Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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), 6057(b), 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

2011

This Form is Open to Public

					Inspection				
Part I	Annual Report Ident	ification Information							
For cale	ndar plan year 2011 or fiscal p	lan year beginning 07/01/2011	_	and ending 06/30/2	012				
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or					
	·	a single-employer plan;	a DFE (s	pecify)					
B This	return/report is:	the first return/report;		return/report;					
		an amended return/report;	a short p	lan year return/report (less th	an 12 months).				
C If the	plan is a collectively-bargaine	d plan, check here							
D Chec	k box if filing under:	Form 5558;	automati	c extension;	the DFVC program;				
		special extension (enter des	cription)						
Part	II Basic Plan Inform	ation—enter all requested informa	ation						
1a Nam	ne of plan	E CENTER FLEXIBLE BENEFIT PL			1b Three-digit plan number (PN) ▶	502			
					1c Effective date of plan 07/01/1995				
	sponsor's name and address	, including room or suite number (En	mployer, if for single	employer plan)	2b Employer Identifica Number (EIN) 61-0663787	tion			
					number	2c Sponsor's telephone number 606-886-8572			
	JTH FRONT AVENUE DNSBURG, KY 41653		104 SOUTH FRONT AVENUE PRESTONSBURG, KY 41653		2d Business code (see instructions) 621330				
Caution	: A penalty for the late or inc	complete filing of this return/repor	t 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.		10/16/2012	KATHY GOBLE					
HEKE	Signature of plan administ	rator	Date	Enter name of individual signing as plan administ					
SIGN HERE									
HERE	Signature of employer/plar	n sponsor	Date	Enter name of individual si	gning as employer or plan spo	onsor			
SIGN									

Date

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

Form 5500 (2011) v.012611

Enter name of individual signing as DFE

Form 5500 (2011) Page **2**

	Plan administrator's name and address (if same as plan sponsor, enter "Sam DUNTAIN COMPREHENSIVE CARE CENTER	61-	Administrator's EIN 61-0663787		
	4 SOUTH FRONT AVENUE ESTONSBURG, KY 41653				ministrator's telephone mber 606-886-8572
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for th	is plan, enter the name, EIN	and	4b EIN
а	Sponsor's name				4c PN
5	Total number of participants at the beginning of the plan year			5	524
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6k	o, 6c, and 6d).		
2	Active participants			6a	577
а	Active participants			0a	311
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6c	
A	Subtotal. Add lines 6a , 6b , and 6c			6d	577
d	Subtotal. Add lines 6a , 6b , and 6c			ou	377
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits		6e	
f	Total. Add lines 6d and 6e.			6f	
g	Number of participants with account balances as of the end of the plan year complete this item)	` •	•	6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer pla	ans complete this item)	7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List	of Plan Characteristic Codes	in the i	nstructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E	des from the List o	of Plan Characteristic Codes in	n the in	structions:
9a	Plan funding arrangement (check all that apply)		it arrangement (check all that	t apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1)	Insurance Code section 412(e)(3) ir	nsuranc	e contracts
	(3) Trust	(3)	Trust		o co
	(4) General assets of the sponsor	(4)	General assets of the spo	onsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, whe	ere indicated, enter the numb	er attac	hed. (See instructions)
а	Pension Schedules	b General S	chedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	ation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Informa	ation – :	Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)	_6 A (Insurance Inform		
	·	(4)	C (Service Provide		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)	D (DFE/Participatin G (Financial Transa	-	
		(*)	_ (,

