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

2010

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [ ] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
HOME HEALTH RESOURCES, INC., PENSION PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 07/01/1998

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
LEXINGTON TWO, INC. DBA HOME HEALTH RESOURCES, INC.

1216 PLEASANT VALLEY BLVD.
ALTOONA, PA 16602

2b Employer Identification Number (EIN) 25-1555689

2c Sponsor's telephone number 814-941-1619

2d Business code (see instructions) 621610

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	04/06/2012	JOSEPH FROMKNECHT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	04/06/2012	JOSEPH FROMKNECHT
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
LEXINGTON TWO, INC. DBA HOME HEALTH RESOURCES, INC.

1216 PLEASANT VALLEY BLVD.
ALTOONA, PA 16602

3b Administrator's EIN
25-1555689

3c Administrator's telephone number
814-941-1619

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

5	Total number of participants at the beginning of the plan year	**5**	78
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**	57
b	Retired or separated participants receiving benefits	**6b**	7
c	Other retired or separated participants entitled to future benefits	**6c**	7
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	71
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	1
f	Total. Add lines **6d** and **6e**	**6f**	72
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**	1
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
1A 1G 3H

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

9a Plan funding arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

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

b General Schedules

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

SCHEDULE 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

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

▶ **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
HOME HEALTH RESOURCES, INC., PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF
LEXINGTON TWO, INC. DBA HOME HEALTH RESOURCES, INC.

D Employer Identification Number (EIN)
25-1555689

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [ ] 100 or fewer [ ] 101-500 [X] More than 500

Part I Basic Information

1	Enter the valuation date: Month 07 Day 01 Year 2010			
2	Assets:			
a	Market value	2a		893750
b	Actuarial value	2b		911986
3	Funding target/participant count breakdown		(1) Number of participants	(2) Funding Target
a	For retired participants and beneficiaries receiving payment	3a	7	182673
b	For terminated vested participants	3b	6	72729
c	For active participants:			
	(1) Non-vested benefits	3c(1)		18112
	(2) Vested benefits	3c(2)		556918
	(3) Total active	3c(3)	49	575030
d	Total	3d	62	830432
4	If the plan is at-risk, check the box and complete items (a) and (b) [ ]			
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		6.64 %
6	Target normal cost	6		139105

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

	03/26/2012
Signature of actuary	Date
JON S. KETZNER, FCA, MAAA	11-01826
Type or print name of actuary	Most recent enrollment number
CBIZ	301-777-1500
Firm name	Telephone number (including area code)
44 BALTIMORE STREET CUMBERLAND, MD 21502	
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)	11651	75
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)	11651	75
10	Interest on item 9 using prior year's actual return of 11.04 %	1286	8
11	Prior year's excess contributions to be added to prefunding balance:		
	a Excess contributions (Item 38 from prior year)		853
	b Interest on (a) using prior year's effective rate of 7.67 %		65
	c Total available at beginning of current plan year to add to prefunding balance		918
	d Portion of (c) to be added to prefunding balance		918
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)	12937	1001

Part III Funding percentages

14	Funding target attainment percentage	14	108.14 %
15	Adjusted funding target attainment percentage	15	109.82 %
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	107.69 %
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
03/14/2012	85000				
			Totals ► 18(b)	85000	18(c) 0

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	76180

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No

b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ 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:	2nd segment:	3rd segment:	
4.44 %	6.62 %	6.74 %	☐ N/A, full yield curve used

b Applicable month (enter code) **21b** 4

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** 71489

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** 71489

	Carryover balance	Prefunding balance	Total balance
35 Balances used to offset funding requirement	0	0	0

36 Additional cash requirement (item 34 minus item 35)..... **36** 71489

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c)..... **37** 76180

38 Interest-adjusted excess contributions for current year (see instructions)..... **38** 4691

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

SCHEDULE I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

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

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

A Name of plan
HOME HEALTH RESOURCES, INC., PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
LEXINGTON TWO, INC. DBA HOME HEALTH RESOURCES, INC.

