

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 2014 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 SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. 403(B) PLAN	<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;">001</td> </tr> <tr> <td colspan="2">1c Effective date of plan 01/01/2010</td> </tr> </table>	1b Three-digit plan number (PN) ▶	001	1c Effective date of plan 01/01/2010	
1b Three-digit plan number (PN) ▶	001				
1c Effective date of plan 01/01/2010					
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. 4283 PARADISE RD SEVILLE, OH 44273	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) 34-1011571</td> </tr> <tr> <td>2c Plan Sponsor's telephone number 330-722-1900</td> </tr> <tr> <td>2d Business code (see instructions) 624100</td> </tr> </table>	2b Employer Identification Number (EIN) 34-1011571	2c Plan Sponsor's telephone number 330-722-1900	2d Business code (see instructions) 624100	
2b Employer Identification Number (EIN) 34-1011571					
2c Plan Sponsor's telephone number 330-722-1900					
2d Business code (see instructions) 624100					

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.	05/19/2016	MICHAEL BEH
	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
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	5 215
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) 164
a(2) Total number of active participants at the end of the plan year	6a(2) 172
b Retired or separated participants receiving benefits	6b 7
c Other retired or separated participants entitled to future benefits.....	6c 64
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 243
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e 0
f Total. Add lines 6d and 6e	6f 243
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g 230
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h 31
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: 2E 2F 2G 2K 2L 2T 3D	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	
9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☐ 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 <u>SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. 403(B) PLAN</u>	B Three-digit plan number (PN) ▶ <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC.</u>	D Employer Identification Number (EIN) <u>34-1011571</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

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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)

NATIONWIDE

ONE NATIONWIDE PLAZA
COLUMBUS, OH 43215

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	RECORDKEEPER	8676	Yes ☒ No ☐	Yes ☒ No ☐	4285	Yes ☐ No ☒

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

ROYAL ALLIANCE INSURANCE AGENCY

ONE WORD FINANCIAL CENTER
14 FLOOR
NEW YORK, NY 10281

(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	ADVISOR	288	Yes ☒ No ☐	Yes ☒ No ☐	3347	Yes ☐ No ☒

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

APS-PENTEGRA

13-3892096

(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	TPA	2394	Yes ☒ No ☐	Yes ☒ No ☐	747	Yes ☐ No ☒

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 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>SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. 403(B) PLAN</u>		B Three-digit plan number (PN) ► <u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC.</u>		D Employer Identification Number (EIN) <u>34-1011571</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)	1563	8742
(2) Participant contributions.....	1b(2)	0	8321
(3) Other.....	1b(3)	0	600
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)	6324	10244
(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)	608386	865782
(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	616273	893689

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	1563	14477
k Total liabilities (add all amounts in lines 1g through 1j)	1k	1563	14477

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	614710	879212
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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)	85402	
(B) Participants	2a(1)(B)	178848	
(C) Others (including rollovers)	2a(1)(C)	600	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		264850
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)	314	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		314
(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)		33255
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		298419

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	22847	
(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)		22847
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)	11070	
(3) Investment advisory and management fees.....	2i(3)		
(4) Other.....	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		11070
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		33917

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		264502
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: **DYER ROCHE & COMPANY**

(2) EIN: **20-1954047**

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	☒	☐	8321
4b	☐	☒	

	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		200000
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

SCHEDULE R (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation		Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.		OMB No. 1210-0110 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 SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. 403(B) PLAN				B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC.				D Employer Identification Number (EIN) 34-1011571	
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): 31-4156830					
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: 0.0% 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): _____

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN

FINANCIAL STATEMENTS

FOR THE YEARS ENDED
DECEMBER 31, 2014 AND 2013



DYER ROCHE & COMPANY, INC.

Certified Public Accountants and Consultants

SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC. 403(b) PLAN

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DYER ROCHE & COMPANY, INC.

