

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 1.2em; font-weight: bold;">2010</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2010 or fiscal plan year beginning <u>07/01/2010</u> and ending <u>06/30/2011</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan; or ☒ a single-employer plan; ☐ a DFE (specify) ____
B This return/report is:	☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	☐
D Check box if filing under:	☒ Form 5558; ☐ automatic extension; ☐ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC. RETIREMENT PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>03/01/1977</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>03/01/1977</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>03/01/1977</u>					
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.</u> <u>4800 PAYNE AVENUE</u> <u>CLEVELAND, OH 44103</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>34-1014291</u></td> </tr> <tr> <td>2c Sponsor's telephone number <u>216-231-7700</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>621498</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>34-1014291</u>	2c Sponsor's telephone number <u>216-231-7700</u>	2d Business code (see instructions) <u>621498</u>	
2b Employer Identification Number (EIN) <u>34-1014291</u>					
2c Sponsor's telephone number <u>216-231-7700</u>					
2d Business code (see instructions) <u>621498</u>					

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	04/16/2012	WILLIE AUSTIN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2010)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") CHIEF EXECUTIVE OFFICER 4800 PAYNE AVENUE CLEVELAND, OH 44103	3b Administrator's EIN 34-1014291 3c Administrator's telephone number 216-231-7700
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN	
5 Total number of participants at the beginning of the plan year	5	48
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	11
b Retired or separated participants receiving benefits.....	6b	10
c Other retired or separated participants entitled to future benefits.....	6c	24
d Subtotal. Add lines 6a , 6b , and 6c	6d	45
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	1
f Total. Add lines 6d and 6e	6f	46
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 1A 1D 1G 3D

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

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

a Pension Schedules

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

b General Schedules

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

SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

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

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

A Name of plan <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC. RETIREMENT PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.</u>	D Employer Identification Number (EIN) <u>34-1014291</u>
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B	F Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500

Part I	Basic Information
1 Enter the valuation date: Month <u>07</u> Day <u>01</u> Year <u>2010</u>	
2 Assets:	
a Market value	2a <u>482952</u>
b Actuarial value	2b <u>506359</u>
3 Funding target/participant count breakdown	
	(1) Number of participants (2) Funding Target
a For retired participants and beneficiaries receiving payment	3a <u>9</u> <u>134269</u>
b For terminated vested participants	3b <u>24</u> <u>180389</u>
c For active participants:	
(1) Non-vested benefits	3c(1) <u>0</u>
(2) Vested benefits	3c(2) <u>206914</u>
(3) Total active	3c(3) <u>15</u> <u>206914</u>
d Total	3d <u>48</u> <u>521572</u>
4 If the plan is at-risk, check the box and complete items (a) and (b)	☐
a Funding target disregarding prescribed at-risk assumptions	4a
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor	4b
5 Effective interest rate	5 <u>6.50</u> %
6 Target normal cost	6 <u>3466</u>

Statement by Enrolled Actuary

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

SIGN HERE	<u>02/29/2012</u>
Signature of actuary	Date
<u>PAUL J. GIBBONS</u>	<u>11-06478</u>
Type or print name of actuary	Most recent enrollment number
<u>FINDLEY DAVIES INC</u>	<u>216-875-1900</u>
Firm name	Telephone number (including area code)
<u>1300 EAST NINTH STREET, SUITE 850</u> <u>CLEVELAND, OH 44114-1516</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 and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2010
v.092308.1

Part II	Beginning of year carryover and prefunding balances	(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	10223	
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	10223	
9	Amount remaining (Item 7 minus item 8).....	0	0
10	Interest on item 9 using prior year's actual return of <u>14.05</u> %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (Item 38 from prior year)		0
b	Interest on (a) using prior year's effective rate of <u>6.52</u> %		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance.....		
12	Reduction in balances due to elections or deemed elections.....		
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12).....	0	0

Part III	Funding percentages		
14	Funding target attainment percentage.....	14	97.08 %
15	Adjusted funding target attainment percentage.....	15	97.08 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	92.05 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	17	%

