Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN **HERE**

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

This Form is Open to Public

	_				Inspection		
Part I	Annual Report Iden	tification Information					
For cale	ndar plan year 2009 or fiscal p			and ending 12/31/20	09		
A This	eturn/report is for:	a multiemployer plan;	a multip	le-employer plan; or			
	·	X 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 tha	n 12 months).		
C If the	plan is a collectively-bargaine	ed plan, check here					
D Chec	k box if filing under:	X Form 5558;	automat	ic extension;	the DFVC program;		
	ŭ	special extension (enter des	scription)		–		
Part	II Basic Plan Inform	nation—enter all requested informa	ation				
	ne of plan	·			1b Three-digit plan		
YATES S	SERVICES, LLC HEALTHCAF	RE BENEFITS PLAN & TRUST			number (PIN)		
					1c Effective date of plan 06/01/2002		
2a Plan	sponsor's name and address	s (employer, if for a single-employer	plan)		2b Employer Identification		
,	ress should include room or s	uite no.)			Number (EIN)		
YATES	SERVICES, LLC				26-3596498		
					2C Sponsor's telephone number		
					601-656-5411		
P.O. BO	X 456 ELPHIA, MS 39350-0456		P.O. BOX 456 PHILADELPHIA, MS 39350-0456				
	,		THE BELLTING WO 00000 0400				
					811310		
Caution	: A penalty for the late or inc	complete filing of this return/repor	rt will be assessed	unless reasonable cause is	established.		
		enalties set forth in the instructions,					
statemer	nts and attachments, as well a	as the electronic version of this return	n/report, and to the I	pest of my knowledge and belie	ef, it is true, correct, and complete.		
CION	Filed with authorized/valid ele	actronic signature	10/14/2010	DANIEL H. SMITH			
SIGN HERE	Thed with authorized/valid ele	etionic signature.	10/14/2010	DANIEL H. SIVITH			
	Signature of plan administ	rator	Date	Enter name of individual sig	ning as plan administrator		
OLON				THOMAS M. DOSE			
SIGN HERE	Filed with incorrect/unrecogni	zed electronic signature.	10/14/2010	0/14/2010 THOMAS M. ROSE			
	Signature of employer/plan	n sponsor	Date	Enter name of individual sig	ning as employer or plan sponsor		

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
l PI	an administrator's name and address (if same as plan sponsor, enter "Same")	

Plan administrator's name and address (if same as plan sponsor, enter "Same") YATES SERVICES, LLC		ne")	3D Administrator's EIN 26-3596498			
	D. BOX 456 ILADELPHIA, MS 39350-0456		nu	ministrator's telephone imber 1-656-5411		
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:	n/report filed for this plan, 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	2631		
6	Number of participants as of the end of the plan year (welfare plans complet	e only lines 6a, 6b, 6c, and 6d).				
а	Active participants		6a	2182		
b	Retired or separated participants receiving benefits		6b			
•			6c			
	Other retired or separated participants entitled to future benefits					
d	Subtotal. Add lines 6a, 6b, and 6c		6d	2182		
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits	6e			
f	Total. Add lines 6d and 6e.		6f	2182		
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	n accrued benefits that were	6h			
7	Enter the total number of employers obligated to contribute to the plan (only		7			
8a b	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 4F					
9a	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all that (1) Insurance	at apply)			
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section 412(e)(3)	insuranc	ce contracts		
	(3) Trust	(3) X Trust				
	(4) General assets of the sponsor	(4) General assets of the sp	onsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the number	oer attac	ched. (See instructions)		
а	Pension Schedules	b General Schedules				
	R (Retirement Plan Information)	(1) H (Financial Inform	,			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Inform		Small Plan)		
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X 10 A (Insurance Infor	,	· - t')		
	·	(4) C (Service Provide				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participati	Ū	,		
	Information) - signed by the plan actuary	(6) G (Financial Trans	action S	schedules)		

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 Corporation Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Fo					n is Open to Public Inspection		
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	9	and er	ding 12	/31/2009	•
A Name of plan YATES SERVICES, LLC	HEALTHCAR	E BENEFITS PLAN & TRUST		B Three plan	e-digit number (PI	N) •	502
C Plan sponsor's name a YATES SERVICES, LLC	s shown on lir	ne 2a of Form 5500.		D Employ 26-359		ation Number (EIN)
		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E (d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	•	persons covered at end of policy or contract year		From	(g) To
47-0322111	69868	GLTD0234H	10)4	01/01/20	09	12/31/2009
2 Insurance fee and compute descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents	brokers, and o	ther persons in
(a) Total a	amount of com	nmissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie		persons).			0
• r ereerie receiring conn		and address of the agent, broke			ons or fees	were paid	
NOBLE HOUSTON NARO		609	BOYD MILL AVE # 11 ANKLIN, TN 37064-3106				
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code
	4874						3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commissi	ons or fees	were paid	
		· · · · · · · · · · · · · · · · · · ·					
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) 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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page	4	

P	art III	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting p the entire group of such individual contracts	oup of employees of the urposes if such contracts	are experien	ce-rated as a unit. W	here contract		
8	Benefit	t and contract type (check all applicable boxes)	<u> </u>					
Ĭ	_	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	
		,	=	L	<u></u>			
		Temporary disability (accident and sickness)	f ∐ Long-term disabil	·	Supplemental uner	nployment	h Prescription drug	
	i ∐ :	Stop loss (large deductible)	j HMO contract	k L	PPO contract		I Indemnity contract	ct
	m 🗌	Other (specify)						
9	Experie	ence-rated contracts:						
Ī		emiums: (1) Amount received		9a(1)		23702		
) Increase (decrease) in amount due but unpaid						
) Increase (decrease) in unearned premium res						
	` ,) Earned ((1) + (2) - (3))				9a(4)		23702
		enefit charges (1) Claims paid				5746		
) Increase (decrease) in claim reserves		21 (2)				
	, ,) Incurred claims (add (1) and (2))				9b(3)		5746
) Claims charged				9b(4)		
	` '	emainder of premium: (1) Retention charges (c				0.5(1)		
	•	(A) Commissions	*	9c(1)(A)				
		(B) Administrative service or other fees		2 (1)(7)				
		(C) Other specific acquisition costs		2 (4)(2)			1	
		(D) Other expenses		0 (4)(D)				
		(E) Taxes		0-(4)(5)			1	
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges						
		(H) Total retention				9c(1)(H)		
	(2	2) Dividends or retroactive rate refunds. (These		_				
		tatus of policyholder reserves at end of year: (1						
		2) Claim reserves	•					
	•							
	(-	3) Other reserves						
11	_	ividends or retroactive rate refunds due. (Do n	ot include amount entere	ed in C(2) .)		9e		
11		xperience-rated contracts:				40-		
	_	otal premiums or subscription charges paid to o				<u>10a</u>		
	re	the carrier, service, or other organization incuri- etention of the contract or policy, other than rep				10b		
	Spec	ify 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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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OMB No. 1210-0110

