                                                                            | 730                        | 56,715,414                | 57,961,736               |
| <b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>                                                                                          |                            |                           |                          |
| <b>a</b> Funding target disregarding prescribed at-risk assumptions.....                                                                                                                                       | <b>4a</b>                  |                           |                          |
| <b>b</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..... | <b>4b</b>                  |                           |                          |
| <b>5</b> Effective interest rate.....                                                                                                                                                                          | <b>5</b>                   | 5.49%                     |                          |
| <b>6</b> Target normal cost.....                                                                                                                                                                               | <b>6</b>                   | 635,590                   |                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| <b>Statement by Enrolled Actuary</b><br>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. |                                        |
| <b>SIGN HERE</b> Jason C. Wells                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 09/23/2020                             |
| Signature of actuary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Date                                   |
| JASON C. WELLS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2007067                                |
| Type or print name of actuary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Most recent enrollment number          |
| AON CONSULTING, INC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 614-436-8100                           |
| Firm name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Telephone number (including area code) |
| 445 HUTCHINSON AVE, SUITE 900                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                        |
| COLUMBUS OH 43235-8619                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        |
| 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 ☐

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

**Schedule SB (Form 5500) 2019**  
**v. 190130**

## Part II Beginning of Year Carryover and Prefunding Balances

|                                                                                                                                                                     | (a) Carryover balance | (b) Prefunding balance |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------|
| <b>7</b> Balance at beginning of prior year after applicable adjustments (line 13 from prior year).....                                                             | 0                     | 837,423                |
| <b>8</b> Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....                                                         | 0                     | 0                      |
| <b>9</b> Amount remaining (line 7 minus line 8).....                                                                                                                | 0                     | 837,423                |
| <b>10</b> Interest on line 9 using prior year's actual return of <u>-4.07%</u> .....                                                                                | 0                     | -34,083                |
| <b>11</b> Prior year's excess contributions to be added to prefunding balance:                                                                                      |                       |                        |
| <b>a</b> Present value of excess contributions (line 38a from prior year).....                                                                                      |                       | 3,021                  |
| <b>b(1)</b> 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>5.66%</u> ..... |                       | 171                    |
| <b>b(2)</b> Interest on line 38b from prior year Schedule SB, using prior year's actual return.....                                                                 |                       | 0                      |
| <b>c</b> Total available at beginning of current plan year to add to prefunding balance.....                                                                        |                       | 3,192                  |
| <b>d</b> Portion of (c) to be added to prefunding balance.....                                                                                                      |                       | 3,192                  |
| <b>12</b> Other reductions in balances due to elections or deemed elections.....                                                                                    | 0                     | 0                      |
| <b>13</b> Balance at beginning of current year (line 9 + line 10 + line 11d – line 12).....                                                                         | 0                     | 806,532                |

## Part III Funding Percentages

|           |                                                                                                                                                                  |           |        |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--------|
| <b>14</b> | Funding target attainment percentage .....                                                                                                                       | <b>14</b> | 85.79% |
| <b>15</b> | Adjusted funding target attainment percentage .....                                                                                                              | <b>15</b> | 85.79% |
| <b>16</b> | Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement ..... | <b>16</b> | 88.83% |
| <b>17</b> | If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage. ....                                        | <b>17</b> | %      |

## Part IV Contributions and Liquidity Shortfalls

| 18 Contributions made to the plan for the plan year by employer(s) and employees: |                                   |                                 |                          |                                   |                                 |         |
|-----------------------------------------------------------------------------------|-----------------------------------|---------------------------------|--------------------------|-----------------------------------|---------------------------------|---------|
| (a) Date<br>(MM-DD-YYYY)                                                          | (b) Amount paid by<br>employer(s) | (c) Amount paid by<br>employees | (a) Date<br>(MM-DD-YYYY) | (b) Amount paid by<br>employer(s) | (c) Amount paid by<br>employees |         |
| 04/12/2019                                                                        | 401,116                           | 0                               |                          |                                   |                                 |         |
| 07/12/2019                                                                        | 401,116                           | 0                               |                          |                                   |                                 |         |
| 10/11/2019                                                                        | 401,116                           | 0                               |                          |                                   |                                 |         |
| 01/13/2020                                                                        | 401,116                           | 0                               |                          |                                   |                                 |         |
| 02/14/2020                                                                        | 431,856                           | 0                               |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 |                          |                                   |                                 |         |
|                                                                                   |                                   |                                 | Totals ►                 | 18(b)                             | 2,036,320                       | 18(c) 0 |

