

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2009</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning <u>01/01/2009</u> and ending <u>12/31/2009</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input checked="" type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information										
1a Name of plan <u>KENTUCKY TEXTILES, INC. EMPLOYEES' RETIREMENT PLAN</u>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>10/01/1981</u></td> </tr> <tr> <td colspan="2">2b Employer Identification Number (EIN) <u>61-0996814</u></td> </tr> <tr> <td colspan="2">2c Sponsor's telephone number <u>859-987-5228</u></td> </tr> <tr> <td colspan="2">2d Business code (see instructions) <u>314000</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>10/01/1981</u>		2b Employer Identification Number (EIN) <u>61-0996814</u>		2c Sponsor's telephone number <u>859-987-5228</u>		2d Business code (see instructions) <u>314000</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>										
1c Effective date of plan <u>10/01/1981</u>											
2b Employer Identification Number (EIN) <u>61-0996814</u>											
2c Sponsor's telephone number <u>859-987-5228</u>											
2d Business code (see instructions) <u>314000</u>											
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>KENTUCKY TEXTILES, INC.</u> <u>1800 SOUTH MAIN STREET</u> <u>PARIS, KY 40361</u>	<u>1800 SOUTH MAIN STREET</u> <u>PARIS, KY 40361</u>										

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

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

SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>10/15/2010</u>	<u>CLIFF SHUMATE</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2009)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") KENTUCKY TEXTILES, INC. 1800 SOUTH MAIN STREET PARIS, KY 40361	3b Administrator's EIN 61-0996814 3c Administrator's telephone number 859-987-5228
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	338
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).	
a Active participants.....	6a 0
b Retired or separated participants receiving benefits.....	6b 0
c Other retired or separated participants entitled to future benefits.....	6c 0
d Subtotal. Add lines 6a , 6b , and 6c	6d 0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e 0
f Total. Add lines 6d and 6e	6f 0
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h 0

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 1I 1G

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

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

a Pension Schedules (1) <input checked="" type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input checked="" type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

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 ending 12/31/2009

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan KENTUCKY TEXTILES, INC. EMPLOYEES' RETIREMENT PLAN		B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF KENTUCKY TEXTILES, INC.		D Employer Identification Number (EIN) 61-0996814	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		F Prior year plan size: <input type="checkbox"/> 100 or fewer <input checked="" type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information

1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2009</u>		
2 Assets:		
a Market value	2a	0
b Actuarial value	2b	0
3 Funding target/participant count breakdown	(1) Number of participants	(2) Funding Target
a For retired participants and beneficiaries receiving payment	3a	0
b For terminated vested participants	3b	0
c For active participants:		
(1) Non-vested benefits	3c(1)	0
(2) Vested benefits	3c(2)	0
(3) Total active	3c(3)	0
d Total	3d	0
4 If the plan is at-risk, check the box and complete items (a) and (b)		<input type="checkbox"/>
a Funding target disregarding prescribed at-risk assumptions	4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor	4b	
5 Effective interest rate	5	6.00 %
6 Target normal cost	6	0

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	Signature of actuary	Date
	JAMES D. ERCEG	10/15/2010
	Type or print name of actuary	08-05576
	STAR CONSULTING GROUP, LLC	Most recent enrollment number
Firm name	513-731-7827	Telephone number (including area code)
10810 STOCKBRIDGE CINCINNATI, OH 45249		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

Part II Beginning of year carryover and prefunding balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	0	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	0	0
9	Amount remaining (Item 7 minus item 8).....	0	0
10	Interest on item 9 using prior year's actual return of <u>5.91</u> %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (Item 38 from prior year)		0
b	Interest on (a) using prior year's effective rate of <u>5.91</u> %		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance.....		0
12	Reduction in balances due to elections or deemed elections.....	0	0
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12).....	0	0

Part III Funding percentages			
14	Funding target attainment percentage.....	14	100.00 %
15	Adjusted funding target attainment percentage.....	15	100.00 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	87.80 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	17	%

Part IV Contributions and liquidity shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
Totals ▶			18(b)		18(c)

19	Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:	
a	Contributions allocated toward unpaid minimum required contribution from prior years.....	19a 0
b	Contributions made to avoid restrictions adjusted to valuation date	19b 0
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	19c 0

20	Quarterly contributions and liquidity shortfalls:
a	Did the plan have a "funding shortfall" for the prior year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b	If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? <input type="checkbox"/> Yes <input type="checkbox"/> No
c	If 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of Quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:				
a Segment rates:	1st segment: 5.64 %	2nd segment: 6.40 %	3rd segment: 6.56 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)				21b 0
22 Weighted average retirement age				22 65
23 Mortality table(s) (see instructions)	<input checked="" type="checkbox"/> Prescribed - combined	<input type="checkbox"/> Prescribed - separate	<input type="checkbox"/> Substitute	

Part VI Miscellaneous items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment.....	27	

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contribution for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29).....	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions).....	31	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	0	0	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b – item 33).....	34	0	
35 Balances used to offset funding requirement	Carryover balance	Prefunding balance	Total balance
	0	0	0
36 Additional cash requirement (item 34 minus item 35).....	36	0	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c).....	37	0	
38 Interest-adjusted excess contributions for current year (see instructions).....	38	0	
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37).....	39	0	
40 Unpaid minimum required contribution for all years	40	0	

