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

	, , , , , , , , , , , , , , , , , , , ,				Inis Form is Open to Pu	IDIIC	
Part I	Annual Report Iden	tification Information					
For cale	ndar plan year 2009 or fiscal p	olan year beginning 01/01/2009	_	and ending 12/31	/2009		
A This	return/report is for:	a multiemployer plan;	a multip	e-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 p	olan year return/report (less	than 12 months).		
C If the	plan is a collectively-bargaine	ed plan, check here					
	k box if filing under:	Form 5558;	_	ic extension;	the DFVC program;		
2 000	g anden	special extension (enter de					
Part	II Rasic Plan Inform	nation—enter all requested inform					
	ne of plan	ialion onto an requested illioni	idion		1b Three-digit plan		
	ND RESIDENTIAL GROUP HE	EALTH & WELFARE PLAN			number (PN) ▶	501	
					1c Effective date of pla	an	
20 Diag		/ complete with the second complete with the s			01/01/2003	4:	
	n sponsor's name and address Iress should include room or s	s (employer, if for a single-employer uite no.)	pian)		2b Employer Identifica Number (EIN)	ition	
,	ND RESIDENTIAL, LLC	,			05-0551632		
					2c Sponsor's telephon	ie	
					number 360-992-7456		
	AIN STREET		IN STREET		2d Business code (see	<u> </u>	
SUITE 7	UVER, WA 98660-2970	SUITE 75 VANCOL	/ER, WA 98660-2970 instructions)			,	
					531110		
Caution	: A penalty for the late or inc	complete filing of this return/repo	ort will be assessed	unless reasonable cause	is established.		
		enalties set forth in the instructions,				dules,	
stateme	nts and attachments, as well a	is the electronic version of this return	rn/report, and to the I	pest of my knowledge and b	elief, it is true, correct, and com	plete.	
SIGN HERE	Filed with authorized/valid ele	ectronic signature.	06/28/2010	ROBBIE DODD			
HEKE	Signature of plan administ	trator	Date	Enter name of individual	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			

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)		Pag	ge 2					
11 ⁻ SU	Plan administrator's name and address (if same as plan sponsor, enter "Sam LLAND RESIDENTIAL, LLC 11 MAIN STREET ITE 750 NCOUVER, WA 98660-2970	ne")					3c Ac	dministrator's -0551632 dministrator's tumber 0-992-7456	
4 a	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report: Sponsor's name	n/report	filed for t	his p	olan, enter	the name, El	N and	4b EIN 4c PN	
5	Total number of participants at the beginning of the plan year						5		403
6	Number of participants as of the end of the plan year (welfare plans complete	e only l	ines 6a. 6	6b. 6	c. and 6d)) <u>.</u>	3		400
а	Active participants	•	·	•	,		6a		385
b	Retired or separated participants receiving benefits						6b		12
С							0		
d	d Subtotal. Add lines 6a, 6b, and 6c			6d		397			
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive b	enefits				<u>6e</u>		
f	Total. Add lines 6d and 6e						6f		397
g	Number of participants with account balances as of the end of the plan year complete this item)						6g		
h	Number of participants that terminated employment during the plan year with less than 100% vested						6h		
7	Enter the total number of employers obligated to contribute to the plan (only								
	If the plan provides pension benefits, enter the applicable pension feature confidence of the plan provides welfare benefits, enter the applicable welfare feature code: 4A 4B 4D 4E 4H 4L								
9a	Plan funding arrangement (check all that apply) (1)		Plan bene (1) (2) (3) (4)	efit ar	Insurance Code sec Trust	nt (check all te extion 412(e)(3 assets of the	s) insuran		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ttached	l, and, wh	nere i	indicated,	enter the nur	nber atta	ched. (See in	structions)
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan		General : (1) (2) (3)	Sche	H (I	Financial Info Financial Info	rmation –	Small Plan)	

(4)

(5)

(6)

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(3)

C (Service Provider Information)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