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

2011

This Form is Open to Public Inspection

		pursuant to L	1110A 3000011 103(a)(2).		Inspection		
For calendar plan year 20	11 or fiscal plar	n year beginning 07/01/2011	and	ending 06/30/2012			
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	CENTER FLEXIBLE BENEFIT P	LANI	nree-digit an number (PN)	502		
C Plan sponsor's name a	s shown on line	e 2a of Form 5500	D Em	ployer Identification Numbe	er (EIN)		
MOUNTAIN COMPREHE	NSIVE CARE	CENTER		0663787	, ,		
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:		<u> </u>					
(a) Name of insurance ca							
ANTHEM HEALTH PLAN	S OF KENTUC	CKY					
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
61-1237516	95120	001003753	381	07/01/2011	06/30/2012		
2 Insurance fee and composition descending order of the		ation. Enter the total fees and total	al commissions paid. List in iten	n 3 the agents, brokers, and	d other persons in		
	amount of com	missions paid	(b)	Total amount of fees paid			
, ,		4762		·	0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons).			
•		and address of the agent, broker,					
CREECH AND STAFFOR	RD INS AGCY I		MALABU DRIVE SUITE 200 NGTON, KY 40502				
		LEXII	NG FOIN, KT 40502				
(I.) A		Fee	es and other commissions paid				
(b) Amount of sales ar commissions pai		(c) Amount		ose	(e) Organization code		
'	4762	0			3		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
Fees and other commissions paid							
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purp	ose	(e) Organization code		
			(,		(1) 51 11 11 11 11 11 11		

Schedule A (Form 5500)	2011	Page 2 - 1	<u> </u>			
(a) Na	ame and address of the agent, broke	r. or other person to whom	commissions or fees were paid			
(4) 110	and and address of the agent, sience	n, or ourer percent to whem	commissions of 1000 word paid			
(L) A		Fees and other commission	ns paid	(-) One of entire		
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code		
•	, ,					
(a) Na	ame 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		
(-) NI-						
(a) Na	ame and address of the agent, broke	er, or other person to whom	commissions or fees were paid			
	<u> </u>					
(b) Amount of sales and base		Fees and other commission		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		
(a) Na	ame and address of the agent, broke	r, 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		
(a) Na	ame 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		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	y 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:				
	a 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			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	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ite participatio	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year				
		(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
	ď	Total of balance and additions (add b and c(6))			. 7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
		Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011	Page 4
	es of the same employer(s) or members of the same employee organizations(s), the ontracts are experience-rated as a unit. Where contracts cover individual employed may be treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes)	
Health (other than dental or vision) b 🗵 Dental	c ☐ Vision d ☐ Life insurance
Temporary disability (accident and sickness) f Long-term	n disability g Supplemental unemployment h Prescription drug
Stop loss (large deductible) j HMO cor	tract k PPO contract I Indemnity contract
Other (specify)	
J (' '/	
erience-rated contracts:	
Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	9a(2)
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	9a(4)
Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	9b(2)
(3) Incurred claims (add (1) and (2))	(-)
(4) Claims charged	9b(4)
Remainder of premium: (1) Retention charges (on an accrual bas	is)
(A) Commissions	9c(1)(A)
(B) Administrative service or other fees	
(C) Other specific acquisition costs	0 (4)(0)

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

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Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) **10** Nonexperience-rated contracts: Total premiums or subscription charges paid to carrier

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid......

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

10a If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(D) 9c(1)(E)

9c(1)(F)

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

2011

This Form is Open to Public Inspection

For calendar plan year 20	11 or fiscal plan	year beginning 07/01/2011	and e	nding 06/30/2012	•	
A Name of plan				B Three-digit 502		
MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT			LAN pla	n number (PN)		
C Plan sponsor's name a	s shown on line	2a of Form 5500	D Emp	loyer Identification Number ((EIN)	
MOUNTAIN COMPREHE	MOUNTAIN COMPREHENSIVE CARE CENTER 61-0663787					
Part I Information	on Concern	ing Insurance Contract (Coverage, Fees, and Con	nmissions Provide inform	nation for each contract	
			a unit in Parts II and III can be re			
1 Coverage Information:						
(a) Name of insurance ca	rrier					
ANTHEM HEALTH PLAN	S OF KENTUC	KY				
	(a) NIAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To	
61-1237516	95120	001003753	281	07/01/2011	06/30/2012	
2 Insurance fee and coming descending order of the		tion. Enter the total fees and total	al commissions paid. List in item	3 the agents, brokers, and o	other persons in	
(a) Total a	amount of comm	nissions paid	(b) -	Total amount of fees paid		
		1190			0	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persons).			
	(a) Name a		or other person to whom commis	sions or fees were paid		
CREECH AND STAFFOR	D INS AGCY II		ALABU DRIVE SUITE 200 IGTON, KY 40502			
			,			
	<u> </u>					
(b) Amount of sales ar	nd base	Fee	s and other commissions paid		-	
commissions pai		(c) Amount	(d) Purpo	se	(e) Organization code	
	1190	0			3	
	(a) Name a	nd address of the agent, broker.	or other person to whom commis	sions or fees were paid		
	(17)	<u> </u>				
(b) Amount of sales and base		Fee	s and other commissions paid			
commissions pai		(c) Amount	(d) Purpo	se	(e) Organization code	
For Denominant Deduction	n Act Notice o	nd OMB Control Numbers and	the instructions for Form FEO	Caba	dulo A (Form 5500) 2011	

