

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), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 24pt; font-weight: bold;">2014</div> This Form is Open to Public Inspection
---	--	---

Part I	Annual Report Identification Information
For calendar plan year 2014 or fiscal plan year beginning <u>01/01/2014</u> and ending <u>12/31/2014</u>	
A This return/report is for:	☐ a multiemployer plan; ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); 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 COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403B THRIFT PLAN 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) COLUMBIANA COUNTY MENTAL HEALTH CLINIC ROGER SIKORSZKY PO BOX 429 40722 STATE ROUTE 154 LISBON, OH 44432-0429	<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;">002</td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/2009</u></td> </tr> <tr> <td colspan="2">2b Employer Identification Number (EIN) <u>34-1417161</u></td> </tr> <tr> <td colspan="2">2c Plan Sponsor's telephone number <u>330-424-9573</u></td> </tr> <tr> <td colspan="2">2d Business code (see instructions) <u>621420</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	002	1c Effective date of plan <u>01/01/2009</u>		2b Employer Identification Number (EIN) <u>34-1417161</u>		2c Plan Sponsor's telephone number <u>330-424-9573</u>		2d Business code (see instructions) <u>621420</u>	
1b Three-digit plan number (PN) ▶	002										
1c Effective date of plan <u>01/01/2009</u>											
2b Employer Identification Number (EIN) <u>34-1417161</u>											
2c Plan Sponsor's telephone number <u>330-424-9573</u>											
2d Business code (see instructions) <u>621420</u>											

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2015	ROGER SIKORSZKY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2015	ROGER SIKORSZKY
	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
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) GLENN E. DAVIS, CPA REALI, GIAMPETRO & SCOTT PO BOX 200 CANFIELD, OH 44406-0200			Preparer's telephone number (optional) 330-702-3100

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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	5 131
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits..... d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 105 6a(2) 97 6b 0 6c 29 6d 126 6e 0 6f 126 6g 126 6h 3
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2G 2L 3D b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	
9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☒ <u>1</u> 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 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2014 This Form is Open to Public Inspection
---	---	---

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014	
A Name of plan COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403B THRIFT PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 COLUMBIANA COUNTY MENTAL HEALTH CLINIC	D Employer Identification Number (EIN) 34-1417161

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
---------------	---

1 Coverage Information:

(a) Name of insurance carrier
MUTUAL OF AMERICA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1614399	88668	051876-A	126	01/01/2014	12/31/2014

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
	53

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

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

MUTUAL OF AMERICA
AKRON REGIONAL OFFICE
3700 EMBASSY PARKWAY, SUITE 500
AKRON, OH 44333

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	53	PORTION OF INCENTIVE COMP PROGRAM	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	1024560
5 Current value of plan's interest under this contract in separate accounts at year end	5	1226220

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

a Type of contract: (1) ☒ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b Balance at the end of the previous year	7b	1064253
--	-----------	---------

c Additions: (1) Contributions deposited during the year	7c(1)	73117	
(2) Dividends and credits	7c(2)		
(3) Interest credited during the year	7c(3)	18566	
(4) Transferred from separate account	7c(4)	470	
(5) Other (specify below)	7c(5)	1036	
▶ FORFEITURES			

(6) Total additions

7c(6)

93189

d Total of balance and additions (add lines 7b and 7c(6))	7d	1157442
---	-----------	---------

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	131911	
(2) Administration charge made by carrier	7e(2)	971	
(3) Transferred to separate account	7e(3)		
(4) Other (specify below)	7e(4)		

(5) Total deductions

7e(5)

132882

f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	1024560
---	-----------	---------

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2014
		This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan <u>COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403B THRIFT PLAN</u>	B Three-digit plan number (PN) ▶ <u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>COLUMBIANA COUNTY MENTAL HEALTH CLINIC</u>	D Employer Identification Number (EIN) <u>34-1417161</u>

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

<u>FIDELITY MANAGEMENT & RESEARCH COMP</u>	<u>82 DEVONSHIRE ST</u> <u>BOSTON, MA 02109</u>
--	--

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

<u>THE VANGUARD GROUP INC</u>	<u>P O BOX 2500</u> <u>VALLEY FORGE, PA 19482-2600</u>
-------------------------------	---

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

<u>DEUTSCHE INV MGMT AMERICAS INC.</u>	<u>222 SOUTH RIVERSIDE PLAZA</u> <u>CHICAGO, IL 60606-5808</u>
--	---

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

<u>OPPENHEIMER FUNDS, INC.</u>	<u>P O BOX 5270</u> <u>DENVER, CO 80217-5270</u>
--------------------------------	---

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

AMERICAN CENTURY INV. MGMT, INC.

