#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**HERE** 

Signature of DFE

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public

					Inspection	15110	
Part I	Annual Report Identif						
For cale	ndar plan year 2010 or fiscal pla		<b>—</b>	and ending 12/31	/2010		
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
		a single-employer plan;	a DFE (s	pecify)			
<b>B</b> This	return/report is:	the first return/report;	the final	return/report;			
	·	x an amended return/report;	a short p	lan year return/report (less	than 12 months).		
C If the	plan is a collectively-bargained	plan, check here	<u>—</u>		• □		
	,	Form 5558:		c extension;	the DFVC program;		
D Chec	k box if filing under:	H	ш	c exterision,	I the bi vo program,		
_		special extension (enter des					
Part		tion—enter all requested informa	ation		T 44	1	
	ne of plan	U OENTER OROUR HEALTH AN		EITO DI ANI	<b>1b</b> Three-digit plan number (PN) ▶	501	
PEACE	HEALTH SOUTHWEST MEDICA	AL CENTER GROUP HEALTH AN	ID WELFARE BENE	FITS PLAN	1c Effective date of pla	an	
					10/01/1977		
		employer, if for a single-employer	plan)		2b Employer Identification		
•	ress should include room or suit	· ·			Number (EIN)		
PEACE	HEALTH SOUTHWEST MEDICA	AL CENTER			91-6068143		
	DECOLIDATE				2c Sponsor's telephon number	ne	
	RESOURCES				360-514-2097		
PO BOX VANCO	. 1600 JVER, WA 98668	PO BOX 1 VANCOU	∣600 √ER, WA 98668		2d Business code (see		
	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		instructions)		
					622000		
Caution	: A penalty for the late or inco	mplete filing of this return/repor	t will be assessed	unless reasonable cause	is established.		
Under pe	enalties of perjury and other pen	alties set forth in the instructions,	declare that I have	examined this return/report	, including accompanying sche	dules,	
statemer	nts and attachments, as well as t	the electronic version of this return	n/report, and to the b	est of my knowledge and b	elief, it is true, correct, and com	nplete.	
SIGN	Filed with authorized/valid electr	onic signature.	10/26/2011	CHRISTINE FULLERTO	N		
HERE	Signature of plan administra	tor	Date	Enter name of individual signing as plan administrator			
					<u> </u>		
SIGN							
HERE	Signature of employer/plan s	snonsor	Date	Enter name of individual	signing as employer or plan sp	oneor	
	Signature of employer/plans	pponsor	Date	Litter Harrie Or Hidridual	aigining as employer or plan sp	011901	
SIGN							

Date

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

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2010) Page **2** 

	Plan administrator's name and address (if same as plan sponsor, enter "San ACEHEALTH SOUTHWEST MEDICAL CENTER		<b>3b</b> Administrator's EIN 91-6068143		
PO	MAN RESOURCES BOX 1600 NCOUVER, WA 98668	3c Administrator's telephone number 360-514-2097			
	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:  Sponsor's name	n/report filed for this plan, enter the name, EIN	and	<b>4b</b> EIN 91-6068143 <b>4c</b> PN	
50 5	UTHWEST WASHINGTON MEDICAL CENTER  Total number of participants at the beginning of the plan year			501	
6	Number of participants as of the end of the plan year (welfare plans complet	e only lines 6a 6b 6c and 6d)	5	3102	
	Transor of paraoparito do of the one of the plan year (notice plane complete	5 5 m y m 155 5 <b>5 a</b> , 5 <b>5 ,</b> 5 and 5 <b>a</b> /.			
а	Active participants		6a	2959	
b	Retired or separated participants receiving benefits		6b		
•	Other retired or separated participants entitled to future benefits		6c	68	
С			00	00	
d	Subtotal. Add lines 6a, 6b, and 6c.		6d	3027	
е	Deceased participants whose beneficiaries are receiving or are entitled to re	6e			
f	Total. Add lines <b>6d</b> and <b>6e</b>	. 6f	3027		
g	Number of participants with account balances as of the end of the plan year	C			
	complete this item)		. 6g		
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h		
7	Enter the total number of employers obligated to contribute to the plan (only		7		
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List of Plan Characteristic Code	s in the	instructions:	
	f the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H 4I 4L				
9a	Plan funding arrangement (check all that apply)  (1)   Insurance	9b Plan benefit arrangement (check all that (1) Insurance	at apply)		
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)		ce contracts	
	(3) Trust	(3) Trust			
10	(4) General assets of the sponsor  Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4) General assets of the spatial department		thed (See instructions)	
а	Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) SB (Single-Employer Defined Benefit Plan Actuarial	b General Schedules (1) H (Financial Inform (2) I (Financial Inform (3) X 4 A (Insurance Inform (4) C (Service Provide (5) D (DFE/Participati	nation) nation – mation) er Inform	Small Plan)	
	Information) - signed by the plan actuary	(6) G (Financial Trans	•	,	

