

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). <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: 1.5em; font-weight: bold;">2014</div> This Form is Open to Public Inspection
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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 <u>COLUMBUS NEIGHBORHOOD HEALTH CENTER 403(B) 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>004</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>01/01/2012</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>004</u>	1c Effective date of plan <u>01/01/2012</u>	
1b Three-digit plan number (PN) ▶	<u>004</u>				
1c Effective date of plan <u>01/01/2012</u>					
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) <u>COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.</u> <u>1800 WATERMARK DRIVE, SUITE 420</u> <u>COLUMBUS, OH 43215-1060</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>31-1533908</u></td> </tr> <tr> <td>2c Plan Sponsor's telephone number <u>614-645-5500</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>621399</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>31-1533908</u>	2c Plan Sponsor's telephone number <u>614-645-5500</u>	2d Business code (see instructions) <u>621399</u>	
2b Employer Identification Number (EIN) <u>31-1533908</u>					
2c Plan Sponsor's telephone number <u>614-645-5500</u>					
2d Business code (see instructions) <u>621399</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.	<u>10/14/2015</u>	<u>FIKRU LEMU NIGUSSE</u>
	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
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)			Preparer's telephone number (optional)

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	5 227
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) 182 6a(2) 225 6b 0 6c 56 6d 281 6e 0 6f 281 6g 276 6h 25
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: 2L 2F 2G b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	
9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☐ A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☐ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 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 COLUMBUS NEIGHBORHOOD HEALTH CENTER 403(B) PLAN	B Three-digit plan number (PN) ▶	004
C Plan sponsor's name as shown on line 2a of Form 5500 COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.	D Employer Identification Number (EIN) 31-1533908	

Part I	Service Provider Information (see instructions)
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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

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

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

EMPLOYEE FIDUCIARY, LLC

PO BOX 3144
MOBILE, AL 36652-3144

61-1579239

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	NONE	7846	Yes ☒ No ☐	Yes ☒ No ☐	286	Yes ☐ No ☒

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

EVERHART FINANCIAL

5890 VENTURE DRIVE, SUITE D
DUBLIN, OH 43017

31-1440043

(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?
27	NONE	5230	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 H (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>	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.	<small>OMB No. 1210-0110</small> 2014 This Form is Open to Public Inspection
For calendar plan year 2014 or fiscal plan year beginning <u>01/01/2014</u> and ending <u>12/31/2014</u>		
A Name of plan <u>COLUMBUS NEIGHBORHOOD HEALTH CENTER 403(B) PLAN</u>		B Three-digit plan number (PN) ► <u>004</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.</u>		D Employer Identification Number (EIN) <u>31-1533908</u>

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)	0	9458
(2) Participant contributions.....	1b(2)	10579	18511
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	23783	41555
(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)	8681	8316
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities.....	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	847349	1385306
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(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	890392	1463146

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	0	0

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	890392	1463146
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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) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	195023	
(B) Participants	2a(1)(B)	337572	
(C) Others (including rollovers)	2a(1)(C)	14025	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		546620
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)	349	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		349
(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)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		71993
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		618962

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	31606	
(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)		31606
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)	14602	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		14602
j Total expenses. Add all expense amounts in column (b) and enter total	2j		46208

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		572754
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: **HW&CO.**

(2) EIN: **34-1663157**

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		100000
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 COLUMBUS NEIGHBORHOOD HEALTH CENTER 403(B) PLAN		B Three-digit plan number (PN) ▶ 004
C Plan sponsor's name as shown on line 2a of Form 5500 COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC.		D Employer Identification Number (EIN) 31-1533908
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 0
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): 61-1579239		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....		3
Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)		
4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?..... ☐ Yes ☐ No ☐ N/A		
If the plan is a defined benefit plan, go to line 8.		
5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. Date: Month _____ Day _____ Year _____		
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.		
6 a Enter the minimum required contribution for this plan year (include any prior year accumulated funding deficiency not waived).....		6a
b Enter the amount contributed by the employer to the plan for this plan year.....		6b
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)		6c
If you completed line 6c, skip lines 8 and 9.		
7 Will the minimum funding amount reported on line 6c be met by the funding deadline?..... ☐ Yes ☐ No ☐ N/A		
8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure or other authority providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?..... ☐ Yes ☐ No ☐ N/A		
Part III Amendments		
9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box. If no, check the "No" box..... ☐ Increase ☐ Decrease ☐ Both ☐ No		
Part IV ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.		
10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan? ☐ Yes ☐ No		
11 a Does the ESOP hold any preferred stock? ☐ Yes ☐ No		
b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.)..... ☐ Yes ☐ No		
12 Does the ESOP hold any stock that is not readily tradable on an established securities market?..... ☐ Yes ☐ No		
For Paperwork Reduction Act Notice 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): _____