Part IV	Contributions and liquidity shortfalls				
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
08/13/2010	15670				
Totals ►			18(b)	15670	18(c)
					0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:	
a Contributions allocated toward unpaid minimum required contribution from prior years.....	19a 0
b Contributions made to avoid restrictions adjusted to valuation date	19b 0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	19c 15554
20 Quarterly contributions and liquidity shortfalls:	
a Did the plan have a "funding shortfall" for the prior year? ☒ Yes ☐ No	
b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☒ Yes ☐ No	
c If 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
0	0
(3) 3rd	(4) 4th
0	0

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:				
a Segment rates:	1st segment: 4.44 %	2nd segment: 6.62 %	3rd segment: 6.74 %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 4
22 Weighted average retirement age				22 65
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 eligible for (and is using) 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 contribution for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29)	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions).....	31	3466
32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	15213	5890
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 (item 31 + item 32a + item 32b – item 33).....	34	9356
	Carryover balance	Prefunding balance
35 Balances used to offset funding requirement		0
36 Additional cash requirement (item 34 minus item 35).....	36	9356
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c).....	37	15554
38 Interest-adjusted excess contributions for current year (see instructions).....	38	6198
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37).....	39	0
40 Unpaid minimum required contribution for all years	40	0

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection.
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For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

A Name of plan <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC. RETIREMENT PLAN</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.</u>	D Employer Identification Number (EIN) <u>34-1014291</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
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a Name of MTIA, CCT, PSA, or 103-12 IE: <u>HEALTHCOMP, INC.GROUP TRUST</u>		
b Name of sponsor of entity listed in (a): <u>HEALTHCOMP, INC.</u>		
c EIN-PN <u>34-1607331-004</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>586747</u>
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

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

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

SCHEDULE I (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information—Small Plan This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.		OMB No. 1210-0110
			2010
			This Form is Open to Public Inspection
For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011			
A Name of plan NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC. RETIREMENT PLAN		B Three-digit plan number (PN) ►	001
C Plan sponsor's name as shown on line 2a of Form 5500 NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.		D Employer Identification Number (EIN) 34-1014291	

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I	Small Plan Financial Information
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Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.**

1 Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
a Total plan assets	1a	489074	586747
b Total plan liabilities	1b		
c Net plan assets (subtract line 1b from line 1a)	1c	489074	586747
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable:			
(1) Employers	2a(1)	15670	
(2) Participants	2a(2)		
(3) Others (including rollovers)	2a(3)		
b Noncash contributions	2b		
c Other income	2c	110895	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		126565
e Benefits paid (including direct rollovers)	2e	21573	
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Administrative service providers (salaries, fees, and commissions)	2h	7319	
i Other expenses	2i		
j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		28892
k Net income (loss) (subtract line 2j from line 2d)	2k		97673
l Transfers to (from) the plan (see instructions)	2l		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.				
		Yes	No	Amount
a Partnership/joint venture interests	3a		X	
b Employer real property	3b		X	
c Real estate (other than employer real property)	3c		X	
d Employer securities	3d		X	
e Participant loans	3e		X	

	Yes	No	Amount
3f Loans (other than to participants)		X	
g Tangible personal property		X	

Part II Compliance Questions

4 During the plan year:	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)		X	
e Was the plan covered by a fidelity bond?	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	X		
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3			

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

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)

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection.
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For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

A Name of plan <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC. RETIREMENT PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.</u>	D Employer Identification Number (EIN) <u>34-1014291</u>

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

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....	1	<u>0</u>
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>36-1561860</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....	3	<u>0</u>

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

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

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

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

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

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

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule R (Form 5500) 2010
v.092308.1

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 items 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 items 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 items 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 items 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 items 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 items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents)

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

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

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

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

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

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

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

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

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

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

- 19** If the total number of participants is 1,000 or more, complete items (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 item 19(b)?