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For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/2009	9	and en	ding 12	/31/2009	•
A Name of plan YATES SERVICES, LLC	HEALTHCAR	E BENEFITS PLAN & TRUST		B Three plan	e-digit number (PI	N) •	502
C Plan sponsor's name a YATES SERVICES, LLC	s shown on lii	ne 2a of Form 5500.		D Employ 26-359		ation Number (EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E CO (d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To
47-0322111	69868	GLUG0234H	92	,	01/01/20	09	12/31/2009
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of con	nmissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and	fees. (Complete as many entrie		persons).			0
• r ereene recenning com		and address of the agent, broke			ons or fees	were paid	
NOBLE HOUSTON NARO		609	BOYD MILL AVE #11 ANKLIN, TN 37064-3106				
(b) Amount of sales ar	nd hase	F	ees and other commissior	s paid			
commissions pa		(c) Amount		d) Purpose	!		(e) Organization code
	17705						3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commissi	ons or fees	were paid	
	(a) · · ·		,				
(b) Amount of sales ar	nd base	F	ees and other commission	ıs paid			
commissions pa	id	(c) Amount		(d) 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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

P	art III	weitare 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	ourposes if such contracts	are experience	ce-rated as a unit. W	here contrac	
8	Benefit	t and contract type (check all applicable boxes))				
	_	Health (other than dental or vision)	b Dental	с	Vision		d X Life insurance
		Temporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unen	nplovment	h Prescription drug
	- =	Stop loss (large deductible)	j HMO contract	·, s_ k□	PPO contract		I Indemnity contract
		Other (specify) AD & D	, I invite contract	., □	11 0 contract		I ☐ Indemnity contract
	□ ,	Other (specify)					
_	F						
Э	•	ence-rated contracts: emiums: (1) Amount received		. 9a(1)		8190	1
) Increase (decrease) in amount due but unpai		· · · ·		0100	
	` ') Increase (decrease) in amount due but unpai) Increase (decrease) in unearned premium re					
) Earned ((1) + (2) - (3))				9a(4)	81901
	_	enefit charges (1) Claims paid				194000	
) Increase (decrease) in claim reserves					
	` ') Incurred claims (add (1) and (2))				9b(3)	194000
	` ') Claims charged				9b(4)	
	` '	emainder of premium: (1) Retention charges (
		(A) Commissions	,	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs					
		(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	2) Dividends or retroactive rate refunds. (These	e amounts were paid in	n cash, or	credited.)	9c(2)	
		tatus of policyholder reserves at end of year: (
		2) Claim reserves	•			· · · ·	
	(3	B) Other reserves				9d(3)	
	e ò	ividends or retroactive rate refunds due. (Do r	not include amount entere	d in c(2) .)			
10	0 None	xperience-rated contracts:				•	
	a To	otal premiums or subscription charges paid to	carrier			10a	
		the carrier, service, or other organization incur etention of the contract or policy, other than rep	, ,		•	10b	
	Spec	cify nature of costs					
	·	•					
P	art IV	Provision of Information					
_			motion necessarity as a	Joto Calcadal	. Д	Yes	X No
<u>1</u>	ı Dia th	ne insurance company fail to provide any inforr	nation necessary to comp	nete Schedule	A:	162	/\ INU

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	prporation		s are required to provide to ERISA section 103(a)(2)		on		m is Open to Public Inspection
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/200	9	and en	iding 12	/31/2009	
A Name of plan YATES SERVICES, LLC	A Name of plan YATES SERVICES, LLC HEALTHCARE BENEFITS PLAN & TRUST				e-digit number (PI	N) •	502
C Plan sponsor's name a YATES SERVICES, LLC	C Plan sponsor's name as shown on line 2a of Form 5500. YATES SERVICES, LLC				yer Identific 6498	cation Number (EIN)
		rning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca	E INSURANC	<u> </u>	(e) Approximate n	umber of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	persons covered at end of		From	(g) To
47-0322111	69868	GUC0234H	policy or contract	24	01/01/20		12/31/2009
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		29223					0
3 Persons receiving com	missions and	fees. (Complete as many entric	es as needed to report all	persons).			
		and address of the agent, broke			ons or fees	were paid	
NOBLE HOUSTON NAR	ON		BOYD MILL AVE #11 ANKLIN, TN 37064-3106				
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	29223						3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(a) Hamo and dadross of the agent, shotor, or other person to whom commissions or roce were paid							
(b) Amount of sales ar		F	ees and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) 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		
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(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
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(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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page 4		

Pa	art I	Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts	are experience	ce-rated as a unit. Wh	ere contract		
8	Ber	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 unem	ployment	h Prescription drug	
	i İ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m		,]		I I machinity contract	
	m	Other (specify)						
9	Evn	erience-rated contracts:						
•		Premiums: (1) Amount received		9a(1)		133178		
	_	(2) Increase (decrease) in amount due but unpaid		 				
		(3) Increase (decrease) in unearned premium res		_ ;_;				
		(4) Earned ((1) + (2) - (3))				9a(4)	1	133178
	b	Benefit charges (1) Claims paid				68329		
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				. 9b(3)		68329
		(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						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)		T		
		(H) Total retention	_			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid ir	n 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	d in c(2) .)		. 9e		
10	_	onexperience-rated contracts:						
	a	Total premiums or subscription charges paid to c				10a		
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	10b		
	Sı	pecify nature of costs	onted in Fatt I, item 2 abo	ve, report am	ount	. 100		
	اح	boony nature or costs in						

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

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	prporation	nurought to FDICA continu (00/o)/0)				n is Open to Public Inspection	
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	9	and en	ding 12	/31/2009	•
A Name of plan YATES SERVICES, LLC	A Name of plan YATES SERVICES, LLC HEALTHCARE BENEFITS PLAN & TRUST			B Three plan	e-digit number (PI	N) •	502
C Plan sponsor's name a YATES SERVICES, LLC	ıs shown on liı	ne 2a of Form 5500.		D Employ 26-359		ation Number (EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		E CO (d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	•	persons covered at end of policy or contract year		From	(g) To
47-0322111	69868	GUG0234H	, ,	103 01/01/2009		09	12/31/2009
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and	8950 fees. (Complete as many entric	es as needed to report all	persons).			0
• r ereene recenning com		and address of the agent, broke			ons or fees	were paid	
NOBLE HOUSTON NARO		609	BOYD MILL AVE #11 ANKLIN, TN 37064-3106				
(b) Amount of sales ar	nd hase	F	ees and other commissior	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	8950						3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales ar			ees and other commission				
commissions pa	id	(c) Amount		(d) Purpose	<u> </u>		(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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page 4	