P O BOX 419786
KANSAS CITY, MO 64141-6786

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

CALVERT INVESTMENT MGMT, INC.

4550 MONTGOMERY AVE
SUITE 1000N
BETHESDA, MD 20814

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

CAPITAL RESEARCH AND MANAGEMENT CO.

333 SOUTH HOPE ST
LOS ANGELES, CA 90071

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

PIMCO

840 NEWPORT CENTER DRIVE
NEWPORT BEACH, CA 92660

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

T. ROWE PRICE ASSOCIATES, INC.

100 EAST PRATT ST.
BALTIMORE, MD 21202

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

REALI, GIAMPETRO & SCOTT

P O BOX 200
CANFIELD, OH 44406

34-1218697

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

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

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

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

MUTUAL OF AMERICA LIFE INSURANCE CO

320 PARK AVENUE
NEW YORK, NY 10022

13-1614399

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13		1682	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☒ No ☐

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

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

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <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 <div style="border: 1px solid black; text-align: center; padding: 5px; font-weight: bold; font-size: 1.2em;">2014</div> This Form is Open to Public Inspection.
---	--	--

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

A Name of plan <u>COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403B THRIFT PLAN</u>	B Three-digit plan number (PN) ►	<u>002</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>COLUMBIANA COUNTY MENTAL HEALTH CLINIC</u>	D Employer Identification Number (EIN) <u>34-1417161</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)
---------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: SEPARATE ACCOUNT SA2

b Name of sponsor of entity listed in (a): MUTUAL OF AMERICA LIFE INSURANCE CO

c EIN-PN <u>13-1614399-000</u>	d Entity code <u>P</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1226220</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):

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

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

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

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

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110
		2014
		This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014	
A Name of plan COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403B THRIFT PLAN	B Three-digit plan number (PN) ► 002
C Plan sponsor's name as shown on line 2a of Form 5500 COLUMBIANA COUNTY MENTAL HEALTH CLINIC	D Employer Identification Number (EIN) 34-1417161

Part I Asset and Liability Statement			
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....	1b(1)		
(2) Participant contributions.....	1b(2)		
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common.....	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property).....	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans.....	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)	1165109	1226220
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities.....	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	1064253	1024560
(15) Other.....	1c(15)		

1d Employer-related investments:

		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	2229362	2250780

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k		

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	2229362	2250780
---	-----------	---------	---------

Part II Income and Expense Statement

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

Income**a Contributions:**

		(a) Amount	(b) Total
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
(B) Participants	2a(1)(B)	79612	
(C) Others (including rollovers)	2a(1)(C)	59685	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		139297

b Earnings on investments:**(1) Interest:**

(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	18566	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		18566

(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		81325
(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)		
c Other income.....	2c		5
d Total income. Add all income amounts in column (b) and enter total.....	2d		239193

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	216437	
(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)		216437
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)		
(2) Contract administrator fees.....	2i(2)	1338	
(3) Investment advisory and management fees.....	2i(3)		
(4) Other.....	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		1338
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		217775

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		21418
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan.....	2l(2)		

Part III Accountant's Opinion

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

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

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

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

☒ Yes ☐ No

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

(1) Name: REALI, GIAMPETRO & SCOTT

(2) EIN: 34-1218697

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

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

Part IV Compliance Questions

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

During the plan year:

- a** Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....
- b** Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....

	Yes	No	Amount
4a		X	
4b		X	

	Yes	No	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
4c			
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
4d			
e Was this plan covered by a fidelity bond?	X		300000
4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
4f			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?.....		X	
4g			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?.....		X	
4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
4i			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)		X	
4j			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
4k			
l Has the plan failed to provide any benefit when due under the plan?.....		X	
4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			
4n			

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)

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

Part V Trust Information (optional)

