Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2009

1 611310	on Benefit Guaranty Corporation				This Form is Open to Pu Inspection	ublic
Part I		tification Information				
For cale	ndar plan year 2009 or fiscal p	plan year beginning 07/01/2006		and ending 06/30/	2007	
A This	return/report is for:	a multiemployer plan;	a multip	le-employer plan; or		
		a single-employer plan;	a DFE (specify)		
			_			
B This	return/report is:	the first return/report;	the final	return/report;		
		an amended return/report;	a short	olan year return/report (less	than 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
D Chec	k box if filing under:	Form 5558;	automat	ic extension;	the DFVC program;	
		special extension (enter des	scription)			
Part	II Rasic Plan Inform	nation—enter all requested inform	. ,			
_	ne of plan	enter an requested inform	ation		1b Three-digit plan	
	•	LDER COUNTY INC. FLEXIBLE BE	ENEFITS PLAN		number (PN) ▶	501
					1c Effective date of pl	an
30 Dis-		- (\		03/01/1988	
	ress should include room or s	s (employer, if for a single-employer suite no.)	pian)		2b Employer Identifica Number (EIN)	ation
	L HEALTH CENTER OF BOU				84-0520493	
					2c Sponsor's telephor	ne
					number 303-443-8500	
1333 IRI	S AVENUE		SAVENUE		2d Business code (see	Δ
BOULDE	ER, CO 80304	BOOLDE	BOULDER, CO 80304			C
					621420	
Caution	: A penalty for the late or in	complete filing of this return/repo	rt will be assessed	unless reasonable cause	is established.	
		enalties set forth in the instructions,				dules,
statemer	nts and attachments, as well a	as the electronic version of this retur	n/report, and to the I	pest of my knowledge and be	elief, it is true, correct, and con	nplete.
SIGN HERE	Filed with authorized/valid ele	ectronic signature.	05/19/2010	BRUCE SHAVER		
		signing as plan administrator				
SIGN						
HERE	Signature of employer/pla	n sponsor	Date	Enter name of individual	signing as employer or plan sp	onsor
SIGN						
HERE			1	i		

Date

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

Form 5500 (2009) v.092307.1

Enter name of individual signing as DFE

	Form 5500 (2009)	Page 2		
	Plan administrator's name and address (if same as plan sponsor, enter "Sam	ne")		Administrator's EIN 4-0520493
	3 IRIS AVENUE ULDER, CO 80304		ı	Administrator's telephone number 03-443-8500
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	/report filed for this pla	n, enter the name, EIN and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	257
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b, 6c,	and 6d).	
а	Active participants		6a	257
b	Retired or separated participants receiving benefits		6b	
С	Other retired or separated participants entitled to future benefits		6c	(
d	Subtotal. Add lines 6a, 6b, and 6c		6d	257
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	6e	
f	Total. Add lines 6d and 6e		6f	257
g	Number of participants with account balances as of the end of the plan year complete this item)			
h	Number of participants that terminated employment during the plan year with less than 100% vested			
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plans of	omplete this item) 7	
	If the plan provides pension benefits, enter the applicable pension feature confidence of the plan provides welfare benefits, enter the applicable welfare feature codes 4A 4B 4D 4H 4L			
	Plan funding arrangement (check all that apply) (1)	(1) X Ir (2) C (3) T (4) G	angement (check all that appl nsurance code section 412(e)(3) insura rust deneral assets of the sponsor dicated, enter the number att	nce contracts

b General Schedules

(1)

(2)

(3)

(4)

(5)

(6)

H (Financial Information)

A (Insurance Information)C (Service Provider Information)

I (Financial Information – Small Plan)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

a Pension Schedules

(1)

(2)

(3)

R (Retirement Plan Information)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