Pa	rt II	Welfare Benefit Contract Informat	ion							
		If more than one contract covers the same gr information may be combined for reporting puthe entire group of such individual contracts with the entire group of	ırpo:	ses if such contracts	are experie	ence	e-rated as a unit. Whe	ere contrac		
8	Bene	efit and contract type (check all applicable boxes)								
	а	Health (other than dental or vision)	b	Dental	С	;	Vision		d Life insuran	ice
	e	Temporary disability (accident and sickness)	f	 Long-term disabili	ty g	ī	Supplemental unemp	oloyment	h Prescription	n drug
	iΓ	Stop loss (large deductible)	i	HMO contract	k	ιĒ	PPO contract		I Indemnity c	ontract
	m	Other (specify)	,			ш				ontidot
	∟	Curer (specify)								
9	Expe	rience-rated contracts:								
		Premiums: (1) Amount received			9a(1)			43635	5	
		(2) Increase (decrease) in amount due but unpaid	i		9a(2)		-			
		(3) Increase (decrease) in unearned premium res			9a(3)					
		(4) Earned ((1) + (2) - (3))						9a(4)		43635
		Benefit charges (1) Claims paid			9b(1)			19395	5	
		(2) Increase (decrease) in claim reserves			9b(2)					
		(3) Incurred claims (add (1) and (2))						9b(3)		19395
		(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				_			_	
		(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	am	ounts were 📗 paid ir	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) An	nount held to provide	benefits af	ter	retirement	9d(1)		
		(2) Claim reserves						9d(2)		
		(3) Other reserves						9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot in	clude amount entered	d in c(2) .)			9e		
10		nexperience-rated contracts:								
	_	Total premiums or subscription charges paid to c						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									
	e _n		niec	im Part i, item 2 abo	ve, report a	amo	ount	100		
	ъp	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

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	prporation	mmaant to FDICA anotice 400(a)(0)				m is Open to Public Inspection		
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/200	9	and ending 12/31/2009				
A Name of plan YATES SERVICES, LLC	HEALTHCAR	RE BENEFITS PLAN & TRUST		B Three plan	e-digit number (PI	N) •	502	
C Plan sponsor's name a YATES SERVICES, LLC	s shown on li	ne 2a of Form 5500.		D Employ 26-359		cation Number (EIN)	
		rning Insurance Contrac Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca UNITED OF OMAHA LIFE	E INSURANC		(e) Approximate n	umber of		Policy or co	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	it end of	(f)	From	(g) To	
			policy or contract					
47-0322111	69868	GVTL0234H	8	807 01/01/2009		009	12/31/2009	
2 Insurance fee and complete descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in item 3	the agents	, brokers, and c	other persons in	
(a) Total a	amount of cor	nmissions paid		(b) To	tal amount	of fees paid		
		51565					0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
		and address of the agent, broke		m commissi	ons or fees	were paid		
NOBLE HOUSTON NARG	ON		BOYD MILL AVE #11 ANKLIN, TN 37064-3106					
(I) A		F	ees and other commissio	ns naid				
(b) Amount of sales ar commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	51565						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)		(e) Organization code	

Schedule A (Form 5500)	2009	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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Schedule A (Form 5500) 2009		Page 4	
Welfare Benefit Contract Information from the same guinformation may be combined for reporting puthe entire group of such individual contracts of the same guinformation may be combined for reporting puthe entire group of such individual contracts of the same guinformation from the	roup of employees of the same urposes if such contracts are e	experience-rated as a unit. Where contra	
and contract type (check all applicable boxes)			
lealth (other than dental or vision)	b Dental	C Vision	d X Life insurance
emporary disability (accident and sickness)	f Long-term disability	g Supplemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	k ☐ PPO contract	I Indemnity contract
other (specify)	_	_	_

	information may be combined for reporting pu the entire group of such individual contracts w					cover individual emplo	yees,	
8	Benefit and contract type (check all applicable boxes)							
	a Health (other than dental or vision)	b Dental	с□	Vision	(J X Life insurance		
		f Long-term disability	g∏	Supplemental unemplo	yment i	n Prescription drug		
	i Stop loss (large deductible)	i HMO contract	k∏	PPO contract		I Indemnity contrac	t.	
	m ☐ Other (specify) ▶	<i>,</i> ¬	Ш					
9	Experience-rated contracts:							
	a Premiums: (1) Amount received	9	9a(1)		254286			
	(2) Increase (decrease) in amount due but unpaid	9	9a(2)					
	(3) Increase (decrease) in unearned premium rese	erve 9	9a(3)					
	(4) Earned ((1) + (2) - (3))				9a(4)		254286	
	b Benefit charges (1) Claims paid	9	9b(1)		330000			
	(2) Increase (decrease) in claim reserves	9	9b(2)					
	(3) Incurred claims (add (1) and (2))				9b(3)		330000	
	(4) Claims charged				9b(4)			
	c Remainder of premium: (1) Retention charges (or	n an accrual basis)						
	(A) Commissions	90	(1)(A)					
	(B) Administrative service or other fees	9c	:(1)(B)					
	(C) Other specific acquisition costs	90	(1)(C)					
	(D) Other expenses	900	(1)(D)					
	(E) Taxes	900	(1)(E)					
	(F) Charges for risks or other contingencies	90	(1)(F)					
	(G) Other retention charges							
	(H) Total retention				9c(1)(H)			
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in cast	sh, or C	redited.)	9c(2)			
	d Status of policyholder reserves at end of year: (1)	— •		· -	9d(1)			
	(2) Claim reserves	·			9d(2)			
	(3) Other reserves				9d(3)			
	Dividends or retroactive rate refunds due. (Do no				9e			
10	,		· · · · · · · · · · · · · · · · · · ·					
. •	Total premiums or subscription charges paid to ca	arrier		Γ	10a			
	retention of the contract or policy, other than repo	, ,			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 A2	☐ Yes	X No	

