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), 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

2012

This Form is Open to Public Inspection

						Inspection	
Part I	Annual Report Identif	fication Information					
For caler	ndar plan year 2012 or fiscal plan	an year beginning 04/01/2012		and ending 04/0	01/2013		
A This	eturn/report is for:	a multiemployer plan;	a multip	le-employer plan; or			
		x a single-employer plan;	a DFE (specify)			
R This	eturn/report is:	X the first return/report;	☐ the final	return/report;			
D IIIIS I	eturn/report is.	an amended return/report;	=	olan year return/report (les	e than 12 m	onthe)	
C If the	nlan is a collectively-hargained i	plan, check here	<u></u>			• □	
	k box if filing under:	Form 5558;	_	ic extension;	_	் ⊔ e DFVC program;	
D Chec	C DOX II IIIIII UIIUEI.	special extension (enter de	—	io exteriori,		o Di vo piogiam,	
Part	I Rasio Plan Informa	ation—enter all requested inform					
1a Nam		ILIOII—enter all requested infor	mation		1h	Three-digit plan	
	LEAGUE SOCCER, LLC HEALT	TH AND WELFARE PLAN				number (PN) ▶	501
					1c	Effective date of plants 04/01/2011	an
	sponsor's name and address; in	include room or suite number (er	mployer, if for a single	-employer plan)	2b	Employer Identifica Number (EIN) 95-4541325	ition
WAGOK	LEAGUE GOOGEN, LEG				2c	Sponsor's telephor number	ne
7TH FLOOR 7TH FLO			TH AVENUE OOR ORK, NY 10018	2d Business code (see instructions) 711210			Э
Caution	A penalty for the late or inco	omplete filing of this return/rep	ort will be assessed	unless reasonable caus	se is establi	shed.	
		nalties set forth in the instructions the electronic version of this retu					
SIGN	Filed with authorized/valid elect	tronic signature.	10/18/2013	JENNIFER TUNIS			
HERE	Signature of plan administra	ator	Date	Enter name of individua	al signing as	plan administrator	
SIGN							
HERE	Signature of employer/plan s	sponsor	Date	Enter name of individua	al signing as	employer or plan sp	onsor
SIGN					<u> </u>		
HERE	Signature of DFE		Date	Enter name of individua	al signing as	DFE	
Preparer		applicable) and address; include	e room or suite numb			telephone number	

Form 5500 (2012) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Plan	Spon	sor Address		nistrator's EIN 541325
JE	NNIFER TUNIS, BENEFITS MANAGER, HUMAN RESOURCES					nistrator's telephone
	0 FIFTH AVENUE				num	per
NE	H FLOOR W YORK, NY 10018					
4	If the name and/or EIN of the plan sponsor has changed since the last return		this r	plan, enter the name.	4b EIN	
	EIN and the plan number from the last return/report:			, , , , , , , , , , , , , , , , , , , ,		
а	Sponsor's name				4c PN	
5	Total number of participants at the beginning of the plan year				5	648
6	Number of participants as of the end of the plan year (welfare plans complete	te only lines 6a,	6b, 6	c, and 6d).		
а	Active participants				6a	648
h	Potired or congreted participants receiving benefits				. 6b	
b	Retired or separated participants receiving benefits					
С	Other retired or separated participants entitled to future benefits				. 6c	
d	Subtotal. Add lines 6a, 6b, and 6c				. 6d	648
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	eceive benefits			. 6e	
f	Total. Add lines 6d and 6e				. 6f	648
q	Number of participants with account balances as of the end of the plan year	(only defined co	ontrib	ution plans		
3	complete this item)				. 6g	
h	Number of participants that terminated employment during the plan year with				01	
7	less than 100% vested				6h	
	If the plan provides pension benefits, enter the applicable pension feature co		•	<u> </u>		structions:
b	If the plan provides welfare benefits, enter the applicable welfare feature cod	des from the Lis	t of P	lan Characteristics Codes	s in the ins	tructions:
	4A 4B 4F 4D 4G 4Q					
9a	Plan funding arrangement (check all that apply)	9b Plan ber	ne <u>fit</u> a	rrangement (check all tha	at apply)	
	(1) X Insurance	(1)	X	Insurance		
	(2) Code section 412(e)(3) insurance contracts (3) Trust	(2)	H	Code section 412(e)(3)	insurance	contracts
	(4) X General assets of the sponsor	(4)	X	General assets of the sp	oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a		vhere	·		ed. (See instructions)
•	Panaian Sahadulas	b General	l Cab	adulaa		,
а	Pension Schedules (1) R (Retirement Plan Information)		i Sch			
	, <u> </u>	(1)		H (Financial Inforn	•	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	Ц	I (Financial Inform		nall Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)	X	3 A (Insurance Infor	,	
		(4)	X	C (Service Provide		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	Ц	D (DFE/Participati		
	Information) - signed by the plan actuary	(6)		G (Financial Trans	saction Sch	nedules)

