

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 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 2016 This Form is Open to Public Inspection
---	--	---

Part I	Annual Report Identification Information For calendar plan year 2016 or fiscal plan year beginning <u>01/01/2016</u> and ending <u>12/31/2016</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.) ☒ 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>SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(B) PLAN</u>	1b	Three-digit plan number (PN) ► <u>002</u>
		1c	Effective date of plan <u>01/01/2009</u>
2a	Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC.</u> <u>4449 STATE ROUTE 159</u> <u>CHILLICOTHE, OH 45601</u>		2b Employer Identification Number (EIN) <u>31-0720849</u> 2c Plan Sponsor's telephone number <u>740-775-1260</u> 2d Business code (see instructions) <u>621112</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	<u>Filed with authorized/valid electronic signature.</u>	<u>12/15/2017</u>	<u>RAYETTA LAMBERT</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)			Preparer's telephone number

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2016)
v. 160205

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	5 233
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) 148 6a(2) 183 6b 2 6c 34 6d 219 6e 0 6f 219 6g 185 6h 2
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: 2F 2G 2L 2M b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:	

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor
--	--

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

a Pension Schedules (1) ☒ R (Retirement Plan Information) (2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small Plan) (3) ☒ <u>1</u> A (Insurance Information) (4) ☒ C (Service Provider Information) (5) ☐ D (DFE/Participating Plan Information) (6) ☐ G (Financial Transaction Schedules)
---	---

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2016 This Form is Open to Public Inspection
---	---	---

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(B) PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC.	D Employer Identification Number (EIN) 31-0720849

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

1 Coverage Information:

(a) Name of insurance carrier
SYMETRA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0742147	68608	LP1123820	38	01/01/2016	12/31/2016

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end **4** 550699**5** Current value of plan's interest under this contract in separate accounts at year end..... **5****6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier **6b****c** Premiums due but unpaid at the end of the year **6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount **6d**
Specify nature of costs ▶**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☒ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **7b** 918247**c** Additions: (1) Contributions deposited during the year **7c(1)** 75695
(2) Dividends and credits..... **7c(2)** 15117
(3) Interest credited during the year..... **7c(3)** -2
(4) Transferred from separate account..... **7c(4)**
(5) Other (specify below)..... **7c(5)** 100307

▶ TRANSFERRED FROM OUTSIDE INVESTMENT

(6) Total additions **7c(6)** 191117**d** Total of balance and additions (add lines **7b** and **7c(6)**). **7d** 1109364**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 539576
(2) Administration charge made by carrier..... **7e(2)** 1198
(3) Transferred to separate account..... **7e(3)**
(4) Other (specify below)..... **7e(4)** 17891

▶ TRANSFERRED TO OUTSIDE INVESTMENT

(5) Total deductions **7e(5)** 558665**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f** 550699

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2016
		This Form is Open to Public Inspection.

For calendar plan year 2016 or fiscal plan year beginning **01/01/2016** and ending **12/31/2016**

A Name of plan SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(B) PLAN	B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC.	D Employer Identification Number (EIN) 31-0720849

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	
MATRIX FINANCIAL SOLUTIONS	700 17TH STREET, STE 300 DENVER, CO 80202

20-1591048

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
NATIONWIDE SECURITIES, LLC	5100 RINGS RD MAIL CODE RR1-01-D1 DUBLIN, OH 43017

36-2434406

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
AMERICAN CENTURY	P.O. BOX 419385 KANSAS CITY, MO 64441

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
AMERICAN FUNDS	3500 WISEMAN BOULEVARD SAN ANTONIO, TX 78251

95-1411037

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

JPMORGAN

245 PARK AVENUE FLOOR 3
NEW YORK, NY 10167

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

PRUDENTIAL

100 MULBERRY ST
GATEWAY CENTER 3, 6TH FLOOR
NEWARK, NJ 07102

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

PUTNAM

P.O. BOX 1553
ANDOVER, MA 01810

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

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

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

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

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

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

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

CPI QUALIFIED PLAN CONSULTANTS, INC

1809 24TH STREET
P.O. BOX 1167
GREAT BEND, KS 67530

48-1205033

(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?
12 15 37 50 60 62 64	"NONE"	17224	Yes ☒ No ☐	Yes ☐ No ☒	10369	Yes ☐ No ☒