D Employer Identification Number (EIN)
25-1555689

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.**

			(a) Beginning of Year	**(b)** End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	**1a**	896454	1159426
b	Total plan liabilities	**1b**		
c	Net plan assets (subtract line 1b from line 1a)	**1c**	896454	1159426
2	**Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a	Contributions received or receivable:			
	(1) Employers	**2a(1)**	85000	
	(2) Participants	**2a(2)**		
	(3) Others (including rollovers)	**2a(3)**		
b	Noncash contributions	**2b**		
c	Other income	**2c**	204799	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	**2d**		289799
e	Benefits paid (including direct rollovers)	**2e**	16726	
f	Corrective distributions (see instructions)	**2f**		
g	Certain deemed distributions of participant loans (see instructions)	**2g**		
h	Administrative service providers (salaries, fees, and commissions)	**2h**	8299	
i	Other expenses	**2i**	1802	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	**2j**		26827
k	Net income (loss) (subtract line 2j from line 2d)	**2k**		262972
l	Transfers to (from) the plan (see instructions)	**2l**		

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	**No**	**Amount**
a	Partnership/joint venture interests	**3a**		X	
b	Employer real property	**3b**		X	
c	Real estate (other than employer real property)	**3c**		X	
d	Employer securities	**3d**		X	
e	Participant loans	**3e**		X	

			Yes	No	Amount
3f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Compliance Questions

4 During the plan year:		Yes	No	Amount
a 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.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e	X		100000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g 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?	4g		X	
h 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?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n 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	4n			

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:**

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)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.**

OMB No. 1210-0110

2010

This Form is Open to Public Inspection.

For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

A Name of plan
HOME HEALTH RESOURCES, INC., PENSION PLAN

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
LEXINGTON TWO, INC. DBA HOME HEALTH RESOURCES, INC.

D Employer Identification Number (EIN)
25-1555689

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): 16-6265706

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):

---

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):

Schedule SB, line 22 - Description of Weighted Average Retirement Age

EIN: 25-1555689

PN: 002

Plan Name: Home Health Resources, Inc. Pension Plan

Age	Retirement Rate	Retirement Probability	Weighted Age
65	100.00%	1.0000	65.00
Total		1.0000	65.00

Home Health Resources, Inc.
Pension Plan
Actuarial Report for the Plan Year Beginning July 1, 2010

Summary of Principal Actuarial Assumptions

Funding Method:	Traditional Unit Credit	
Actuarial Assumptions:		
Pre-retirement for Retirement and Spousal Benefits:		
Investment Return - Segment rates (4 month lookback)		
Sample Rates:	First segment	4.44%
	Second segment	6.62%
	Third segment	6.74%
Mortality:	2010 Combined Static Mortality	
Turnover:	None	
Salary Scale:	5.00%	
Retirement Rates:	Normal retirement age or attained age, if later	
Post-retirement for Retirement Benefits:		
Investment Return - Segment rates (4 month lookback)		
Sample Rates:	First segment	4.44%
	Second segment	6.62%
	Third segment	6.74%
Mortality:	2010 Combined Static Mortality	
Actuarial Value of Assets:	24 month average limited by 90%/110% corridor	
Assumed Form of Payment:	Five-year certain and life annuity	
Marital Assumptions:	85% of plan participants are married, and husbands are four years older than their wives.	
Effective Rate of Interest:	6.64%	

Home Health Resources, Inc.
Pension Plan
Actuarial Report for the Plan Year Beginning July 1, 2010

Summary of Principal Plan Provisions

Effective Date:	July 1, 1998
Plan Year:	July 1 through June 30
Eligibility:	
Minimum Age:	None
Entry Date*:	Immediate entry at date of hire
* Participation was frozen effective July 1, 2010	
Normal Retirement Age:	65
Normal Retirement Date:	The first day of the month coinciding with or next following the participant's 65th birthday.
Early Retirement Date:	The first day of the month coinciding with or next following the participant's attainment of age 55 with five years of vesting service.
Accrued Benefit:	A benefit commencing at Normal Retirement Date equal to: 1.50% of average monthly compensation times years of accrual service
Disability Benefit:	Actuarial equivalent of vested accrued benefit payable at Normal Retirement Date.
Year of Service:	A year of accrual and vesting service is credited for each plan year in which an employee completes at least 1,000 hours of service. Years of service prior to January 1, 1998 are excluded for benefit accrual purposes.
Normal Form of Benefit:	Five year certain and life annuity or actuarial equivalent joint and 50% spouse survivor annuity.
Compensation:	Total compensation, including overtime, flex benefit elections, bonuses and commissions. Final benefits are based on the average of the 60 highest consecutive months within the last 120 months preceding the date of determination.
Vesting:	The plan provides for no vesting until the completion of five years of service at which time the participant becomes 100% vested. Also, full vesting is provided upon the attainment of age 65.