6a Name of trust

6b Trust's EIN

<div>SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Retirement Plan Information</div> <div>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).</div> <div>▶ File as an attachment to Form 5500.</div>	<div>OMB No. 1210-0110</div> <div>2014</div> <div>This Form is Open to Public Inspection.</div>
For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014		
A Name of plan COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403B THRIFT PLAN		B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 COLUMBIANA COUNTY MENTAL HEALTH CLINIC		D Employer Identification Number (EIN) 34-1417161
Part I Distributions		
All references to distributions relate only to payments of benefits during the plan year.		
1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....		1
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): 13-1614399		
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 10
Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)		
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?..... ☐ Yes ☐ No ☐ N/A		
If the plan is a defined benefit plan, go to line 8.		
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____		
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived).....		6a
b Enter the amount contributed by the employer to the plan for this plan year.....		6b
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)		6c
If you completed line 6c, skip lines 8 and 9.		
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?..... ☐ Yes ☐ No ☐ N/A		
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?..... ☐ Yes ☐ No ☐ N/A		
Part III Amendments		
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... ☐ Increase ☐ Decrease ☐ Both ☐ No		
Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.		
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ☐ Yes ☐ No		
11 a Does the ESOP hold any preferred stock? ☐ Yes ☐ No		
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)..... ☐ Yes ☐ No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?..... ☐ Yes ☐ No		
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.		
Schedule R (Form 5500) 2014 v. 140124		

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

a Name of contributing employer

b EIN

c Dollar amount contributed by employer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- a** Enter the percentage of plan assets held as:
 Stock: _____% 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): _____

6715 Tippecanoe Road, Building F
P.O. Box 200
Canfield, OH
44406-0200
330-702-3100
Fax 330-702-3101



Real, Giampetro & Scott

A PROFESSIONAL CORPORATION

CERTIFIED PUBLIC ACCOUNTANTS

3879A East State Street
P.O. Box 1378
Hermitage, PA
16148-0378
724-347-5575
Fax 724-347-4191

INDEPENDENT AUDITORS' REPORT

Trustees

Columbiana County Mental Health Clinic
403(b) Thrift Plan
Lisbon, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of the Columbiana County Mental Health Clinic 403(b) Thrift Plan which comprise the Statements of Net Assets Available For Benefits - Modified Cash Basis as of December 31, 2014 and 2013, and the related Statement of Changes in Net Assets Available for Benefits - Modified Cash Basis for the year ended December 31, 2014, and the related notes to the financial statements

Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan Administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note C, which was certified by Mutual of America, the trustee of the Plan, except for comparing the information with the related information included in the financial statements. We have been informed by the Plan Administrator that the trustee holds the Plan's investment assets and executes investment transactions. The Plan Administrator has obtained a certification from the trustee as of December 31, 2014 and 2013, and for the year ended December 31, 2014, that the information provided to the Plan Administrator by the trustees is complete and accurate.

Disclaimer of Opinion

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

Basis of Accounting

We draw attention to Note B to the financial statement, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matter

The supplemental Schedule H, Line 4i – Schedule of Assets (Held at End of Year) as of December 31, 2014, is required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, and is presented for the purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

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

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

Rebekah M. Mumpert & Co. LLC

Canfield, Ohio
September 28, 2015

**Columbiana County Mental Health Clinic
403(B) Thrift Plan**

Lisbon, Ohio

Report on Examination of Financial Statements

For the Years Ended December 31, 2014 and 2013

TABLE OF CONTENTS

INDEPENDENT AUDITORS' REPORT.....	PAGE 1
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS AS OF DECEMBER 31, 2014 AND 2013.....	3
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS FOR THE YEAR ENDED DECEMBER 31, 2014.....	4
NOTES TO FINANCIAL STATEMENTS.....	5
SUPPLEMENTAL INFORMATION	
FORM 5500 SCHEDULE H, PART IV, LINE 4i – SCHEDULE OF ASSETS (HELD AT END OF YEAR)	12

6715 Tippecanoe Road, Building F
P.O. Box 200
Canfield, OH
44406-0200
330-702-3100
Fax 330-702-3101



Real, Giampetro & Scott
A PROFESSIONAL CORPORATION

CERTIFIED PUBLIC ACCOUNTANTS

3879A East State Street
P.O. Box 1378
Hermitage, PA
16148-0378
724-347-5575
Fax 724-347-4191

INDEPENDENT AUDITORS' REPORT

Trustees
Columbiana County Mental Health Clinic
403(b) Thrift Plan
Lisbon, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of the Columbiana County Mental Health Clinic 403(b) Thrift Plan which comprise the Statements of Net Assets Available For Benefits – Modified Cash Basis as of December 31, 2014 and 2013, and the related Statement of Changes in Net Assets Available for Benefits - Modified Cash Basis for the year ended December 31, 2014, and the related notes to the financial statements

Management's Responsibility for the Financial Statements

Plan management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

Basis for Disclaimer of Opinion

As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Plan Administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note C, which was certified by Mutual of America, the trustee of the Plan, except for comparing the information with the related information included in the financial statements. We have been informed by the Plan Administrator that the trustee holds the Plan's investment assets and executes investment transactions. The Plan Administrator has obtained a certification from the trustee as of December 31, 2014 and 2013, and for the year ended December 31, 2014, that the information provided to the Plan Administrator by the trustees is complete and accurate.