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

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

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

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CPI QUALIFIED PLAN CONSULTANTS, INC	12 15 37 50 60 64	5596
(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.	
JPMORGAN 245 PARK AVENUE FLOOR 3 NEW YORK, NY 10167	SUBSIDY TO OFFSET CUSTODIAL AND TRADING EXPENSES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CPI QUALIFIED PLAN CONSULTANTS, INC	12 15 37 50 60 64	1145
(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.	
COLUMBIA ONE FINANCIAL CENTER BOSTON, MA 02110	SUBSIDY TO OFFSET CUSTODIAL AND TRADING EXPENSES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CPI QUALIFIED PLAN CONSULTANTS, INC	12 15 37 50 60 64	2302
(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.	
SYMETRA FUNDS 777 108TH AVE. NE BELLEVUE, WA 98004	SUBSIDY TO OFFSET CUSTODIAL AND TRADING EXPENSES	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	WHITED SEIGNEUR SAMS & RAHECPASLLP	b EIN:	31-0962125
c Position:	INDEPENDENT AUDITOR		
d Address:	213 SOUTH PAINT STREET CHILLICOTHE, OH 45601-3828	e Telephone:	740-702-2600

Explanation: WE HAD NOT PUT THE AUDITOR CONTRACT OUT FOR BID IN OVER 3 YEARS. THIS FIRM WAS SELECTED BY OUR BOARD OF DIRECTORS FINANCE COMMITTEE.

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) 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 2016 This Form is Open to Public Inspection
---	--	--

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016		
A Name of plan SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(B) PLAN	B Three-digit plan number (PN) ►	002
C Plan sponsor's name as shown on line 2a of Form 5500 SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC.	D Employer Identification Number (EIN) 31-0720849	

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	0	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....	1b(1)	0	0
(2) Participant contributions	1b(2)	0	0
(3) Other.....	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	0	0
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other.....	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common.....	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property).....	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans.....	1c(8)	231243	185313
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities.....	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)	3979090	3450638
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)	918247	550699
(15) Other	1c(15)	0	0

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)	0	0
(2) Employer real property	1d(2)	0	0
e Buildings and other property used in plan operation	1e	0	0
f Total assets (add all amounts in lines 1a through 1e)	1f	5128580	4186650

Liabilities

g Benefit claims payable	1g	0	0
h Operating payables	1h	0	0
i Acquisition indebtedness	1i	0	0
j Other liabilities	1j	0	0
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	5128580	4186650
---	-----------	---------	---------

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)	203233	
(B) Participants	2a(1)(B)	299685	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		502918
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)	8544	
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		8544
(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)	90658	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		90658
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	2071514	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	2025351	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		46163
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	7421	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		7421

		(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)		109237
c Other income.....	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		764941

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	1698614	
(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)		1698614
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)	8257	
(3) Investment advisory and management fees.....	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		8257
j Total expenses. Add all expense amounts in column (b) and enter total	2j		1706871

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-941930
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: **BHM CPA GROUP, INC.**

(2) EIN: **31-1413463**

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.)	4c		X	
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.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
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.)	4j		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
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			
o Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	4o			

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
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part V Trust Information

6a Name of trust	6b Trust's EIN
6c Name of trustee or custodian	6d Trustee's or custodian's telephone number

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 sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2016 This Form is Open to Public Inspection.
---	---	--

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan <u>SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(B) PLAN</u>	B Three-digit plan number (PN) ▶ <u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC.</u>	D Employer Identification Number (EIN) <u>31-0720849</u>

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	<u>0</u>
2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits): EIN(s): <u>75-3182674</u>		
Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.		
3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year	3	

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, see the Instructions for Form 5500.