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

OMB No. 1210-0110

			RISA section 103(a)(2).	111131 011	m is Open to Public Inspection	
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009	and er			
A Name of plan HOLLAND RESIDENTIAL	_ GROUP HEAL	TH & WELFARE PLAN		e-digit number (PN)	501	
•	C Plan sponsor's name as shown on line 2a of Form 5500. HOLLAND RESIDENTIAL, LLC D Employer Identification Number (EIN) 05-0551632					
			overage, Fees, and Communit in Parts II and III can be repo			
1 Coverage Information:						
(a) Name of insurance ca		NCE COMPANY				
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	entract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
57-0144607	62049	E7757032	131	01/01/2009	12/31/2009	
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	commissions paid. List in item 3	the agents, brokers, and c	ther persons in	
(a) Total a	amount of comn		(b) To	tal amount of fees paid	40500	
	20615 12528					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all persons).			
	(a) Name ar		or other person to whom commiss	ions or fees were paid		
DON JEFFREY BRINK			OUTHWEST BARBUR BLVD. LAND, OR 97239			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa	id	(c) Amount	(d) Purpose	e	(e) Organization code	
	9850	7520 FEE	ES		3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
DOUGLAS GRANT THURSTON 112 NW 114TH STREET VANCOVUER, WA 98685						
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code	
	1399	1460 FEE	ES		3	
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	Sch	edule A (Form 5500) 2009	

Schedule A (Form 5500) 20	09	Page 2- 1	
(a) Nam ZINA OSTER	10200	er, or other person to whom commissions or fees were pa D SW GREENBURG ROAD FLAND, OR 97223	id
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
637	1545	FEES	3
DONALD TERRY GOTHAM	27705	er, or other person to whom commissions or fees were pa 5 150TH PLACE SE 7, WA 98042	id
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose FEES	(e) Organization code
(a) Nam	e and address of the agent broke	er, or other person to whom commissions or fees were pa	id
CINDEE LEE HULM	23940) SW SCHOLLS FERRY ROAD SBORO, OR 97123	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
925	998	FEES	3
(a) Nam	e and address of the agent, broke	er, or other person to whom commissions or fees were pa	id
DEBORAH ANN BERRY		. 9TH PLACE A, AZ 85203	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
1555	57	FEES	3
(a) Nam	e and address of the agent, broke	er, or other person to whom commissions or fees were pa	id
SCOTT DANIEL JONES		SW BARBUR BLVD TLAND, OR 97239	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount 136	(d) Purpose	code 3
			<u> </u>

Schedule A (Form 5500) 2	2009	Page 2- 2	
(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were pai	
KAREN CLAY KUNKLER	1709 1	NW 45TH AVENUE S, WA 98607	
(b) Amount of sales and base	ı	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1064	203	FEES	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	d
ROXANA BUSCHMAN	400 N VANC	ORTHEAST 149TH STREET OUVER, WA 98685	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1079	71	FEES	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	d
LORI HOWARD	1407	NORTHEAST 102 AVENUE OUVER, WA 98664	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
763	8	FEES	3
(a) Na	ime and address of the agent, broke	r, or other person to whom commissions or fees were pai	d
JUDY INEZ BUCHOLTZ	12517	217TH AVENUE CT EAST IEY LAKE, WA 98391	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
562	129	FEES	3

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
562	129	FEES	3	

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

DENNIS CARL CRANDALL

815 EATONVILLE HWY. EATONVILLE, WA 98328

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
639	10	FEES	3

Schedule A (Form 5500) 2	2009	Page 2- 3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
JANET ANNE RAMOS		WEST CENTER AVENUE WOOD, CO 80226	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
370	139	FEES	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	 uid
BETTY WILCOX		PARADISE VILLAS GROVE RADO SPRINGS, CO 80921	
(b) Amount of sales and base		ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
359	19	FEES	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
JEFFREY MARK TATHWELL	10615	SW ORIOLE CIRCLE ERTON, OR 97007	
(b) Amount of sales and base	- 	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
146	138	FEES	3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
MANUEL TORRES	20235	N. CAVE CREEK ROAD NIX, AZ 85024	-
(b) Amount of sales and base		ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
203	63	FEES	3

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

412 JEFFERSON PKWY.
LAKE OSWEGO, OR 97035

FEES

46

(c) Amount

Fees and other commissions paid

(d) Purpose

(e) Organization

code

3

MONTGOMERY & GRAHAM INC.