Disclaimer of Opinion

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

Basis of Accounting

We draw attention to Note B to the financial statement, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matter

The supplemental Schedule H, Line 4i – Schedule of Assets (Held at End of Year) as of December 31, 2014, is required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, and is presented for the purpose of additional analysis and is not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on the supplemental schedules referred to above.

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

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

Reed, Murphy & Co. LLC

Canfield, Ohio
September 28, 2015

**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
(MODIFIED CASH BASIS)**

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

		December 31,	
		2014	2013
ASSETS			
Investments at fair value			
Interest in registered investment companies		<u>\$ 2,250,780</u>	<u>\$ 2,229,362</u>
	TOTAL ASSETS	<u>2,250,780</u>	<u>2,229,362</u>
LIABILITIES			
		<u>-</u>	<u>-</u>
	NET ASSETS AVAILABLE FOR PLAN BENEFITS	<u><u>\$ 2,250,780</u></u>	<u><u>\$ 2,229,362</u></u>

THE ACCOMPANYING NOTES ARE AN INTEGRAL PART OF THESE FINANCIAL STATEMENTS.

**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
(MODIFIED CASH BASIS)**

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

For the Year Ended December 31, 2014

Additions to net assets attributed to:

Investment income

Net appreciation in fair value of investments

\$ 99,891

Other income

5

99,896

Contributions:

Participants'

79,612

Rollover

59,685

139,297

TOTAL ADDITIONS

239,193

Deductions from net assets attributed to:

Benefits paid to participants

216,437

Fees

1,338

TOTAL DEDUCTIONS

217,775

NET INCREASE

21,418

NET ASSETS AVAILABLE FOR BENEFITS

Beginning of year

2,229,362

End of year

\$ 2,250,780

THE ACCOMPANYING NOTES ARE AN INTEGRAL PART OF THESE FINANCIAL STATEMENTS.

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

A. DESCRIPTION OF THE PLAN

The following description of the Columbiana County Mental Health Clinic 403(b) Thrift Plan provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The Plan is a defined contribution plan covering all employees of the Columbiana County Mental Health Clinic who have six months of service and are age twenty-one or older. It is subject to the provisions of ERISA.

Contributions

Participants may contribute a portion of their compensation to the Plan, limited to the maximum of \$17,500. The Company can make a profit sharing contribution in an amount determined at the sole discretion of the Company. Employer matching contributions are not provided under the Plan.

Participant Accounts

Each participant's account is credited with an allocation of (a) the Corporation's contribution and (b) Plan earnings and with an allocation on investment advisory fees. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

Vesting

Vesting in the participants' accounts is based on years of service. A participant is 100% vested after three years of credited service.

Forfeitures

At December 31, 2014, forfeited non-vested accounts totaled \$4,920.

Payment of Benefits

On termination of service, a participant may elect to receive either a lump-sum amount equal to the value of his or her account, or specified payment option as defined by the Plan.

Investment Option

Upon enrollment in the Plan, a participant may direct employee contributions in 1% increments in any of the investment options offered by the Plan. Participants may change their investment allocations daily.

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

A. DESCRIPTION OF THE PLAN (CONTINUED)

Participant Loans

Participants may borrow directly from Mutual of America using a portion of their Plan account as security for the loan. Such loans are subject to certain limitations. Participants receiving loans are required to pledge as collateral, an interest accumulation fund account value of 100% of the loan amount for the period of time the loan is outstanding. Loan balances outstanding from Plan participants to Mutual of America were approximately \$2,974 and \$5,633 as of December 31, 2014 and 2013, respectively. Approximately \$11,409 and \$11,409 of interest accumulation account values serve as collateral for the related loans as of December 31, 2014 and 2013, respectively, and are included in investments in the statements of net assets available for benefits.

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting

The accounting records of the Plan are maintained on the modified cash basis of accounting. The modified cash basis for presentation differs principally from accounting principles generally accepted in the United States of America in that there are no provisions for employee or employer contributions receivable and no provision for any liabilities of the Plan. Contributions and earnings are recorded when received by the Plan and distributions and expenses are recorded when paid by the Plan.