Schedule R (Form 5500) 2016
v. 160205

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): _____	

Part VII	IRS Compliance Questions
-----------------	---------------------------------

20a Is the plan a 401(k) plan? If "No," skip b	☐ Yes ☐ No
20b How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:	☐ Design-based safe harbor ☐ "Prior year" ADP test ☐ "Current year" ADP test ☐ N/A
21a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:	☐ Ratio percentage test ☐ Average benefit test ☐ N/A
21b Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?	☐ Yes ☐ No
22a If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter / / and the serial number .	
22b If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter / / .	



bhm cpa group, inc.
CERTIFIED PUBLIC ACCOUNTANTS

**Scioto Paint Valley Mental
Health Center, Inc. 403(b) Plan
EIN 31-0720849 Plan 002**

FINANCIAL STATEMENTS

December 31, 2016

One East Campus View Blvd. Suite 300 • Columbus, OH 43235 • (614) 389-5775 • FAX (614) 467-3920
PO Box 875 • 129 Pinckney Street • Circleville, OH 43113 • (740) 474-5210 • FAX (740) 474-7319
PO Box 687 • 528 S. West Street • Piketon, OH 45661 • (740) 289-4131 • FAX (740) 289-3639

www.bhmcpgroup.com



bhm cpa group, inc.
CERTIFIED PUBLIC ACCOUNTANTS



C O N T E N T S

	Page
Independent Auditor's Report	1
Financial Statements:	
Statement of Net Assets Available for Plan Benefits	3
Statement of Changes in Net Assets Available for Plan Benefits	4
Notes to Financial Statements	5
Supplemental Schedule:	
Schedule of assets held (held at year end)	11



bhm cpa group, inc.
CERTIFIED PUBLIC ACCOUNTANTS

To the Trustees
Scioto Paint Valley Mental Health Center, Inc. 403(b) Plan
4449 State Route 159
Chillicothe, Ohio 45601

INDEPENDENT AUDITOR'S REPORT

Report on the Financial Statements

We were engaged to audit the accompanying financial statements of Scioto Paint Valley Mental Health Center, Inc. 403(b) Plan, which comprise the statements of net assets available for benefits as of December 31, 2016 and 2015, and the related statement of changes in net assets available for benefits for the year ended December 31, 2016, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these 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 (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 4, which was certified by MG Trust Company, LLC, the custodian 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 (or custodian) holds the plan's investment assets and executes investment transactions. The plan administrator has obtained a certification from the trustee (or custodian) as of December 31, 2016 and 2015 and for the year ended December 31, 2016, that the information provided to the plan administrator by the trustee (or custodian) 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.

One East Campus View Blvd. Suite 300 • Columbus, OH 43235 • (614) 389-5775 • FAX (614) 467-3920
PO Box 875 • 129 Pinckney Street • Circleville, OH 43113 • (740) 474-5210 • FAX (740) 474-7319
PO Box 687 • 528 S. West Street • Piketon, OH 45661 • (740) 289-4131 • FAX (740) 289-3639

www.bhmcpagroup.com

Other Matter

The supplemental schedule of assets held is required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA and are presented for the purpose of additional analysis and are not a required part of the financial statements. Because of the significance of the matter described in the Basis for Disclaimer of Opinion paragraph, we do not express an opinion on these supplemental schedules.

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 (or custodian), have been audited by us in accordance with auditing standards generally accepted in the United States of America and, in our opinion, are presented in compliance with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

BHM CPA Group

Columbus, Ohio
October 13, 2017

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(b) Plan

STATEMENTS OF NET ASSETS AVAILABLE FOR PLAN BENEFITS

For the years ended December 31, 2016 and 2015

	<u>2016</u>	<u>2015</u>
ASSETS		
Investments (at fair value)		
Cash	\$ 25,631	\$ 29,091
Investments	3,450,638	\$ 3,979,090
Investment Contract with Insurance Company	550,699	918,247
	<u>4,026,968</u>	<u>4,926,428</u>
Receivables:		
Loans Receivable from Participants	185,313	227,783
	<u>185,313</u>	<u>227,783</u>
TOTAL ASSETS	<u>\$ 4,212,281</u>	<u>\$ 5,154,211</u>
NET ASSETS AVAILABLE FOR PLAN BENEFITS	<u>\$ 4,212,281</u>	<u>\$ 5,154,211</u>

The accompanying notes are an integral part of these financial statements.