|                                                                                                                                      |            |           |
|--------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| <b>19</b> Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year: |            |           |
| <b>a</b> Contributions allocated toward unpaid minimum required contributions from prior years.....                                  | <b>19a</b> | 0         |
| <b>b</b> Contributions made to avoid restrictions adjusted to valuation date .....                                                   | <b>19b</b> | 0         |
| <b>c</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....               | <b>19c</b> | 1,956,391 |

**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**

|                                                 |                                                                                                                                              |                        |                        |                                                     |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------|-----------------------------------------------------|
| <b>21</b> Discount rate:                        |                                                                                                                                              |                        |                        |                                                     |
| <b>a</b> Segment rates:                         | 1st segment:<br>3.74 %                                                                                                                       | 2nd segment:<br>5.35 % | 3rd segment:<br>6.11 % | <input type="checkbox"/> N/A, full yield curve used |
| <b>b</b> Applicable month (enter code).....     |                                                                                                                                              |                        |                        | <b>21b</b> 4                                        |
| <b>22</b> Weighted average retirement age ..... |                                                                                                                                              |                        |                        | <b>22</b> 62                                        |
| <b>23</b> Mortality table(s) (see instructions) | <input type="checkbox"/> Prescribed - combined <input checked="" type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute |                        |                        |                                                     |

**Part VI Miscellaneous Items**

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

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

|                                                                                                                                      |           |   |
|--------------------------------------------------------------------------------------------------------------------------------------|-----------|---|
| <b>28</b> Unpaid minimum required contributions for all prior years .....                                                            | <b>28</b> | 0 |
| <b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) ..... | <b>29</b> | 0 |
| <b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29) .....                                    | <b>30</b> | 0 |

**Part VIII Minimum Required Contribution For Current Year**

|                                                                                                                                                                                      |                     |                    |               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------|---------------|
| <b>31</b> Target normal cost and excess assets (see instructions):                                                                                                                   |                     |                    |               |
| <b>a</b> Target normal cost (line 6) .....                                                                                                                                           | <b>31a</b>          | 635,590            |               |
| <b>b</b> Excess assets, if applicable, but not greater than line 31a .....                                                                                                           | <b>31b</b>          | 0                  |               |
| <b>32</b> Amortization installments:                                                                                                                                                 | Outstanding Balance | Installment        |               |
| <b>a</b> Net shortfall amortization installment .....                                                                                                                                | 8,236,182           | 2,127,222          |               |
| <b>b</b> Waiver amortization installment .....                                                                                                                                       | 0                   | 0                  |               |
| <b>33</b> 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 ..... | <b>33</b>           |                    |               |
| <b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)....                                                           | <b>34</b>           | 2,762,812          |               |
|                                                                                                                                                                                      | Carryover balance   | Prefunding balance | Total balance |
| <b>35</b> Balances elected for use to offset funding requirement .....                                                                                                               | 0                   | 806,421            | 806,421       |
| <b>36</b> Additional cash requirement (line 34 minus line 35) .....                                                                                                                  | <b>36</b>           | 1,956,391          |               |
| <b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....                                                  | <b>37</b>           | 1,956,391          |               |
| <b>38</b> Present value of excess contributions for current year (see instructions)                                                                                                  |                     |                    |               |
| <b>a</b> Total (excess, if any, of line 37 over line 36) .....                                                                                                                       | <b>38a</b>          | 0                  |               |
| <b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....                                                                | <b>38b</b>          | 0                  |               |
| <b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....                                                                      | <b>39</b>           | 0                  |               |
| <b>40</b> Unpaid minimum required contributions for all years .....                                                                                                                  | <b>40</b>           | 0                  |               |

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

|                                                                                  |                                                                                                                         |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <b>41</b> If an election was made to use PRA 2010 funding relief for this plan:  |                                                                                                                         |
| <b>a</b> Schedule elected .....                                                  | <input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years                                               |
| <b>b</b> Eligible plan year(s) for which the election in line 41a was made ..... | <input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 19—Discounted Employer Contributions