(b) Amount of sales and base

commissions paid

Schedule A (Form 5500) 200	09	Page 2- 4	
(a) Name	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	aid
KATIE JEAN LEE		SE YAMHILL LAND, OR 97233	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
209	17	FEES	3
(a) Name	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	aid
BRIAN T. MURPHY		47TH AVENUE SW TLE, WA 98136	
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
206	12	FEES	3
(a) Name	and address of the agent broke	r, or other person to whom commissions or fees were pa	aid
GILBERTO ESTRADA	385 R	IDGEVIEW DRIVE SANT HILL, CA 94523	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
136	38	FEES	3
(a) Name	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	aid
PAMELA ARLESTE WHITFIELD	118 10	07TH AVENUE NE EVUE, WA 98004	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
134	26	FEES	3
(a) Name	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	aid
KRISTEN ELISE RANDALL	9538 \	WEST SAN JUAN CIRCLE ETON, CO 80128	

Fees and other commissions paid

11 FEES

(d) Purpose

(c) Amount

(e) Organization code

(b) Amount of sales and base commissions paid

Schedule A (Form 5500) 2	2009	Page 2- 5		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were p	 paid	
KATHERIE MARIE FRAZIER	3815 H	H. STREET OUVER, WA 98663		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
124	30	FEES	3	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were	paid	
VIRGINIA F. FINER	4319 L	AKE WASHINGTON BLVD. NW AND, WA 98033		
(b) Amount of sales and base	ſ	Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
143	9	FEES	3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were	naid	
MARDEIO MATTHEW CANNON	2520 \	VENTURE OAKS WAY AMENTO, CA 95833	o di d	
(h) Amount of color and bace	<u> </u>	Fees and other commissions paid	(a) Organization	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
120	3	FEES	3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were p	naid	
CHAD EDWARD WARRINER	1661 E	EAST GIRARD PLACE EWOOD, CO 80113	yana	
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
46	47	FEES	3	

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

806 NW 79TH STREET

VANCOUVER, WA 98665

(c) Amount

Fees and other commissions paid

(d) Purpose

(e) Organization

code

3

THURSTON DOUGLAS G.

(b) Amount of sales and base

commissions paid

Schedule A (Form 5500) 20	009	Page 2- 6	
	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
JOE QUINTANA		ORTH CENTRAL AVENUE ENIZ, AZ 85004	
(b) Amount of sales and base _		Fees and other commissions paid	(e) Organization
commissions paid 68	(c) Amount	(d) Purpose	code 3
(a) Nam		r, or other person to whom commissions or fees were pa	id
GINA MARIE WESOLCK		AKE WOOD CIRCLE DLAND PARK, CO 80863	
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
61	5	FEES	3
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
THERESA A. BALLWEBER		NE 279TH STREET EFIELD, WA 98642	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
24	23	FEES	3
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
RUSSELL REOPELLE	3423	173RD STREET CT. E. MA, WA 98446	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
37			3
(a) Nam	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
KEVIN LEE SURLES	1100 \	WILLOWRIDGE CIR. SVILLE, TX 75067	-

Fees and other commissions paid

FEES

16

(d) Purpose

(c) Amount

(e) Organization

code

3

(b) Amount of sales and base commissions paid

Schedule A (Form 5500) 2	2009	Page 2- 7					
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	id				
CHAD LAVERNC FRAZIER	HAD LAVERNC FRAZIER 1151 SOUZA WAY FOLSOM, CA 95630						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid 13	(c) Amount	(d) Purpose	code 3				
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	id				
DAWN R. TRAPANI	1111	MAIN STREET OUVER, WA 98660					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
13			3				
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	id				
TASHA L. BECKMAN	20269	SMOKEY HILL RD. ENNIAL, CO 80015					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
9	9		3				
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	id				
CHRISTINA MARIE ALGAR	1692 (CRESCENT DRIVE IUT CREEK, CA 94598					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
8			3				
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were pai	id				
CAROL JEAN HALL	P.O. E	ROX 15158 ON, AZ 85708					

