Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2009

i crisic	in benefit dualanty dorporation				This Form is Open to Pub Inspection	lic
Part I	Annual Report Iden	tification Information				
For caler	ndar plan year 2009 or fiscal p	olan year beginning 07/01/2009		and ending 06/	/30/2010	
A This	eturn/report is for:	a multiemployer plan;	a multiple	e-employer plan; or		
		a single-employer plan;	a DFE (s	pecify)		
B This r	eturn/report is:	the first return/report;		return/report;		
		an amended return/report;	a short p	lan year return/report (le	ss than 12 months).	
C If the	plan is a collectively-bargaine	ed plan, check here				
D Chec	k box if filing under:	Form 5558;	automati	c extension;	the DFVC program;	
	· ·	special extension (enter des	scription)		_	
Part	II Basic Plan Inforn	nation—enter all requested informa	ation			
1a Nam	ne of plan				1b Three-digit plan	500
MOUNT	AIN COMPREHENSIVE CAR	E CENTER FLEXIBLE BENEFIT PL	AN		number (PN) ▶	502
					1c Effective date of plan	1
2a Plan	snonsor's name and address	s (employer, if for a single-employer	nlan)		2b Employer Identification	nn .
	ress should include room or s	, .	pian		Number (EIN)	511
MOUNT	AIN COMPREHENSIVE CAR	E CENTER			61-0663787	
					2c Sponsor's telephone	
					number 606-886-8572	
	JTH FRONT AVENUE DNSBURG, KY 41653		TH FRONT AVENUE NSBURG, KY 41653			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11120101			instructions)	
					621330	
Caution	A penalty for the late or in	complete filing of this return/repo	rt will be assessed	unless reasonable cau	se is established.	
		enalties set forth in the instructions, as the electronic version of this return				
SIGN	Filed with authorized/valid ele	ectronic signature.	01/03/2011	DURWARD HALE		
HERE	Signature of plan adminis	trator	Date	Enter name of individu	ual signing as plan administrator	
SIGN						
HERE	Signature of employer/pla	n sponsor	Date	Enter name of individu	ual signing as employer or plan spor	nsor
SIGN HERE						
HEKE	Signature of DFE		Date	Enter name of individu	ual signing as DFE	

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

Form 5500 (2009) v.092307.1

	Form 5500 (2009) Page 2				
MC	OUNTAIN COMPREHENSIVE CARE CENTER		3b Administrator's EIN 61-0663787 3c Administrator's telephone number 606-886-8572		
4 a	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 the plan number from the last return/report: Sponsor's name	N and	4b EIN 4c PN		
5	Total number of participants at the beginning of the plan year	5	299		
6 а	Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d). Active participants	6a	498		
	Retired or separated participants receiving benefits. Other retired or separated participants entitled to future benefits.	6b 6c			
	Subtotal. Add lines 6a , 6b , and 6c	6d 6e	498		
f g	Total. Add lines 6d and 6e	6f			
	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6g 6h			
7 8a	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Code	. 7	instructions:		
b ı	f the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes i	n the inst	tructions:		
9a	Plan funding arrangement (check all that apply) (1)	insurand			
	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number of the control of		ched. (See instructions)		

(2)

(3) (4)

(5)

(6)

I (Financial Information – Small Plan)

G (Financial Transaction Schedules)

C (Service Provider Information)D (DFE/Participating Plan Information)

______ **A** (Insurance Information)

(2)

(3)

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

nurought to FDICA continu 402(a)(2)					m is Open to Public Inspection	
For calendar plan year 200	09 or fiscal pla	an year beginning 07/01/2009)	and ending	06/30/2010	
A Name of plan MOUNTAIN COMPREHE	A Name of plan MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT PROPERTY.			Three-digit plan number (PN)	502
C Plan sponsor's name a MOUNTAIN COMPREHE				Employer Identii 61-0663787	fication Number (EIN)
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number persons covered at end		Policy or co	ontract year
(b) EIN	code	identification number	policy or contract year		f) From	(g) To
13-5581829	65978	1095113	91	07/01/2	2009	06/30/2010
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. List in	item 3 the agent	ts, brokers, and c	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		0				0
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all pers	ons).		
	(a) Name	and address of the agent, broke	r, or other person to whom co	mmissions or fee	es were paid	
(b) Amount of sales ar	nd base	F	ees and other commissions pa	aid		
commissions pai	d	(c) Amount	(d) F	urpose		(e) Organization code
(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 commissions pa	aid		
commissions pai		(c) Amount	(d) F	urpose		(e) Organization code