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

Schedule SB, Line 26 - Schedule of Active Participant Data

July 1, 2010 Valuation
 Northeast Ohio Neighborhood Health Services, Inc.
 (EIN: 34-1014291; PN: 001)

Attained Age	Years of Credited Service									
	Under 1	1 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 & up
Under 25	-	-	-	-	-	-	-	-	-	-
25 to 29	-	-	-	-	-	-	-	-	-	-
30 to 34	-	-	-	-	-	-	-	-	-	-
35 to 39	-	-	-	-	-	-	-	-	-	-
40 to 44	-	-	-	1 (*)	-	-	-	-	-	-
45 to 49	-	-	-	-	-	2 (*)	1 (*)	1 (*)	-	-
50 to 54	-	-	-	-	-	1 (*)	-	-	-	-
55 to 59	-	-	-	2 (*)	1 (*)	1 (*)	-	-	-	-
60 to 64	-	-	-	-	-	-	-	1 (*)	-	-
65 to 69	-	-	-	-	-	-	-	-	2 (*)	1 (*)
70 & up	-	-	-	-	-	-	-	-	-	1 (*)

* Average compensation is not shown since there are fewer than 1,000 active participants in this plan

APPENDIX B

STATEMENT OF ACTUARIAL ASSUMPTIONS AND METHODS

<i>Interest Rates</i>	<p>Funding: 24-Month Segment Rates for March 2009:</p> <table> <tr> <td>a. First Rate, Years 1-5</td><td>4.44%</td></tr> <tr> <td>b. Second Rate, Years 5-20</td><td>6.62%</td></tr> <tr> <td>c. Third Rate, Years 20+</td><td>6.74%</td></tr> <tr> <td>d. Effective Interest Rate using the above rates</td><td>6.50%</td></tr> <tr> <td>e. Interest rate for developing expected value of assets (limited by statute)</td><td>7.50%</td></tr> </table>	a. First Rate, Years 1-5	4.44%	b. Second Rate, Years 5-20	6.62%	c. Third Rate, Years 20+	6.74%	d. Effective Interest Rate using the above rates	6.50%	e. Interest rate for developing expected value of assets (limited by statute)	7.50%
a. First Rate, Years 1-5	4.44%										
b. Second Rate, Years 5-20	6.62%										
c. Third Rate, Years 20+	6.74%										
d. Effective Interest Rate using the above rates	6.50%										
e. Interest rate for developing expected value of assets (limited by statute)	7.50%										
<i>Salary Scale</i>	<p>Future salaries are projected using the appropriate salary scale below. For accrued benefits actual individual pay histories have been used with missing years filled in using the appropriate salary scale below.</p> <p>Funding: N/A</p>										
<i>Mortality</i>	<p>Funding: RP-2000 static, non-generational Mortality Table for “small plans” projected by Scale AA to between 7 and 15 years beyond the year following the date of the obligation and blended as described in Regulation 1.430(h)(3), male and female.</p>										
<i>Rates of Retirement</i>	<p>100% at age 65.</p> <p>Weighted Average Retirement Age is 65. This is the average retirement age for someone eligible to retire at all ages using the assumed retirement rates and no other decrements.</p>										
<i>Rates of Disability</i>	None.										
<i>Rates of Turnover</i>	2% at all ages.										
<i>Assumptions Made In Valuing Spouse's Benefit</i>	<p>Seventy-five percent of the male and seventy-five percent of the female employees included in the valuation are assumed to be married. These percentages are used as the probabilities that survivor benefits will be payable due to preretirement deaths. The wife is assumed to be three years younger than the husband.</p>										

APPENDIX B (Continued)

<i>Optional Form Election</i>	All employees are assumed to elect the life annuity benefit.			
<i>Annual Increases to Maximum Benefits and Plan Compensation Limits</i>	Funding:	0.00%		
<i>Annual Increases to Social Security</i>	Funding:	<u>Taxable Wage Base</u> N/A	<u>Cost of Living Index</u> N/A	<u>Average Earnings</u> N/A
<i>Provision for Expenses</i>	The expected administrative (i.e. non-investment) expenses that will be paid from plan assets, which were assumed to equal actual expenses during the prior year, were included in the Target Normal Cost for minimum contribution purposes.			
<i>Asset Method</i>	<p>Funding: Market Value of Assets plus an adjustment to defer full recognition of investment losses and gains over a two-year period. The investment (gain)/loss for every year equals the market value at the beginning of the year projected to the end of the year using the interest rate above, but no greater than the third segment rate for the plan year, minus the end of the year actual market value. The actuarial value of assets will be no less than 90% and no more than 110% of the market value (including interest-adjusted accrued but unpaid contributions).</p> <p>Market Value of Assets plus, for Funding and ASC 960-20 purposes only, any contributions for prior plan years that will be made in this plan year. For funding purposes only, contributions made after the end of the prior plan year will be discounted for interest at the prior year's effective date.</p>			
<i>Employees Valued</i>	Only participants as of the valuation date were valued.			