Fees and other commissions paid

(d) Purpose

(c) Amount

(e) Organization code

3

(b) Amount of sales and base commissions paid

Schedule A	(Earm	EEOO'	2000
Scriedule A	(FOIIII	5500	1 2009

PETER K. DOBRATZ

Page **2-**8

(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1			3
(a) Name	and address of the agent, bro	ker, or other person to whom commissions or fees were pa	id
PAM BRUNING		80 W. CASINO RD. ERETT, WA 98204	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1			3
(a) Name	and address of the agent, bro	ker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent, bro	ker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent, bro	ker, or other person to whom commissions or fees were pa	id
(a) Name	and address of the agent, bro	ker, or other person to whom commissions or fees were pa	id
	and address of the agent, bro	ker, or other person to whom commissions or fees were particle. Fees and other commissions paid	
(a) Name (b) Amount of sales and base commissions paid	and address of the agent, broken agent, brok		
(b) Amount of sales and base	-	Fees and other commissions paid	(e) Organization

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

12050 N. PECOS STREET

WESTMINSTER, CO 80234

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	
mployer(s) or members of the same en erience-rated as a unit. Where contracts a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d Life insuran h Prescription I Indemnity c

Pa	rt III	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts v	urposes if such contracts	are experienc	ce-rated as a unit. Wh	ere contract	
8	Bene	efit and contract type (check all applicable boxes)	•		<u> </u>		
	аΓ	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance
	_	<u>.</u>	-	<u>_</u>	4		_
	e [Temporary disability (accident and sickness)	f Long-term disabilit	· <u> </u>	Supplemental unemp	oloyment	h Prescription drug
	i L	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m >	Other (specify) VOLUNTARY LIFE					
9	Ехре	rience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	1	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves				r	
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n 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)		Т	
		(H) Total retention	_			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in c(2) .)		9e	
10	Noi	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			10a	89124
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b	
	Sn	ecify 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	

Schedule A (Form 5500) 2009

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

This Form is Open to Public Inspection

For calendar plan year 200	09 or fiscal plan	year beginning 01/01/2009	and e	nding 12/31/2009			
A Name of plan HOLLAND RESIDENTIAL GROUP HEALTH & WELFARE PLAN				e-digit number (PN)	501		
C Plan sponsor's name a HOLLAND RESIDENTIAL		2a of Form 5500.	D Emplo	oyer Identification Number (51632	EIN)		
			Coverage, Fees, and Com a unit in Parts II and III can be repo				
1 Coverage Information:							
(a) Name of insurance ca		MPANY					
/I.) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
13-5581829	65978	KM05569018	801	01/01/2009	12/31/2009		
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	al commissions paid. List in item 3	the agents, brokers, and c	other persons in		
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
		17760			16		
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persons).				
			or other person to whom commiss	ions or fees were paid			
MERCER HEALTH & BEI	NEFITS		W COLUMBIA LAND, OR 97201				
(b) Amount of sales ar	nd base	Fee	s and other commissions paid				
commissions pai		(c) Amount	(d) Purpos		(e) Organization code		
	13221	16 NC	N MONETARY COMPENSATION	N.	3		
	(a) Name ar	nd address of the agent, broker,	or other person to whom commiss	ions or fees were paid			
MERCER HEALTH & BEI		111 S ¹	W COLUMBIA LAND, OR 97201	·			
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid				
commissions pai		(c) Amount	(d) Purpos	e	(e) Organization code		
		4539 EN	HANCED CONTINGENT COMMI	SSION	3		
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500.	Sch	edule A (Form 5500) 2009 v 092308 1		

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

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	
over(s) or members of the sa	ame e