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

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	ch carrier may be treated as a unit fo	r purposes of	
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	500886
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd	5	659428
6	Cont	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	•	1 100	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ □	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma		counts)	
•	a		ite participation guaran	,	
	u		· · · · · · · · · · · · · · · · · · ·		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)	7c(5)		
		>			
		(6)Total additions		7c(6)	0
	d .	Total of balance and additions (add b and c(6)).			
		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)	0	
		(4) Other (specify below)	. 70(4)	-	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)			

Page 4	
nployer(s) or members of the same en prience-rated as a unit. Where contra- is a unit for purposes of this report.	
c Vision g Supplemental unemployment k PPO contract	d X Life insura h ☐ Prescripti l ☐ Indemnity

		If more than one contract covers the same gr information may be combined for reporting po the entire group of such individual contracts of	irposes if such contracts a	re experienc	ce-rated as a unit. Whe	ere contract	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disability	/ g	Supplemental unemp	loyment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Expe	erience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)			7
		(2) Increase (decrease) in amount due but unpaid	ı	` '			1
		(3) Increase (decrease) in unearned premium res	_	• • •			1
		(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	<u> </u>	9c(1)(B)			<u> </u>
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	<u> </u>	9c(1)(D)			<u> </u>
		(E) Taxes	<u> </u>	9c(1)(E)			<u> </u>
		(F) Charges for risks or other contingencies.	L	9c(1)(F)			_
		(G) Other retention charges		9c(1)(G)	ı		
		(H) Total retention			i	9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	enefits 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	in c(2) .)		9e	
10	No	nexperience-rated contracts:			,		
	_	Total premiums or subscription charges paid to o			ŀ	10a	
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b	
	Sp	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

Part III

Welfare Benefit Contract Information

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2009

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2).				Inspection			
For calendar plan year 200	09 or fiscal pla	n year beginning 07/01/2009)	and er	nding <mark>06</mark>	6/30/2010	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	CENTER FLEXIBLE BENEFIT	PLAN		e-digit number (P	N) •	502
	Plan sponsor's name as shown on line 2a of Form 5500. MOUNTAIN COMPREHENSIVE CARE CENTER D Employer Identification Number (EIN) 61-0663787						
	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		NCE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)) From	(g) To
57-0144607	62049	E7817000	12	22	07/01/20	009	06/30/2010
2 Insurance fee and compute descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	st in item 3	the agents	s, brokers, and o	ther persons in
(a) Total a	amount of com	<u> </u>		(b) To	tal amount	of fees paid	
	11624						
3 Persons receiving com		ees. (Complete as many entrie					
	(a) Name a	and address of the agent, broke	r, or other person to whor REGENCY CIRCLE	m commiss	ions or fees	s were paid	
MARY DUFF			INGTON, KY 40503				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose			(e) Organization code
	4040	1123					
	(a) Name a	and address of the agent, broke	r or other person to who	m commiss	ions or fee	s were naid	
THELMA F. BOSWELL	(a) Name (BEAMS DRIVE	11 00111111133	10113 01 100	3 Were paid	
HARRODSBURG, KY 40330							
(b) Amount of sales ar commissions pai			ees and other commission				(e) Organization code
commissions par		(c) Amount		(d) Purpose	-		(e) Organization code
	1843	41					

Schedule A (Form 5500) 2	2009	Page 2- 1			
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	d		
CREECH AND STAFFORD INS AGO	1 1110	HIGH STREET NGTON, KY 40513			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
1480	0				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	<u></u>		
JOHN ROBERTS FINCH	243 R	REGENCY CIRCLE			
	LEAII	NGTON, KY 40503			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
1153	69				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	d		
BB&T INSURANCE SERVICES INC		GALLIMORE DAIRY ROAD ENSBORO, NC 27409			
	OKEL	27403			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
1054	45				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	d		
MCGOHAN BRABENDER AGCY INC		SOUTH DIXIE DRIVE FON, OH 45439			
	D/(11	ON, OT 40400			
			1		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
656	0				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	d		
DARRELL L. PATTON		OX 925 STONSBURG, KY 41653			
	TREC	71 CNOBONO, NT 41000			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
413	0				

Schedule A (Form 5500) 2	009	Page 2- 2	
(a) Nar	me and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
DEE ANN SLADE	104 P	OTOMAC COURT KFORT, KY 40601	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
292	14		
(a) Nar		r, or other person to whom commissions or fees were pa	id
LOUIS LERMAN		SURREY RIDGE ROAD KSVILLE, TN 37043	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
164	107		
(a) Nar	ne and address of the agent broke	r, or other person to whom commissions or fees were pa	id.
ANNE OWENS	1516	DEER LAKE DRIVE IGTON, KY 40515	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
167	73		
(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were pa	id
LISA GRAVES	1400 (GLENNS CREEK RD KFORT, KY 40601	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	y	r, or other person to whom commissions or fees were pa	id
CATHY M. LERMAN	2985 : CLAR	SURREY RIDGE ROAD KSVILLE, TN 37043	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
45	17		