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(b) Plan**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR PLAN BENEFITS**

For the years ended December 31, 2016 and 2015

	<u>2016</u>	<u>2015</u>
ADDITIONS:		
Additions to net assets attributed to:		
Contributions:		
Participant contributions	\$ 299,685	\$ 319,735
Employer contributions	203,233	\$ 348,019
Rollovers and Transfers	-	11,289
Total contributions	<u>502,918</u>	<u>679,043</u>
Investment income:		
Dividends	90,658	137,558
Interest	8,544	9,674
Net appreciation in fair value of investments	162,821	(158,225)
Net investment income	<u>262,023</u>	<u>(10,993)</u>
TOTAL ADDITIONS	<u>764,941</u>	<u>668,050</u>
DEDUCTIONS:		
Deductions from net assets attributed to:		
Administrative fees	8,257	8,463
Benefits Paid to Participants	<u>1,698,614</u>	<u>434,305</u>
TOTAL DEDUCTIONS	<u>1,706,871</u>	<u>442,768</u>
NET INCREASE	(941,930)	225,282
Net assets available for plan benefits at beginning of year	<u>5,154,211</u>	<u>4,928,929</u>
NET ASSETS AVAILABLE FOR PLAN BENEFITS AT END OF YEAR	<u>\$ 4,212,281</u>	<u>\$ 5,154,211</u>

The accompanying notes are an integral part of these financial statements.

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC 403(b) PLAN
NOTES TO THE FINANCIAL STATEMENTS

1. DESCRIPTION OF PLAN

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

General. The Plan is a defined contribution plan covering all employees of Scioto Paint Valley Mental Health Center, Inc. (Company) who normally work more than 20 hours per week. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Board of Trustees of Scioto Paint Valley Mental Health Center, Inc. oversees governance of the Plan.

Contributions. Each year, participants may contribute any percent of pretax annual compensation, as defined in the Plan. However, pre-tax contributions that are deferred from compensation are subject to the dollar limit for the calendar year as provided by law. The maximum dollar limit applies to the aggregate of all amounts that are contributed to this plan and all other 401(k), 403(b) and SEPs of this employer or any other employer during the calendar year. Participants who have attained age 50 before the end of any calendar year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Company elected to contribute 5.00% of regular wages. These matching contributions are a discretionary amount to be determined by the Employer each plan year. Contributions are subject to certain limitations.

Participant Accounts. Each participant's account is credited with the participant's contribution and allocations of (a) the Company's contribution, and (b) Plan earnings or losses. 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 vested account, less applicable withdrawal fees.

Vesting. Participants are immediately vested in all contribution received from the employee, employer, or rollover contributions plus any earnings they generate.

Participant Loans. Participants may borrow from their fund accounts a minimum of \$1,000 up to a maximum equal to the lesser of \$50,000 or 50% of their account balance. The loans are secured by the balance in the participant's account and bear interest at Prime plus 1%. Principal and interest is paid ratably through biweekly payroll deductions.

Payment of Benefits. On termination of service due to death, disability, or retirement, a participant may elect to receive payment(s), transfer to another plan, or remain in plan. However, if plan valuation is less than \$5,000, the participant will receive a lump sum amount equal to the value in his or her account. For termination of service due to other reasons or financial hardship, a participant may receive the value of the vested interest in his or her account as a lump sum distribution.

Forfeitures. Due to the Plan's 100% vesting policy, no forfeitures are incurred.

**SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC 403(b) PLAN
NOTES TO THE FINANCIAL STATEMENTS**

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

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

Notes Receivable from Participants

Loans to participants are reported at their unpaid principal balances plus any accrued but unpaid interest. Generally, a default occurs when any scheduled payment is not paid when due. However, there will be a grace period from the due date of the missed payment through the first day of the third month after the end of the quarter in which the required payment was due but not made. If the missed payment is made during the grace period then no distribution will be deemed to have occurred. If the missed payment is not made during the grace period then a distribution will be deemed to have occurred as provided in Treasury Regulation 1.72(p)-1, A-4(a). The Plan Administrator will take such steps as it deems necessary to preserve plan assets in the event of a default. If a Plan loan is in default the loan will not be offset against the vested account balance until a distributable event occurs in the Plan. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan, and thereby resulting in taxable income to the participant.