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

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

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

A Name of plan NE OH NEIGHBORHOOD HLTH SVCS, INC. -THE GCHA RET C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Northeast Ohio Neighborhood Health Services, Inc.	B Three-digit plan number (PN) <u>001</u> D Employer Identification Number (EIN) 34-1014291
--	---

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

Part I Basic Information

1	Enter the valuation date: Month <u>7</u> Day <u>1</u> Year <u>2010</u>		
2	Assets:		
	a Market value.....	2a	482,952
	b Actuarial value.....	2b	506,359
3	Funding target/participant count breakdown	(1) Number of participants	(2) Funding Target
	a For retired participants and beneficiaries receiving payment.....	3a	134,269
	b For terminated vested participants.....	3b	180,389
	c For active participants:		
	(1) Non-vested benefits.....	3c(1)	0
	(2) Vested benefits.....	3c(2)	206,914
	(3) Total active.....	3c(3)	206,914
	d Total.....	3d	521,572
4	If the plan is at-risk, check the box and complete items (a) and (b) ☐		
	a Funding target disregarding prescribed at-risk assumptions.....	4a	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor.....	4b	
5	Effective interest rate.....	5	6.50 %
6	Target normal cost.....	6	3,466

Statement by Enrolled Actuary

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

SIGN HERE	 Signature of actuary	<u>02/29/2012</u> Date <u>11-06478</u> Most recent enrollment number <u>(216) 875-1900</u> Telephone number (including area code)		
<table style="width:100%;"> <tr> <td style="width:50%;"> <u>AUL J. GIBBONS</u> Type or print name of actuary <u>INDLEY DAVIES INC</u> Firm name <u>300 EAST NINTH STREET, SUITE 850</u> Address of the firm <u>LEVELAND OH 44114-1516</u> </td> <td style="width:50%;"></td> </tr> </table>			<u>AUL J. GIBBONS</u> Type or print name of actuary <u>INDLEY DAVIES INC</u> Firm name <u>300 EAST NINTH STREET, SUITE 850</u> Address of the firm <u>LEVELAND OH 44114-1516</u>	
<u>AUL J. GIBBONS</u> Type or print name of actuary <u>INDLEY DAVIES INC</u> Firm name <u>300 EAST NINTH STREET, SUITE 850</u> Address of the firm <u>LEVELAND OH 44114-1516</u>				

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 ☐

or Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.

Schedule SB (Form 5500) 2010
v.092308.1

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2010 This Form is Open to Public Inspection
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For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

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A Name of plan NE OH NEIGHBORHOOD HLTH SVCS, INC. -THE GCHA RET C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Northeast Ohio Neighborhood Health Services, Inc.	B Three-digit plan number (PN) ►	001
D Employer Identification Number (EIN) 34-1014291		
E Type of plan: ☒ Single ☐ Multiple-A ☐ Multiple-B ☐ F Prior year plan size: ☒ 100 or fewer ☐ 101-500 ☐ More than 500		

Part I Basic Information

1 Enter the valuation date: Month <u>7</u> Day <u>1</u> Year <u>2010</u>			
2 Assets:			
a Market value.....	2a	482,952	
b Actuarial value.....	2b	506,359	
3 Funding target/participant count breakdown		(1) Number of participants	(2) Funding Target
a For retired participants and beneficiaries receiving payment	3a	9	134,269
b For terminated vested participants	3b	24	180,389
c For active participants:			
(1) Non-vested benefits.....	3c(1)		0
(2) Vested benefits.....	3c(2)		206,914
(3) Total active	3c(3)	15	206,914
d Total.....	3d	48	521,572
4 If the plan is at-risk, check the box and complete items (a) and (b) ☐			
a Funding target disregarding prescribed at-risk assumptions	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor.....	4b		
5 Effective interest rate	5	6.50 %	
6 Target normal cost.....	6	3,466	

Statement by Enrolled Actuary

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

SIGN HERE	 Signature of actuary	<u>02/29/2012</u> Date <u>11-06478</u> Most recent enrollment number <u>(216) 875-1900</u> Telephone number (including area code)
<u>AUL J. GIBBONS</u> Type or print name of actuary <u>INDLEY DAVIES INC</u> Firm name <u>300 EAST NINTH STREET, SUITE 850</u> Address of the firm <u>LEVELAND OH 44114-1516</u>		

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 ☐

or Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.