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2012

pursuant to ERISA section 103(a)(2).					This Form is Open to Public Inspection	
For calendar plan year 20	12 or fiscal plar	n year beginning 01/01/2012	ar	nd ending 12	2/31/2012	
A Name of plan MAJOR LEAGUE SOCCER, LLC HEALTH AND WELFARE PLAN			В	Three-digit plan number (Pl	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 MAJOR LEAGUE SOCCER, LLC D Employer Identification Number (EIN) 95-4541325						(EIN)
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca						
	()))))	() ()	(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	of	From	(g) To
13-1898173	64297	000000047213	19	04/01/20)12	04/01/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	I commissions paid. List in li	ne 3 the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		1707	,	,	•	37
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persor	ns).		
	(a) Name a	and address of the agent, broker,	or other person to whom com	missions or fees	were paid	
BSC GROUP SERVICES	LLC		ROSPECT STREET FIELD, NJ 07090			
(b) Amount of sales ar	nd base	Fee	s and other commissions paid	t c		
commissions pa	id	(c) Amount	(d) Pu	•		(e) Organization code
	1546	37 AD	DITIONAL COMPENSATION	N.		3
	(a) Name a	and address of the agent, broker,	or other person to whom com	missions or fees	were paid	
SAGEVIEW CONSULTIN	IG INC.	18TH	EST 34TH STREET FLOOR YORK, NY 10120			
(b) Amount of sales ar	nd base	Fee	s and other commissions paid	d		
commissions pa		(c) Amount	(d) Pu	rpose		(e) Organization code
	161					3
For Donomicals Dodicatio	n Ant Nation a	and OMP Control Numbers, see	the instructions for Form 5		Caha	dulo A (Form 5500) 2012

Schedule A (Form 5500)	2012	Page 2 - 1					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization				
(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 pa	aid				
(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	er, or other person to whom commissions or fees were pa	aid				
	T		<u> </u>				
(b) Amount of sales and base	(-) A	Fees and other commissions 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 pa	aid				
	, , , , , , , , , , , , , , , , , , ,						
(h) Amount of color and back		Fees and other commissions paid	(2) Orner in eties				
(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 pa	aid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

		•
חבי	Ω	- 5
ay	ı	•

Pa	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivithis report.	idual contra	cts with each carrier m	ay be treated a	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 en			5	
		acts With Allocated Funds:			<u> </u>	
	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	
		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	d annuity			
		(3) X other (specify) ► INSURED GROUP VOLUNTARY LIFE PLAN				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7		acts With Unallocated Funds (Do not include portions of these contracts ma		<u>L</u>		
•				tion guarantee		
	u			ion gaarantee		
		(3) guaranteed investment (4) other				
	h	Delence at the and of the previous year			7b	
		Balance at the end of the previous year	- (1)		/ 10	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
)		. ,			
		(6)Total additions			7c(6)	
	_	of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:	[
		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)			
	١	•				
	1	5) Total deductions			7e(5)	
	,	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

	Schedule A (Form 5500) 2012		Page 4		
art II	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the same urposes if such contracts are	experience-rát	ed as a unit. Where contrac	
Bene	efit and contract type (check all applicable boxes)				
а	Health (other than dental or vision)	b Dental	C Visi	on	d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	g Sup	plemental unemployment	h Prescription drug
i	Stop loss (large deductible)	j HMO contract	k PP€	O contract	I Indemnity contract
Expe	erience-rated contracts:				
а	Premiums: (1) Amount received		9a(1)	5931	_
	(2) Increase (decrease) in amount due but unpai		9a(2)	483	
	(3) Increase (decrease) in unearned premium res	<u></u>	9a(3)	0.74	64
	(4) Earned ((1) + (2) - (3))			9a(4)	04
	Benefit charges (1) Claims paid		9b(1) 9b(2)		
	(2) Increase (decrease) in claim reserves(3) Incurred claims (add (1) and (2))	<u> </u>		9b(3)	
	(4) Claims charged				
	Remainder of premium: (1) Retention charges (c		•••••	<u> </u>	
	(A) Commissions	·	:(1)(A)		
	(B) Administrative service or other fees		:(1)(B)		
	(C) Other specific acquisition costs	90	:(1)(C)		
	(D) Other expenses	90	:(1)(D)		
	(E) Taxes		(1)(E)		
	(F) Charges for risks or other contingencies.	90	:(1)(F)		