Certified Public Accountants and Consultants

Richard W. Dyer, CPA
Cathy G. Roche, CPA
Bert E. Humpal, CPA
J. Matthew Wickham, CPA, CMA, CFE

Andrea L. Hostetler, CPA
Morgan L. Durst, CPA
Karen L. Holt, CPA

INDEPENDENT AUDITORS' REPORT

To The Administrative Committee of
Society For Handicapped Citizens of Medina County, Inc. 403(b) Plan
Medina, Ohio

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Society For Handicapped Citizens of Medina County, 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.

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 3, which was certified by Nationwide Financial Services, the trustee of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the plan administrator that the trustee holds the Plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee as of and for the years ended, 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

We were engaged for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of delinquent participant contributions and schedule of assets (held at end of year), which are the responsibility of plan management, are presented for the purpose of additional analysis and are not a required part of the financial statements but are required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, it is inappropriate to and we do not express an opinion on the supplemental schedules referred to above.

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

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

Dyer Roche & Company, Inc.

Wooster, Ohio
April 30, 2016

SOCIETY FOR HANDICAPPED CITIZENS OF MEDINA COUNTY, INC 403(B) PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2014 AND 2013

	<u>2014</u>	<u>2013</u>
Investments:		
Investments, at fair value	\$ 865,782	\$ 608,386
Notes receivable from participants	<u>10,244</u>	<u>6,324</u>
Total investments	<u>876,026</u>	<u>614,710</u>
Receivables:		
Employer corrective contributions	<u>17,663</u>	<u>1,563</u>
Total receivables	<u>17,663</u>	<u>1,563</u>
Total Assets	893,689	616,273
Liabilities:		
Forfeiture payable	<u>14,477</u>	<u>1,563</u>
Total liabilities	<u>14,477</u>	<u>1,563</u>
Net assets available for benefits	<u>\$ 879,212</u>	<u>\$ 614,710</u>

See accompanying independent auditors' report
and notes to the financial statements which are
an integral part of these statements.

SOCIETY FOR HANDICAPPED CITIZENS

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	<u>2014</u>	<u>2013</u>
Additions to Net Assets Attributed To:		
Investment income:		
Interest and dividends	\$ 314	\$ 227
Net unrealized gain (loss)	33,255	59,259
Contributions:		
Participant	170,527	140,337
Employer - discretionary and matching	91,138	72,881
Employer - corrective contribution	<u>3,185</u>	<u>1,563</u>
Total additions	<u>298,419</u>	<u>274,267</u>
Deductions From Net Assets Attributed To:		
Benefits paid to participants	22,847	55,207
Administrative expenses	<u>11,070</u>	<u>7,574</u>
Total deductions	<u>33,917</u>	<u>62,781</u>
Net increase (decrease) in assets	264,502	211,486
Net Assets Available For Plan Benefits:		
Beginning of year	<u>614,710</u>	<u>403,224</u>
End of year	<u>\$ 879,212</u>	<u>\$ 614,710</u>

See accompanying independent auditors' report
and notes to the financial statements which are
an integral part of these statements.

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS

Note 1: Description of Plan

The following description of the Society for Handicapped Citizens of Medina County, 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.

General

The Plan is a defined contribution plan sponsored by Society for Handicapped Citizens of Medina County, Inc. (hereinafter called the "Organization") covering employees with at least 20 hours a week and one year/1,000 hours of service with the Organization. Entry into the Plan occurs on the first day of the first month following the date this requirement is met. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Contributions

Each year, participants may contribute from 1% to 20% of pretax annual compensation, as defined in the Plan. The Organization's discretionary non-elective contribution of 0.5% is allocated to all eligible participants in the Plan year. The Organization also has elected to make a matching contribution of 50% of the employees authorized deferral, with a maximum of 3% of the employees' gross wages.

Participant Accounts

Each participant's account is credited with the allocation of (a) participant contributions, (b) plan earnings, and (c) forfeitures of terminated participants' non-vested accounts. Allocations are based on participant earnings or account balances, as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's account.

Vesting

Participants are immediately vested in their contributions plus actual earnings thereon. Vesting in the Organization's matching and discretionary contribution portion of their accounts plus actual earnings thereon is based on their years of service. A participant is 100% vested after three years of credited service.