Pa	rt II	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr						
		information may be combined for reporting put the entire group of such individual contracts with the entire					ts cover individual employees	,
8	Ben	efit and contract type (check all applicable boxes)						_
_	а	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance	
	L					n amala, maant	범	
	e	Temporary disability (accident and sickness)				nemployment		
	1	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
								_
9		erience-rated contracts:			1		_	
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res				0=(4)		
	h	(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves				9b(3)		
		(3) Incurred claims (add (1) and (2))(4) Claims charged				9b(3)		_
	С	Remainder of premium: (1) Retention charges (o		•••••		<u>35(4)</u>		
	Ŭ	(A) Commissions	,	9c(1)(A)				
		(B) Administrative service or other fees		- (1)(-)				
		(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	<u></u>	<u></u>		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	er retirement	9d(1)		
		(2) Claim reserves						
		(3) Other reserves				· · · ·		
40	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)		9e		
10	_	nexperience-rated contracts:				40	2203	42
	a	Total premiums or subscription charges paid to c					2203	43
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo			•			
	Sr	pecify nature of costs	art i, noin 2 abo	. c, roport ar				_
	-1	,						

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

Schedule A (Form 5500) 2009

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.

OMB No. 1210-0110

,	nis Form is Open to Public Inspection							
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009								
A Name of plan HOLLAND RESIDENTIA	-			B Three-	digit umber (PN)	501		
C Plan sponsor's name as shown on line 2a of Form 5500. HOLLAND RESIDENTIAL, LLC D Employer Identification Number (EIN) 05-0551632								
		ing Insurance Contract Individual contracts grouped a						
1 Coverage Information:		<u> </u>						
(a) Name of insurance ca		PF AMERICA						
	(-) NAIO	(A) Contract on	(e) Approximate num	nber of	Poli	cy or contract year		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at e	end of	(f) From	(g) To		
01-0278678	62235	124098	10	1	01/01/2009	12/31/2009		
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 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								
840 79								
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all pe	ersons).				
		and address of the agent, broke			ns or fees were pa	aid		
MERCER HEALTH & BE	• • • • • • • • • • • • • • • • • • • •	111	SW COLUMBIA RTLAND, OR 97201					
						T		
(b) Amount of sales a			ees and other commissions			(a) Organization and		
commissions pa	840	(c) Amount		(d) Purpose NHANCED CONTINGENT COMMISSION		(e) Organization code		
	840	79			51014	3		
	(a) Name a	ınd address of the agent, broke	r. or other person to whom	commissio	ns or fees were pa	aid		
	(1)		,					
(b) Amount of sales a	nd base	Fe	ees and other commissions	paid				
commissions pa		(c) Amount	(d	l) Purpose		(e) Organization code		

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 contracts with each carrier mathis report.				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						
ployer(s) or members of the same employee organization(s), the rience-rated as a unit. Where contracts cover individual employees, s a unit for purposes of this report.						
c Vision g Supplemental unemployment k PPO contract	d ☒ Life insurance h ☐ Prescription drug l ☐ Indemnity contract					

		If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experience	ce-rated as a unit. Who	ere contrac		
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f X Long-term disabili	ity g	Supplemental unemp	oloyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT					
9	Ехре	rience-rated contracts:						
	a i	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		. 9b(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		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: () Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due. (Do r				9d(3) 9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to	carrier			10a		6356
	b	If the carrier, service, or other organization incur						
		retention of the contract or policy, other than rep				10b		

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

Specify nature of costs

Schedule A (Form 5500) 2009

Part III

Welfare Benefit Contract Information

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

Pension Benefit Guaranty Co	orporation	pursuant to ERISA section 103(a)(2).				rm is Open to Public Inspection			
For calendar plan year 20	09 or fiscal pla	n year beginning 01/01/2009	and	ending 12/3	31/2009				
A Name of plan HOLLAND RESIDENTIAL	L GROUP HEA	ALTH & WELFARE PLAN		ee-digit In number (PN))	501			
	C Plan sponsor's name as shown on line 2a of Form 5500. HOLLAND RESIDENTIAL, LLC D Employer Identification Number (E 05-0551632								
on a separat	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 UNUM LIFE INSURANCE		DF AMERICA							
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or c	ontract year			
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) i	From .	(g) To			
01-0278678	62235	079369	381	381 01/01/2009		12/31/2009			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. List in item	3 the agents, I	orokers, and	other persons in			
(a) Total amount of commissions paid (b) Total amount of fees paid									
1684 309						309			
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons).						
 		and address of the agent, broker, o		ssions or fees v	vere paid				
MERCER HEALTH & BE		111 S\	N COLÚMBIA LAND, OR 97201		•				
(h) Amount of color or		Fees	s and other commissions paid						
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code			
1684		309 EN	HANCED CONTINGENT COMM			3			
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(b) Amount of sales ar	nd hase	Fees	s and other commissions paid						
commissions pa		(c) Amount	(d) Purpose			(e) Organization code			
	n Ant Natio	and OMP Control Numbers and	the instructions (or Ferry 550	•		Podulo A (Form 5500) 2000			