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

	Form is Open to Public Inspection						
For calendar plan year 20	10 or fiscal pla	an year beginning 01/01/2010	ar	nd ending 12/31/2010			
A Name of plan PEACEHEALTH SOUTH BENEFITS PLAN	WEST MEDIC	CAL CENTER GROUP HEALTH	AND WELEADE	Three-digit plan number (PN)	501		
C Plan sponsor's name as shown on line 2a of Form 5500.  PEACEHEALTH SOUTHWEST MEDICAL CENTER  D Employer Identification Number (EIN) 91-6068143							
on a separat	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca		OF NORTH AMERICA					
(b) EINI	(c) NAIC	(d) Contract or	(e) Approximate number of		or contract year		
<b>(b)</b> EIN	code	identification number	persons covered at end o policy or contract year	(f) From	<b>(g)</b> To		
23-1503749	65498	OK964714	968	01/01/2010	12/31/2010		
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							
2782							
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all person	s).			
	(a) Name	and address of the agent, broke		missions or fees were paid			
SPONG & ASSOCIATES	, INC.		BOX 93485 DENIX, AZ 85070				
(b) Amount of sales ar	nd base	F	ees and other commissions paid				
commissions pa		(c) Amount	<b>(d)</b> Pur	(e) Organization code			
	2782				3		
	(a) Name	and address of the agent, broke	r, or other person to whom com	missions or fees were paid			
	(a) Hamo	and address of the agont, broke	r, or ourse person to union cons	moderno er rece wore paid			
(b) Amount of sales ar	nd base	F	ees and other commissions paid				
commissions pa	id	(c) Amount	<b>(d)</b> Pur	pose	(e) Organization code		

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(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	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	(e) Organization code		
	(o) runount		(d) Purpose	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with th	ne acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ched	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	•		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
	_	(6)Total additions			7c(6)	
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(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)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page	4

Schedule A (Form	เ ออบบ	) ZUTU
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Pa	rt II	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 urpos	of employees of the ses if such contracts	are experienc	ce-rated as a unit. Wh	nere contrac	
8	Ben	efit and contract type (check all applicable boxes		<u></u>	_	_		_
	а	Health (other than dental or vision)	b	Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f	Long-term disabili	ty <b>g</b>	Supplemental unem	ployment	h Prescription drug
	i	Stop loss (large deductible)	ΙĪ	HMO contract	k	PPO contract		I Indemnity contract
	m	_	•		<u> </u>	J		
	L	Guier (Specify)						
9	Exne	rience-rated contracts:						
•		Premiums: (1) Amount received			9a(1)			_
	_	(2) Increase (decrease) in amount due but unpai						
		(3) Increase (decrease) in unearned premium re						
		(4) Earned ((1) + (2) - (3))					. 9a(4)	
	b	Benefit charges (1) Claims paid					., ••(.)	
		(2) Increase (decrease) in claim reserves			1			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )					. 9b(3)	
		(4) Claims charged					9b(4)	
	С	Remainder of premium: (1) Retention charges (					•(.)	
	•	(A) Commissions		•	9c(1)(A)			7
		(B) Administrative service or other fees			9c(1)(B)			7
		(C) Other specific acquisition costs			- (()(-)			7
		(D) Other expenses			9c(1)(D)			7
		(E) Taxes			0 (4)(5)			7
		(F) Charges for risks or other contingencies						
		(G) Other retention charges			0 (4)(0)			
		(H) Total retention					. 9c(1)(H	)
		(2) Dividends or retroactive rate refunds. (These		_				
	d	Status of policyholder reserves at end of year: (						
	<u>.</u>	(2) Claim reserves						
		(3) Other reserves						
	е	Dividends or retroactive rate refunds due. (Do r						
10	_	nexperience-rated contracts:	000	sidde difficulti criteres	3 III <b>0(2)</b> ./		., 50	
. •	a	Total premiums or subscription charges paid to	carrie	er			. 10a	86679
	b	If the carrier, service, or other organization incur						
		retention of the contract or policy, other than rep					. 10b	
	Sp	ecify nature of costs						
	Ċ	•						
Pa	rt I	/ Provision of Information						