Part III

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

OMB No. 1210-0110

		pursuant to ERISA section 103(a)(2			Inspection			
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009		and en	ding 1	2/31/2009	•	
A Name of plan YATES SERVICES, LLC	HEALTHCAR	E BENEFITS PLAN & TRUST		B Three plan i	-digit number (F	PN) •	502	
YATES SERVICES, LLC	C Plan sponsor's name as shown on line 2a of Form 5500. YATES SERVICES, LLC D Employer Identification Number (EIN) 26-3596498							
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								
	(a) NIAIC	(d) Contract or	(e) Approximate nu	mber of		Policy or co	ntract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f) From	(g) To	
62-0427913	54518	82041	187	6	01/01/2	009	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 a	amount of con	nmissions paid		(b) Tot	tal amoun	t of fees paid		
		0					0	
3 Persons receiving com		fees. (Complete as many entries						
	(a) Name	and address of the agent, broker	, or other person to whon	n commissio	ons or fee	s were paid		
(b) Amount of sales ar commissions pai		(c) Amount	Fees and other commissions paid (d) Purpose				(e) Organization code	
commissions par	u	(C) Amount	(u) i dipose			(e) Organization code	
	(a) Name	and address of the agent, broker	, or other person to whon	n commissio	ons or fee	s were paid		
	(*)		,			,		
(b) Amount of sales ar	(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount	(d) Purpose	l		(e) Organization code	

Schedule A (Form 5500)	2009	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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page 4	

Schedule A	(Form	5500	2000
Scriedule A	LEOHII	5500	1 ZUUS

Pa	art II								
		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	ırpose	es if such contracts	are experienc	ce-rated as a unit. Wh	ere contract		
8	Ben	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	b	Dental	С	Vision		d Life insuran	ice
	е	Temporary disability (accident and sickness)	f	Long-term disabili	ty g	Supplemental unem	ployment	h Prescription	
	i Î	Stop loss (large deductible)	i 🗏	HMO contract	. k	PPO contract		I Indemnity c	
	m	Other (specify)	_	1		1		- 🗀	
	_	_							
9	Ехре	erience-rated contracts:							
	а	Premiums: (1) Amount received			9a(1)				
		(2) Increase (decrease) in amount due but unpaid	I		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					5106207		
		(2) Increase (decrease) in claim reserves			9b(2)				
		(3) Incurred claims (add (1) and (2))					9b(3)		5106207
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (o					2050	_	
		(A) Commissions			9c(1)(A)		9959	_	
		(B) Administrative service or other fees			9c(1)(B)		402430	<u> </u>	
		(C) Other specific acquisition costs			9c(1)(C)		40.40	\exists	
		(D) Other expenses			9c(1)(D)		4849	<u> </u>	
		(E) Taxes						_	
		(F) Charges for risks or other contingencies						_	
		(G) Other retention charges					00(4)(U)		417238
		(H) Total retention		_	_		9c(1)(H)		417230
		(2) Dividends or retroactive rate refunds. (These							
	d	Status of policyholder reserves at end of year: (1)		•			9d(1)		
		(2) Claim reserves					9d(2)		
	_	(3) Other reserves					9d(3)		
4.0	е .	Dividends or retroactive rate refunds due. (Do no	ot incl	ude amount entered	d in c(2) .)		9e		
IU	_	nexperience-rated contracts:					40-		
	a	Total premiums or subscription charges paid to c					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								
Specify nature of costs								· ·	
	- 1								

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

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

► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					This For	m 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 YATES SERVICES, LLC	HEALTHCAR	E BENEFITS PLAN & TRUST			e-digit number (PI	v) •	502	
C Plan sponsor's name a YATES SERVICES, LLC	ıs shown on liı	ne 2a of Form 5500.		D Emplo 26-359	-	ation Number	(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								
	(a) NIAIC	(d) Contract or	(e) Approximate n	umber of		Policy or c	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract		(f)	From	(g) To	
62-0427913	62-0427913 54518 82041 306 01/01/2009		009	12/31/2009				
2 Insurance fee and complete descending order of the		nation. Enter the total fees and	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								
							0	
3 Persons receiving com	missions and	fees. (Complete as many entr	es as needed to report all	persons).				
	(a) Name	and address of the agent, brok	er, or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	I	ees and other commission	ns paid				
commissions paid (c) Amount (d) Purpose					(e) Organization code			
	(a) Nama	and address of the agent, brok	or or other person to who	m commiss	ione or food	wore poid		
	(a) Name	and address of the agent, brok	er, or other person to who	III COITIIIISS	ions or rees	were paid		
(b) Amount of sales ar	nd base		ees and other commission	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	Fees and other commissions paid	
(b) Amount of sales and base		(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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page 4	

	Schedule A ((Form	5500	2009
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Pa	art III	I Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contract	
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)	- -		•		
9	Expe	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		9a(3)		1	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid				1009625	
		(2) Increase (decrease) in claim reserves		9b(2)		Ι	
		(3) Incurred claims (add (1) and (2))				9b(3)	1009625
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				
		(A) Commissions		9c(1)(A)		1621	
		(B) Administrative service or other fees		9c(1)(B)		59314	
		(C) Other specific acquisition costs		9c(1)(C)		500	
		(D) Other expenses		9c(1)(D)		598	
		(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>	·····		9c(1)(H)	61533
		(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 n	ot include amount entered	l in c(2) .)		. 9e	
10	Noı	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			. 10a	
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep					
	Sp	ecify nature of costs		-, p			
	-1	,					

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

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

pursuant to ERISA section 103(a)(2).				m 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 YATES SERVICES, LLC	HEALTHCARI	E BENEFITS PLAN & TRUST		B Three plan	e-digit number (Pl	N) •	502
C Plan sponsor's name a YATES SERVICES, LLC	s shown on lir	ne 2a of Form 5500.		D Emplo 26-359		cation Number (EIN)
		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance can DELTA DENTAL	rrier						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	
(5) EIN	code	identification number		policy or contract year		From	(g) To
62-0812197 0000 4076 928 01/01/2009			009	12/31/2009			
2 Insurance fee and commodescending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving com	missions and t	5658 fees. (Complete as many entric		nersons)			0
• 1 CISONS ICCCIVING COM					iono or food	. wara naid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid NOBLE HOUSTON NARON 609 BOYD MILL AVE # 11 FRANKLIN, TN 37064							
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code
5658					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 pai	d	(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	Fees and other commissions paid	
(b) Amount of sales and base		(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

Par	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	ridual contracts with each carrier may	be treated as	a unit for purposes of
4 C	Current value of plan's interest under this contract in the general account at year	end	4	
	Current value of plan's interest under this contract in separate accounts at year e		5	
6 C	Contracts With Allocated Funds:			
a	State the basis of premium rates			
k	•		6b	
C	,		6c	
C	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			
€	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 check here		
7 C	Contracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
a	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
k	Balance at the end of the previous year		7b	
C	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)	
	d Total of balance and additions (add b and c(6)).		7d	
	e Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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	

