

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 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 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning 01/01/2007 and ending 12/31/2007	
A	This return/report is for: ☐ a multiemployer plan; ☒ a single-employer plan; ☐ a multiple-employer plan; or ☐ a DFE (specify) ____
B	This return/report is: ☐ the first return/report; ☐ the final return/report; ☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558; ☐ automatic extension; ☒ the DFVC program; ☐ special extension (enter description)

Part II	Basic Plan Information—enter all requested information	
1a	Name of plan 403 (B) THRIFT PLAN OF COMMUNITY HEALTH CARE	1b Three-digit plan number (PN) ▶ 003
		1c Effective date of plan 01/01/1997
2a	Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) COMMUNITY HEALTH CARE 101 E 26TH STREET TACOMA, WA 98421	2b Employer Identification Number (EIN) 91-1349657 2c Sponsor's telephone number 253-597-4550 2d Business code (see instructions) 621410

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/21/2010	DAVID FLENTGE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") COMMUNITY HEALTH CARE 101 E 26TH STREET TACOMA, WA 98421	3b Administrator's EIN 91-1349657 3c Administrator's telephone number 253-597-4550
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	406
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	
b Retired or separated participants receiving benefits.....	6b	
c Other retired or separated participants entitled to future benefits.....	6c	
d Subtotal. Add lines 6a , 6b , and 6c	6d	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	
f Total. Add lines 6d and 6e	6f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 2L

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

9a Plan funding arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

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

b General Schedules

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2009 This Form is Open to Public Inspection
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For calendar plan year 2009 or fiscal plan year beginning 01/01/2007 and ending 12/31/2007		
A Name of plan 403 (B) THRIFT PLAN OF COMMUNITY HEALTH CARE	B Three-digit plan number (PN) ▶	003
C Plan sponsor's name as shown on line 2a of Form 5500. COMMUNITY HEALTH CARE		
D Employer Identification Number (EIN) 91-1349657		

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.
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1 Coverage Information:

(a) Name of insurance carrier
MUTUAL OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1614399	88668	020138H	457	01/01/2007	12/31/2007

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
0	1265

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ANNETTE GARRETT 3400 188TH ST SW SUITE 565 LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	396	COMPENSATION	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
DENNIS DUDLEY 3400 188TH ST SW SUITE 565 LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	176	COMPENSATION	3

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

DARRYL ROBBINS

3400 188TH STREET SW SUITE 565
LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	176	COMPENSATION	3

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

MICHAEL KELLEY

3400 188TH STREET SW SUITE 565
LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	162	COMPENSATION	3

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

CHRIS CHIPPERFIELD

3400 188TH STREET SW SUITE 565
LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	147	COMPENSATION	3

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

STEPHEN ROUTOS

3400 188TH STREET SW SUITE 565
LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	147	COMPENSATION	3

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

MICHAEL DIXON

3400 188TH STREET SW SUITE 565
LYNNWOOD, WA 98037

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	61	COMPENSATION	3

Part II Investment and Annuity Contract Information

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

4 Current value of plan's interest under this contract in the general account at year end **4** 2306706**5** Current value of plan's interest under this contract in separate accounts at year end **5** 6189237**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier **6b****c** Premiums due but unpaid at the end of the year **6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☒ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **7b** 2156603**c** Additions: (1) Contributions deposited during the year **7c(1)** 477573(2) Dividends and credits **7c(2)** 0(3) Interest credited during the year **7c(3)** 73735(4) Transferred from separate account **7c(4)** 6134(5) Other (specify below) **7c(5)** 11372

▶ FINANCIAL ADJ & R/O CONTRIBUTIONS

(6) Total additions **7c(6)** 568814**d** Total of balance and additions (add **b** and **c(6)**). **7d** 2725417**e** Deductions:(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)** 403413(2) Administration charge made by carrier **7e(2)** 650(3) Transferred to separate account **7e(3)** 0(4) Other (specify below) **7e(4)** 14648

▶ FORFEITURES

(5) Total deductions **7e(5)** 418711**f** Balance at the end of the current year (subtract **e(5)** from **d**) **7f** 2306706

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs ▶

Part IV Provision of Information

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

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