Investment Valuation and Income Recognition

Unaudited information has been certified by MG Trust Company, LLC for a limited scope audit. The Plan's investments are stated at fair value. Shares of registered investment companies and mutual funds are valued at quoted market prices, which represent the net asset value of shares held by the Plan at year-end.

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

Payment of Benefits

Benefits are recorded when paid.

Plan Expenses

Plan administration expenses are paid by the sponsor company, Scioto Paint Valley Mental Health Center, Inc., except for certain withdrawal and participant fees.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

Date of Management's Review

In preparing these financial statements, the Plan has evaluated events and transactions for potential recognition or disclosure through October 13, 2017, the date the financial statements were available to be issued.

**SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC 403(b) PLAN
NOTES TO THE FINANCIAL STATEMENTS**

3. FAIR VALUE MEASUREMENTS

The Plan's investments are reported at fair value in the accompanying statement of net assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value at the reporting date.

The fair value measurement accounting literature 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, and Level 3 inputs are unobservable and have the lowest 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. Level 3 inputs were only used when Level 1 or 2 inputs were not available.

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2016 and 2015.

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. The fair values of common stocks, corporate bonds, and U.S. Government securities are based on the closing price reported on the active market where the individual securities are traded.

Level 2 Fair Value Measurements

Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly:

- a. Quoted market prices for similar assets or liabilities in active markets
- b. Quoted prices for identical or similar assets or liabilities in inactive markets
- c. Inputs other than quoted prices that are observable for the asset or liability
- d. 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. No Level 2 inputs were available to the Plan.

Level 3 Fair Value Measurements

The guaranteed investment contract with an insurance company is not actively traded and significant other observable inputs are not available. Thus, the fair value of the guaranteed investment contract is determined using an income approach by discounting the related cash values based on current yields of similar instruments with comparable durations considering the credit-worthiness of the issuer.

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC 403(b) PLAN
NOTES TO THE FINANCIAL STATEMENTS

3. FAIR VALUE MEASUREMENTS (Continued)

The following tables set forth, by level within the fair value hierarchy, the Plan's investments at fair value as of December 31, 2016 and 2015:

December 31, 2016	Fair Value	Identical Assets (Level 1)	Unobservable Inputs (Level 3)
Mutual Funds	\$ 3,450,638	\$ 3,450,638	-
Investment contract with insurance company	550,699	-	550,699
Total investments at fair value	<u>\$ 4,001,337</u>	<u>\$ 3,450,638</u>	<u>\$ 550,699</u>

Assets at Fair Value			
December 31, 2015	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Unobservable Inputs (Level 3)
Mutual Funds:	\$ 3,979,090	\$ 3,979,090	\$ -
Investment contract with insurance company	918,247	-	918,247
Total investments at fair value	<u>\$ 4,897,337</u>	<u>\$ 3,979,090</u>	<u>\$ 918,247</u>

Transfers between Levels

For years ended December 31, 2016 and 2015, there were no significant transfers between Levels 1 and 3.

Changes in Fair Value of Level 3 Assets and Related Gains and Losses

The following table reconciles the beginning and ending balances of fair value measurements using significant unobservable inputs (Level 3) for the investment contract with insurance company for the year ended December 31, 2016:

Beginning balance	\$ 918,247
Total gains or losses included in changes in net assets available for benefits:	15,115
Purchases, issuances, sales, and settlements:	
Purchases	176,002
Sales	(558,665)
Ending balance	<u>\$ 550,699</u>

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC 403(b) PLAN
NOTES TO THE FINANCIAL STATEMENTS

4. INFORMATION PREPARED AND CERTIFIED BY CUSTODIAN

The December 31, 2016 and 2015 Statements of Net Assets Available for Benefits, the investment activities included on the Statement of Changes in Net Assets Available for Benefits for the year ended December 31, 2016, and the accompanying notes to the financial statements were prepared in part of entirely from information certified by the Custodian in accordance with 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 information certified includes total cash and investments of \$4,026,968 and \$4,926,428 at December 31, 2016 and December 31, 2015, respectively.