Schedule A (Form 5500)	2011	Page 2 - 1	<u> </u>			
(a) Na	ame and address of the agent, broke	r. or other person to whom	commissions or fees were paid			
(4) 110	and and address of the agent, sience	n, or ourer percent to whem	commissions of 1000 word paid			
(L) A		Fees and other commission	ns paid	(-) One of the first		
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code		
•	, ,					
(a) Na	ame 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		
(-) NI-						
(a) Na	ame and address of the agent, broke	er, or other person to whom	commissions or fees were paid			
	<u> </u>					
(b) Amount of sales and base		Fees and other commission		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		
(a) Na	ame and address of the agent, broke	r, 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		
(a) Na	ame 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		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	y 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:				
	a 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			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	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ite participatio	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year				
		(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
	ď	Total of balance and additions (add b and c(6))			. 7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
		Balance at the end of the current year (subtract e(5) from d)			. 7f	

Page 4	
employer(s) or members of the same en sperience-rated as a unit. Where contra- d as a unit for purposes of this report.	
c x Vision g ☐ Supplemental unemployment k ☐ PPO contract	d Life insurance h Prescription dru l Indemnity contra
./4)	
1(1)	

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10b

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		Schedule A (Form 5500) 2011			P	age	e 4				
Par	t II	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of e urposes	if such contracts	are experiei	ńce	-rated as a unit. Whe	ere contra			
8 B	Ben	efit and contract type (check all applicable boxes)									
á	a	Health (other than dental or vision)	b [] [Dental	С	X	Vision		d 🗌	Life insurance	
•	•	Temporary disability (accident and sickness)	f∏L	ong-term disabilit	у д	П	Supplemental unemp	oloyment	h	Prescription drug	
i	Ī	Stop loss (large deductible)	j∏H	IMO contract	k	Ī	PPO contract		ıĒ	Indemnity contract	
r	n	Other (specify)									
	L										
9 E	хр	erience-rated contracts:									
a	3	Premiums: (1) Amount received			9a(1)						
		(2) Increase (decrease) in amount due but unpai	d		9a(2)						
		(3) Increase (decrease) in unearned premium res	serve		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 (on an acc	crual 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				-		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These		_		-	edited)	9c(2)	_		
	d	Status of policyholder reserves at end of year: (1		ш .		3		· · ·			
	u		•	•				9d(1) 9d(2)			
		(2) Claim reserves									
	_	(3) Other reserves						9d(3)			
	е	Dividends or retroactive rate refunds due. (Do n	ot includ	e amount entered	i in C(2).)			9e			

retention	of the contract or po	olicy, other than re	ported in Part I,	item 2 above,	report amount	
Specify natu	ure of costs	•				

10 Nonexperience-rated contracts:

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

a Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

¹² If the answer to line 11 is "Yes," specify the information not provided. **\rightarrow**