Columbus Neighborhood Health Center, Inc. 403(b) Plan

YEARS ENDED DECEMBER 31, 2014 AND 2013

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

YEARS ENDED DECEMBER 31, 2014 AND 2013

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Independent Auditors' Report

Board of Trustees
Columbus Neighborhood Health Center, Inc. 403(b) Plan
Columbus, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Columbus Neighborhood Health Center, Inc. 403(b) Plan, which comprise the statements of net assets available for benefits as of December 31, 2014 and 2013, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on conducting the audits 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 (DOL) Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA), the plan administrator instructed us not to perform, and we did not perform, any auditing procedures with respect to the information summarized in Note 5, which was certified by MG Trust Company, LLC, the trustee of the Plan, except for comparing such 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 certifications from the trustee as of and for the years ended December 31, 2014 and 2013, that the information provided to the plan administrator by the trustee is complete and accurate.

Disclaimer of Opinion

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

Other Matter

The supplemental schedule of assets held for investment purposes at year end on page 12 for the year ended December 31, 2014 is required by the DOL's Rules and Regulations for Reporting and Disclosure under the ERISA 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 schedule referred to above.

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

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

HW & Co.

Columbus, Ohio
October 13, 2015

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Assets:		
Investments, at fair value	<u>\$ 1,426,861</u>	<u>\$ 871,132</u>
Receivables:		
Employer contributions	9,458	
Participant contributions	18,511	10,579
Notes receivable from participants	<u>8,316</u>	<u>8,681</u>
	<u>36,285</u>	<u>19,260</u>
Net assets available for benefits	<u><u>\$ 1,463,146</u></u>	<u><u>\$ 890,392</u></u>

See notes to financial statements.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014	2013
Additions to net assets attributed to:		
Investment income:		
Net appreciation in fair value of investments	\$ 31,344	\$ 62,014
Interest and dividends	40,998	19,121
	<u>72,342</u>	<u>81,135</u>
Contributions:		
Participants	337,572	284,504
Employer	195,023	75,064
Rollover	14,025	251,208
	<u>546,620</u>	<u>610,776</u>
Total additions	<u>618,962</u>	<u>691,911</u>
Deductions from net assets attributed to:		
Benefits paid to participants	31,606	44,020
Administrative expenses	14,602	10,890
	<u>46,208</u>	<u>54,910</u>
Total deductions	<u>46,208</u>	<u>54,910</u>
Net increase in net assets	572,754	637,001
Net assets available for benefits, beginning	<u>890,392</u>	<u>253,391</u>
Net assets available for benefits, ending	<u><u>\$ 1,463,146</u></u>	<u><u>\$ 890,392</u></u>

See notes to financial statements.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2014 AND 2013

1. Description of the Plan:

General:

The following description of Columbus Neighborhood Health Center, Inc. 403(b) Plan (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

The Plan was established January 1, 2012 and covers all eligible employees of Columbus Neighborhood Health Center, Inc. (CNHC or the Company). Employees are eligible to defer under the 403(b) provision immediately upon hire. The Plan is a defined contribution plan subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The plan administrator is responsible for oversight of the Plan and with the help of an investment adviser, determines the appropriateness of the Plan's investment offerings, monitors investment performance and reports to the CNHC's Board of Trustees.

Contributions:

Effective November 1, 2012, participants may elect to have a portion of their compensation (as defined) deferred and contributed to the Plan on both a pre-tax and after-tax basis. Each year, participants may contribute up to 100% of their compensation (which may not exceed annual dollar limits established by the Internal Revenue Service) into the Plan. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute, at the discretion of the plan administrator, amounts representing distributions from other qualified retirement plans or IRAs (rollover). Participants direct the investment of their contributions into various investment options offered by the Plan.