<p>SCHEDULE C (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Service Provider Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2009</p> <hr/> <p>This Form is Open to Public Inspection.</p>
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For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

<p>A Name of plan <u>KENTUCKY TEXTILES, INC. EMPLOYEES' RETIREMENT PLAN</u></p>	<p>B Three-digit plan number (PN) ▶ <u>001</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>KENTUCKY TEXTILES, INC.</u></p>	<p>D Employer Identification Number (EIN) <u>61-0996814</u></p>

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

STAR CONSULTING GROUP, LLC

10810 STOCKBRIDGE LANE
CINCINNATI, OH 45249

01-0519120

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

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

PNC BANK N. A.

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21	NONE	19111	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LYNCH COX GILMAN & MAHAN PSC

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	2003	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of 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	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
 (complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN;
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN;
c Position:	
d Address:	e Telephone:

Explanation:

**SCHEDULE H
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan KENTUCKY TEXTILES, INC. EMPLOYEES' RETIREMENT PLAN	B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 KENTUCKY TEXTILES, INC.	D Employer Identification Number (EIN) 61-0996814	

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1552151	0
(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)	26431	0
(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)	1875271	0
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities	1d(1)	
(2)	Employer real property	1d(2)	
e	Buildings and other property used in plan operation.....	1e	
f	Total assets (add all amounts in lines 1a through 1e)	1f	3453853 0
Liabilities			
g	Benefit claims payable	1g	0 0
h	Operating payables	1h	
i	Acquisition indebtedness	1i	
j	Other liabilities.....	1j	
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	0 0
Net Assets			
l	Net assets (subtract line 1k from line 1f).....	1l	3453853 0

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.

		(a) Amount	(b) Total
Income			
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers.....	2a(1)(A)	0
	(B) Participants	2a(1)(B)	
	(C) Others (including rollovers).....	2a(1)(C)	
(2)	Noncash contributions	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)	0
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	
	(B) U.S. Government securities	2b(1)(B)	
	(C) Corporate debt instruments	2b(1)(C)	
	(D) Loans (other than to participants)	2b(1)(D)	
	(E) Participant loans	2b(1)(E)	
	(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)	

		(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		0

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)	3453853	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		3453853
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses: (1) Professional fees			
(2) Contract administrator fees	2i(2)		
(3) Investment advisory and management fees	2i(3)		
(4) Other	2i(4)		
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		3453853

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-3453853
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unqualified **(2)** Qualified **(3)** Disclaimer **(4)** Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? Yes No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **DULWORTH, BREEDING, & KARNIS, LLP** **(2)** EIN: **61-1165017**

d The opinion of an independent qualified public accountant is **not attached** because:

(1) This form is filed for a CCT, PSA, or MTIA. **(2)** It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.

During the plan year:

	Yes	No	Amount
4a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.).....		X	
4b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		X	
4c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
4d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.).....		X	
4e Was this plan covered by a fidelity bond?.....	X		1000000
4f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
4g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
4h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
4i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.).....	X		
4j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.).....	X		
4k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?.....	X		
4l Has the plan failed to provide any benefit when due under the plan?		X	
4m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....			
4n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year Yes No Amount: 0

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

SCHEDULE R (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Retirement Plan Information This schedule is required to be filed under section 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2009 This Form is Open to Public Inspection.
--	--	---

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009 and ending 12/31/2009

A Name of plan <u>KENTUCKY TEXTILES, INC. EMPLOYEES' RETIREMENT PLAN</u>	B Three-digit plan number (PN) ►	<u>001</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>KENTUCKY TEXTILES, INC.</u>	D Employer Identification Number (EIN) <u>61-0996814</u>	

Part I	Distributions
---------------	----------------------

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions.....

1	0
---	---

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits):
 EIN(s): 25-1211909

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year.....

3	0
---	---

Part II	Funding Information (If the plan is not subject to the minimum funding requirements of section of 412 of the Internal Revenue Code or ERISA section 302, skip this Part)
----------------	---

4 Is the plan administrator making an election under Code section 412(d)(2) or ERISA section 302(d)(2)?..... Yes No N/A
If the plan is a defined benefit plan, go to line 8.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions and enter the date of the ruling letter granting the waiver. **Date:** Month _____ Day _____ Year _____
If you completed line 5, complete lines 3, 9, and 10 of Schedule MB and do not complete the remainder of this schedule.

6 a Enter the minimum required contribution for this plan year	6a	
b Enter the amount contributed by the employer to the plan for this plan year	6b	
c Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount).....	6c	

If you completed line 6c, skip lines 8 and 9.