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

2011

This Form is Open to Public Inspection

		parsaanitto	ETTION 30011011 103(a)(2).		Inspection
For calendar plan year 20°	11 or fiscal plan	year beginning 07/01/2011	and	d ending 06/30/2012	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE (CENTER FLEXIBLE BENEFIT F	DL ANI	hree-digit blan number (PN)	502
C Plan sponsor's name a	s shown on line	e 2a of Form 5500	D En	nployer Identification Nur	mber (EIN)
MOUNTAIN COMPREHE				-0663787	,
			Coverage, Fees, and Co a unit in Parts II and III can be		
1 Coverage Information:					
(a) Name of insurance ca	rrior				
` '		107			
ANTHEM HEALTH PLAN	S OF KENTUC	KY .			
	(c) NAIC	(d) Contract or	(e) Approximate number of		y or contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
61-1237516	95120	001003753	337	07/01/2011	06/30/2012
2 Insurance fee and coming descending order of the		ation. Enter the total fees and to	tal commissions paid. List in ite	m 3 the agents, brokers,	and other persons in
(a) Total a	amount of comr	missions paid	(b) Total amount of fees pa	aid
		53570			0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all persons	s).	
	(a) Name a	nd address of the agent, broker	, or other person to whom comn	nissions or fees were pai	id
CREECH AND STAFFOR	D INS AGCY I		MALABU DRIVE SUITE 200 NGTON, KY 40502		
		LLXI	NGTON, KT 40302		
		Fo	es and other commissions paid		
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purp	(e) Organization code	
	53570	0	(4) . 4.		3
	(a) Name a	nd address of the agent, broker	, or other person to whom comn	nissions or fees were pai	id
	. ,	<i>5 /</i>	′ 1	'	
Fees and other commissions paid					
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purp	pose	(e) Organization code
-		` '			, , ,

Schedule A (Form 5500)	2011	Page 2 - 1	<u> </u>			
(a) Na	ame and address of the agent, broke	r. or other person to whom	commissions or fees were paid			
(4) 110	and and address of the agent, sience	n, or ourer percent to whem	commissions of 1000 word paid			
(L) A		Fees and other commission	ns paid	(-) One of the first		
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code		
•	, ,					
(a) Na	ame 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		
(-) NI-						
(a) Na	ame and address of the agent, broke	er, or other person to whom	commissions or fees were paid			
	<u> </u>					
(b) Amount of sales and base		Fees and other commission		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		
(a) Na	ame and address of the agent, broke	r, 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		
(a) Na	ame and address of the agent, broke	er, or other person to whom	commissions or fees were paid			
	T			1		
(b) Amount of sales and base		Fees and other commission		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	idual contract	s with each carrier ma	y 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			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	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ite participatio	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year				
		(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
	ď	Total of balance and additions (add b and c(6))			. 7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
		Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011		Page 4		
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 of	roup of employees of the sa urposes if such contracts ar	e experience-ra	ted as a unit. Where contrac	
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	b Dental	C Vis	ion	d Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g 🗌 Su	pplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k 🗌 PP	O contract	I Indemnity contract
Other (specify)				
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpaid		9a(2)		
(3) Increase (decrease) in unearned premium res	serve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
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)	
Remainder of premium: (1) Retention charges (o	n an accrual basis)			

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a | X | Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid......

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions

(B) Administrative service or other fees

(C) Other specific acquisition costs..... (D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

9c(1)(A)

9c(1)(B) 9c(1)(C)

9c(1)(D) 9c(1)(E)

9c(1)(F)

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

¹² If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2011

		pursuant to El	RISA section 103(a)(2).	Tills Fol	Inspection	
For calendar plan year 20	11 or fiscal plan	year beginning 07/01/2011	and er	oding 06/30/2012		
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE (CENTER FLEXIBLE BENEFIT PL	A N I	e-digit number (PN)	502	
C Plan sponsor's name a MOUNTAIN COMPREHE			D Emplo	oyer Identification Number 63787	(EIN)	
			overage, Fees, and Com unit in Parts II and III can be rep			
1 Coverage Information:						
(a) Name of insurance ca	rrier					
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
58-0663085	60380	ZY056	34	07/01/2012	06/30/2012	
2 Insurance fee and com- descending order of the		tion. Enter the total fees and tota	I commissions paid. List in item 3	the agents, brokers, and	other persons in	
(a) Total a	amount of comn		(b) To	otal amount of fees paid		
	9597					
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).			
	(a) Name a	9 .	or other person to whom commiss	ions or fees were paid		
THOMAS A. MORRIS & A	ASSOC INC.		EXECUTIVE DR, SUITE 204 GTON, KY 40505			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose		(e) Organization code	
5344 0						
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees were paid		
CREECH AND STAFFORD INS AGCY INC. 210 MALABU DRIVE STE 200 LEXINGTON, KY 40502						
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pai		(c) Amount	(d) Purpos	e	(e) Organization code	
	2559	0				
For Bonomical Bodinette	n Ast Notice o	nd OMP Central Numbers and	the instructions for Form FF00	Cala	dula A /Farm FF00) 2011	