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, line 2 above, report amount...... Specify nature of costs

10 Nonexperience-rated contracts:

Part III

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

(H) Total retention

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

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(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...... (2) Claim reserves

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2012

Pension Benefit Guaranty Co	prporation		 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 			This Form is Open to Public Inspection	
For calendar plan year 20	12 or fiscal pla	an year beginning 01/01/2012	and	ending 12	2/31/2012	•	
A Name of plan MAJOR LEAGUE SOCCER, LLC HEALTH AND WELFARE PLAN				ree-digit an number (P	N) •	501	
C Plan sponsor's name as shown on line 2a of Form 5500 MAJOR LEAGUE SOCCER, LLC D Employer Identification Number (EIN) 95-4541325						(EIN)	
		ning Insurance Contract C . Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca							
FIRST UNUM LIFE INSU	RANCE COM	PANY			Dallarran		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year		From	(g) To	
13-1898173	64297	047214	648	04/01/20	012	04/01/2013	
2 Insurance fee and complete descending order of the		nation. Enter the total fees and total	Il commissions paid. List in line	3 the agents,	, brokers, and o	ther persons in	
		nmissions paid	(b)	Total amount	of fees paid		
		2632			•	211	
3 Persons receiving com	missions and	fees. (Complete as many entries a	as needed to report all persons).			
_	(a) Name	and address of the agent, broker,	or other person to whom comm	issions or fees	s were paid		
BSC GROUP SERVICES	LLC		ROSPECT STREET FIELD, NJ 07090				
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid				
commissions pai		(c) Amount	(d) Purp	ose		(e) Organization code	
	1316	211 AD	DITIONAL COMPENSATION			3	
	(a) Name	and address of the agent, broker,	or other person to whom comm	issions or fees	s were paid		
SAGEVIEW CONSULTIN		112 W 18TH	EST 34TH STREET FLOOR YORK, NY 10120				
(h) Amount of sales or	(b) Amount of sales and base Fees and other commissions paid						
commissions pa		(c) Amount	(d) Purp	ose	(e) Organization code		
	1316					3	
For Panerwork Reduction	n Act Notice	and OMB Control Numbers, see	the instructions for Form 55	00	Scher	 	

Schedule A (Form 5500)	2012	Page 2 - 1					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid				
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization				
(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 pa	aid				
(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	er, or other person to whom commissions or fees were pa	aid				
	T		<u> </u>				
(b) Amount of sales and base	(-) A	Fees and other commissions 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 pa	aid				
	, , , , , , , , , , , , , , , , , , ,						
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties				
(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 pa	aid				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

		•
חבי	Δ	- 5
ay		•

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of					
		this report.					
		ent value of plan's interest under this contract in the general account at year					
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd		5		
6		racts With Allocated Funds:					
	а	State the basis of premium rates					
		Premiums paid to carrier			6b		
		Premiums due but unpaid at the end of the year			6c		
		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	d annuity				
		(3) other (specify)					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan o	heck here			
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)			
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee			
		(3) ☐ guaranteed investment (4) ☐ other ▶					
		(e) [] 3					
	b	Balance at the end of the previous year			7b		
		Additions: (1) Contributions deposited during the year	. 7c(1)				
		(2) Dividends and credits	. 7c(2)				
		(3) Interest credited during the year	. 7c(3)				
		(4) Transferred from separate account	. 7c(4)				
		(5) Other (specify below)	. 7c(5)				
		(6)Total additions			7c(6)		
	d∃	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>	<u></u>	7d		
	e [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)				
		•					
	,	(E) Total deductions			7e(5)		
		(5) Total deductions					
		Dalance at the end of the current year (Subtract line re(3) from line rd)			/ 1		

	Schedule A (Form 5500) 2012		Page	4	
		4: a.n			
rt I	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 employees of the surposes if such contracts	are experience-	rated as a unit. Where contract	
Ber	efit and contract type (check all applicable boxes)			<u> </u>	
а	Health (other than dental or vision)	b Dental	c	'ision	d X Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g ∏s	supplemental unemployment	h Prescription drug
i İ	Stop loss (large deductible)	j HMO contract	_ =	PPO contract	I Indemnity contract
m		,			
•••					
Ехр	erience-rated contracts:				
а	Premiums: (1) Amount received		9a(1)	92479	
	(2) Increase (decrease) in amount due but unpai	d	9a(2)	8653	3
	(3) Increase (decrease) in unearned premium res	serve	9a(3)		
	(4) Earned ((1) + (2) - (3))			9a(4)	101132
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 (c	on an accrual basis)			
	(A) Commissions		9c(1)(A)		
	(B) Administrative service or other fees				
	(C) Other specific acquisition costs				
	(D) Other expenses		9c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

Specify nature of costs

Part III

(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 line 9c(2).).....