	P	age 4	
group of employees of the sa ourposes if such contracts ar	e experienc	ce-rated as a unit. Where cont	
3)			
b X Dental	С	Vision	d Life insurance
- 📙	a	<u></u>	블
	- T =		H
J HIMO contract	ĸ	PPO contract	I Indemnity contract
F			100
		436	466
id			
	9b(1)	405	722
	9b(2)		
		9b(3	3) 40572
		9b(4	4)
on an accrual basis)			
	9c(1)(A)		
	9c(1)(B)	25	5086
	9c(1)(C)		
	9c(1)(D)		
	9c(1)(E)		
	9c(1)(F)		
	9c(1)(G)		
		9c(1)	(H) 2508
_			
<u> </u>			•
1) / anount hold to provide be	Jilonio ailei	9d(2	
	burposes if such contracts are with each carrier may be trees. b Dental	proup of employees of the same employ ourposes if such contracts are experience with each carrier may be treated as a unit of the same employ ourposes if such contracts are experience with each carrier may be treated as a unit of the same employ our poses. Dental C C I	group of employees of the same employer(s) or members of the same courposes if such contracts are experience-rated as a unit. Where cont with each carrier may be treated as a unit for purposes of this report.

9d(3)

9e

10a

10b

	,		•	, ,			•
retentio	n of the c	ontract o	or policy, other t	han reported in Part	I, item 2 above	, report amount	
Specify na	ture of co	sts 🕨					

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	

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

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

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

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This For	m is Open to Public Inspection		
For calendar plan year 200	09 or fiscal pla	an year beginning 01/01/2009	9	and er	nding 12	/31/2009	
A Name of plan YATES SERVICES, LLC			e-digit number (Pl	N) •	502		
C Plan sponsor's name a YATES SERVICES, LLC	s shown on li	ne 2a of Form 5500.		D Employer Identification Number (EIN) 26-3596498			
	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 UNITED HEALTHCARE	rrier						
/L) [IN]	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or contract year	
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To
36-2739571	79413	235628	10	1044 01/01/20		09	12/31/2009
2 Insurance fee and complete descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
-				tal amount	unt of fees paid		
11333 0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
NOBLE HOUSTON NAR(ON		BOYD MILL AVE #11 ANKLIN, TN 37064-3106				
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
	11333						3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(-) and dadiese of the agent, arener, or early person to mission or rose note part							
(b) Amount of sales ar	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) 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			
(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 pair				
(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			
(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			

Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page	4

Pa	art III	Welfare Benefit Contract Informat	ion					
		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	are experie	ence	e-rated as a unit. W	here contrac	
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	c	X	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit		므	Supplemental unen	nnlovment	h Prescription drug
	: [=	_	=		пріоуппені	
	'	Stop loss (large deductible)	j HMO contract	K	. П	PPO contract		I Indemnity contract
	m	Other (specify)						
9	Expe	rience-rated contracts:	ı					
		Premiums: (1) Amount received		9a(1)			101996	
		(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium res	•				1 2 (1)	404000
		(4) Earned ((1) + (2) - (3))			·····		9a(4)	101996
		Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves					01 (0)	
		(3) Incurred claims (add (1) and (2))					9b(3)	
		(4) Claims charged					9b(4)	
	С	Remainder of premium: (1) Retention charges (o		0.747/4				
		(A) Commissions		9c(1)(A				
		(B) Administrative service or other fees		9c(1)(B				
		(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)	_			
		(D) Other expenses		9c(1)(E)	_			
		(E) Charges for risks on other continuous		9c(1)(F)	_			
		(F) Charges for risks or other contingencies		9c(1)(G				
		(G) Other retention charges					9c(1)(H)	
		(H) Total retention	_	-	_			1
		(2) Dividends or retroactive rate refunds. (These	_	-			_ ` _	
	d	Status of policyholder reserves at end of year: (1	•					
		(2) Claim reserves					_ ` _	
	•	(3) Other reserves					• • •	
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	i in C(2).) .			9e	
10		nexperience-rated contracts:	orrior				10a	
		Total premiums or subscription charges paid to c If the carrier, service, or other organization incurr					<u>10a</u>	
	D	retention of the contract or policy, other than repo					10b	
	Sp	ecify nature of costs	, , , , , , , , , , , , , , , , , , , ,	, ,			L	,
		,						
_	13	Dravialan of Information						
Pa	art IV	/ Provision of Information					7	
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Sched	ule	A?	Yes	× No

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.

OMB No. 1210-0110

2009

pursuant to ERISA section 103(a)(2).				tion	This Fo	rm is Open to Public Inspection		
For calendar plan year 20	09 or fiscal pla	an year beginning 01/01/200	9	and er	nding 12/31	1/2009		
A Name of plan YATES SERVICES, LLC	HEALTHCAR	RE BENEFITS PLAN & TRUST			e-digit number (PN)	•	502	
C Plan sponsor's name a YATES SERVICES, LLC		D Employer Identification Number (EIN) 26-3596498						
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 MUTUAL OF OMAHA	rrier					Dalianas		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate n persons covered a policy or contract	at end of	(f) F	•	(g) To	
47-0246511	71412	T66BA-51308		40	01/01/2009)	12/31/2009	
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	total commissions paid. I	_ist in item 3	the agents, b	rokers, and	other persons in	
(a) Total amount of commissions paid				(b) Total amount of fees paid				
3 Persons receiving com	missions and	fees. (Complete as many entri		l persons).				
<u> </u>		and address of the agent, broke			ions or fees w	ere paid		
						•		
(b) Amount of sales ar			es and other commissions paid (d) Purpose			(e) Organization code		
commissions paid (c) Amount				(u) i uiposi			(c) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to who	om commiss	ions or fees w	ere paid		
	(a) Hame	and addition of the agont, protes	or, or other person to write	<u> </u>	1010 U 1000 W	oro para		
(b) Amount of sales ar	nd hase	F	ees and other commission	ons paid_				
commissions pa		(c) Amount		(d) Purpose	е	_	(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	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	y be treated as a	unit for purposes of
4 C	urrent value of plan's interest under this contract in the general account at year	end	. 4	
	urrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 C	ontracts With Allocated Funds:			
а	State the basis of premium rates •			
b	•		. 6b	
С	Premiums due but unpaid at the end of the year		. 6с	
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 check here		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
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:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	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			. 7f	