7 Will the minimum funding amount reported on line 6c be met by the funding deadline? Yes No N/A

8 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change?..... Yes No N/A

Part III	Amendments
-----------------	-------------------

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased or decreased the value of benefits? If yes, check the appropriate box(es). If no, check the "No" box..... Increase Decrease Both No

Part IV	ESOPs (see instructions). If this is not a plan described under Section 409(a) or 4975(e)(7) of the Internal Revenue Code, skip this Part.
----------------	---

10 Were unallocated employer securities or proceeds from the sale of unallocated securities used to repay any exempt loan?..... Yes No

11 a Does the ESOP hold any preferred stock? Yes No

b If the ESOP has an outstanding exempt loan with the employer as lender, is such loan part of a "back-to-back" loan? (See instructions for definition of "back-to-back" loan.) Yes No

12 Does the ESOP hold any stock that is not readily tradable on an established securities market? Yes No

Part V Additional Information for Multiemployer Defined Benefit Pension Plans

13 Enter the following information for each employer that contributed more than 5% of total contributions to the plan during the plan year (measured in dollars). See instructions. Complete as many entries as needed to report all applicable employers.

a Name of contributing employer _____

b EIN _____

c Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____

c Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____

c Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____

c Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____

c Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

a Name of contributing employer _____

b EIN _____

c Dollar amount contributed by employer _____

d Date collective bargaining agreement expires (If employer contributes under more than one collective bargaining agreement, check box and see instructions regarding required attachment. Otherwise, enter the applicable date.) Month _____ Day _____ Year _____

e Contribution rate information (If more than one rate applies, check this box and see instructions regarding required attachment. Otherwise, complete items 13e(1) and 13e(2).)

(1) Contribution rate (in dollars and cents) _____

(2) Base unit measure: Hourly Weekly Unit of production Other (specify): _____

14 Enter the number of participants on whose behalf no contributions were made by an employer as an employer of the participant for:

a The current year	14a	
b The plan year immediately preceding the current plan year	14b	
c The second preceding plan year	14c	

15 Enter the ratio of the number of participants under the plan on whose behalf no employer had an obligation to make an employer contribution during the current plan year to:

a The corresponding number for the plan year immediately preceding the current plan year	15a	
b The corresponding number for the second preceding plan year	15b	

16 Information with respect to any employers who withdrew from the plan during the preceding plan year:

a Enter the number of employers who withdrew during the preceding plan year	16a	
b If item 16a is greater than 0, enter the aggregate amount of withdrawal liability assessed or estimated to be assessed against such withdrawn employers	16b	

17 If assets and liabilities from another plan have been transferred to or merged with this plan during the plan year, check box and see instructions regarding supplemental information to be included as an attachment.

Part VI Additional Information for Single-Employer and Multiemployer Defined Benefit Pension Plans

18 If any liabilities to participants or their beneficiaries under the plan as of the end of the plan year consist (in whole or in part) of liabilities to such participants and beneficiaries under two or more pension plans as of immediately before such plan year, check box and see instructions regarding supplemental information to be included as an attachment.

19 If the total number of participants is 1,000 or more, complete items (a) through (c)

- a** Enter the percentage of plan assets held as:
 Stock: _____% Investment-Grade Debt: _____% High-Yield Debt: _____% Real Estate: _____% Other: _____%
- b** Provide the average duration of the combined investment-grade and high-yield debt:
 0-3 years 3-6 years 6-9 years 9-12 years 12-15 years 15-18 years 18-21 years 21 years or more
- c** What duration measure was used to calculate item 19(b)?
 Effective duration Macaulay duration Modified duration Other (specify): _____



Pension Benefit Guaranty Corporation
1200 K Street, N.W., Washington, D.C. 20005-4026

November 9, 2009

VIA OVERNIGHT DELIVERY

Kentucky Textiles, Inc.
Attn: Cliff Shumate, President
1 West 20th Street
Paris, Kentucky 40361-1140

Frozen Products, Inc.
2008 Cypress Street
Paris, KY 40361

WS Racing
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Partnership between Clifford W. Shumate and Kathryn Shumate
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Estate of Clifford W. Shumate
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Re: Employer Liability -- Kentucky Textiles, Inc. Employees Retirement Plan
PBGCC Case No: 20099600

To Ms. Kathryn Shumate, Mr. Cliff Shumate and other concerned individuals:

The Pension Benefit Guaranty Corporation ("PBGC") notifies you of its determination of liability owed by each of the following persons and entities:

1. Kentucky Textiles, Inc.;
2. Frozen Products, Inc.;
3. WS Racing
4. Partnership between Clifford W. Shumate and Kathryn Shumate;
5. Estate of Clifford Shumate; and
6. Kathryn Shumate.

By this letter, PBGC demands payment of such liability from each of the above listed persons and entities of \$4,123,408.12, plus interest that continues to accrue.

Kentucky Textiles, Inc. ("KTI") established the Kentucky Textiles, Inc. Employees Retirement Plan (the "Pension Plan") effective October 1, 1981. On August 6, 2009, PBGC and KTI entered into an Agreement for Appointment of Trustee and Termination of Plan ("Agreement"). Under the Agreement, (i) the Pension Plan was terminated under 29 U.S.C. § 1341(c)(2)(B)(iii)(I), (ii) November 30, 2003, was established as the termination date, and (iii) PBGC was appointed statutory trustee of the Pension Plan.