During 2016, the Plan's investments (including gains and losses on investments bought and sold well as held during the year) increased in value by \$162,821.

5. INVESTMENT CONTRACT WITH INSURANCE COMPANY

In 2010, the Plan entered into a deposit administration contract with Symetra Life Insurance Company (Symetra). The contract was renewed in 2012. The Symetra Daily Fixed Account is an unallocated group annuity that offers a fixed rate of return that is daily valued, similar to a mutual fund.

The contract is presented on the face of the statement of net assets available for benefits at fair value with an adjustment to contract value in arriving at net assets available for benefits. Contract value, as reported by Symetra, represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer all or a portion of their investment at contract value.

Certain events limit the Plan's ability to transact at contract value with Symetra. Such events include the following: (a) amendments to the plan documents (including complete or partial termination or merger with another plan), (b) changes to the plan's prohibition on competing investment plan options or deletion of equity wash provision, (c) bankruptcy of the plan sponsor or other plan sponsor events (for example divestiture or spin-offs of a subsidiary) that cause a significant withdrawal from the plan, or (d) the failure of the trust to qualify for exemption from federal income taxes or any required prohibited transaction exemption under the Employee Retirement Income Security Act of 1974. The plan administrator does not believe that any events that would limit the plan's ability to transact at contract value with the Plan participants are probably of occurring.

6. SEPARATED PARTICIPANTS WITH DEFERRED VESTED BENEFITS

At December 31, 2016, the Plan held \$1,101,979 of investments for participants who have separated from the Company. Distribution of these funds is made in accordance with the Plan Adoption Agreement.

7. 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.

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC 403(b) PLAN
NOTES TO THE FINANCIAL STATEMENTS

8. TAX STATUS

The Company has an agreement with CUNA Mutual Retirement Solutions whereby specified plan administration services will be provided to the Plan by means of a prototype plan sponsored by CUNA Mutual Retirement Solutions. CUNA Mutual Retirement Solutions and Plan Administration believe that the Plan is designed and is currently operated in compliance with the applicable requirements of the Internal Revenue Code as of the report date. During 2010, the Plan was amended to a combination custodial account and annuity contract type of plan. This amendment had no effect on benefits and net assets.

9. PLAN TERMINATION

Although it has not expressed any intent to do so, the Company has the right under the Plan to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to Schedule H of Form 5500:

	2016	2015
Net assets or benefits per Form 5500	\$ 4,186,650	\$ 5,128,580
Cash	25,631	29,091
Accounts receivable	-	-
Payment of Loan Principal	-	(3,460)
Net assets available or benefits per the financial statements	<u>\$ 4,212,281</u>	<u>\$ 5,154,211</u>

SCIOTO PAINT VALLEY MENTAL HEALTH CENTER, INC. 403(b) Plan

**EIN 31-0720849
PLAN NUMBER 002**

SCHEDULE H, LINE 4 i - SCHEDULE OF ASSETS (HELD AT YEAR END)

For the year ended December 31, 2016

(a)	(b) Identity of issue, borrower, lessor or similar party	(c) Description of investment maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current Value
	Loan Fund	Other Loans 4.25%-4.25%	-	185,313
	AB Discovery Value	Value of INT In Regist Invest Co.	-	30,895
	AB High Income	Value of INT In Regist Invest Co.	-	7,860
	Amer Century Disciplined Gth	Value of INT In Regist Invest Co.	-	24,395
	American Century Disciplined Gth	Value of INT In Regist Invest Co.	-	72,491
	American Funds Europacific	Value of INT In Regist Invest Co.	-	54,955
	Columbia Contrarian Core	Value of INT In Regist Invest Co.	-	237,648
	Deutsche Small CAP Growth	Value of INT In Regist Invest Co.	-	37,633
	JPM Smartretirement 2015	Value of INT In Regist Invest Co.	-	367,527
	JPM Smartretirement 2020	Value of INT In Regist Invest Co.	-	702,485
	JPM Smartretirement 2025	Value of INT In Regist Invest Co.	-	455,176
	JPM Smartretirement 2030	Value of INT In Regist Invest Co.	-	549,343
	JPM Smartretirement 2035	Value of INT In Regist Invest Co.	-	313,295
	JPM Smartretirement 2040	Value of INT In Regist Invest Co.	-	138,235
	JPM Smartretirement 2045	Value of INT In Regist Invest Co.	-	91,114
	JPM Smartretirement 2050	Value of INT In Regist Invest Co.	-	62,282
	JPM Smartretirement 2055	Value of INT In Regist Invest Co.	-	37,935
	JPM Smartretirement Inc	Value of INT In Regist Invest Co.	-	28,449
	Principl Real Estate Secrts	Value of INT In Regist Invest Co.	-	7,739
	Principial LRG CAP SP 500 In	Value of INT In Regist Invest Co.	-	14,418
	Prudential Total Return Bond	Value of INT In Regist Invest Co.	-	158,378
	Putnam Equity Income	Value of INT In Regist Invest Co.	-	58,385
	Symetra Daily Val Fix Acct	Value of INT In Regist Invest Co.	-	550,699
			-	4,186,650
	Total		\$ -	\$4,186,650