Page	4

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 Bene	fit and contract type (check all applicable boxes)							
а	Health (other than dental or vision)	b Dental	c×	Vision		d X Life insurance		
e	Temporary disability (accident and sickness)	f X Long-term disabilit	у д	Supplemental unen	nployment	h Prescription drug		
i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract		
m ×	4D 0 D			_				
	Carlot (openity)							
9 Expe	rience-rated contracts:							
	remiums: (1) Amount received		9a(1)					
((2) Increase (decrease) in amount due but unpaid	I	• • • • • •					
	(3) Increase (decrease) in unearned premium res							
	(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		9c(1)(F)					
	(G) Other retention charges		9c(1)(G)		0-(4)(11)			
	(H) Total retention	_	_)		
	(2) Dividends or retroactive rate refunds. (These	ш :						
	Status of policyholder reserves at end of year: (1	•						
	(2) Claim reserves				9d(2)			
	(3) Other reserves				9d(3)			
	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	i in c(2) .)		9e			
	nexperience-rated contracts: Total premiums or subscription charges paid to c	orrior			10a	59594		
_	If the carrier, service, or other organization incurr				<u>10a</u>	33334		
	retention of the contract or policy, other than repo				10b			
	ecify nature of costs		· · · · · · · · · · · · · · · · · · ·			1		
Op.	rony matane or occio							
Part IV	Provision of Information							
					1 v	✓ Na		
11 Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	× No		

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Service Provider Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

B Three-digit plan number (PN) ▶	502
,	502
1	302
D Employer Identification Numb	er (EIN)
26-3596498	
ection with services rendered to the plan which the plan received the required disc	or the person's position with the
nsation	
er of this Part because they received only	
ctions for definitions and conditions)	X Yes No
• •	vice providers who
ou disclosures on eligible indirect comper	sation
ou disclosure on eligible indirect compens	sation
ou disclosures on eligible indirect compen	sation
ou disclosures on eligible indirect compen	sation

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

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ν	Δ	
ıay		•

answered	d "yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
DELTA DE	NTAL	<u> </u>	· •			
62-081219	7					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	CONTRACT ADMINISTRATOR	5658	Yes No 🛚	Yes No 🛚		Yes No 🛚
			(a) Enter name and EIN or	address (see instructions)		
LINITED H	EALTHCARE					
36-273957 (b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or
13	CONTRACT ADMINISTRATOR	11333	Yes No 🛚	Yes No 🛚		Yes No X
ı			(a) Enter name and EIN or	address (see instructions)		
UNITED O			· <i>,</i>	<u> </u>		
		T ()		(0)	1 ()	1 (1)
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
13	CONTRACT ADMINISTRATOR	112317	Yes No 🛚	Yes No X		Yes No X

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(a) Enter name and EIN or address (see instructions)								
(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a		
	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or		
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element	estimated amount?		
					(f). If none, enter -0			
			Yes No	Yes No		Yes 📗 No 📗		
		(a) Enter name and EIN or	address (see instructions)				
(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a		
()		by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or		
	a party-in-interest	Citici o .	sponsor)	disclosures?	compensation for which you answered "Yes" to element			
					(f). If none, enter -0			
			Yes No	Yes No		Yes No		
			->-					
		(a) Enter name and EIN or	address (see instructions)				
(b)	(c)	(d)	(e)	(f)	(g)	(h)		
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a		
, ,	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or		
	a party-in-interest	0.1.01	sponsor)	disclosures?	compensation for which you answered "Yes" to element			
					(f). If none, enter -0			
			Yes No	Yes No		Yes No		

Schedule	C	(Form	5500)	2009
Ochicadic	\sim	(1 01111	3300	2000

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Part I Service Provider Information (continued)

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

many entiries as needed to report the required information for each source.		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(a) Describe the indirect	compensation, including any
(a) Enter name and Env (address) of source of maneer compensation	formula used to determine	the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

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Part II Service Providers Who Fail or Refuse to Provide Information					
Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
а	Name:	b EIN:	
С	Position:		
d	Address:	e Telephone:	
Ex	xplanation:		
а	Name:	b EIN:	
C	Position:	4 2	
d	Address:	e Telephone:	
Ex	xplanation:		
а	Name:	b EIN:	
C	Position:	D EIII.	
d	Address:	e Telephone:	
Ex	xplanation:		
а	Name:	b EIN;	
C	Position:	D LIN,	
d	Address:	e Telephone:	
	Address.	• relephone.	
Ex	xplanation:		
а	Name:	b EIN;	
C	Position:		
d	Address:	e Telephone:	
Ex	xplanation:		

SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

, ,					•
For calendar plan year 2009 or fiscal plan year beginning 01/01/2009		and en	ding 12/31/2009		1
A Name of plan		В	Three-digit		
YATES SERVICES, LLC HEALTHCARE BENEFITS PLAN & TRUST			plan number (PN	√) →	502
C Plan sponsor's name as shown on line 2a of Form 5500		D	Employer Identific	cation Number (E	EIN)
YATES SERVICES, LLC			00.0500400		
			26-3596498		
Part I Asset and Liability Statement					
1 Current value of plan assets and liabilities at the beginning and end of the plan the value of the plan's interest in a commingled fund containing the assets of n lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance benefit at a future date. Round off amounts to the nearest dollar. MTIAs, C and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. Se	nore than one se contract wh CTs, PSAs, a	e plan on a line nich guarantee and 103-12 IEs	e-by-line basis unles es, during this plan y	s the value is repear, to pay a spe	oortable on ecific dollar
Assets		(a) Begi	nning of Year	(b) End	of Year
a Total noninterest-bearing cash	1a		36509		148482
b Receivables (less allowance for doubtful accounts):					
(1) Employer contributions	1b(1)				
(2) Participant contributions	1b(2)				
(3) Other	1b(3)				
C General investments:					
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)				
(2) U.S. Government securities	1c(2)				
(3) Corporate debt instruments (other than employer securities):					
(A) Preferred	1c(3)(A)				
(B) All other	1c(3)(B)				
(4) Corporate stocks (other than employer securities):					
(A) Preferred	1c(4)(A)				
(B) Common	1c(4)(B)				
(5) Partnership/joint venture interests	1c(5)				
(6) Real estate (other than employer real property)	1c(6)				
(7) Loans (other than to participants)	1c(7)				
(8) Participant loans	1c(8)				
(9) Value of interest in common/collective trusts	1c(9)				
(10) Value of interest in pooled separate accounts	1c(10)				
(11) Value of interest in master trust investment accounts	1c(11)				
(12) Value of interest in 103-12 investment entities	1c(12)				
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)				
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)				

1c(15)

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	36509	148482
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k		
	Net Assets	•		
I	Net assets (subtract line 1k from line 1f)	11	36509	148482