Year applied for contributions: 2019

| <b>Date</b>        | <b>Amount</b>  | <b>Days to<br/>Discount to<br/>1/1/2019 at<br/>5.49%</b> | <b>Interest<br/>Adjusted<br/>Contribution</b> |
|--------------------|----------------|----------------------------------------------------------|-----------------------------------------------|
| April 12, 2019     | \$ 401,116     | 101                                                      | \$ 395,227                                    |
| July 12, 2019      | 401,116        | 192                                                      | 389,996                                       |
| October 11, 2019   | 401,116        | 283                                                      | 384,834                                       |
| January 13, 2020   | 401,116        | 377                                                      | 379,575                                       |
| February 14, 2020  | <u>431,856</u> | 409                                                      | <u>406,759</u>                                |
| Total Contribution | \$ 2,036,320   |                                                          | \$ 1,956,391                                  |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 22—Description of Weighted Average Retirement Age

The average retirement age shown in line 22 has been calculated by assuming the following retirement rates and no decrements other than retirement for this calculation. All retirements are assumed to occur at beginning of year.

| (a) | (b)              | (c)    | (d)<br>Product  | (e)              | (f)    | (g)<br>Product  |
|-----|------------------|--------|-----------------|------------------|--------|-----------------|
| Age | Rate             | Weight | (a) × (b) × (c) | Rate             | Weight | (a) × (b) × (c) |
| 55  | 2.50%            | 1.0000 | 1.38            | 7.50%            | 1.0000 | 4.13            |
| 56  | 2.50%            | 0.9750 | 1.37            | 7.50%            | 0.9250 | 3.89            |
| 57  | 2.50%            | 0.9506 | 1.35            | 7.50%            | 0.8556 | 3.66            |
| 58  | 2.50%            | 0.9269 | 1.34            | 7.50%            | 0.7915 | 3.44            |
| 59  | 2.50%            | 0.9037 | 1.33            | 7.50%            | 0.7321 | 3.24            |
| 60  | 5.00%            | 0.8811 | 2.64            | 15.00%           | 0.6772 | 6.09            |
| 61  | 5.00%            | 0.8370 | 2.55            | 15.00%           | 0.5756 | 5.27            |
| 62  | 20.00%           | 0.7952 | 9.86            | 60.00%           | 0.4893 | 18.2            |
| 63  | 10.00%           | 0.6362 | 4.01            | 30.00%           | 0.1957 | 3.7             |
| 64  | 10.00%           | 0.5725 | 3.66            | 30.00%           | 0.1370 | 2.63            |
| 65  | 30.00%           | 0.5153 | 10.05           | 90.00%           | 0.0959 | 5.61            |
| 66  | 30.00%           | 0.3607 | 7.14            | 90.00%           | 0.0096 | 0.57            |
| 67  | 100.00%          | 0.2525 | 16.92           | 100.00%          | 0.0010 | 0.06            |
|     | Weighted Average |        | 63.60           | Weighted Average |        | 60.49           |
|     | Weight           |        | 50%             |                  |        | 50%             |
|     |                  |        |                 |                  |        | 62.05           |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, Part V—Statement of Actuarial Assumptions/Methods

|                                             |                                                                                                                                                                           |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Interest Rates for Minimum Funding Purposes | Based on segment rates with a four-month lookback (as of September 2018), each adjusted as needed to fall within the 25-year average interest rate stabilization corridor |
| 1st Segment Rate                            | 3.74%                                                                                                                                                                     |
| 2nd Segment Rate                            | 5.35%                                                                                                                                                                     |
| 3rd Segment Rate                            | 6.11%                                                                                                                                                                     |
| Interest Rates for Maximum Tax Purposes     | Based on segment rates with a four-month lookback (as of September 2018), without regard to interest rate stabilization                                                   |
| 1st Segment Rate                            | 2.28%                                                                                                                                                                     |
| 2nd Segment Rate                            | 3.81%                                                                                                                                                                     |
| 3rd Segment Rate                            | 4.46%                                                                                                                                                                     |
| Retirement Age                              |                                                                                                                                                                           |
| Active Participants                         | See Table 1                                                                                                                                                               |
| Terminated Vested Participants              | Age 65                                                                                                                                                                    |
| Mortality Rates                             |                                                                                                                                                                           |
| Healthy and Disabled                        | 2019 static mortality table for annuitants and non-annuitants per §1.430(h)(3)-1(e)                                                                                       |
| Withdrawal Rates                            | See Table 2                                                                                                                                                               |
| Disability Rates                            | None                                                                                                                                                                      |
| Decrement Timing                            | Beginning of year decrements                                                                                                                                              |
| Surviving Spouse Benefit                    | It is assumed that 80% of males and 80% of females have an eligible spouse, and that males are three years older than their spouses.                                      |
| Benefit Limits                              | Projected benefits are limited by the current IRC section 415 maximum benefit of \$225,000.                                                                               |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Valuation of Plan Assets