Home Health Resources, Inc.
Pension Plan
Actuarial Report for the Plan Year Beginning July 1, 2010

Summary of Principal Plan Provisions

Other Benefits:	Benefits are payable to or on behalf of married vested participants who die prior to retirement, who become disabled and qualify for total disability benefits under the Plan and who retire early upon meeting the Plan's requirements for early retirement. Participants who continue with the company after reaching their Normal Retirement Age will generally accrue additional benefits.

Schedule SB, line 26 - Schedule of Active Participant Data
EIN/PN: 25-1555689 / 002

Home Health Resources, Inc.
Pension Plan
Actuarial Report for the Plan Year Beginning July 1, 2010

Schedule of Active Participant Data

Years of Service

Age	Under 1		1 to 4		5 to 9		10 to 14		15 to 19		20 to 24		25 to 29		30 to 34		35 to 39		40 & up	
	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.	No.	Avg. Comp.
Under 25	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25 to 29	0	0	7	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30 to 34	1	0	3	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35 to 39	0	0	3	0	3	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
40 to 44	0	0	4	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 49	1	0	6	0	3	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
50 to 54	0	0	3	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
55 to 59	2	0	2	0	3	0	3	0	1	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	1	0	1	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0
65 to 69	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70 & up	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Schedule SB, line 25 - Change in Method

EIN: 25-1555689
PN: 002
Plan Name: Home Health Resources, Inc. Pension Plan

As permitted by temporary regulations, the Plan's interest rate assumption was changed from the full yield curve to segment rates.

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

2010

This Form is Open to Public Inspection

For calendar plan year 2010 or fiscal plan year beginning 07/01/2010 and ending 06/30/2011

▶ **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

Home Health Resources, Inc. Pension Plan

B Three-digit plan number (PN) ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF

Lexington Two, Inc. dba Home Health Resources, Inc.

D Employer Identification Number (EIN)

25-1555689

E Type of plan: [X] Single [ ] Multiple-A [ ] Multiple-B

F Prior year plan size: [ ] 100 or fewer [ ] 101-500 [X] More than 500

Part I Basic Information

1	Enter the valuation date: Month 7 Day 1 Year 2010			
2	Assets:			
a	Market value	2a		893,750
b	Actuarial value	2b		911,986
3	Funding target/participant count breakdown		(1) Number of participants	(2) Funding Target
a	For retired participants and beneficiaries receiving payment	3a	7	182,673
b	For terminated vested participants	3b	6	72,729
c	For active participants:			
(1)	Non-vested benefits	3c(1)		18,112
(2)	Vested benefits	3c(2)		556,918
(3)	Total active	3c(3)	49	575,030
d	Total	3d	62	830,432
4	If the plan is at-risk, check the box and complete items (a) and (b) [ ]			
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		6.64 %
6	Target normal cost	6		139,105

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

03/26/2012
Date

Jon S. Ketzner, FCA, MAAA
Type or print name of actuary

11-01826
Most recent enrollment number

CBIZ
Firm name

(301)777-1500
Telephone number (including area code)

44 Baltimore Street

Cumberland MD 21502
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 [ ]

SB Actuary Signature

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)	11,651	75
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)	11,651	75
10	Interest on item 9 using prior year's actual return of 11.04 %	1,286	8
11	Prior year's excess contributions to be added to prefunding balance:		
	a Excess contributions (Item 38 from prior year)		853
	b Interest on (a) using prior year's effective rate of 7.67 %		65
	c Total available at beginning of current plan year to add to prefunding balance		918
	d Portion of (c) to be added to prefunding balance		918
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)	12,937	1,001

Part III Funding percentages

14	Funding target attainment percentage	14	108.14 %
15	Adjusted funding target attainment percentage	15	109.82 %
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	107.69 %
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
03/14/2012	85,000				
			Totals ► 18(b)	85,000	18(c) 0

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	76,180

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No

b If 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ 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:	2nd segment:	3rd segment:	☐ N/A, full yield curve used
4.44 %	6.62 %	6.74 %	

b Applicable month (enter code)	**21b**	4
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**		71,489
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**		71,489

	Carryover balance	Prefunding balance	Total balance
35 Balances used to offset funding requirement	0	0	0

36 Additional cash requirement (item 34 minus item 35)	**36**	71,489
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (Item 19c)	**37**	76,180
38 Interest-adjusted excess contributions for current year (see instructions)	**38**	4,691
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