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	ontributions:			
(1	N. Described an acceptable to each force (A) Fundamen			
) Received or receivable in cash from: (A) Employers	2a(1)(A)	5683888	
	(B) Participants	2a(1)(B)	2365718	
	(C) Others (including rollovers)	2a(1)(C)	325709	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		8375315
b E	arnings on investments:			
(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		
(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		

Pac	ıe	3

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
C Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		8375315
Expenses	'		
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	6521554	
(2) To insurance carriers for the provision of benefits	2e(2)	626208	
(3) Other	2e(3)	569681	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		7717443
f Corrective distributions (see instructions)			
g Certain deemed distributions of participant loans (see instructions)	0		-
h Interest expense	2h		-
i Administrative expenses: (1) Professional fees	2i(1)		
(2) Contract administrator fees	2i(2)	545899	
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	0:(5)		545899
j Total expenses. Add all expense amounts in column (b) and enter total	2j		8263342
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		111973
Transfers of assets:			
(1) To this plan	21(1)		
(2) From this plan	21(2)		
· · ·			
Part III Accountant's Opinion		unched to this Ferry 5500 Occur	
3 Complete lines 3a through 3c if the opinion of an independent qualified public a attached.	accountant is a	ttached to this Form 5500. Comp	Diete line 3d if an opinion is not
a The attached opinion of an independent qualified public accountant for this plan	n is (see instru	ctions):	
(1) Unqualified (2) Qualified (3) Disclaimer (4)	Adverse		
$oldsymbol{b}$ Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103	3-8 and/or 103-	12(d)?	Yes X No
c Enter the name and EIN of the accountant (or accounting firm) below:			
(1) Name: REA, SHAW, GIFFIN & STUART LLP		(2) EIN: 64-0295411	
d The opinion of an independent qualified public accountant is not attached beca (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached		t Form 5500 pursuant to 29 CFR	2520.104-50.

Pai	t IV	Compliance Questions					
4		and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 2 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.	4f, 4g,	4h, 4k, 4	m, 4n, or	5.	
	During	the plan year:		Yes	No	Amo	unt
а	period	nere a failure to transmit to the plan any participant contributions within the time described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures ully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X		
b	close o	any loans by the plan or fixed income obligations due the plan in default as of the of the plan year or classified during the year as uncollectible? Disregard participant loans and by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is ed.)	4b		X		
С	Were	any leases to which the plan was a party in default or classified during the year as ectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X		
d	reporte	there any nonexempt transactions with any party-in-interest? (Do not include transactions ed on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is ed.)	4d		X		
е	Was th	nis plan covered by a fidelity bond?	4e	X			1000000
f	Did the	e plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused ud or dishonesty?	4f		X		
g	Did the	e plan hold any assets whose current value was neither readily determinable on an					
h	establi	ished market nor set by an independent third party appraiser?e plan receive any noncash contributions whose value was neither readily	4g		X		
"		ninable on an established market nor set by an independent third party appraiser?	4h		X		
i		e plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, ee instructions for format requirements.)	4i		Х		
j	value	any plan transactions or series of transactions in excess of 5% of the current of plan assets? (Attach schedule of transactions if "Yes" is checked, and structions for format requirements.)	4j		X		
k		all the plan assets either distributed to participants or beneficiaries, transferred to another or brought under the control of the PBGC?	4k		X		
ı	Has th	e plan failed to provide any benefit when due under the plan?	41		X		
m		is an individual account plan, was there a blackout period? (See instructions and 29 CFR 101-3.)	4m				
n		was answered "Yes," check the "Yes" box if you either provided the required notice or one exceptions to providing the notice applied under 29 CFR 2520.101-3	4n				
5a		resolution to terminate the plan been adopted during the plan year or any prior plan year? enter the amount of any plan assets that reverted to the employer this year	Yes	X No	Amou	nt:	
5b		ng this plan year, any assets or liabilities were transferred from this plan to another plan(s) erred. (See instructions.)	, ident	fy the pla	ın(s) to wh	nich assets or liabi	lities were
	5b(1)	Name of plan(s)			5b(2) EIN	l (s)	5b(3) PN(s)
							1

FINANCIAL STATEMENTS

December 31, 2009 and 2008

CONTENTS

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INDEPENDENT AUDITORS' REPORT	1
FINANCIAL STATEMENTS	
Statements of net assets available for benefits - cash basis	2
Statement's of changes in net assets available for benefits - cash basis	3
Statement's of benefit obligations - cash basis	4
Statement's of changes in benefit obligations - cash basis	5
Notes to financial statements	6-8



2415 NINTH STREET P O BOX 2090 MERIDIAN MS 39302-2090 TELEPHONE (601) 693-2841 FAX (601) 693-2851 611 SPRING STREET P O BOX 562 WAYNESBORO MS 39367 TELEPHONE (601) 735-2317 FAX (601) 735-0585

INDEPENDENT AUDITORS' REPORT

TO THE ADMINISTRATIVE COMMITTEE OF YATES SERVICES, LLC HEALTHCARE BENEFIT PLAN PHILADELPHIA MISSISSIPPI

We have audited the accompanying statements of net assets available for benefits-cash basis and of benefit obligations-cash basis of Yates Services, LLC Healthcare Benefit Plan as of December 31, 2009 and 2008, and the related statements of changes in net assets available for benefits-cash basis and of changes in benefit obligations-cash basis for the years then ended. These financial statements are the responsibility of the Plan's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 2, these financial statements were prepared on the cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of Yates Services, LLC Healthcare Benefit Plan as of December 31, 2009 and 2008, and the changes in its financial status for the years then ended, on the basis of accounting described in Note 2.

Rea, Shaw, Giffin & Stuart

REA, SHAW, GIFFIN & STUART, LLP

Meridian, Mississippi October 5, 2010

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS - CASH BASIS

December 31, 2009 and 2008

		2009	2008		
ASSETS	\$	148,482	\$	36,509	
LIABILITIES					
Net assets available for benefits	\$	148,482	\$	36,509	

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS – CASH BASIS Years Ended December 31, 2009 and 2008

		2009	2008
ADDITIONS Additions to plan assets attributed to: Employer's contributions Employee's contributions Reinsurance benefits	\$	5,683,888 2,365,718 325,709	\$ 8,768,478 3,034,591 789,877
Total additions	<u>\$</u>	8,375,315	\$ 12,592,946
DEDUCTIONS Deductions from plan assets attributed to: Health claims Excess loss insurance premiums Administrative fees Disability and life insurance premiums	\$	6,521,554 626,208 545,899 569,681	\$ 10,197,632 569,007 880,553 909,245
Total deductions	\$	8,263,342	\$ 12,556,437
Net increase	\$	111,973	\$ 36,509
NET ASSETS AVAILABLE FOR BENEFITS Beginning of year	_	36,509	-
End of year	\$	148,482	\$ 36,509