Title IV of the Employee Retirement Income Security Act of 1974 ("ERISA") imposes joint and several liability upon the contributing sponsor of a single-employer plan, and all members of that sponsor's controlled group, upon termination of the plan under 29 U.S.C. § 1342. 29 U.S.C. § 1362(a). A "controlled group" is a group of trades or businesses related by common ownership, as determined under PBGC regulations that are coextensive with Treasury regulations under Internal Revenue Code § 414(b) and (c). *See* 29 U.S.C. § 1301(a)(14)(A), (B); *see also* 29 C.F.R. §§ 4001.2, 4001.3. An unincorporated trade or business operated by a married couple is a "partnership" for controlled group purposes and leads to the personal liability of each partner for the plan's unfunded benefit liabilities. *See Pension Benefit Guaranty Corp. v. Beverley*, 404 F.3d 243 (4th Cir. 2005). Furthermore, an operating farm constitutes a "trade" or "business" under 29 U.S.C. § 1301(a)(14)(A),(B).

As of the Pension Plan's termination date, the Pension Plan's sponsor, KTI, was a member of a controlled group, which included Frozen Products, Inc.; WS Racing, LLC; and an unincorporated business that operated and/or leased one or more farms ("The Shumate Partnership") (collectively, the "Controlled Group"). As the owners of the Shumate Partnership, Clifford W. Shumate (now represented by his estate) and Kathryn Shumate are jointly and severally liable for the partnerships debts, including those relating to the Pension Plan.

Each member of the Controlled Group is jointly and severally liable for the total amount of the unfunded benefit liabilities to all participants and beneficiaries under the Pension Plan, as of the termination date, together with interest thereon ("Employer Liability"). *See* 29 U.S.C. § 1362(b)(1)(A). "Unfunded benefit liabilities" means the value of the plan's benefit liabilities, under assumptions PBGC prescribes, minus the value of its assets. 29 U.S.C. § 1301(a)(18). *See* 29 C.F.R. Pt. 4044. The rate of interest is the rate prescribed in 29 C.F.R. § 4062.7(c).

The Pension Plan's unfunded benefit liabilities as of November 30, 2003, the Pension Plan's termination date, were \$2,888,856. Interest of \$1,234,552.12 has accrued from November 30, 2003, through September 30, 2009. Thus, as of September 30, 2009, the amount of the Employer Liability is \$4,123,408.12. Interest continues to accrue at the applicable rate.

PBGC may demand payment immediately upon determining the Employer Liability when PBGC's ability to assert or obtain payment is in jeopardy. 29 C.F.R. § 4068.3(c). When PBGC issues such a demand, there is no right to appeal the determination of Employer Liability under 29 C.F.R. § 4003. *See* 29 C.F.R. § 4068.3(c). In this case, PBGC believes that its ability to assert or obtain payment is in jeopardy, and accordingly demands immediate payment of the Employer Liability.

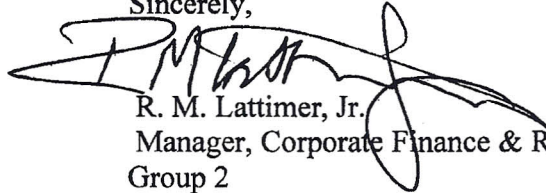
As of the termination date, there was significant positive net worth among the Controlled Group members. If payment of the entire Employer Liability by November 20, 2009 would result in severe hardship, pursuant to 29 CFR § 4062.9, PBGC is authorized to prescribe commercially reasonable terms for payment. If you request such terms on behalf of any member of the Controlled Group, provide PBGC with: (i) the payment terms you propose; (ii) any outstanding items from the subpoena PBGC issued to Kathryn Shumate on August 28, 2009; and (iii) any other information relevant to the prescription of commercially reasonable terms for payment of the Employer Liability. Otherwise, \$4,123,408.12 should be paid to PBGC by November 20, 2009, by wire transfer to PBGC's account at the State Street Bank and Trust Company, Boston, Massachusetts (see the enclosed Transfer Instructions).

If payment of the Employer Liability has not been made or agreed upon by November 20, 2009, PBGC will consider all options available to it, including the commencement of a civil action in U.S. District Court. In addition, PBGC may seek to collect the following claims, which are owed jointly and severally by each member of the Controlled Group:

- 1) \$386,981.22 - Unpaid insurance premiums, interest, and penalties (collectively, "Premiums") for the Pension Plan through September 30, 2009. 29 U.S.C. § 1307(a), (e); *see also* 29 U.S.C. § 1307(e)(2); and
- 2) \$829,217.45 - Unpaid minimum funding contributions and interest owed to the Pension Plan through September 30, 2009. *See* 29 U.S.C. § 1362(c).

If you have any questions, please contact Rhonda Baird, Attorney, Office of the Chief Counsel, at the above address, or by telephone at (202) 326-4020, extension 3880.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. M. Lattimer, Jr.', written over a horizontal line.

R. M. Lattimer, Jr.
Manager, Corporate Finance & Restructuring
Group 2
Department of Insurance Supervision and
Compliance
202-326-4000, ext. 3081

Enclosure

cc: Matthew Watkins, Esq.
Steven A. Goodman, Esq.
Barton T. Rogers, Esq.