Payment of Benefits

On termination of service, a participant may elect to receive the value of his or her account in a lump-sum amount or in the form of a rollover to another qualified plan.

Notes Receivable From Participants

Participants may borrow from their fund accounts a maximum of 50% of the member's vested amount. Loan transactions are treated as transfers to (from) the investment fund from (to) the loan. The loans are secured by the balance in the participants account and bear an interest rate commensurate with local prevailing rates as determined by the plan administrator. Principal and interest are paid ratably through monthly payroll deductions. Interest received for the years ended December 31, 2014 and 2013 amounted to \$314 and \$227, respectively.

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS

Note 1: Description of Plan (Continued)

Forfeited Accounts

According to the plan document forfeitures of terminated participants' non-vested accounts are allocated to reduce employer non-elective or matching contributions or plan expenses. Forfeitures amounted to \$14,477 and \$221 for the years December 31, 2014 and 2013, respectively. During 2015 accumulated forfeitures were utilized to reduce the Organization's corrective contribution (see note 5).

Investment Options

Upon enrollment in the Plan, a participant may direct employee contributions among investment choices in increments of 1 percent. Participants may change their investment option on any normal business day.

Note 2: Summary of Accounting Policies

Basis of Accounting

The financial statements of the Plan are prepared using the accrual method of accounting in conformity with generally accepted accounting principles.

Payment of Benefits

Benefits are recorded when paid.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual amounts could differ from these estimates.

Administrative Expenses

Expenses paid by the Plan include fees for recordkeeping of plan assets and third party administration of participant accounts.

Investment Valuation and Income Recognition

The Plan's investments are stated at fair market value in the investment accounts held by Advanced Pension Solutions. Purchases are recorded on the date of contribution at the stated value. Interest is recorded on the accrual basis.

Subsequent Event

Management evaluates events occurring subsequent to the date of the financial statements in determining the accounting for and disclosure of transactions and events that affect the financial statements.

Effective January 1, 2015, the Plan was amended to allow for automatic deferrals of 2%.

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS

Note 2: Summary of Accounting Policies (Continued)

Subsequent Event (Continued)

Subsequent events have been evaluated through April 30, 2016, which is the date the financial statements were available to be issued.

Notes Receivable

Notes receivable from participants are measured at their unpaid principal balance plus any accrued but unpaid interest. Interest income is recorded on the accrual basis. Related fees are recorded as administrative expenses and are expensed when they are incurred. No allowance for credit losses has been recorded as of December 31, 2014 or 2013. If a participant ceases to make loan repayments and the plan administrator deems the participant loan to be in default, the participant loan balance is reduced and a benefit payment is recorded.

Note 3: Fair Value Measurements

The Plan's investments are reported at fair value in the accompanying statement of net assets available for benefits.

<u>December 31, 2014</u>	<u>Level 1</u>	<u>Level 3</u>	<u>Total</u>
Equity Funds:			
Domestic	\$ 459,038	\$ -	\$ 459,038
International	120,564	-	120,564
Mutual Funds:			
Domestic	237,113	-	237,113
International	32,661	-	32,661
Money Markets:			
Domestic	16,406	-	16,406
Notes Receivable from participants:	<u>-</u>	<u>10,244</u>	<u>10,244</u>
Total	<u>\$ 865,782</u>	<u>\$ 10,244</u>	<u>\$ 876,026</u>

<u>December 31, 2013</u>	<u>Level 1</u>	<u>Level 3</u>	<u>Total</u>
Equity Funds:			
Domestic	\$ 324,129	\$ -	\$ 324,129
International	85,983	-	85,983
Mutual Funds:			
Domestic	173,266	-	173,266
International	14,401	-	14,401
Money Markets:			
Domestic	10,607	-	10,607
Notes Receivable from participants:	<u>-</u>	<u>6,324</u>	<u>6,324</u>
Total	<u>\$ 608,386</u>	<u>\$ 6,324</u>	<u>\$ 614,710</u>

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS

Note 3: Fair Value Measurements (Continued)

FASB ASC 820, Fair Value Measurements, establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. This hierarchy consists of three broad levels: Level 1 inputs consist of unadjusted quoted prices in active markets for identical assets and have the highest priority. The Plan uses appropriate valuation techniques based on the available inputs to measure the fair value of its investments. When available, the Plan measures fair value using Level 1 inputs because they generally provide the most reliable evidence of fair value. There were no Level 2 inputs available to the Plan.