Smoothed fair market value of assets over the current and prior two years, adjusted for contributions, benefit payments, administrative expenses, and expected earnings. The average value of assets calculated in this manner is further limited to not less than 90% nor more than 110% of fair market value.

A characteristic of this method is that the expected distribution of the value of plan assets is skewed toward understatement relative to the corresponding market values for expected long-term rates of return in excess of the third segment rate under IRC section 430(h)(2)(C)(iii).

Expected Return on Assets

|                |       |
|----------------|-------|
| 2017 Plan Year | 6.25% |
| 2018 Plan Year | 6.25% |
| 2019 Plan Year | 6.25% |

Trust Expenses Included in Target Normal Cost

Based on prior year administrative expenses and current year PBGC Premium

Actuarial Method

Standard unit credit cost method

Valuation Date

January 1, 2019

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Table 1

**Retirement Rates**

| <b>Age</b> | <b>Standard</b> | <b>Rule of 89</b> |
|------------|-----------------|-------------------|
| 55         | 2.50%           | 7.50%             |
| 56         | 2.50%           | 7.50%             |
| 57         | 2.50%           | 7.50%             |
| 58         | 2.50%           | 7.50%             |
| 59         | 2.50%           | 7.50%             |
| 60         | 5.00%           | 15.00%            |
| 61         | 5.00%           | 15.00%            |
| 62         | 20.00%          | 60.00%            |
| 63         | 10.00%          | 30.00%            |
| 64         | 10.00%          | 30.00%            |
| 65         | 30.00%          | 90.00%            |
| 66         | 30.00%          | 90.00%            |
| 67         | 100.00%         | 100.00%           |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Table 2

**Withdrawal Rates**

| <b>Age</b> | <b>Rate</b> | <b>Age</b> | <b>Rate</b> |
|------------|-------------|------------|-------------|
| 15         | 9.9384%     | 45         | 6.3540%     |
| 16         | 9.9384%     | 46         | 6.0053%     |
| 17         | 9.9384%     | 47         | 5.6227%     |
| 18         | 9.9384%     | 48         | 5.2000%     |
| 19         | 9.9384%     | 49         | 4.7337%     |
| 20         | 9.9384%     | 50         | 4.2247%     |
| 21         | 9.8898%     | 51         | 3.6823%     |
| 22         | 9.8398%     | 52         | 3.1228%     |
| 23         | 9.7877%     | 53         | 2.5661%     |
| 24         | 9.7331%     | 54         | 2.0347%     |
| 25         | 9.6742%     | 55         | 1.5488%     |
| 26         | 9.6114%     | 56         | 1.1247%     |
| 27         | 9.5438%     | 57         | 0.7718%     |
| 28         | 9.4704%     | 58         | 0.4939%     |
| 29         | 9.3906%     | 59         | 0.2879%     |
| 30         | 9.3031%     | 60         | 0.1465%     |
| 31         | 9.2065%     | 61         | 0.0594%     |
| 32         | 9.1000%     | 62         | 0.0152%     |
| 33         | 8.9820%     | 63         | 0.0000%     |
| 34         | 8.8511%     | 64         | 0.0000%     |
| 35         | 8.7062%     |            |             |
| 36         | 8.5466%     |            |             |
| 37         | 8.3717%     |            |             |
| 38         | 8.1815%     |            |             |
| 39         | 7.9756%     |            |             |
| 40         | 7.7543%     |            |             |
| 41         | 7.5151%     |            |             |
| 42         | 7.2556%     |            |             |
| 43         | 6.9760%     |            |             |
| 44         | 6.6758%     |            |             |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, Part V—Summary of Plan Provisions