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

2009

For calendar plan year 200	For calendar plan year 2009 or fiscal plan year beginning 07/01/2006 and ending 06/30/2007						
A Name of plan	ER COUNTY INC. FLEXIBLE BE	B B	Three-		501		
MENTAL HEALTH CENT	ER COUNTY INC. FLEXIBLE BE	INEFITS PLAIN	plan n	number (PN)	301		
C Plan sponsor's name a					er Identification Number	(EIN)	
MENTAL HEALTH CENT	ER OF BOULD	ER COUNTY INC.	8	34-0520)493		
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
KAISER FOUNDATION H		OF COLORADO, INC.					
			(e) Approximate number	r of	Policy or o	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year	of	(f) From	(g) To	
84-0591617	95669	05281	256		07/01/2006	06/30/2007	
2 Insurance fee and composition descending order of the		tion. Enter the total fees and tota	I commissions paid. List in i	item 3 t	he agents, brokers, and	other persons in	
	amount of comm	nissions paid		(b) Tota	al amount of fees paid		
		31114				0	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all perso	ons).			
	(a) Name a	nd address of the agent, broker, o		mmissio	ons or fees were paid		
LLOYD J. SWA, JR.			OX 462140 RA, CO 80046				
						<u> </u>	
(b) Amount of sales ar			Fees and other commissions paid				
commissions pa	8722	(c) Amount	(d) Pu NUS AND NON-MONETAR	(d) Purpose		(e) Organization code	
	0122	0 50	NOO / IND NON MONE I/ II	CI OII I		3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom con	mmissio	ons or fees were paid		
AON CONSULTING, INC		4100 E	E. MISSISSIPPI AVE, SUITE ER, CO 80246		•		
		DEINVI	LN, CO 60240				
(b) Amount of sales and base Fees and other			and other commissions pai	id			
commissions pa		(c) Amount	(d) Pt	urpose		(e) Organization code	
	22392					3	
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form	5500.	Scl	nedule A (Form 5500) 2009 v.092308.1	

Schedule A (Form 5500)	2009	Page 2- 1	Page 2- 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
	I						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai					
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page 4		

1817985

10a

10b

	Schedule A (Form 5500) 2009		Р	age 4		
Part II	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experience	ce-rated as a unit. Whe	ere contrac	
8 Ben	efit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment	h X Prescription drug
i ĺ	Stop loss (large deductible)	j X HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)	• 🗆	<u> </u>	1		- L
٠٠٠ ا	_ Carion (opeony) /					
9 Expe	erience-rated contracts:					
a	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid		• •			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (,				
	(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					
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention	_			9c(1)(H))
	(2) Dividends or retroactive rate refunds. (These	e 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)	
е	Dividends or retroactive rate refunds due. (Do r	ot include amount entered	d in c(2) .)		9e	

Specify nature of costs	Þ

10 Nonexperience-rated contracts:

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

a Total premiums or subscription charges paid to carrier 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, item 2 above, report amount.....

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

2009

For calendar plan year 200	09 or fiscal plan	year beginning 07/01/2006		and er	nding 06/30/2007	
A Name of plan MENTAL HEALTH CENT	NEFITS PLAN	B Three	e-digit number (PN)	501		
C Plan sponsor's name a MENTAL HEALTH CENT				D Emplo 84-052	oyer Identification Number 20493	r (EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca HUMANA DENTAL INSU		ANY				
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			contract year
(3) =	code	identification number	policy or contract year		(f) From	(g) To
39-0714280	70580	1029393	25	57	07/01/2006	06/30/2007
2 Insurance fee and comp descending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in item 3	the agents, brokers, and	d other persons in
(a) Total a	amount of comm			(b) To	otal amount of fees paid	1010
		5972				1213
3 Persons receiving com		ees. (Complete as many entries a				
LLOYD J. SWA, JR.	(a) Name a	nd address of the agent, broker, o	or other person to whon OX 462140	n commiss	ions or fees were paid	
LEGID G. GWA, GIV.			RA, CO 80046			
(b) Amount of sales ar		Fees and other commissions paid				_
commissions pai		(c) Amount	LUME INCENTIVES	(d) Purpose	9	(e) Organization code
	50	1213 VO	LOME INCENTIVES			3
	(a) Name a	nd address of the agent, broker, o	or other person to whon	n commiss	ions or fees were paid	
AON CONSULTING, INC			E. MISSISSIPPI AVE, S ER, CO 80246	UITE 1500)	
			,			
		Faas	and other commission	ns naid		
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose		(e) Organization code
,	5922	0	,			3
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for F	orm 5500.	So	thedule A (Form 5500) 2009 v.092308.1

Schedule A (Form 5500)	2009	Page 2- 1	Page 2- 1				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
	I						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai					
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e		5		
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page 4		

9c(1)(H)

9c(2)

9d(1) 9d(2)

9d(3)