CNHC may make discretionary contributions to participants' accounts as determined by the Company's Board of Trustees. Participants are eligible to receive employer discretionary contributions if they complete at least one hour of service during the Plan year. During 2014, CNHC made a discretionary contribution based on participant's eligible wages earned during each quarter of the Plan year. During 2013, CNHC made a discretionary contribution based on participant's eligible wages earned during the first quarter of the Plan year. CNHC contributed 2% of quarterly compensation for 2014 and 3% of quarterly compensation for 2013. Discretionary contributions paid by CNHC totaled \$195,023 in 2014 and \$75,064 in 2013.

Participant accounts:

Each participant's account is credited with the participant's contributions and Company contributions, as well as Plan earnings. Participants' accounts are charged with an allocation of administrative expenses that are paid by the Plan. Allocations are based on participant earnings, account balances, or specific participant transactions, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

YEARS ENDED DECEMBER 31, 2014 AND 2013

1. Description of the Plan (continued):

Vesting:

Participants are immediately vested in their contributions plus earnings thereon. A year of service means a period a participant completes 1,000 hours of service. Vesting in the Company's contributions plus earnings thereon is in accordance with the following schedule:

<u>Years of Service</u>	<u>Vesting Percentage</u>
Less than 2	0%
2	20%
3	50%
4 or more	100%

Payment of benefits:

On termination of service due to death, disability or retirement, a participant may elect to receive either a lump-sum amount equal to the value of the participant's vested interest in their account, or in the form of an annuity. For termination of service other than death, a participant may receive the value of the vested interest in their account as a lump-sum distribution. All distributions are to be made in cash.

Notes receivable from participants:

Active participants may borrow from their accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their account balance. Note transactions are treated as transfers between investment funds and the participant notes fund. Repayment of a note must be made over a period not to exceed five years, unless the note is used to purchase a principal residence, in which case the note is to be repaid over a reasonable period of time that may exceed five years. The notes are secured by the balance in the participant's account. Interest rates on participant notes were 4.25% as of December 31, 2014 and 2013. Principal and interest must be paid through payroll deductions or in cash on a timely basis. The balance of notes receivable was \$8,316 at December 31, 2014 and \$8,681 at December 31, 2013.

Forfeitures:

When certain terminations of participation in the Plan occur, the nonvested portion of a participant's account (as defined) represents a forfeiture. Forfeitures may be used to reduce Company contributions or to pay Plan expenses.

The amount of unallocated forfeited accounts amounted to \$22,283 at December 31, 2013. There were no unallocated forfeitures at December 31, 2014. Forfeitures of \$29,258 in 2014 were used to reduce the employer discretionary contributions. No forfeitures were used in 2013.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

YEARS ENDED DECEMBER 31, 2014 AND 2013

2. Summary of significant accounting policies:

Basis of accounting:

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

Use of estimates:

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Actual results may differ from those estimates and assumptions.

Investment valuation and income recognition:

Investments are stated 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. The plan administrator, with the assistance of an investment adviser, determines the Plan's valuation policies utilizing information provided by the trustee. See Note 4 for a discussion of fair value measurements.

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

Payment of benefits:

Benefits are recorded when paid.

Expenses:

Certain expenses are paid by the Plan with the expense allocated to each participant. Third-party administrator fees and other professional fees are currently paid by CNHC and are excluded from these financial statements. Fees related to the administration of notes receivable from participants are charged directly to the participant's account and are included in administrative expenses. CNHC provides other accounting and administrative services at no cost to the Plan. No such employees, nor CNHC, receive compensation from the Plan. Administrative expenses of the Plan paid by CNHC amounted to \$13,962 in 2014 and \$16,417 in 2013. Additionally, investment related expenses are included in net appreciation in fair value of investments.

Reclassifications:

Certain amounts in the 2013 financial statements have been reclassified to conform to the 2014 presentation.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

YEARS ENDED DECEMBER 31, 2014 AND 2013

2. Summary of significant accounting policies (continued):

Subsequent events:

In preparing these financial statements, the Plan's management has evaluated events and transactions for potential recognition through October 13, 2015, the date the financial statements were available to be issued.