General Information

|                                  |                                           |
|----------------------------------|-------------------------------------------|
| Original Effective Date          | July 1, 1967                              |
| Effective Date of Last Amendment | November 1, 2016                          |
| Plan Year/Employer Fiscal Year   | January 1 to December 31                  |
| Employer ID Number               | 31-4391798                                |
| Plan Number                      | 001                                       |
| Plan Administrator               | Southeastern Ohio Regional Medical Center |

Eligibility

All employees of employer are eligible to participate in the plan on the January 1 nearest the completion of one year of service and attaining age 21. As of April 30, 2007, no new participants shall enter the plan.

Service

Service shall equal total years of service with the employer. A year of credited service is credited for each year in which an employee works 1,800 hours and a pro-rata year if less hours are earned, provided at least 500 hours of service are earned. A break in service occurs at the start of any plan year in which the employee works 500 hours or less for the employer in such year. Service will not be interrupted by:

- (1) A leave of absence granted by the employer;
- (2) A period of service in the Armed Forces of the United States under which employment rights are granted.

An employee will be given credit for his pre-break service if either of the following occurs:

- (1) The employee had a vested interest in his accrued benefit at the time of his break in service; or
- (2) The employee's period of absence was less than his pre-break service, or five years, whichever is greater.

A year of eligibility service is granted for a calendar year in which an employee worked at least 1,000 hours.

No credited service shall be earned after April 30, 2007.

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

|                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Normal Retirement Date    | Normal retirement date is the first day of the month coincident with or next following the later of 1) the attainment of age 65 and 2) the fifth anniversary of participation in the plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Normal Retirement Benefit | The amount of annual benefit to be paid in monthly installments for life is 1.5% of the average compensation up to covered compensation multiplied by the participant's years of credited service, limited to a maximum of 35, plus 2.15% of the participant's average compensation in excess of covered compensation multiplied by the participant's years of credited service, limited to a maximum of 35.                                                                                                                                                                                                                                                   |
| Average Compensation      | The average of the final five years of compensation in which service was earned. Compensation for years were less than one year of service is earned shall be annualized to a 1,800 hour basis. Average compensation is frozen as of April 30, 2007.                                                                                                                                                                                                                                                                                                                                                                                                           |
| Delayed Retirement        | A participant may continue in the employment of the employer after his normal retirement date. In such event he will receive at actual retirement or death the greater of the actuarial equivalent of his normal retirement benefit or the accrued benefit as of the delayed retirement date based on service and average compensation to that date.                                                                                                                                                                                                                                                                                                           |
| Accrued Benefit           | The accrued benefit at any time prior to a participant's normal retirement date shall be the benefit as calculated in the normal retirement benefit section above, using average compensation and service as of the date of determination.                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Early Retirement Benefits | Upon the completion of 10 years of service and the attainment of age 55, a participant may elect to retire. He may receive a monthly benefit for life beginning at his normal retirement date equal to the accrued benefit at early retirement date. Payments may begin immediately, with the benefit being reduced 1/180th per month for each of the first five years and then 1/360th per month for each additional year that the early retirement date precedes the normal retirement date. If a participant's age plus service sum to at least 89 (called the "Rule of 89"), they may receive their accrued benefit without reduction at early retirement. |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Death Benefit

In the event of a married active participant's death, after having become eligible for early retirement, the benefit payable to the spouse will be calculated assuming that the participant had retired on the day prior to death and elected a joint and one-half survivor benefit.

In the event of a married vested participant's death prior to having become eligible for early retirement, the benefit payable to the spouse will be calculated assuming the participant had terminated on the date of death, survived to the earliest retirement age, elected a joint and one-half survivor benefit, and died the next day.

Severance Benefits

Upon the termination of employment after five or more years of vesting service or after reaching normal retirement age, a participant shall be 100% vested in his accrued benefit which will be payable at normal retirement date.

A participant who terminates with 10 or more years of service may elect to receive a reduced benefit as early as age 55.