Schedule A (Form 5500) 2	2009	Page 2- 3	
(a) No	me and address of the agent broke	er, or other person to whom commissions or fees were paid	A
MARK HOLLAND	PO B	OX 38366 MANTOWN, TN 38183	J
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
60	(c) Amount	(u) i dipose	couc
(a) Na BENJAMIN BARTLETT GAUNT	6923	er, or other person to whom commissions or fees were paid FALLEN LEAF CIRCLE SVILLE, KY 40241	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 47	(c) Amount	(d) Purpose	code
		er, or other person to whom commissions or fees were paid	d
BART GAUNT		OX 6118 SVILLE, KY 40206	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 47	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	l
CAROL LAMB	309 F	OX HARBOUR DR NGTON, KY 40517	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 15	(c) Amount	(d) Purpose	code
433			
JAMES P. BARTA	215 V	er, or other person to whom commissions or fees were paid VOOD ROAD	<u>d</u>
	LOUR	SVILLE, KY 40222	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Schedule A (Form 5500) 2	009	Page 2- 4	
(a) Nar	ne and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
KAREN TOBIAS		MB 308 RANKLIN, TN 37069	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
6		0	
(a) Nar	ne and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
WENDY S. CASE	1	18 PROMONADE CT. OUISVILLE, KY 40223	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
2		0	
(a) Nar	ne and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
NORMA J. DAVIS	20	69 RUFFIAN TRAIL ORBIN, KY 40701	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
2		0	
(a) Nar	ne and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
MICHAEL J. BOONE	1(0200 FOREST GREEN BOULEVARD OUISVILLE, KY 40223	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1		0	
(a) Nar	ne and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
CONNIE OSBORNE	11	18 WHITTINGTON CIRCLE ICHMOND, KY 40475	
		Face and althous according to a self-	I
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
1	1.,	0	

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4	
nployer(s) or members of the same en erience-rated as a unit. Where contracts as a unit for purposes of this report.	
c ☐ Visiong ☐ Supplemental unemploymentk ☐ PPO contract	d 🛛 Life insurar h 📗 Prescription l 📗 Indemnity of

Pá	art III	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts with the entire group of the entir					s cover individual employees,
8	Bene	ofit and contract type (check all applicable boxes)	·		· · ·		
	а	Health (other than dental or vision)	b Dental	с	Vision		d X Life insurance
	e [Temporary disability (accident and sickness)	f Long-term disability	<u> </u>	Supplemental unem		h Prescription drug
		<u> </u>		·	1	oloyment	
	' _	Stop loss (large deductible)	j HMO contract	k_	PPO contract		I Indemnity contract
	m	Other (specify)					
_	F	de la companya de la					
9		rience-rated contracts:	Γ	0-(4)			
		Premiums: (1) Amount received	F	9a(1)			-
		(2) Increase (decrease) in amount due but unpaid	Ī	9a(2)			-{
		(3) Increase (decrease) in unearned premium res	<u>-</u>	, , , , , , , , , , , , , , , , , , , 		02/4)	
		(4) Earned ((1) + (2) - (3))	T T	9b(1)		9a(4)	
		Benefit charges (1) Claims paid	-	9b(1) 9b(2)			-
		(2) Increase (decrease) in claim reserves(2) Increase (decrease) and (4) and (2)	<u>-</u>			9b(3)	
		(3) Incurred claims (add (1) and (2))(4) Claims charged				9b(3) 9b(4)	
		Remainder of premium: (1) Retention charges (o				35(4)	
	U	(A) Commissions	, , , , , , , , , , , , , , , , , , ,	9c(1)(A)			1
		(B) Administrative service or other fees	ħ.	9c(1)(B)			1
		(C) Other specific acquisition costs	ħ.	9c(1)(C)			1
		(D) Other expenses	-	9c(1)(D)			
		(E) Taxes	F	9c(1)(E)			
		(F) Charges for risks or other contingencies	<u> </u>				1
		(G) Other retention charges	-	9c(1)(G)			1
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)		
		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	Nor	nexperience-rated contracts:				•	
		Total premiums or subscription charges paid to c	arrier			10a	78315
	b	If the carrier, service, or other organization incurr	ed any specific costs in co	onnection wit	h the acquisition or		
		retention of the contract or policy, other than repo	orted in Part I, item 2 abov	e, report am	ount	. 10b	
	Sp	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