Investment Valuation and Income Recognition

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

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

Payment of Benefits

Benefits are recorded for financial statement purposes when paid. During 2014 benefits paid to participants totaled \$216,437. As of December 31, 2014, no participant has elected to withdraw from the plan that has not been paid.

Estimates

The preparation of financial statements in conformity with the modified cash basis of accounting requires the plan administrator to make estimates and assumptions that affect certain reported amounts of assets and changes therein and disclosures of contingent assets and liabilities. Accordingly, actual results may differ from those estimates.

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

B. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Uncertain Tax Positions

The Plan adopted Topic 740 (Fin 48) on January 1, 2009. The Plan files tax returns in the U.S. Federal jurisdiction. Generally, this jurisdiction has statutes of limitations that run three years, which means tax years that remain subject to examination would be tax years ended December 31, 2011 and beyond. Presently, the Plan is under no examination from any jurisdiction. The Plan Administrator evaluated tax positions, statutes of limitations, tax law and changes and new authoritative rulings and concludes a low possibility of material unrecognized tax benefits that would need to be recorded and disclosed.

C. INVESTMENTS

The Plan invests in mutual funds held by Mutual of America. As permitted by 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the trustee has certified the following information as complete and accurate. The Plan Administrator has instructed the independent public accountants not to perform any auditing procedures on the data that is certified. The following is a summary of the Plan's investments and change in value at December 31, 2014 and 2013:

Investment	2014		2013
	Fair Value	Appreciation (Depreciation) Of Value	Fair Value
Investment Accumulation Account *	\$ 1,024,561	\$ 18,566	\$ 1,064,253
MofA Money Market Fund	9,489	(131)	10,091
MofA All America Fund	54,499	5,273	65,045
MofA Bond Fund	12,177	599	12,030
MofA Composite Fund	9,579	697	9,120
MofA Mid-Term Bond Fund	10,485	208	10,535
MofA Mid-Cap Equity Index Fund *	148,437	12,101	163,156
MofA Equity Index Fund	86,730	9,816	81,730
MofA Conservative Allocation Fund	3,635	560	10,818
MofA Moderate Allocation Fund	6,292	473	10,438
MofA Aggressive Allocation Fund	1,946	476	17,106
MofA Mid-Cap Value Fund	8,625	905	6,598
MofA Small Cap Growth Fund	62,015	1,520	79,436
MofA Small Cap Value Fund	31,331	931	35,982
MofA International Fund	490	(26)	792
MofA 2025 Retirement Fund	2,418	169	2,573
MofA 2030 Retirement Fund	1,003	2,181	50,430
MofA 2035 Retirement Fund	6,065	389	5,430
MofA 2040 Retirement Fund	43,903	2,593	38,785
MofA 2045 Retirement Fund	26,137	1,468	23,408
MofA 2050 Retirement Fund	179	4	-

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

C. INVESTMENTS (CONTINUED)

Investment	2014		2013
	Fair Value	Appreciation (Depreciation) Of Value	Fair Value
T Rowe Price Blue Chip Growth	47,844	1,940	5,245
Deutsche VSI Capital Growth Fund VIP	69,945	7,865	75,353
American Century VP Capital Apprec.	50,114	2,735	40,638
Calvert VP SRI Balanced Portfolio	97	11	225
Fidelity VIP Asset Manager	850	26	828
Fidelity VIP Equity-Income Fund *	125,657	8,214	102,834
Fidelity VIP Contrafund *	136,854	13,934	133,680
Fidelity VIP Mid Cap	40,818	1,863	30,519
Vanguard VIF Diversified Value	106,491	5,173	30,630
Vanguard VIF International	60,705	(6,987)	99,942
Vanguard VIF REIT Index Portfolio	61,030	6,514	102
Oppenheimer Main Street VA	379	(169)	11,610
TOTALS	\$ 2,250,780	\$ 99,891	\$ 2,229,362

* - This investment represents 5% or more of net assets available for benefits.

D. NON-PARTICIPANT DIRECTED INVESTMENTS

All assets and significant components of the change in net assets are participant directed. Therefore, no separate reporting of nonparticipant directed activity.

E. PARTY-IN-INTEREST TRANSACTIONS

The Plan does not consider Company contributions to the Plan to be party-in-interest transactions. The Company provides certain accounting, administrative, and investment management services to the Plan for which no fees are charged. The company paid administrative expenses of the Plan totaling \$6,850 in 2014. The Plan paid internal fees of \$1,338.