Part II Beginning of year carryover and prefunding balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	10,223	0
8 Portion used to offset prior year's funding requirement (Item 35 from prior year)	10,223	0
9 Amount remaining (Item 7 minus item 8).....	0	0
10 Interest on item 9 using prior year's actual return of <u>14.05</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Excess contributions (Item 38 from prior year)		0
b Interest on (a) using prior year's effective rate of <u>6.52</u> %		0
c Total available at beginning of current plan year to add to prefunding balance		0
d Portion of (c) to be added to prefunding balance.....		0
12 Reduction in balances due to elections or deemed elections.....	0	0
13 Balance at beginning of current year (item 9 + item 10 + item 11d - item 12)	0	0

Part III Funding percentages

14 Funding target attainment percentage.....	14	97.08 %
15 Adjusted funding target attainment percentage.....	15	97.08 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	92.05 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	17	%

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

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
08/13/2010	15,670				
Totals ▶			18(b)	15,670	18(c) 0

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

a Contributions allocated toward unpaid minimum required contribution from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	19c	15,554

20 Quarterly contributions and liquidity shortfalls:

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

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

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:				
a Segment rates:	1st segment: 4.44 %	2nd segment: 6.62 %	3rd segment: 6.74 %	☐ N/A, full yield curve used
b Applicable month (enter code)				21b 4
22 Weighted average retirement age				22 65
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 eligible for (and is using) 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 contribution for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29)	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions)	31	3,466
32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	15,213	5,890
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 (item 31 + item 32a + item 32b - item 33)	34	9,356
	Carryover balance	Prefunding balance
35 Balances used to offset funding requirement	0	0
36 Additional cash requirement (item 34 minus item 35)	36	9,356
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c)	37	15,554
38 Interest-adjusted excess contributions for current year (see instructions)	38	6,198
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37)	39	0
40 Unpaid minimum required contribution for all years	40	0

APPENDIX A

SUMMARY OF PRINCIPAL PLAN PROVISIONS

<i>Plan Sponsor</i>	Northeast Ohio Neighborhood Health Services, Inc.
<i>EIN/PN</i>	34-1014291/001
<i>Effective Date</i>	July 1, 1984; amended and restated effective July 1, 1989.
<i>Plan Year</i>	The 12-month period beginning each July 1.
<i>Participation</i>	Each employee who was a member of the collective bargaining unit represented by Local 47, Service Employees International Union, becomes a participant on the first day of the next following month he has both attained age 21 and completed one Year of Service. No new participants on or after August 28, 1998.
<i>Compensation</i>	Total wages, salary, commissions, overtime pay and other incentive pay, as limited by IRC Section 401(a)(17).
<i>Average Monthly Compensation</i>	1/60th of Compensation for the highest 5 consecutive completed years of employment out of the last 10 years prior to the date of termination, where the pay is annualized for any year in which less than 1,800 hours are earned.
<i>Social Security Covered Compensation</i>	The average of the Social Security Maximum Taxable Wage Bases for the 35-year period ending with the year in which Social Security Retirement Age is attained. Social Security Retirement Age is 65 for employees born before 1938, 67 for those born after 1954, and 66 for those born in between.
<i>Vesting Service</i>	One year of vesting service is earned for each plan year in which 1,000 hours are worked.

APPENDIX A (Continued)

Credited Service

Years of credited service are figured according to the following table:

<u>Hours Paid in Plan Year</u>	<u>Years of Credited Service</u>
Less than 1,000	0.0
1,000 - 1,159	0.5
1,160 - 1,319	0.6
1,320 - 1,479	0.7
1,480 - 1,639	0.8
1,640 - 1,799	0.9
1,800 or more	1.0

No hours are credited for employment after August 28, 1998.

Accrued Benefit

A monthly life annuity starting at age 65 equal to the greater of (i) or (ii):

- (i) 1.2% of Average Monthly Compensation plus 0.65% of Average Monthly Compensation in excess of Social Security Covered Compensation multiplied by the number of Years of Credited Service up to 25.
- (ii) Accrued benefit under the plan provisions in effect as of June 30, 1989.