Optional Methods of Settlement

All optional methods of settlement are actuarially equivalent to the normal form of annuity. If a married participant does not elect the normal form of annuity or does not elect one of the optional methods of settlement described below, then the participant's retirement benefit shall automatically be paid under option [1] below. The options are:

- (1) A reduced benefit to be paid during the participant's lifetime with one half the reduced benefit to be continued to his spouse for her lifetime after his death.
- (2) A reduced benefit to be paid during the participant's lifetime with either 66⅔%, 75% or 100% of the reduced benefit to be continued to his spouse for her lifetime after his death.
- (3) A reduced benefit to be paid for either 120 months certain or 180 month certain and thereafter for life.

All optional methods of settlement are actuarially equivalent to the normal form of annuity and are based on the 1971 GAM table for males and 8% interest.

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Amendment or Termination of Plan

The employer reserves the right to amend or terminate the plan at any time. Generally, the Pension Benefit Guaranty Corporation reserves the right to terminate the plan if the employer fails to meet the minimum funding standards or is unable to pay benefits when due.

If the plan is terminated, the plan assets will be distributed among the plan participants based upon a priority allocation procedure and the employer shall be liable for any unfunded vested benefits to the extent required by law.

The above description is a summary only; for additional details, reference should be made to the formal plan document.

Plan Changes Since the Prior Year

The funding, financial accounting, and plan reporting valuations do not reflect any plan changes.

Other Information to Fully and Fairly Disclose the Actuarial Position of the Plan

Due to software limitations with the electronic filing process, information filed electronically cannot be controlled by the Enrolled Actuary. The values on the signed Schedule SB will govern to the extent there are any differences in the entries filed electronically and the actual data contained on the signed Schedule SB.

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 26—Schedule of Active Participant Data as of January 1, 2019

| Attained Age | Number of Participants    |     |     |       |       |       |       |       |       |     |
|--------------|---------------------------|-----|-----|-------|-------|-------|-------|-------|-------|-----|
|              | Years of Credited Service |     |     |       |       |       |       |       |       |     |
|              | <1                        | 1-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40+ |
| <25          |                           |     |     |       |       |       |       |       |       |     |
| 25-29        |                           |     |     |       |       |       |       |       |       |     |
| 30-34        | 1                         | 1   |     |       |       |       |       |       |       |     |
| 35-39        | 5                         | 23  | 6   |       |       |       |       |       |       |     |
| 40-44        | 1                         | 13  | 13  |       |       |       |       |       |       |     |
| 45-49        | 1                         | 10  | 15  | 15    | 5     |       |       |       |       |     |
| 50-54        | 1                         | 8   | 5   | 8     | 19    | 1     |       |       |       |     |
| 55-59        | 2                         | 6   | 6   | 5     | 7     | 12    |       |       |       |     |
| 60-64        | 4                         | 11  | 5   | 8     | 7     | 11    | 3     |       |       |     |
| 65-69        |                           | 3   | 1   | 2     |       | 1     | 1     | 1     |       |     |
| 70+          |                           |     |     | 1     |       |       |       |       |       |     |

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Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 32—Schedule of Amortization Bases

| Type of Base | Present Value of Installment | Date Established | Years Remaining | Amortization Installment |
|--------------|------------------------------|------------------|-----------------|--------------------------|
| Shortfall    | \$ 330,105                   | January 1, 2013  | 1               | \$ 330,105               |
| Shortfall    | \$ 604,711                   | January 1, 2014  | 2               | \$ 307,906               |
| Shortfall    | \$ 354,072                   | January 1, 2015  | 3               | \$ 122,383               |
| Shortfall    | \$ 983,231                   | January 1, 2016  | 4               | \$ 259,507               |
| Shortfall    | \$ 2,200,081                 | January 1, 2017  | 5               | \$ 472,907               |
| Shortfall    | \$ 1,040,850                 | January 1, 2018  | 6               | \$ 191,938               |
| Shortfall    | \$ 2,723,132                 | January 1, 2019  | 7               | \$ 442,476               |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 19—Discounted Employer Contributions