Schedule A (Form 5500) 2	2011	Page 2 - 1	
(a) Nan LESLIE K. KIMBROUGH	P.O. E	er, or other person to whom commissions or fees were paid 3OX 54468 IGTON, KY 40555	I
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 967	(c) Amount	(d) Purpose	code
(a) Nan		r, or other person to whom commissions or fees were paid	l
RUEANN EMERSON	2480 LEXIN	FORTUNE DR., SUITE 100 IGTON, KY 40509	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
714	0	(a) r dipose	code
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	l
JOHN R. DIXON		BOX 1558 TONSBURG, KY 41653	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
5	0		
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	l
CHARLIE G. JOHNSTON		JIM MEYER DR. #A ANDRIA, LA 71303	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization
commissions paid 5	(c) Amount	(d) Purpose	code
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	 I
RALPH E. HOPKINS		3OX 606 RGETOWN, KY 40324	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Schedule A	(Form	5500)	2011

Page **2** - 2

(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were paid	
ΓΙΜΟΤΗΥ Τ. TEAGUE		SHADY LANE RD. SVILLE, 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) Na	ime and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	т —		
(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, broke	r, or other person to whom commissions or fees were paid	
(a) 140	and diddress of the agent, broke	r, or other person to whem commissions or rece were para	
		Food and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
commissions paid	(c) Amount	(a) i dipose	Code
(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent, broke	r, or other person to whom commissions or fees were paid	
			-
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	<u> </u>	I .	

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	idual contract	s with each carrier ma	y 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			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	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ite participatio	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year				
		(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
	ď	Total of balance and additions (add b and c(6))			. 7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
		Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011	Page 4
information may be combined for reporting purposes if	ployees of the same employer(s) or members of the same employee organizations(s), the such contracts are experience-rated as a unit. Where contracts cover individual employees carrier may be treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes)	
Health (other than dental or vision) b De	ntal c Vision d Life insurance
Temporary disability (accident and sickness) f Lo	ng-term disability $\mathbf{g} \square$ Supplemental unemployment $\mathbf{h} \square$ Prescription drug
Stop loss (large deductible)	IO contract
Other (specify) SUPPLEMENTAL	
Other (specify) FOOT FEEMENTAL	
erience-rated contracts:	
Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	9a(4)
Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	
(4) Claims charged	9b(4)
Remainder of premium: (1) Retention charges (on an accru	ual 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)

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

m X Other (specify) ▶SUPPLEMENTAL

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received...... (2) Increase (decrease) in amount due but unpaid.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(E)

9c(1)(F)

¹² If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2011

This Form is Open to Public Inspection

		F *** * * * * * * * * * * * * * * * * *			mspection	
For calendar plan year 20	11 or fiscal plan	year beginning 07/01/2011	and er	nding 06/30/2012		
A Name of plan MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT		CENTER FLEXIBLE BENEFIT PL	LAN B Three plan	ee-digit number (PN)	502	
•	C Plan sponsor's name as shown on line 2a of Form 5500 MOUNTAIN COMPREHENSIVE CARE CENTER D Employer Identification Number (EIN) 61-0663787					
			Coverage, Fees, and Com a unit in Parts II and III can be rep			
1 Coverage Information:						
(a) Name of insurance ca	rrier					
ANTHEM LIFE INSURAN	CE COMPANY					
	(-) NAIO	(1) Octobria	(e) Approximate number of	Policy or co	ontract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To	
35-0980405	61069	00202661	0	07/01/2011	06/30/2012	
2 Insurance fee and composite descending order of the		tion. Enter the total fees and total	al commissions paid. List in item 3	3 the agents, brokers, and c	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
•	3609				0	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whom commiss	sions or fees were paid		
CREECH AND STAFFOR	RD INS AGCY II		ALABU DRIVE STE 200 IGTON, KY 40502			
(h) Amount of color or	nd book	Fee	s and other commissions paid			
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpos	е	(e) Organization code	
	3609	0			3	
	(a) Name a	nd address of the agent, broker,	or other person to whom commiss	sions or fees were paid		
	(,)					
(b) Amount of sales ar	nd base	Fee	s and other commissions paid			
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose		e	(e) Organization code			
For Paperwork Reductio	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	. Sched	lule A (Form 5500) 2011 v.012611	