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 20	09 or fiscal pla	an year beginning 07/01/2009	9	and er	nding 06	/30/2010	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	E CENTER FLEXIBLE BENEFIT	PLAN		e-digit number (Pl	N) •	502
C Plan sponsor's name a MOUNTAIN COMPREHE				D Emplo	-	ation Number	(EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		JCKY					
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
61-1237516	95120	202661-00202664	49	98	07/01/20	09	06/30/2010
2 Insurance fee and com 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
(a) Total amount of commissions paid (b) Total amount of fees paid							
		9325					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		m commiss	ions or fees	were paid	
CREECH AND STAFFOR	RD INS AGCY		E HIGH STREET #201 KINGTON, KY 40507				
(b) Amount of sales ar	ad basa	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	9325						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F	ees and other commission	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		
	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		

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

Page 4		

Pa	rt I	I Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the urposes 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 X 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	Stop loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract
	m	Other (specify)	_	_	-		_
9	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpai	d	9a(2)			
		(3) Increase (decrease) in unearned premium re-					
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		. 9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		0 (4)(0)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (<u>—</u>			9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do r				9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to	carrier			10a	110130
	b	If the carrier, service, or other organization incur	red any specific costs in o	connection wit	th the acquisition or		
		retention of the contract or policy, other than rep	orted in Part I, item 2 abo	ve, report am	ount	. 10b	
	S	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	× 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 20	09 or fiscal pla	an year beginning 07/01/2009	9	and er	nding 06	/30/2010	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	E CENTER FLEXIBLE BENEFIT	PLAN		e-digit number (PI	N) •	502
C Plan sponsor's name a MOUNTAIN COMPREHE				D Emplo	-	ation Number	(EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		JCKY					
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
61-1237516	95120	202661-00202664	3	48	07/01/20	009	06/30/2010
2 Insurance fee and com 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
(a) Total amount of commissions paid (b) Total amount of fees paid							
_		2512					0
3 Persons receiving com		fees. (Complete as many entrie					
CREECH AND STAFFOR			er, or other person to who E HIGH STREET #201 KINGTON, KY 40507	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	2512						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
	(L) Hame	and addition of the agon, went	., c. c percent to			word para	
(b) Amount of sales ar	nd hase	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) 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				

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

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(-)	

	Schedule A	(Form 5500)	2009
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Pa	art I	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts to	oup of employees of the surposes if such contracts	are experienc	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	CX	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ty g [Supplemental unem	ployment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	ł	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				. 9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				. 9b(4)		_
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)	r				
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies.						
		(G) Other retention charges		9c(1)(G)		1		
		(H) Total retention		·····		. 9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	. 9d(1)		
		(2) Claim reserves				. 9d(2)		
		(3) Other reserves				. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in c(2) .)		. 9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o	arrier			. 10a	2530)2
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than repo	, .		•	. 10b		
	S	pecify nature of costs						

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

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

nursuant to FDICA continu 402(a)(2)					Form is Open to Public Inspection	
For calendar plan year 20	09 or fiscal pla	n year beginning 07/01/2009)	and end	ding 06/30/2010	- P
A Name of plan MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT PLAN B Three-digit plan number (PN)						502
C Plan sponsor's name a MOUNTAIN COMPREHE				D Employ 61-0663	rer Identification Numb 3787	er (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:		<u> </u>		•		
(a) Name of insurance ca		CKY				
		<u> </u>	(e) Approximate nun	nher of	Policy o	or contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at a policy or contract y	end of	(f) From	(g) To
61-1237516	95120	202661-00202664	284	1	07/01/2009	06/30/2010
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid						
55972 0						
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).						
					ons or fees were paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid CREECH AND STAFFORD INS AGCY INC 465 E HIGH STREET #201 LEXINGTON, KY 40507						
(h) Amount of color or	nd book	Fe	ees and other commissions	s paid		
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose			(e) Organization code
55972						
	(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	Fe	ees and other commissions	s paid		
commissions pa		(c) Amount	(0	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				

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts with each c	arrier may be treated as a unit for	purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e		_	
_		racts With Allocated Funds:	-	···1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan check here	▶ ∏	
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accou	ints)	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te participation guarantee		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year			
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add b and c(6))		7d	
	-	Deductions:	= (4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year			
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	7e(3)	0	
		(4) Other (specify below)	. 7e(4)	U	
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		7f	

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Schedule A (Fo	//// (UUS 2005
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Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts to	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Wh	nere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term 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	Ехр	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	1	9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		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)			
		(H) Total retention	<u></u>	<u></u>		. 9c(1)(H)
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	. 9d(1)	
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in c(2) .)		. 9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to o	arrier			. 10a	1100461
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	, ,		•	. 10b	
	Sp	pecify nature of costs					

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