Benefit accruals ceased August 28, 1998.

Normal Retirement Benefit

Eligibility:

The first day of the month coincident with or next following age 65 or, if later, fifth anniversary of joining the Plan.

Monthly Benefit:

The Accrued Benefit.

Early Retirement Benefit

Eligibility:

The first day of any month following age 55 and 5 years of Vesting Service.

APPENDIX A (Continued)

Early Retirement Benefit (Continued)

Monthly Benefit:

The Accrued Benefit at early retirement reduced actuarially for each month retirement precedes age 65 in accordance with the following:

<u>Age</u>	<u>Early Retirement Factor</u>
65	1.0000
64	0.8935
63	0.8003
62	0.7184
61	0.6462
60	0.5823
59	0.5256
58	0.4752
57	0.4303
56	0.3902
55	0.3543

Disability Retirement Benefit

Eligibility:

The first day of the month following five months of permanent and total disability at any age with 10 years of Vesting Service.

Monthly Benefit:

The Accrued Benefit.

Termination Benefit

Eligibility:

Upon termination of employment prior to retirement after completion of at least five years of Vesting Service.

Monthly Benefit:

The vested benefit commences in full at age 65, or in a reduced amount under the early retirement provisions.

Death Benefit

Eligibility:

100% vested and married for at least one year.

Monthly Benefit:

A monthly benefit for life commencing at the time the participant would have been eligible for retirement. The benefit is equal to 50% of the benefit vested on the date of death, adjusted as appropriate for early commencement and the 50% Joint and Survivor Annuity form of payment.

APPENDIX A (Continued)

<i>Benefits Available as Lump Sums</i>	This plan pays only small benefit amounts (lump sums less than \$5,000).
<i>Optional forms of Payment</i>	50%, 60 2/3%, 75%, and 100% Joint & Survivor. 5 and 10 year certain.
<i>Maximum Benefit Limit</i>	The Internal Revenue Code Section 415 Maximum Benefit payable as a life annuity at Social Security Normal Retirement Age.
<i>Plan Compensation Limit</i>	The Section 401(a)(17) Maximum Compensation that can be recognized for benefit calculation purposes.
<i>Changes in Plan Provisions</i>	The automatic changes, if any, in the plan compensation limit and maximum benefit limit were recognized as amendments for funding purposes. Such changes are anticipated for FAS 87 expense purposes and are not treated as amendments.

Schedule SB, Line 32 – Schedule of Amortization Bases
Northeast Ohio Neighborhood Health Services, Inc.
July 1, 2010 Valuation
EIN/PN: 34-1014291/001

EXHIBIT VII
SCHEDULE OF AMORTIZATION BASES

Plan Year Beginning

7/01/2010

	Date Established	Present Value of Payments	Remaining Years	Amortization Installment
<i>Shortfall Amortization Bases</i>	7/01/2010	\$ (29,393)	7.00	\$ (4,900)
	7/01/2009	(36,271)	6.00	(6,820)
	7/01/2008	<u>80,877</u>	5.00	<u>17,610</u>
	Total	\$ 15,213		\$ 5,890
<i>Waiver Amortization Bases</i>	7/01/2010	\$ 0	0.00	\$ 0

Schedule SB, line 25 – Change in Method
Northeast Ohio Neighborhood Health Services, Inc.
July 1, 2010 Valuation
EIN/PN: 34-1014291/001

Changes in Methods

The segmented interest rates used for determining the funding target were 5.31%, 6.54%, and 6.73%. These rates were updated to the rates required for the current plan year.

The mortality table for the funding target was changed as required under PPA '06.

***Justification for
Changes in Method***

Changes in the asset method and interest rates are automatically approved per Regulations 1.430(g)-1(f)(3) and 1.430(h)(2)-1(h)(3), respectively.

Schedule SB, line 22 – Description of Weighted Average Retirement Age
Northeast Ohio Neighborhood Health Services, Inc.
July 1, 2010 Valuation
EIN/PN: 34-1014291/001

Rates of Retirement

100% at age 65.

Weighted Average Retirement Age is 65. This is the average retirement age for someone eligible to retire at all ages using the assumed retirement rates and no other decrements.