Schedule A (Form 5500)	2011	Page 2 - 1	<u> </u>	
(a) Na	ame and address of the agent, broke	r. or other person to whom	commissions or fees were paid	
(4) 110	and and address of the agent, protect	n, or ourer percent to whem	commissions of 1000 word paid	
(L) A		Fees and other commission	ns paid	(-) One of entire
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code
•	, ,			
(a) Na	ame 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
(-) NI-				
(a) Na	ame and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	ame and address of the agent, broke	r, 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
(a) Na	ame and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
	T			1
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	idual contract	s with each carrier ma	y 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			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	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ite participatio	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year				
		(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
	ď	Total of balance and additions (add b and c(6))			. 7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
		Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011	Page 4
	of the same employer(s) or members of the same employee organizations(s), the ntracts are experience-rated as a unit. Where contracts cover individual employed hay be treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes) Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify)	
erience-rated contracts:	
Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	9a(4)
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)
Remainder of premium: (1) Retention charges (on an accrual basis	3)
(A) Commissions	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received...... (2) Increase (decrease) in amount due but unpaid.....

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(D) 9c(1)(E)

9c(1)(F)

¹² If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2011

		pursuant to Ef	RISA section 103(a)(2).	Tills For	Inspection
For calendar plan year 20	11 or fiscal plan	year beginning 07/01/2011	and en	ding 06/30/2012	•
A Name of plan MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT P			ΛNI	e-digit number (PN)	502
	C Plan sponsor's name as shown on line 2a of Form 5500 MOUNTAIN COMPREHENSIVE CARE CENTER D Employer Identification Number (EIN) 61-0663787				
			overage, Fees, and Comiunit in Parts II and III can be repo		
1 Coverage Information:					
(a) Name of insurance ca		NCE COMPANY			
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
57-0144607	62049	E7817000	94	07/01/2011	06/30/2012
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					
	6044 1793				
3 Persons receiving com	3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).				
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
MARY DUFF	MARY DUFF 176 PASADENA DRIVE LEXINGTON, KY 40503				
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpose		(e) Organization code
	2341	1620			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
BB&T INSURANCE SER		414 GA	ALLIMORE DAIRY ROAD NSBORO, NC 27409		
(b) Amount of sales ar	nd hase	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code
	1024	24			
For Borrows de Borlondo	n Ast Notice	nd OMB Control Numbers	the instructions for Form FEOO	Cala	dula A (Form 5500) 2011

Schedule A (Form 5500)	2011	Page 2 - 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were pa	iid
MCGOHAN/BRABENDER AGCY		SOUTH DIXIE DRIVE ON, OH 45439	
(b) Amount of sales and base	(e) Organization		
commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	code
452	0		
		er, or other person to whom commissions or fees were pa	iid
THELMA F. BOSWELL	3136 LEXII	HYDE PARK DRIVE NGTON, KY 40503	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 405	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were pa	lid
CREECH AND STAFFORD INS AGC		IALABU DRIVE STE 200 NGTON, KY 40502	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 362	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were pa	iid
DARRELL L. PATTON		BOX 925 BTONSBURG, KY 41653	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
294	0		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were pa	iid
DEE ANN SLADE		OTOMAC COURT IKFORT, KY 40601	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 251	(c) Amount	(d) Purpose	code
		1	