9e

162251

:	Schedule A (Form 5500) 2009		P	age 4		
Part III	Welfare Benefit Contract Information If more than one contract covers the same goinformation may be combined for reporting pothe entire group of such individual contracts.	roup of employees of the s urposes if such contracts a	are experienc	ce-rated as a unit. W	here contrac	
8 Benefit	and contract type (check all applicable boxes)					
a∏⊦	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance
e	Temporary disability (accident and sickness)	f Long-term disability	√ g 🗍	Supplemental unen	nployment	h Prescription drug
i∏s	Stop loss (large deductible)	j HMO contract		PPO contract		I Indemnity contract
	Other (specify)	• 🗆		_		- <u> </u>
🗆 、	Saler (openly)					
9 Experie	ence-rated contracts:					
a Pre	miums: (1) Amount received		9a(1)			
(2)	Increase (decrease) in amount due but unpai	d	9a(2)			
(3)	Increase (decrease) in unearned premium res	serve	9a(3)			
(4)	Earned ((1) + (2) - (3))	<u>.</u>			9a(4)	
b Be	enefit charges (1) Claims paid		9b(1)			
(2)	Increase (decrease) in claim reserves		9b(2)			
(3)	Incurred claims (add (1) and (2))				9b(3)	
(4)	Claims charged				9b(4)	
C Re	emainder 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)			

9c(1)(F)

10	No	nexperience-rated contracts:		
	а	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 Litem 2 above, report amount	10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

(F) Charges for risks or other contingencies

(H) Total retention (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

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

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

2009

For calendar plan year 20	09 or fiscal plan	year beginning 07/01/2006		and en	nding 06/30/2007		
A Name of plan MENTAL HEALTH CENT	ER OF BOULD	ER COUNTY INC. FLEXIBLE BE	ENEFITS PLAN		e-digit number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500. MENTAL HEALTH CENTER OF BOULDER COUNTY INC. D Employer Id 84-0520493					yer Identification Number (0493	EIN)	
	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 ca							
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ntract year	
(b) EIN	code	identification number	persons covered at end policy or contract year		(f) From	(g) To	
39-1263473	73288	1029393	233		07/01/2006	06/30/2007	
2 Insurance fee and com- descending order of the		tion. Enter the total fees and tota	al commissions paid. List in	n item 3	the agents, brokers, and o	ther persons in	
(a) Total a	amount of comn	nissions paid		(b) To	tal amount of fees paid		
		8126				1424	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all pers	sons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom co	ommissi	ions or fees were paid		
LLOYD J. SWA, JR.			BOX 462140 PRA, CO 80046				
			,				
(b) Amount of sales ar	nd hase	Fee	s and other commissions pa	aid			
commissions pai		(c) Amount	(d) F	Purpose)	(e) Organization code	
	1948	1424 VC	VOLUME INCENTIVES			3	
	(a) Name a	nd address of the agent, broker,	or other person to whom co	ommissi	ions or fees were paid		
AON CONSULTING, INC. 4100 E. MISSISSIPPI AVE, SUITE 1500 DENVER, CO 80246							
(b) Amount of color or	nd hasa	Fees	s and other commissions pa	aid			
(b) Amount of sales ar commissions pa		(c) Amount		Purpose)	(e) Organization code	
	6178	0				3	
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Schedule A (Form 5500) 200							

Schedule A (Form 5500)	2009	Page 2- 1			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contrad	cts with each carrier may	be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity	_		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1)		ion guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			. 7d	
		Deductions:				
			7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page 4	

10b

	Schedule A (Form 5500) 2009		F	Page 4		
Part II	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts	are experien	ce-rated as a unit. Wh	ere contracts	
8 Bene	efit and contract type (check all applicable boxes))				
а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
еĪ	Temporary disability (accident and sickness)	f Long-term disability	tv a	Supplemental unem	plovment I	h Prescription drug
i	Stop loss (large deductible)	i HMO contract	_ =	PPO contract	, , ,	I Indemnity contract
' <u> </u>	_ · · · · · · · · · · · · · · · · · · ·	J I TIMO CONTIACT	N.	_ FFO contract		I Indemnity contract
m [Other (specify) ▶ AD&D					
0 Fvns	rience-rated contracts:					
	Premiums: (1) Amount received		9a(1)			1
	(2) Increase (decrease) in amount due but unpai					<u> </u>
	(3) Increase (decrease) in unearned premium re					
	(4) Earned ((1) + (2) - (3))			1	9a(4)	
_	Benefit charges (1) Claims paid				1 ()	
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))				. 9b(3)	
	(4) Claims charged				. 9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees					
	(C) Other specific acquisition costs					
	(D) Other expenses					
	(E) Taxes					
	(F) Charges for risks or other contingencies					1
	(G) Other retention charges				0 (4)(1)	
	(H) Total retention	_			. 9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These					
d	Status of policyholder reserves at end of year: (,				
	(2) Claim reserves				. 9d(2)	
	(3) Other reserves				. 9d(3)	
	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in c(2) .)		. 9e	
	nexperience-rated contracts:				40	4470/
а	Total premiums or subscription charges paid to	carrier			. 10a	41785

Part IV F	Provision of Information			
11 Did the in	surance company fail to provide any information necessary to complete Schedule A?	☐ Yes	П No	

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, item 2 above, report amount.....