TRANSFER INSTRUCTIONS – State Street Bank & Trust (#3801)

CASH:

EXPRESS MAIL

State Street Corporation
Public Funds Division
Lafayette Corporate Center, 6th Floor
2 Avenue de Lafayette
Boston, MA 02111-1724
Attention: Mary Ellen MacDonald 617-664-9416
Checks should be made payable to "State Street Bank as Custodian for PBGC." Each payment must include plan name, PBGC case number, and what the payment represents.

FEDERAL WIRE*

State Street Bank and Trust Company
Boston, Massachusetts
ABA# 0110-0002-8 DDA# 52166048
Public Funds/State St/3801
Attn: Mary Ellen MacDonald
Ref: Plan name and PBGC Case #

***When transferring funds by the federal wire system, State Street Bank MUST be notified one day prior to the actual transfer, which must occur no later than 12:00 noon on the day of transfer. The exact amount must be furnished to assure proper credit. Ms. Mary Ellen MacDonald can be reached at 617-664-9416 to confirm the transfer. Please send an email identifying the wire amount, plan name, and PBGC case # one day prior to the date of wire transfer to mmacdonald@statestreet.com.**

SECURITIES:

Prior to transferring securities to State Street, an electronic file MUST be emailed to Mary Ellen MacDonald at mmacdonald@statestreet.com with an attached Excel spreadsheet with a minimum of the following fields filled in:

**Security Name / Cusip / Shares / Original Face / Settlement Location
Your delivery instruction should also be included in the email.**

DTC

Agent Bank: 26022 Participant: 0997
SSB Custodian for PBGC fund 3801

FED

State St Bos/SPEC/3801 (Instructions must be given exactly as stated here.)

MBS

PTC code – SSFND - 98086

PHYSICAL*

DTC / New York Window
55 Water Street, Plaza level – 3rd Floor
New York, New York 10041

Account: State Street, Account Name: PBGC, Account Number: 3801

***Physical securities must be registered in State Street Bank's nominee name, "Beat & Co". Checks representing dividends, interest, or other distributions from PBGC trust fund assets should be made payable to "Beat & Co". Physical assets transferred by non-bank custodians must be sent by overnight mail. Each transfer MUST include the plan name, PBGC case number, and what the transfer represents.**



Pension Benefit Guaranty Corporation
1200 K Street, N.W., Washington, D.C. 20005-4026

November 9, 2009

VIA OVERNIGHT DELIVERY

Kentucky Textiles, Inc.
Attn: Cliff Shumate, President
1 West 20th Street
Paris, Kentucky 40361-1140

Frozen Products, Inc.
2008 Cypress Street
Paris, KY 40361

WS Racing
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Partnership between Clifford W. Shumate and Kathryn Shumate
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Estate of Clifford W. Shumate
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Re: Employer Liability -- Kentucky Textiles, Inc. Employees Retirement Plan
PBGCC Case No: 20099600

To Ms. Kathryn Shumate, Mr. Cliff Shumate and other concerned individuals:

The Pension Benefit Guaranty Corporation ("PBGC") notifies you of its determination of liability owed by each of the following persons and entities:

1. Kentucky Textiles, Inc.;
2. Frozen Products, Inc.;
3. WS Racing
4. Partnership between Clifford W. Shumate and Kathryn Shumate;
5. Estate of Clifford Shumate; and
6. Kathryn Shumate.

By this letter, PBGC demands payment of such liability from each of the above listed persons and entities of \$4,123,408.12, plus interest that continues to accrue.

Kentucky Textiles, Inc. ("KTI") established the Kentucky Textiles, Inc. Employees Retirement Plan (the "Pension Plan") effective October 1, 1981. On August 6, 2009, PBGC and KTI entered into an Agreement for Appointment of Trustee and Termination of Plan ("Agreement"). Under the Agreement, (i) the Pension Plan was terminated under 29 U.S.C. § 1341(c)(2)(B)(iii)(I), (ii) November 30, 2003, was established as the termination date, and (iii) PBGC was appointed statutory trustee of the Pension Plan.

Title IV of the Employee Retirement Income Security Act of 1974 ("ERISA") imposes joint and several liability upon the contributing sponsor of a single-employer plan, and all members of that sponsor's controlled group, upon termination of the plan under 29 U.S.C. § 1342. 29 U.S.C. § 1362(a). A "controlled group" is a group of trades or businesses related by common ownership, as determined under PBGC regulations that are coextensive with Treasury regulations under Internal Revenue Code § 414(b) and (c). *See* 29 U.S.C. § 1301(a)(14)(A), (B); *see also* 29 C.F.R. §§ 4001.2, 4001.3. An unincorporated trade or business operated by a married couple is a "partnership" for controlled group purposes and leads to the personal liability of each partner for the plan's unfunded benefit liabilities. *See Pension Benefit Guaranty Corp. v. Beverley*, 404 F.3d 243 (4th Cir. 2005). Furthermore, an operating farm constitutes a "trade" or "business" under 29 U.S.C. § 1301(a)(14)(A),(B).