Level 1 Fair Value Measurements

The fair value of mutual funds is based on quoted net asset values of the shares held by the plan at year-end.

Level 3 Fair Value Measurements

The inputs used in the valuation methodology are unobservable and significant of the fair value measurement.

Participant loans are not actively traded and significant other observable inputs are not available. Thus, the fair value of the participant loans is equal to the amortized cost of the loans because the loans are secured by each respective participant's account balance.

Note 4: Investments

Upon enrollment in the Plan, a participant may direct contributions in any of the 33 investment funds in 2014. The following information included in the accompanying financial statements was obtained from data that has been prepared and certified to as complete and accurate by the trustee. The following table presents the fair values of investments for the periods ending December 31, 2014 and 2013. Investments that represent 5% or more of the Plan's net assets are separately identified as follows:

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS

Note 4: Investments (Continued)

	<u>2014</u>	<u>2013</u>
Investments at fair value as determined by quoted market prices:		
BOA Fixed Fund	\$ 72,110	\$ 47,588
NW Dest 2015	126,253	91,839
NW Dest 2020	-	39,477
NW Dest 2025	101,973	74,356
NW Dest 2050	<u>47,064</u>	<u>-</u>
Total investments representing 5% or more of Plan's net assets	347,400	253,260
Investment less than 5% of the Plan's net assets	<u>528,626</u>	<u>361,450</u>
Total investments at fair value	\$ <u>876,026</u>	\$ <u>614,710</u>

Note 5: Corrective Contribution Receivable

The corrective contribution receivable represents amounts due to the Plan as a result of errors made during 2014 in the determination of eligible compensation for purposes of determining employee deferrals, company match and discretionary non-elective contributions. The plan sponsor expects this amount (which includes lost earnings), less accumulated forfeitures (see Note 1), to be paid into the Plan during 2016.

As a result of this situation, the Organization may be assessed fines and/or penalties which have not been determined at this time.

Note 6: Related-Party Transactions and Party In Interest Transactions

Fees incurred by the plan for investment management services are included in administrative expenses and totaled \$8,676 and \$5,938 for the years ended December 31, 2014 and 2013. The Plan also made direct payments during 2014 and 2013 to the third party administrator of \$2,394 and \$1,476, respectively which are also included in administrative expenses. The Plan Sponsor pays directly any other fees related to the plan's operations.

Note 7: Plan Termination

The Organization has the right under the Plan to discontinue participant 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.

SOCIETY FOR HANDICAPPED CITIZENS OF
MEDINA COUNTY, INC. 403(b) PLAN
NOTES TO FINANCIAL STATEMENTS

Note 8: Tax Status

The Internal Revenue Service has determined and informed the Company by a letter dated March 3, 2008 that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (IRC). Although the Plan has been amended since receiving the determination letter, the plan administrator and the Plan's counsel believe that the plan is designed and is currently being operated in compliance with the applicable requirements of the Internal Revenue Code, and therefore, believe the Plan is qualified and the related trust is tax-exempt.

Management has evaluated income tax positions taken or expected to be taken, if any, on income tax returns filed and the likelihood that, upon examination by the relevant jurisdictions, those income tax positions would be sustained. Based on the results of this examination management determined there are no positions that necessitated disclosure and/or adjustment.

The Plan's federal income tax returns are subject to examination by the IRS, generally for three years after they were filed.

Note 9: Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, credit and market 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 the participants' account balances and the amounts reported in the statements of net assets available for benefits.