Yes

No

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **Insurance Information**

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Pension Benefit Guaranty Co	orporation		s are required to provide o ERISA section 103(a)(2		ion	This For	m is Open to Public Inspection
For calendar plan year 20	-						
A Name of plan PEACEHEALTH SOUTH BENEFITS PLAN	WEST MEDIC	CAL CENTER GROUP HEALTH	AND WELFARE		e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name a PEACEHEALTH SOUTH				<b>D</b> Emplo 91-606		ation Number	(EIN)
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:							
(a) Name of insurance ca		OF NORTH AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or co	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
23-1503749	65498	FLK960421	2959 01/01/2		01/01/20	10	12/31/2010
2 Insurance fee and com descending order of the		mation. Enter the total fees and t	otal commissions paid. I	ist in item 3	the agents,	, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		21555					
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
<u> </u>		and address of the agent, broke			ions or fees	were paid	
SPONG & ASSOCIATES	, INC.		BOX 93485 OENIX, AZ 85070				
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code
	21555						3
	(a) Name	and address of the agent, broke	or other person to who	m commiss	ions or fees	were naid	
	(a) Name	and address of the agent, broke	or, or other person to whe	iii commiss	10113 01 1003	were paid	
(b) Amount of sales ar	nd base	<u> </u>	ees and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(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	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	(e) Organization code		
	(o) runount		(d) Purpose	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with th	ne acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ched	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	•		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
	_	(6)Total additions			7c(6)	
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(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)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page	4

Schedule A	(Form	5500	2010

	If more than one contract covers the same gr	oud of emblovees of the				- l ( /- )
	the entire group of such individual contracts	urposes if such contracts	are experien	ce-rated as a unit. V	Vhere contrac	ployee organization(s), the ts cover individual employees,
8 Ber	nefit and contract type (check all applicable boxes)					
а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabi	<u> </u>	<u></u>	mployment	h Prescription drug
i İ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)	, 🗆	[	]		
0 Evn	erience-rated contracts:					
	Premiums: (1) Amount received		9a(1)			
u	(2) Increase (decrease) in amount due but unpaid					
	(3) Increase (decrease) in unearned premium res					
	(4) Earned ((1) + (2) - (3))				9a(4)	
b	Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves		(-)			
	(3) Incurred claims (add (1) and (2))				9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (c	n an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs					
	(D) Other expenses					
	(E) Taxes					
	(F) Charges for risks or other contingencies.					
	(G) Other retention charges					
	(H) Total retention	_				)
	(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	e benefits after	retirement		
	(2) Claim reserves					
	(3) Other reserves					
<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entere	ed in <b>c(2)</b> .)		9e	
	onexperience-rated contracts:				4.0	499853
	Total premiums or subscription charges paid to d				<u>10a</u>	499033
b	If the carrier, service, or other organization incurrent or of the contract or policy, other than rep	, ,		•	10b	

No

Yes

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

**Provision of Information** 

Part IV

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

	orm is Open to Public Inspection			
For calendar plan year 2010 or fiscal p	lan year beginning 01/01/2010	and er	nding 12/31/2010	
A Name of plan PEACEHEALTH SOUTHWEST MEDI BENEFITS PLAN	CAL CENTER GROUP HEALTH AN	ID WELEADE	e-digit number (PN)	501
C Plan sponsor's name as shown on I PEACEHEALTH SOUTHWEST MEDI		<b>D</b> Emplo 91-606	oyer Identification Number 58143	(EIN)
on a separate Schedule A	rning Insurance Contract C A. Individual contracts grouped as a			
1 Coverage Information:				
(a) Name of insurance carrier CIGNA LIFE INSURANCE COMPANY	OF NORTH AMERICA			
(c) NAIC		(e) Approximate number of	Policy or	contract year
(b) EIN (c) NAIC code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To
23-1503749 65498	VDT960515	933	01/01/2010	12/31/2010
2 Insurance fee and commission infor descending order of the amount paid		I commissions paid. List in item 3	the agents, brokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid				
15420				
3 Persons receiving commissions and	I fees. (Complete as many entries a	as needed to report all persons).		
<b>(a)</b> Name	e and address of the agent, broker, o		ions or fees were paid	
SPONG & ASSOCIATES, INC.		0X 93485 NIX, AZ 85070		
(b) Amount of sales and base	Fees	s and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	e	(e) Organization code
15420				3
	and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
	·		·	
(b) Amount of sales and base Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	e	(e) Organization code

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(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	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with th	ne acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ched	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	•		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
	_	(6)Total additions			7c(6)	
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(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)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page	4