As of the Pension Plan's termination date, the Pension Plan's sponsor, KTI, was a member of a controlled group, which included Frozen Products, Inc.; WS Racing, LLC; and an unincorporated business that operated and/or leased one or more farms ("The Shumate Partnership") (collectively, the "Controlled Group"). As the owners of the Shumate Partnership, Clifford W. Shumate (now represented by his estate) and Kathryn Shumate are jointly and severally liable for the partnerships debts, including those relating to the Pension Plan.

Each member of the Controlled Group is jointly and severally liable for the total amount of the unfunded benefit liabilities to all participants and beneficiaries under the Pension Plan, as of the termination date, together with interest thereon ("Employer Liability"). *See* 29 U.S.C. § 1362(b)(1)(A). "Unfunded benefit liabilities" means the value of the plan's benefit liabilities, under assumptions PBGC prescribes, minus the value of its assets. 29 U.S.C. § 1301(a)(18). *See* 29 C.F.R. Pt. 4044. The rate of interest is the rate prescribed in 29 C.F.R. § 4062.7(c).

The Pension Plan's unfunded benefit liabilities as of November 30, 2003, the Pension Plan's termination date, were \$2,888,856. Interest of \$1,234,552.12 has accrued from November 30, 2003, through September 30, 2009. Thus, as of September 30, 2009, the amount of the Employer Liability is \$4,123,408.12. Interest continues to accrue at the applicable rate.

PBGC may demand payment immediately upon determining the Employer Liability when PBGC's ability to assert or obtain payment is in jeopardy. 29 C.F.R. § 4068.3(c). When PBGC issues such a demand, there is no right to appeal the determination of Employer Liability under 29 C.F.R. § 4003. *See* 29 C.F.R. § 4068.3(c). In this case, PBGC believes that its ability to assert or obtain payment is in jeopardy, and accordingly demands immediate payment of the Employer Liability.

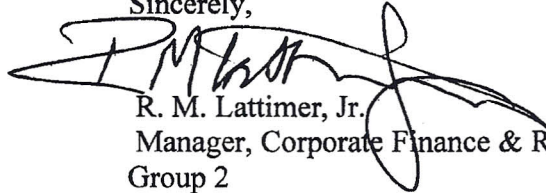
As of the termination date, there was significant positive net worth among the Controlled Group members. If payment of the entire Employer Liability by November 20, 2009 would result in severe hardship, pursuant to 29 CFR § 4062.9, PBGC is authorized to prescribe commercially reasonable terms for payment. If you request such terms on behalf of any member of the Controlled Group, provide PBGC with: (i) the payment terms you propose; (ii) any outstanding items from the subpoena PBGC issued to Kathryn Shumate on August 28, 2009; and (iii) any other information relevant to the prescription of commercially reasonable terms for payment of the Employer Liability. Otherwise, \$4,123,408.12 should be paid to PBGC by November 20, 2009, by wire transfer to PBGC's account at the State Street Bank and Trust Company, Boston, Massachusetts (see the enclosed Transfer Instructions).

If payment of the Employer Liability has not been made or agreed upon by November 20, 2009, PBGC will consider all options available to it, including the commencement of a civil action in U.S. District Court. In addition, PBGC may seek to collect the following claims, which are owed jointly and severally by each member of the Controlled Group:

- 1) \$386,981.22 - Unpaid insurance premiums, interest, and penalties (collectively, "Premiums") for the Pension Plan through September 30, 2009. 29 U.S.C. § 1307(a), (e); *see also* 29 U.S.C. § 1307(e)(2); and
- 2) \$829,217.45 - Unpaid minimum funding contributions and interest owed to the Pension Plan through September 30, 2009. *See* 29 U.S.C. § 1362(c).

If you have any questions, please contact Rhonda Baird, Attorney, Office of the Chief Counsel, at the above address, or by telephone at (202) 326-4020, extension 3880.

Sincerely,

A handwritten signature in black ink, appearing to read "R. M. Lattimer, Jr.", written over a horizontal line.

R. M. Lattimer, Jr.
Manager, Corporate Finance & Restructuring
Group 2
Department of Insurance Supervision and
Compliance
202-326-4000, ext. 3081

Enclosure

cc: Matthew Watkins, Esq.
Steven A. Goodman, Esq.
Barton T. Rogers, Esq.

TRANSFER INSTRUCTIONS – State Street Bank & Trust (#3801)

CASH:

EXPRESS MAIL

State Street Corporation
Public Funds Division
Lafayette Corporate Center, 6th Floor
2 Avenue de Lafayette
Boston, MA 02111-1724
Attention: Mary Ellen MacDonald 617-664-9416
Checks should be made payable to "State Street Bank as Custodian for PBGC." Each payment must include plan name, PBGC case number, and what the payment represents.