Society for Handicapped Citizens of Medina County, Inc. 403 (b) Plan
Supplemental Schedule - Schedule of Delinquent Participant Contributions
Schedule H, Line 4a
December 31, 2014

EIN: 34-1011157
Plan Number: 001

Participant Contributions Transferred Late to Plan	Total That Constitute Nonexempt Prohibited Transactions			Total Fully Corrected Under VFCP and PTE 2002- 51
	Contributions Not Corrected	Contributions Corrected Outside VFCP	Contributions Pending Correction in VFCP	
8,321	0	8,321	0	0

See accompanying independent auditors' report
and notes to the financial statements which are
and integral part of these statements.

Society for Handicapped Citizens of Medina County, Inc. 403 (b) Plan
Supplemental Schedule - Schedule of Assets (Held At End of Year)
Schedule H, Line 4i
December 31, 2014

EIN: 34-1011157
Plan Number: 001

(a)	(b)	(c)	(d)	(e)
Party in Interest	Identity of issue, borrower, lessor, or similar party	Description of investments including maturity date, rate of interest, collateral, par, or maturity value	Cost	Current value
	Nationwide Financial Services	- AmFds Cap World Growth Inc	1	\$15,539
	Nationwide Financial Services	- AmFds EuroPacfc Growth	1	21,731
	Nationwide Financial Services	- BOA Fixed	1	72,110
	Nationwide Financial Services	- BlkRk GNMA Inv A	1	778
	Nationwide Financial Services	- Eagle Series Mid Cap Gr A	1	6,311
	Nationwide Financial Services	- Invsco RealEst A	1	25,957
	Nationwide Financial Services	- JPM Gr Advantage A	1	21,728
	Nationwide Financial Services	- JPM Hi Yld A	1	35,923
	Nationwide Financial Services	- JPM SmCap Eq A	1	7,376
	Nationwide Financial Services	- JPM US Equity A	1	29,350
	Nationwide Financial Services	- Lazard Emrg Mkt Eq Open	1	17,406
	Nationwide Financial Services	- MnSty LgCap R2	1	29,349
	Nationwide Financial Services	- Nw Dest 2010	1	4,166
	Nationwide Financial Services	- Nw Dest 2015	1	126,253
	Nationwide Financial Services	- Nw Dest 2020	1	37,454
	Nationwide Financial Services	- Nw Dest 2025	1	101,973
	Nationwide Financial Services	- Nw Dest 2030	1	18,172
	Nationwide Financial Services	- Nw Dest 2035	1	29,689
	Nationwide Financial Services	- Nw Dest 2040	1	32,881
	Nationwide Financial Services	- Nw Dest 2045	1	39,381
	Nationwide Financial Services	- Nw Dest 2050	1	47,064
	Nationwide Financial Services	- Nw Dest 2055	1	10,317
	Nationwide Financial Services	- MdCap Mkt Indx A	1	5,193
	Nationwide Financial Services	- NW Mny Mkt Prm	1	16,406
	Nationwide Financial Services	- NW Rtrmt Inc R	1	20,582
	Nationwide Financial Services	- NW SmCap Indx A	1	1,454
	Nationwide Financial Services	- Natixis Loomis Val A	1	15,956
	Nationwide Financial Services	- PIMCO Ttl Rtn A	1	18,874
	Nationwide Financial Services	- Vic Syc Estblshd Val A	1	18,284
	Nationwide Financial Services	- Vic Sm Co Oppr A	1	20,622
	Nationwide Financial Services	- NW HM ST Bd A	1	3,868
	Nationwide Financial Services	- Drey Intl Bd A	1	13,635
*	Participant loans	4.25%, various maturity dates		10,244
		Total Investment Value		<u>\$ 876,026</u>

Column (a) * - indicates Party in Interest
Column (d) 1 - indicates Participant directed investment

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Society for Handicapped Citizens of Medina County, Inc. 403 (b) Plan
Supplemental Schedule - Schedule of Assets (Held At End of Year)
Schedule H, Line 4i
December 31, 2014

EIN: 34-1011157
Plan Number: 001

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