F. INCOME TAX STATUS

The Plan has been designed to qualify under Section 403(b) of the Internal Revenue Code (Code). The terms of the Plan have been prepared to conform with the sample language provided by the Internal Revenue Service (IRS) in the draft Listing of Required Modifications issued April 4, 2009. The plan sponsor (Mutual of America) has applied for a determination letter on the Plan and is awaiting the IRS's determination. The Plan is required to operate in conformity with the Code to maintain the tax exempt status for plan participants under Section 403(b).

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

G. PLAN TERMINATION

Although it has not expressed any intent to do so, the Corporation has the right under the Plan to discontinue its contributions at any time and to terminate the Plan, subject to the provisions of ERISA. In the event of Plan termination, participants will become 100% vested in their accounts.

H. RISKS AND UNCERTAINTIES

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

I. DERIVATIVES

The Plan has no investment that, in whole or in part, is accounted for as a derivative instrument under FASB ASC 815, *Accounting for Derivative Instruments and Hedging Activities* during the current Plan year.

J. FAIR VALUE MEASUREMENTS

Financial Accounting Standards Board ASC 820, *Fair Value Measurements and Disclosures*, establishes a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurement) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the asset or liability;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

J. FAIR VALUE MEASUREMENTS (CONTINUED)

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

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

Following is a description of the valuation methodologies used for assets measured at fair value. There were no changes in the methodologies used in 2014 and 2013.

Pooled Separate Accounts - valued at unit value price as determined by the custodian at year end.

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

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2014 and 2013:

Assets at Fair Value as of December 31, 2014

	Level 1	Level 2	Level 3	Total
Cash Equivalent Funds	\$ -	\$ 1,034,049	\$ -	\$ 1,034,049
Allocation Funds	-	11,873	-	11,873
Balanced Funds	-	10,526	-	10,526
Blended Funds	-	54,878	-	54,878
Bond Funds	-	22,662	-	22,662
Growth Funds	-	407,590	-	407,590
Index Funds	-	296,197	-	296,197
Target Date Funds	-	79,706	-	79,706
Value Funds	-	333,299	-	333,299
Total pooled funds	\$ -	\$ 2,250,780	\$ -	\$ 2,250,780

NOTES TO FINANCIAL STATEMENTS

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN

December 31, 2014

J. FAIR VALUE MEASUREMENTS (CONTINUED)

Assets at Fair Value as of December 31, 2013

	Level 1	Level 2	Level 3	Total
Cash Equivalent Funds	\$ -	\$ 1,074,344	\$ -	\$ 1,074,344
Allocation Funds	-	38,362	-	38,362
Balanced Funds	-	10,172	-	10,172
Blended Funds	-	76,655	-	76,655
Bond Funds	-	22,565	-	22,565
Growth Funds	-	364,871	-	364,871
Index Funds	-	244,988	-	244,988
Target Date Funds	-	120,627	-	120,627
Value Funds	-	276,778	-	276,778
Total pooled funds	\$ -	\$ 2,229,362	\$ -	\$ 2,229,362

K. SUBSEQUENT EVENTS

Subsequent events have been considered up to September 28, 2015, the day the financial statements are available to be issued, which is the day the financial statements were complete in a form and format that complies with generally accepted accounting principles and have been approved for issuance by Those Charged with Governance of the Corporation.

SUPPLEMENTAL INFORMATION

FORM 5500 SCHEDULE H, PART IV, LINE 4i -
SCHEDULE OF ASSETS (HELD AT END OF YEAR)

COLUMBIANA COUNTY MENTAL HEALTH CLINIC 403(B) THRIFT PLAN
E. I. #34-1059585

December 31, 2014

a.	b. Identity of Issue	c. Description of Investment	e. Current Value
	Mutual of America	Group Annuity Contract General Account	\$ 1,024,560
	Mutual of America	Group Annuity Contract Separate Account	1,226,220

SEE INDEPENDENT AUDITORS' REPORT ON SUPPLEMENTAL INFORMATION.

PARTY IN INTEREST -
IDENTITY - MUTUAL OF AMERICA
DESCRIPTION - GENERAL ACCOUNT
COST - 0
CURRENT VALUE - 1024560

PARTY IN INTEREST -
IDENTITY - MUTUAL OF AMERICA
DESCRIPTION - SEPARATE ACCOUNT
COST - 0
CURRENT VALUE - 1226220