FEDERAL WIRE*

State Street Bank and Trust Company
Boston, Massachusetts
ABA# 0110-0002-8 DDA# 52166048
Public Funds/State St/3801
Attn: Mary Ellen MacDonald
Ref: Plan name and PBGC Case #

***When transferring funds by the federal wire system, State Street Bank MUST be notified one day prior to the actual transfer, which must occur no later than 12:00 noon on the day of transfer. The exact amount must be furnished to assure proper credit. Ms. Mary Ellen MacDonald can be reached at 617-664-9416 to confirm the transfer. Please send an email identifying the wire amount, plan name, and PBGC case # one day prior to the date of wire transfer to mmacdonald@statestreet.com.**

SECURITIES:

Prior to transferring securities to State Street, an electronic file MUST be emailed to Mary Ellen MacDonald at mmacdonald@statestreet.com with an attached Excel spreadsheet with a minimum of the following fields filled in:

Security Name / Cusip / Shares / Original Face / Settlement Location
Your delivery instruction should also be included in the email.

DTC

Agent Bank: 26022 Participant: 0997
SSB Custodian for PBGC fund 3801

FED

State St Bos/SPEC/3801 (Instructions must be given exactly as stated here.)

MBS

PTC code – SSFND - 98086

PHYSICAL*

DTC / New York Window
55 Water Street, Plaza level – 3rd Floor
New York, New York 10041

Account: State Street, Account Name: PBGC, Account Number: 3801

***Physical securities must be registered in State Street Bank's nominee name, "Beat & Co". Checks representing dividends, interest, or other distributions from PBGC trust fund assets should be made payable to "Beat & Co". Physical assets transferred by non-bank custodians must be sent by overnight mail. Each transfer MUST include the plan name, PBGC case number, and what the transfer represents.**



Pension Benefit Guaranty Corporation
1200 K Street, N.W., Washington, D.C. 20005-4026

November 9, 2009

VIA OVERNIGHT DELIVERY

Kentucky Textiles, Inc.
Attn: Cliff Shumate, President
1 West 20th Street
Paris, Kentucky 40361-1140

Frozen Products, Inc.
2008 Cypress Street
Paris, KY 40361

WS Racing
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Partnership between Clifford W. Shumate and Kathryn Shumate
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Estate of Clifford W. Shumate
c/o Kathryn Shumate
406 Houston Oaks Drive
Paris, Kentucky 40361

Kathryn Shumate
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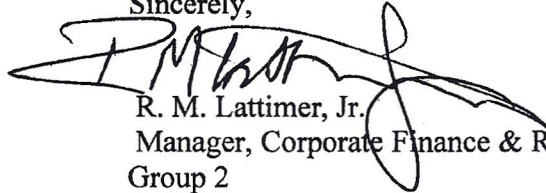
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Manager, Corporate Finance & Restructuring
Group 2
Department of Insurance Supervision and
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202-326-4000, ext. 3081

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MBS

PTC code – SSFND - 98086

PHYSICAL*

DTC / New York Window
55 Water Street, Plaza level – 3rd Floor
New York, New York 10041

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**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

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 ending 12/31/2009

▶ **Round off amounts to nearest dollar.**

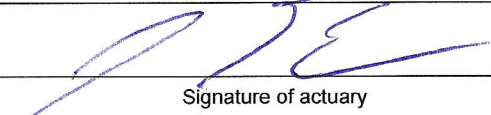
▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan KENTUCKY TEXTILES, INC. EMPLOYEES' RETIREMENT PLAN		B Three-digit plan number (PN) ▶	001
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF KENTUCKY TEXTILES, INC.		D Employer Identification Number (EIN) 61-0996814	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		F Prior year plan size: <input type="checkbox"/> 100 or fewer <input checked="" type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information			
1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2009</u>			
2 Assets:			
a Market value	2a	0	
b Actuarial value	2b	0	
3 Funding target/participant count breakdown			
		(1) Number of participants	(2) Funding Target
a For retired participants and beneficiaries receiving payment	3a	0	0
b For terminated vested participants	3b	0	0
c For active participants:			
(1) Non-vested benefits	3c(1)		0
(2) Vested benefits	3c(2)		0
(3) Total active	3c(3)	0	0
d Total	3d	0	0
4 If the plan is at-risk, check the box and complete items (a) and (b) <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions	4a		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been at-risk for fewer than five consecutive years and disregarding loading factor	4b		
5 Effective interest rate	5	6.00 %	
6 Target normal cost	6	0	

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE		10/15/2010
	Signature of actuary	Date
JAMES D. ERCEG	Type or print name of actuary	08-05576
STAR CONSULTING GROUP, LLC	Firm name	Most recent enrollment number
10810 STOCKBRIDGE CINCINNATI, OH 45249	Address of the firm	513-731-7827
		Telephone number (including area code)

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

Part II Beginning of year carryover and prefunding balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (Item 13 from prior year)	0	0
8	Portion used to offset prior year's funding requirement (Item 35 from prior year)	0	0
9	Amount remaining (Item 7 minus item 8).....	0	0
10	Interest on item 9 using prior year's actual return of <u>5.91</u> %	0	0
11	Prior year's excess contributions to be added to prefunding balance:		
a	Excess contributions (Item 38 from prior year)		0
b	Interest on (a) using prior year's effective rate of <u>5.91</u> %		0
c	Total available at beginning of current plan year to add to prefunding balance		0
d	Portion of (c) to be added to prefunding balance.....		0
12	Reduction in balances due to elections or deemed elections.....	0	0
13	Balance at beginning of current year (item 9 + item 10 + item 11d – item 12).....	0	0