Year applied for contributions: 2019

| <b>Date</b>        | <b>Amount</b>  | <b>Days to<br/>Discount to<br/>1/1/2019 at<br/>5.49%</b> | <b>Interest<br/>Adjusted<br/>Contribution</b> |
|--------------------|----------------|----------------------------------------------------------|-----------------------------------------------|
| April 12, 2019     | \$ 401,116     | 101                                                      | \$ 395,227                                    |
| July 12, 2019      | 401,116        | 192                                                      | 389,996                                       |
| October 11, 2019   | 401,116        | 283                                                      | 384,834                                       |
| January 13, 2020   | 401,116        | 377                                                      | 379,575                                       |
| February 14, 2020  | <u>431,856</u> | 409                                                      | <u>406,759</u>                                |
| Total Contribution | \$ 2,036,320   |                                                          | \$ 1,956,391                                  |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 22—Description of Weighted Average Retirement Age

The average retirement age shown in line 22 has been calculated by assuming the following retirement rates and no decrements other than retirement for this calculation. All retirements are assumed to occur at beginning of year.

| (a)              | (b)     | (c)    | (d)<br>Product  | (e)              | (f)    | (g)<br>Product  |
|------------------|---------|--------|-----------------|------------------|--------|-----------------|
| Age              | Rate    | Weight | (a) × (b) × (c) | Rate             | Weight | (a) × (b) × (c) |
| 55               | 2.50%   | 1.0000 | 1.38            | 7.50%            | 1.0000 | 4.13            |
| 56               | 2.50%   | 0.9750 | 1.37            | 7.50%            | 0.9250 | 3.89            |
| 57               | 2.50%   | 0.9506 | 1.35            | 7.50%            | 0.8556 | 3.66            |
| 58               | 2.50%   | 0.9269 | 1.34            | 7.50%            | 0.7915 | 3.44            |
| 59               | 2.50%   | 0.9037 | 1.33            | 7.50%            | 0.7321 | 3.24            |
| 60               | 5.00%   | 0.8811 | 2.64            | 15.00%           | 0.6772 | 6.09            |
| 61               | 5.00%   | 0.8370 | 2.55            | 15.00%           | 0.5756 | 5.27            |
| 62               | 20.00%  | 0.7952 | 9.86            | 60.00%           | 0.4893 | 18.2            |
| 63               | 10.00%  | 0.6362 | 4.01            | 30.00%           | 0.1957 | 3.7             |
| 64               | 10.00%  | 0.5725 | 3.66            | 30.00%           | 0.1370 | 2.63            |
| 65               | 30.00%  | 0.5153 | 10.05           | 90.00%           | 0.0959 | 5.61            |
| 66               | 30.00%  | 0.3607 | 7.14            | 90.00%           | 0.0096 | 0.57            |
| 67               | 100.00% | 0.2525 | 16.92           | 100.00%          | 0.0010 | 0.06            |
| Weighted Average |         |        | 63.60           | Weighted Average |        | 60.49           |
| Weight           |         |        | 50%             |                  |        | 50%             |
|                  |         |        |                 |                  |        | 62.05           |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
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Schedule SB, Part V—Summary of Plan Provisions

General Information

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Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
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|                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Normal Retirement Date    | Normal retirement date is the first day of the month coincident with or next following the later of 1) the attainment of age 65 and 2) the fifth anniversary of participation in the plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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|                         |                                                               |
|-------------------------|---------------------------------------------------------------|
| <b>Plan Name</b>        | <b>Southeastern Ohio Regional Medical Center Pension Plan</b> |
| <b>Plan Sponsor EIN</b> | <b>31-4391798</b>                                             |
| <b>ERISA Plan No.</b>   | <b>001</b>                                                    |
| <b>Plan Year End</b>    | <b>12/31/2019</b>                                             |

The required attachment noted below is included within the Accountant's Opinion attachment to the  
Form 5500 Schedule H, Part III, which consists of the entire Audit report issued by the Plan's  
Independent Qualified Public Accountant (IQPA).

| <b>Form/Schedule</b> | <b>Line Item</b> | <b>Description</b>                       |
|----------------------|------------------|------------------------------------------|
| 5500 Schedule H      | Line 4i          | Schedule of Assets (Held at End of Year) |

Schedule SB Attachment (Form 5500)—2019 Plan Year  
Southeastern Ohio Regional Medical Center Pension Plan  
EIN: 31-4391798 PN: 001

Schedule SB, line 32—Schedule of Amortization Bases

| Type of Base | Present Value of Installment | Date Established | Years Remaining | Amortization Installment |
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