(a) No	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
ANNE OWENS		DEER LAKE DRIVE	
ANNE OWENS		GTON, KY 40515	
(b) Amount of calca and have		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
218	21	(1)	
(a) Na			
LOUIS LERMAN		r, or other person to whom commissions or fees were paid SURREY RIDGE ROAD	
LOUIS LERIVIAN	CLARI	KSVILLE, TN 37043	
(h) Amount of color and hace		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
159	79	(5)	
(-) NI-	and a delivery of the arrest through		
		r, or other person to whom commissions or fees were paid	
JOHN ROBERTS FINCH		GTON, KY 40503	
	,	Fees and other commissions paid	() 0
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
177	(6) Amount	(u) 1 dipose	code
177	·		
(-) NI-	and a delivery of the arrest through		
	•	r, or other person to whom commissions or fees were paid	
LISA GRAVES		GLENNS CREEK RD KFORT, KY 40601	
	· ·	Fees and other commissions paid	
(b) Amount of sales and base		·	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
138	9		
		r, or other person to whom commissions or fees were paid	
BENJAMIN BARTLETT GAUNT		FALLEN LEAF CIRCLE SVILLE, KY 40241	
	20010	77122, 171 40241	
		The state of the s	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
59	12		

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Schedule A (Form 5500) 2011

(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	d
BART GAUNT		ST GERMAINE CT VILLE, KY 40207	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na MARK HOLLAND	P.O. B	r, or other person to whom commissions or fees were paid OX 38366 IANTOWN, TN 38183	1
(b) Amount of sales and base commissions paid 58		Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na	2985 \$	r, or other person to whom commissions or fees were paid SURREY RIDGE ROAD KSVILLE, TN 37043	1
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na KAREN TOBIAS	PMB 3	r, or other person to whom commissions or fees were paid 008 KLIN, TN 37069	1
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
6	0		
CAROL LAMB	309 FC	r, or other person to whom commissions or fees were paid OX HARBOUR DR GTON, KY 40517	1
(b) Amount of sales and base commissions paid 3	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code

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Schedule A (Form 5500) 2011

Schedule A (Form 5500)	2011	Page 2 - 4	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were pa	id
WENDY S. CASE	118 PF	ROMONADE CT. VILLE, KY 40223	.a
(b) Amount of sales and base	J	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
2	0		
(a) Nar		r, or other person to whom commissions or fees were pa	id
MICHAEL J. BOONE		CLEAR SPRINGS TRACE VILLE, KY 40223	
(b) Amount of sales and base	ļ	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1	0		
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base	F	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base	F	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(c) Amount

(b) Amount of sales and base commissions paid

Fees and other commissions paid

(d) Purpose

(e) Organization code

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier ma	y be treated	d as a unit for purposes of
4	Curr	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			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	ating plan ch	eck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ite participatio	on guarantee		
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year				
		(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
	d	Total of balance and additions (add b and c(6))	<u>-</u>		. 7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)			. 7f	

Schedule A (Form 5500) 2011		Page [,]	4	
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	group of employees of the sa purposes if such contracts an	re experience-r	ated as a unit. Where contract	
and contract type (check all applicable boxes)			
ealth (other than dental or vision)	b Dental	c V	ision	d X Life insurance
emporary disability (accident and sickness)	f Long-term disability	g∏s	upplemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	k	PO contract	I Indemnity contract
Other (specify)	- <u>-</u>	<u> </u>		
nce-rated contracts:				
niums: (1) Amount received		9a(1)		
Increase (decrease) in amount due but unpai	id	9a(2)		
Increase (decrease) in unearned premium re	serve	9a(3)		
Earned ((1) + (2) - (3))	<u></u>		9a(4)	
nefit charges (1) Claims paid	<u> </u>	9b(1)		
Increase (decrease) in claim reserves		9b(2)		
Incurred claims (add (1) and (2))			9b(3)	
Claims charged			9b(4)	
mainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
		- ::::-:		-

Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disabilit Stop loss (large deductible) **HMO** contract Other (specify) Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid..... (3) Increase (decrease) in unearned premium reserve...... (4) Earned ((1) + (2) - (3)) Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) (4) Claims charged..... Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs..... 9c(1)(C) (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies 9c(1)(F) (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) 9d(3) (3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 72386 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b 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			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Part III

¹² If the answer to line 11 is "Yes," specify the information not provided.