Part III Funding percentages			
14	Funding target attainment percentage.....	14	100.00 %
15	Adjusted funding target attainment percentage.....	15	100.00 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	16	87.80 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.....	17	%

Part IV Contributions and liquidity shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
Totals ▶			18(b)		18(c)

19	Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
a	Contributions allocated toward unpaid minimum required contribution from prior years.....	19a	0
b	Contributions made to avoid restrictions adjusted to valuation date	19b	0
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	19c	0
20	Quarterly contributions and liquidity shortfalls:		
a	Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
b	If 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c	If 20a is "Yes," see instructions and complete the following table as applicable:		

Liquidity shortfall as of end of Quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions used to determine funding target and target normal cost

21 Discount rate:

a Segment rates:	1st segment: 5.64 %	2nd segment: 6.40 %	3rd segment: 6.56 %	<input type="checkbox"/> N/A, full yield curve used
-------------------------	------------------------	------------------------	------------------------	---

b Applicable month (enter code) **21b** 0

22 Weighted average retirement age **22** 65

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment..... Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment..... Yes No

27 If the plan is eligible for (and is using) alternative funding rules, enter applicable code and see instructions regarding attachment..... **27**

Part VII Reconciliation of unpaid minimum required contributions for prior years

28 Unpaid minimum required contribution for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (item 19a).....	29	0
30 Remaining amount of unpaid minimum required contributions (item 28 minus item 29).....	30	0

Part VIII Minimum required contribution for current year

31 Target normal cost, adjusted, if applicable (see instructions).....	31	0
32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment	0	0
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33	
34 Total funding requirement before reflecting carryover/prefunding balances (item 31 + item 32a + item 32b – item 33).....	34	0
	Carryover balance	Prefunding balance
35 Balances used to offset funding requirement	0	0
36 Additional cash requirement (item 34 minus item 35).....	36	0
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c).....	37	0
38 Interest-adjusted excess contributions for current year (see instructions).....	38	0
39 Unpaid minimum required contribution for current year (excess, if any, of item 36 over item 37).....	39	0
40 Unpaid minimum required contribution for all years	40	0

Plan Name: Kentucky Textiles, Inc. Employees' Retirement Plan

Employer Identification Number / Plan Number: 61-0996814 / 001

Plan Effective Date: 10/01/1981

Plan Year: January 1, 2009 to December 31, 2009

Plan service start date: Service starts at the later of hire or 10/01/1981

Eligibility requirements: No one is eligible to enter the plan after 12/31/01

Plan Entry Date: All entry dates are prior to 12/31/01

Eligibility Requirements

	<u>Normal Retirement</u>	<u>Early Retirement</u>	<u>Disability Retirement</u>	<u>Death Benefits</u>
Age Requirement	65	55	None	None
Service Requirement	5	10		5
Age plus Service Over-ride	None	None	None	None

Vesting Schedule

<u>Service</u>	<u>Vesting %</u>	<u>Service</u>	<u>Vesting %</u>	<u>Service</u>	<u>Vesting %</u>
0 years	0.0%	4 years	0.0%	8 years	100.0%
1 year	0.0%	5 years	100.0%	9 years	100.0%
2 years	0.0%	6 years	100.0%	10 years	100.0%
3 years	0.0%	7 years	100.0%	11 years	100.0%

Normal Form of Payment: Straight Life Annuity

Benefit Formula Type:

(NO FUTURE BENEFIT ACCRUAL AFTER 12/31/01)

Death Benefit payable from plan: Qualified Pre-retirement Spouse's Annuity

Method used to determine the accrued benefit payable at termination:

The accrued benefit is calculated by adding the peaces earned each year together through the date of termination/freeze.

Actuarial Methods

ERISA Valuation - Contribution Alternatives

- a. **Cost Method Current Valuation** Minimum contribution requirements were developed using the Unit Credit cost method.
- b. **Cost Method Last Valuation** Minimum contribution requirements for the January 1, 2006, valuation were developed using the Unit Credit cost method.
- c. **Asset Valuation Method** The actuarial value for 2007 is Market. The actuarial value for 2006 was market. The actuarial value must be between 80% and 120% of market.
- d. **Current Valuation Date** January 1, 2009
- e. **Last Valuation Date** January 1, 2008

FAS 87 - Corporate Accounting

- a. **Cost Method** Expense and liabilities are calculated using the projected unit credit cost method as described in FAS Statement No. 87
- b. **Asset Valuation Method** The market-related value of assets used to develop annual pension expense is equal to the fair value of assets.

FAS 35 - Plan Accounting

- a. **Cost Method** Liabilities for FAS 35 are developed using the traditional unit credit cost method.
- b. **Asset Valuation Method** The FAS Statement No. 35 funded status is developed using the market value of assets, adjusted for contributions receivable and benefits payable.

Actuarial Assumptions

I. Economic Assumptions

ERISA Valuation - Contribution Alternatives

- a. Investment return (pre-retirement)
- b. Investment return (post-retirement)
- c. Current liability rate for Full Funding Limitation
- d. Current liability rate for Additional Funding Charge
- e. Salary increase rate