Schedule A (Form	เ ออบบ	) ZUTU
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Part III Welfare Benefit Contract Info If more than one contract covers the sa information may be combined for repor the entire group of such individual cont	ame group of employees of the ting purposes if such contracts	s are experienc	e-rated as a unit. Who	ere contrac	
8 Benefit and contract type (check all applicable b	ooxes)		_		_
<b>a</b> Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
e X Temporary disability (accident and sickne	ess) <b>f</b> Long-term disabi	lity <b>g</b>	Supplemental unemp	oloyment	<b>h</b> Prescription drug
i Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
m ☐ Other (specify) ▶	<i>,</i>	_	ı		_ ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			_
(2) Increase (decrease) in amount due but		<del></del>			
(3) Increase (decrease) in unearned premiu					
(4) Earned ((1) + (2) - (3))				9a(4)	
<b>b</b> Benefit charges (1) Claims paid					
(2) Increase (decrease) in claim reserves					
(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
(4) Claims charged				9b(4)	
<b>c</b> Remainder of premium: (1) Retention char	ges (on an accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees		. (1)(5)			
(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 continger	ncies				
(G) Other retention charges		. 9c(1)(G)			
(H) Total retention				9c(1)(H)	)
(2) Dividends or retroactive rate refunds. (	These amounts were paid	in cash, or	credited.)	9c(2)	
<b>d</b> Status of policyholder reserves at end of ye	ear: (1) Amount held to provide	e benefits after	retirement	9d(1)	
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
<b>e</b> Dividends or retroactive rate refunds due.	(Do not include amount entere	ed in <b>c(2)</b> .)		9e	
<b>10</b> Nonexperience-rated contracts:					
a Total premiums or subscription charges pa	id to carrier			10a	493711
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount					
Specify nature of costs					
Part IV Provision of Information					

Yes

No

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

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

mmar. and to FDICA ===tion 400(=)(0)				n is Open to Public Inspection			
For calendar plan year 20	10 or fiscal pl	an year beginning 01/01/201	0	and en	nding 12	/31/2010	
A Name of plan PEACEHEALTH SOUTH BENEFITS PLAN	WEST MEDIC	CAL CENTER GROUP HEALTH	AND WELFARE		e-digit number (PI	v) <b>•</b>	501
C Plan sponsor's name a PEACEHEALTH SOUTH				<b>D</b> Employ 91-606	-	ation Number (I	EIN)
		rning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		OF NORTH AMERICA  (d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	•	persons covered at end of policy or contract year		From	<b>(g)</b> To
23-1503749	65498	FLX963053	295	,	01/01/20	110	12/31/2010
2 Insurance fee and composition descending order of the		nation. Enter the total fees and t	otal commissions paid. Li	st in item 3	the agents	, brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
23843							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
		and address of the agent, broke		m commissi	ons or fees	were paid	
SPONG & ASSOCIATES	SPONG & ASSOCIATES, INC.  PO BOX 93485 PHOENIX, AZ 85070						
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code
	23843						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
(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 commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos wore paid	
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(b) Amount of sales and base		Fees and other commission		(e) Organization
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(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(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	
(a) 110	and and address of the agent, prone	w, or other percent to whem	commissions of 1000 were paid	
		Fees and other commission	an noid	
(b) Amount of sales and base commissions paid	(c) Amount	rees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	idual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with th	ne acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan ched	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
			ate participation	•		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
	_	(6)Total additions			7c(6)	
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(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)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
		Balance at the end of the current year (subtract <b>e(5)</b> from <b>d</b> )			7f	

Page	4

		If more than one contract covers the same grant information may be combined for reporting p the entire group of such individual contracts.	roup of employees of the surposes if such contracts	are experien	ce-rated as a unit. Wh	ere contrac	
8	Ben	efit and contract type (check all applicable boxes)		Todica as a c	inition purposes of this	з тероп.	
	a 「	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> X Life insurance
	-	<b>■</b>	<u>.</u> ∺	L	<u> </u>		
	e [ 	Temporary disability (accident and sickness)	f ∐ Long-term disabili	´ -	Supplemental unem	pioyment	h ☐ Prescription drug
	ַ י	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
<b>9</b> [	Ехре	erience-rated contracts:					
	a I	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	b	9a(2)			
		(3) Increase (decrease) in unearned premium res	serve	9a(3)		1	
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (c	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				00(4)(H)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention	_			. 9c(1)(H)	<u>'</u>
		(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)					
	d						
		(2) Claim reserves				. 9d(2)	
	_	(3) Other reserves				. 9d(3)	
40	<u>e</u>	( ) ( )				9e	
10		nexperience-rated contracts:				40-	725601
		Total premiums or subscription charges paid to carrier				. 10a	723001
	b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisitio retention of the contract or policy, other than reported in Part I, item 2 above, report amount				10b	
	Sn	acify nature of costs					
	Sp	ecify nature of costs					

Yes

No

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

**Provision of Information** 

Part IV