Schedule H, Line 4i
Schedule of Assets (Held At End of Year)

Name of Plan:

► Scioto Paint Valley Mental Health Center, Inc. 403(b) Plan

Employer Identification Number: ► 31-0720849

For plan year (beginning/ending): ► 1/1/2016 to 12/31/2016

Plan number: ► 002

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par or maturity value	(d) Cost	(e) Current value
	LOAN FUND	OTHER LOANS 4.25% - 4.50%	N/A	185,313
	AB DISCOVERY GROWTH	VALUE OF INT IN REGIST INVEST CO	N/A	30,895
	AB DISCOVERY VALUE	VALUE OF INT IN REGIST INVEST CO	N/A	7,860
	AB HIGH INCOME	VALUE OF INT IN REGIST INVEST CO	N/A	24,395
	AMER CENTURY DISCIPLINED GTH	VALUE OF INT IN REGIST INVEST CO	N/A	72,491
	AMERICAN FUNDS EUROPACIFIC	VALUE OF INT IN REGIST INVEST CO	N/A	54,955
	COLUMBIA CONTRARIAN CORE	VALUE OF INT IN REGIST INVEST CO	N/A	237,648
	DEUTSCHE SMALL CAP GROWTH	VALUE OF INT IN REGIST INVEST CO	N/A	37,633
	JPM SMARTRETIREMENT 2015	VALUE OF INT IN REGIST INVEST CO	N/A	367,527
	JPM SMARTRETIREMENT 2020	VALUE OF INT IN REGIST INVEST CO	N/A	702,485
	JPM SMARTRETIREMENT 2025	VALUE OF INT IN REGIST INVEST CO	N/A	455,176
	JPM SMARTRETIREMENT 2030	VALUE OF INT IN REGIST INVEST CO	N/A	549,343
	JPM SMARTRETIREMENT 2035	VALUE OF INT IN REGIST INVEST CO	N/A	313,295
	JPM SMARTRETIREMENT 2040	VALUE OF INT IN REGIST INVEST CO	N/A	138,235
	JPM SMARTRETIREMENT 2045	VALUE OF INT IN REGIST INVEST CO	N/A	91,114
	JPM SMARTRETIREMENT 2050	VALUE OF INT IN REGIST INVEST CO	N/A	62,282
	JPM SMARTRETIREMENT 2055	VALUE OF INT IN REGIST INVEST CO	N/A	37,935
	JPM SMARTRETIREMENT INC	VALUE OF INT IN REGIST INVEST CO	N/A	28,449
	PRINCIPL REAL ESTATE SECRTS	VALUE OF INT IN REGIST INVEST CO	N/A	7,739
	PRINCIPAL LRG CAP SP 500 IN	VALUE OF INT IN REGIST INVEST CO	N/A	14,418
	PRUDENTIAL TOTAL RETURN BOND	VALUE OF INT IN REGIST INVEST CO	N/A	158,378
	PUTNAM EQUITY INCOME	VALUE OF INT IN REGIST INVEST CO	N/A	58,385
	SYMETRA DAILY VAL FIX ACCT	VALUE OF FUNDS HELD IN INSUR CO	N/A	550,699