STATEMENTS OF BENEFIT OBLIGATIONS - CASH BASIS

December 31, 2009 and 2008

		2009	2008		
Amounts currently payable to or for participants, beneficiaries, and dependents: Health claims payable	\$	-	\$	-	
Other obligations for health benefit coverage, at present value of estimated amounts:					
Claims incurred but not reported		461,242	_	637,820	
Plan's total benefit obligations	\$	461,242	\$	637,820	

STATEMENT'S OF CHANGES IN BENEFIT OBLIGATIONS - CASH BASIS

Years Ended December 31, 2009 and 2008

		2009		2008
Amounts currently payable to or for participants, beneficiaries, and dependents: Balance at beginning of year Claims reported and approved for payment Claims paid	\$	- 6,521,554 (6,521,554)	\$	- 10,197,632 (10,197,632)
Balance at end of year	<u>\$</u>		<u>\$</u>	<u>-</u>
Other obligations for health benefit coverage, at present value of estimated amounts: Balance at beginning of year Net change during the year:	\$	637,820	\$	946,159
Health claims		(176,578)	_	(308,339)
Balance at end of year	\$	461,242	\$	637,820
Plan's total benefit obligations at end of year	\$	461,242	\$	637,820

YATES SERVICES, LLC HEALTHCARE BENEFIT PLAN NOTES TO FINANCIAL STATEMENTS

Note 1. Description of the Plan

The following description of the Yates Services, LLC Healthcare Benefit Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The Plan provides health, dental, disability and death benefits, which are offered to substantially all employees of Yates Services, LLC (Employer). It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Benefits

The Plan provides health benefits (hospital, surgical, major medical, vision and dental) and disability and death benefits to all full-time employees who complete a 180-day waiting period. Coverage of eligible dependents is available. Participation in the Plan is voluntary.

Current health claims of active participants and their dependents and beneficiaries are provided under group insurance contracts with Blue Cross Blue Shield of TN, Delta Dental of TN, and United Healthcare Insurance Company. Disability and death benefits are covered by group-term policies with United of Omaha Life Insurance Company.

Contributions

The Plan agreement may require contributions by members of the Plan as a condition to their participation in the Plan. Also a charge may be made to a member for dependents that are covered by the Plan. The Employer makes contributions to the Plan as required to meet payments of benefits and expenses of the Plan.

Other

Although it has not expressed any intention to do so, the Employer has the right under the Plan to modify the benefits provided to active employees, to discontinue its contributions at any time, and to terminate the Plan subject to the provisions set forth in ERISA.

Note 2. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by the Plan:

Basis of accounting

The records of the Plan are maintained on the cash basis of accounting. Under the cash basis, revenues are recognized when received rather than when earned, and expenditures are recognized when paid rather than when incurred.

Use of estimates

The preparation of financial statements requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

Plan benefits

The Plan's administrator estimates plan obligations at December 31 for health claims incurred by active participants but not reported at that date.

Reclassification

Certain accounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

Note 3. Income Tax Status

The Plan has not obtained a determination letter from the Internal Revenue Service. However, the plan administrator and the plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Plan's financial statements.

Note 4. Fidelity Bond

A fidelity bond for \$1,000,000 covered the Plan in both 2009 and 2008.

Note 5. Insurance

The Plan has purchased insurance to cover losses on claims in excess of \$125,000.

Note 6. Medicare Prescription Drug Improvement and Modernization Act of 2003 (MPD)

The MPD was signed into law on December 8, 2003 and became effective January 1, 2006. The law provides senior citizens and persons with disabilities prescription drug coverage. The Plan is not entitled to any benefits under the new law, and the new law has no effect on the estimated plan benefit obligations.

Note 7. Concentrations

The Plan maintains a trust funding account with a financial institution and, at times, the cash balance is in excess of federally insured amounts.

Note 8. Subsequent Events

Management has evaluated subsequent events through October 5, 2010 the date on which the financial statements were available to be issued.

FAX NO. :6152234130

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Form 5500

Department of the Treasury Internal Revenue Benice

Department of Labor Employee Remofits Security Administration

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4066 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 8047(e), and 6058(e) of the internal Revenue Code (the Code).

OMB Nos. 1210-0110 1210-0089

2009

		1	Complete all and a li			l <u> —</u>		
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A	This return/report is for:	e multiemplayer p			dending			
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YAT	ES SERVICES,	LLC HEALTHCA	RE BENEFITS	PLAN	plan numb	er (PN) 🕨 502		
& T	RUST				1c Effective d	ate of plan		
					06/01/2	002		
2 a	Plan sponsor's name and	address (employer, if to	r a single-employer plan)		2b Employer	dentification		
	(Address should include a	-			Number (El	N)		
	ËS SERVICES,	LIC			26-3596	498		
	. BOX 456				2c Sponsor's	telephone		
PHI	LADELPHIA	MS 3	39350-0456		number			
					601-656	-5411		
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BUATO	Monta and augmente, se w	ell as the electronic version	n of this return/report, and to	the best of my knowledg	o and belief, it is true, non	nect, and complete.		
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(,),	Bignature of plan admis	Metrator	Date	Enter name of India	vidual signing as plan	administrator		
SION	Thomas !	M. Rre	10/12/2010	Thoma		50		
100	Signature of employer	plan sponsor	Dano	Enter name of India	Adual signing as empi	dyer or plan aponsor		
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HERE	Signature of DFE		Date	Fotor name of local	idual elanina en DFE			

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 algaing as DFE

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_	Form 5500 (2009)			_							
3	2 Plan admiration		Pa	2				·-			
S	Plan administrator's name and address (If same as plan sponsor, or	rnter "Sa	me")				131				
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8	EIN and the plan number from the last return/report: Sponsor's name						-, 0 10	11101101	110,	AD GIV	
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5	Total number of participants at the beginning of the plan year										
6	Number of participants as of the and of the plan year (westere plans			_			<u> </u>		5		2631
		ocmple	te only	iines (Ba, ti	b, Ac, a	nd 6 d).			alatin angelin	eletator de la fil
a	Active participants										7500
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	Subtotal. Add lines 54, 6b, and 5e ,	• • • •	· • • •	<i></i>		• • • •		• • • •	60		2182
e	Deceased participants whose paneficiaries are receiving or are entitle	lari to ne		-							^
_									80		0
f	Total. Add lines 64 and 60								81		2182
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9	Number of participants with account balances as of the end of the p	olan yea	r (only (defina	d con	tribution	plans				
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