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 contracts with each carrier mathis report.				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	
employer(s) or members of the same en xperience-rated as a unit. Where contract d as a unit for purposes of this report.	
c Vision g Supplemental unemployment k PPO contract	d ☐ Life insurance h☐ Prescription drug I☐ Indemnity contract
a(1)	

Pa	art II	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 of the surposes if such contracts a	are experienc	e-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
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у g [Supplemental unem	ployment l	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT	_	•		_
9	Expe	rience-rated contracts:	_				
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	j	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n 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					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1					
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in c(2) .)		9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			10a	12838
	b	If the carrier, service, or other organization incurr				10h	

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

Specify nature of costs **\rightarrow**

Schedule A (Form 5500) 2009

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

Pension Benefit Guaranty Co	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection		
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009							
A Name of plan HOLLAND RESIDENTIAL GROUP HEALTH & WELFARE PLAN					e-digit number (Pl	N) •	501
C Plan sponsor's name a HOLLAND RESIDENTIAL		ne 2a of Form 5500.		D Employer Identification Number (EIN) 05-0551632			
		ning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca VISION SERVICE PLAN	rrier						
4	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
91-6056925	47317	30005935	2	33	01/01/20	009	12/31/2009
2 Insurance fee and composite descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
_							
3 Persons receiving com		fees. (Complete as many entri					
MERCER HEALTH & BEI		and address of the agent, broke	er, or other person to who I SW COLUMBIA	m commiss	ions or fees	were paid	
WENGEN HEAETH & BEI	NETTTO		RTLAND, OR 97201				
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions paid (c) Amount		(c) Amount	(d) Purpose			(e) Organization code	
	1425						3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code

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					
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		

Pa	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	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		

9d(3)

9e

10a

10b

30837

	Schedule A (Form 5500) 2009		P	age 4		
Part III	Welfare Benefit Contract Information If more than one contract covers the same group information may be combined for reporting purporthe entire group of such individual contracts with	o of employees of the soses if such contracts a	are experien	ce-rated as a unit. Whe	ere contracts	oyee organization(s), the cover individual employees,
8 Bene	fit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	Dental	c	Vision	d	Life insurance
e	Temporary disability (accident and sickness) f	Long-term disability	v a [Supplemental unemp	olovment h	Prescription drug
ř	Stop loss (large deductible)	HMO contract		PPO contract	,	Indemnity contract
· _	, , , ,	I TIMO CONTIACT	~ _	11 O contract	•	
m _	Other (specify)					
Q Eyno	rience-rated contracts:					
•	remiums: (1) Amount received	Г	9a(1)			
	2) Increase (decrease) in amount due but unpaid	-	9a(1)			
	Increase (decrease) in amount due but unpaid Increase (decrease) in unearned premium reserv	_	9a(3)			
	4) Earned ((1) + (2) - (3))	_			9a(4)	
_	Benefit charges (1) Claims paid	F	9b(1)		0(.)	
	2) Increase (decrease) in claim reserves	F	- 11			
	3) Incurred claims (add (1) and (2))	_			9b(3)	
	4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (on a	n accrual basis)			, ,	
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention	_	_		9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These an	nounts were paid in	cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) A	mount held to provide b	penefits after	retirement	9d(1)	
	(2) Claim reserves				9d(2)	

(3) Other reserves

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

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.....

Specify	nature	٥f	costs	
Opedin	Hatule	OI.	COSIS	•

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	