Specify nature of costs **\rightarrow**

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

2009

For calendar plan year 20	09 or fiscal plar	year beginning 07/01/2006		and er	nding 06/30/2007	
A Name of plan MENTAL HEALTH CENTER OF BOULDER COUNTY INC. FLEXIBLE BENE			ENEFITS PLAN		e-digit number (PN)	501
C Plan sponsor's name as shown on line 2a of Form 5500. MENTAL HEALTH CENTER OF BOULDER COUNTY INC.				D Emplo 84-052	oyer Identification Number (20493	EIN)
	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 ca		ANCE COMPANY				
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate null persons covered at policy or contract	end of	Policy or co	ontract year (g) To
35-0472300	70254	670324	12	•	07/01/2006	06/30/2007
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	st in item 3	the agents, brokers, and o	other persons in
(a) Total a	amount of comr			(b) To	otal amount of fees paid	
		11598				0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).		
	(a) Name a	nd address of the agent, broker,		n commiss	sions or fees were paid	
LLOYD J. SWA, JR.			3OX 462140 DRA, CO 80046			
42.4		Faa	s and other commission	hien e		
(b) Amount of sales ar commissions pa		(c) Amount		d) Purpose	e	(e) Organization code
·	1779	0	,	•		3
	(a) Name a	nd address of the agent, broker,	or other person to whom	n commiss	ions or fees were paid	
AON CONSULTING, INC. 4100 E. MISSISSIPPI AVE, SUITE 1500 DENVER, CO 80246						
(b) Amount of sales ar			s and other commission			
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code
	9819	0				3
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Fe	orm 5500.	Sch	edule A (Form 5500) 2009

Schedule A (Form 5500)	2009	Page 2- 1	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
	I		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai	
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contrad	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				
-	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			7d	
		Deductions:	7.44			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	_ ` _			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page 4		

Schedule A (Form	5500	2009 (
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Pa	rt I	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees irposes if such co	ntracts are e	xperienc	ce-rated as a unit. Wh	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	b Dental		С	Vision		$\mathbf{d} \ \square$ Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term	disability	g	Supplemental unem	ployment	h Prescription dr	ug
	i [Stop loss (large deductible)	j HMO cont	ract	k	PPO contract		I Indemnity cont	ract
	m	Other (specify)							
9	Ехр	erience-rated contracts:							
	а	Premiums: (1) Amount received		9	a(1)				
		(2) Increase (decrease) in amount due but unpaid	I	9	a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9	a(3)				
		(4) Earned ((1) + (2) - (3))					9a(4)		
	b	Benefit charges (1) Claims paid		9	b(1)				
		(2) Increase (decrease) in claim reserves			b(2)				
		(3) Incurred claims (add (1) and (2))		-			9b(3)		
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (o							
		(A) Commissions			(1)(A)			1	
		(B) Administrative service or other fees			(1)(B)			1	
		(C) Other specific acquisition costs			1)(C)			1	
		(D) Other expenses		_	1)(D)				
		(E) Taxes			1)(E)				
		(F) Charges for risks or other contingencies		_	1)(F)				
					1)(G)				
							9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	_		_				
	لہ								
	d	Status of policyholder reserves at end of year: (1		•			9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
40	е	·	ot include amount	entered in c	(2) .)		9e		
10	_	nexperience-rated contracts:							00000
	a	Total premiums or subscription charges paid to c					10a		96636
	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, item 2 above, report amount					10b			
	SI	pecify nature of costs							

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Form 5500, Box D – DFVCP FILING

This Form 5500 is being filed under the DFVCP Program for:

EIN: 84-0520493

Plan Sponsor: Mental Health Center of Boulder County Inc.

Plan Name & Number: Mental Health Center of Boulder County Inc.

Flexible Benefits Plan, Plan 501

Plan Year(s): 7/1/2002, 7/1/2003, 7/1/2004, 7/1/2005, 7/1/2006,

7/1/2007