3. Investments:

The following presents the fair value of investments (all participant directed) at December 31, 2014 and 2013. Investments that represent 5% or more of the Plan's net assets in either year are separately identified.

	<u>2014</u>	<u>2013</u>
Investments, as provided by MG Trust Company, LLC:		
Mutual funds:		
Vanguard Target Retirement 2040, 4,869 shares in 2014 and 3,602 shares in 2013	\$ 144,910	\$ 102,005
Vanguard Total Bond Market Signal, 11,647 shares in 2014, and 8,720 shares in 2013	126,602	92,085
Vanguard Target Retirement 2025, 6,968 shares in 2014 and 2,073 shares in 2013	115,185	32,644
American Mutual, 2,953 shares in 2014 and 2,094 shares in 2013	109,719	72,909
American Europacific Growth R6, 2,269 shares in 2014 and 1,608 shares in 2013	106,849	78,850
Vanguard Growth Index Signal, 1,940 shares in 2014 and 1,569 shares in 2013	104,181	69,548
Vanguard Target Retirement 2015, 6,544 shares in 2014 and 3,851 shares in 2013	100,053	56,877
PIMCO Real Return, 6,482 shares in 2014 and 4,566 shares in 2013	70,778	50,090
Other (less than 5% of Plan net assets)	507,029	292,341
Cash and cash equivalents:		
Other (less than 5% of Plan net assets)	<u>41,555</u>	<u>23,783</u>
Total investments	<u>\$ 1,426,861</u>	<u>\$ 871,132</u>

The Plan's investments (including gains and losses on investments bought and sold during the year, as well as held at the end of the year) appreciated in value as follows:

	<u>2014</u>	<u>2013</u>
Mutual funds	<u>\$ 31,344</u>	<u>\$ 62,014</u>

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

YEARS ENDED DECEMBER 31, 2014 AND 2013

4. Fair value measurements:

The framework for measuring fair value 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) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

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

Level 2 – Inputs to the methodology include:

- Quoted market 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.

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 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 maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value.

Money market funds are valued based on its face value which approximates its fair value.

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

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 techniques 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.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

YEARS ENDED DECEMBER 31, 2014 AND 2013

4. Fair value measurements (continued):

Assets measured at fair value on a recurring basis at December 31, 2014 and 2013 were as follows:

	2014		2013	
	Level 1	Total	Level 1	Total
Mutual funds:				
Target allocation funds	\$ 535,914	\$ 535,914	\$ 253,390	\$ 253,390
Bond funds	277,494	277,494	203,269	203,269
Value funds	205,307	205,307	121,003	121,003
Blended funds	199,625	199,625	134,218	134,218
Growth funds	166,966	166,966	135,469	135,469
Money market funds	<u>41,555</u>	<u>41,555</u>	<u>22,309</u>	<u>22,309</u>
	<u>\$ 1,426,861</u>	<u>\$ 1,426,861</u>	<u>\$ 869,658</u>	<u>\$ 869,658</u>

5. Information certified by trustee:

Certain information related to investments disclosed in the accompanying financial statements and supplemental schedule, including investments held at December 31, 2014 and 2013, and net appreciation in fair value of investments, interest and dividends for the years ended December 31, 2014 and 2013, was obtained or derived from information supplied to the plan administrator and certified as complete and accurate by MG Trust Company, LLC (the trustee of the Plan).

6. Plan termination:

Although it has not expressed intent to do so, CNHC 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 would become 100% vested in their employer contributions.

7. Tax status:

The Plan has been designed to qualify under Section 403(b) of the Internal Revenue Code (the "Code"). The terms of the Plan have been prepared to conform with the sample language provided by the Internal Revenue Service (IRS) in Revenue Procedure 2007-71. The plan administrator intends to apply for a determination letter on the Plan once the IRS opens such a program. The Plan is required to operate in conformity with the Code to maintain the tax-exempt status for plan participants under Section 403(b).

U.S. GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service and the Department of Labor. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The statute of limitations is open for years since the Plan began on January 1, 2012.

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b) PLAN

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

YEARS ENDED DECEMBER 31, 2014 AND 2013

8. Risks and uncertainties:

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

9. Reconciliation of financial statements to Form 5500:

The following is a reconciliation of total contributions, per the financial statements, to Form 5500 for the year ended December 31, 2013.

	<u>2013</u>
Total contributions, per financial statements	\$ 610,776
Amount representing employee's prior year contributions receivable	<u>11,492</u>
Total contributions, per Form 5500	<u>\$ 622,268</u>

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b)PLAN

E.I.N.: 31-1533908 PLAN NUMBER: 004

SCHEDULE H, LINE 4i

SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES AT YEAR END

DECEMBER 31, 2014

Description	Number of Shares	Cost	Current Value
Participant directed investments:			
Mutual Funds:			
Vanguard Target Retirement 2040	4,869		\$ 144,910
Vanguard Total Bond Market Signal	11,647		126,602
Vanguard Target Retirement 2025	6,968		115,185
American Mutual	2,953		109,719
American EuroPacific Growth R6	2,269		106,849
Vanguard Growth Index Signal	1,940		104,181
Vanguard Target Retirement 2015	6,544		100,053
PIMCO Real Return	6,482		70,778
Vanguard Target Retirement 2050	2,277		67,445
Vanguard Target Retirement 2035	2,934		52,342
Vanguard Mid-Cap Value Index	1,352		47,580
Vanguard US REIT Index Adm	377		43,264
Vanguard Target Retirement 2020	1,343		38,225
PIMCO Global Bond	3,526		32,654
Vanguard Wellesley	1,223		31,261
PIMCO Low Duration	2,751		27,616
Prudential Small-Cap Value CL Z	1,054		26,973
Vanguard Small Cap Growth Index	624		22,079
Columbia Acorn	676		21,602
Prudential Dryden High Yield Z	3,582		19,844
Vanguard Target Retirement 2030	611		17,755
Vanguard Total Stock Market Index Admiral	341		17,614
DFA Emerging Value	650		16,748
American Fundamental Investors	237		12,331
Royce Penn Mutual	521		6,771
Vanguard Total International Stock Index	97		2,533
Columbia Mid Cap Index Z	86		1,338
American Funds Capital World Growth and Income R6	23		1,054
Cash and cash equivalents:			
Vanguard Prime Money Market	41,555		41,555
			1,426,861
* Participant loans, interest rate of 4.25%		\$ 0	8,316
Total assets held for investments			\$ 1,435,177

* Indicates party-in-interest to the Plan.

The above information has been certified by MG Trust Company, LLC, the trustee, as complete and accurate.

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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**2014****This Form is Open to Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

- 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

Columbus Neighborhood Health Center 403(b) Plan

1b Three-digit plan number (PN) ▶

004

1c Effective date of plan
01/01/2012**2a** Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)

Columbus Neighborhood Health Center, Inc.

1800 Watermark Drive, Suite 420

Columbus OH 43215-1060

2b Employer Identification Number (EIN)
31-1533908**2c** Plan Sponsor's telephone number
614-645-5500**2d** Business code (see instructions)
621399**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	<i>F. Lemu Nigusse</i>	<i>10/14/2015</i>	Fikru Lemu Nigusse
	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
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)			Preparer's telephone number (optional)

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

Form 5500 (2014)
v. 140124

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor 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	5 227
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	
a(1) Total number of active participants at the beginning of the plan year	6a(1) 182
a(2) Total number of active participants at the end of the plan year	6a(2) 225
b Retired or separated participants receiving benefits	6b 0
c Other retired or separated participants entitled to future benefits	6c 56
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 281
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e	6f 281
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 276
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h 25
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: 2L 2F 2G	
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)	9b Plan benefit arrangement (check all that apply)
(1) ☐ Insurance	(1) ☐ Insurance
(2) ☐ Code section 412(e)(3) insurance contracts	(2) ☐ Code section 412(e)(3) insurance contracts
(3) ☒ Trust	(3) ☒ Trust
(4) ☐ General assets of the sponsor	(4) ☐ General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

COLUMBUS NEIGHBORHOOD HEALTH CENTER, INC. 403(b)PLAN

E.I.N.: 31-1533908 PLAN NUMBER: 004

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