Total premiums or subscription charges paid to carrier

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.

SCHEDULE A (Form 5500)

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

2012

This Form is Open to Public

		pursuant to Er	RISA section 103(a)(2).			Inspection
For calendar plan year 20	12 or fiscal plan	year beginning 01/01/2012	and	ending 12	2/31/2012	-
A Name of plan MAJOR LEAGUE SOCCE	A Name of plan MAJOR LEAGUE SOCCER, LLC HEALTH AND WELFARE PLAN			ree-digit an number (P	N) •	501
	Plan sponsor's name as shown on line 2a of Form 5500 IAJOR LEAGUE SOCCER, LLC D Employer Identification Number (EIN) 95-4541325					
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:						
(a) Name of insurance ca		ANY				
			(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		From	(g) To
13-1898173	64297	461664	648	04/01/20)12	04/01/2013
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	commissions paid. List in line	3 the agents,	brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid	(b)	Total amount	of fees paid	
		5120				0
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all persons)	١.		
		nd address of the agent, broker, o			s were paid	
BSC GROUP SERVICES		133 PR	ROSPECT STREET FIELD, NY 07090		•	
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	5120	840 ADI	840 ADDITIONAL COMPENSATION			3
	(a) Name a	nd address of the agent, broker, o	r other person to whom comm	issions or fees	were paid	
41.5.4		Fees	and other commissions paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purp	ose	(e) Organization code	
			,, ,			
For Department Deduction	or Panarwork Poduction Act Natice and OMP Control Numbers, see the instructions for Form 5500.					

Schedule A (Form 5500)	2012	Page 2 - 1							
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid						
	,	.,,							
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization						
(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 pa	aid						
(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	er, or other person to whom commissions or fees were pa	aid						
	T		<u> </u>						
(b) Amount of sales and base	(-) A	Fees and other commissions 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 pa	aid						
	, , , , , , , , , , , , , , , , , , ,								
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties						
(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 pa	aid						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization						
commissions paid	(c) Amount	(d) Purpose	code						

_	•
Pane	٠.'
uqu	

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	as a unit for purposes of			
4	Curre	nt value of plan's interest under this contract in the general account at year	end		4	
_		nt value of plan's interest under this contract in separate accounts at year e			5	
6	Contr	acts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		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	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Contr	acts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	L				71-	
		Balance at the end of the previous year			7b	
		Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2) 7c(3)			
		(3) Interest credited during the year	7c(4)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	10(3)			
	,					
		(6)Total additions			7c(6)	
		otal of balance and additions (add lines 7b and 7c(6))			7d	
		Deductions:	Γ			
	(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)			
	l					
	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)				

Schedule A (Form 5500) 2012		Pa	ge 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	roup of employees of the sourposes if such contracts a	are experienc	e-rated as a unit. Where contra	
efit and contract type (check all applicable boxes))			
Health (other than dental or vision)	b Dental	С	Vision	d Life insurance
Temporary disability (accident and sickness)	f X Long-term disability	y g	Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k 🗍	PPO contract	I Indemnity contract
Other (specify)			<u>'</u>	-
				
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)	29014	12
(2) Increase (decrease) in amount due but unpai	d	9a(2)	2536	39
(3) Increase (decrease) in unearned premium re-	serve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	31551
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 (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs		9c(1)(C)		

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, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

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

(D) Other expenses 9c(1)(D)

(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 line 9c(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......

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

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.

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation 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.

Service Provider Information

OMB No. 1210-0110

2012

This Form is Open to Public Inspection.

or calendar plan year 2012 or fiscal plan year beginning 04/01/2012	and ending 04/01/201	3
A Name of plan MAJOR LEAGUE SOCCER, LLC HEALTH AND WELFARE PLAN	B Three-digit plan number (PN)	501
		,
Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification N	lumber (EIN)
MAJOR LEAGUE SOCCER, LLC	95-4541325	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the info or more in total compensation (i.e., money or anything else of monetary value) in oplan during the plan year. If a person received only eligible indirect compensation answer line 1 but are not required to include that person when completing the rem	connection with services rendered to the n for which the plan received the required	plan or the person's position with the
Information on Persons Receiving Only Eligible Indirect Com	npensation	
Check "Yes" or "No" to indicate whether you are excluding a person from the rema		
indirect compensation for which the plan received the required disclosures (see in	structions for definitions and conditions)	Yes X No
If you answered line 1a "Yes," enter the name and EIN or address of each perso received only eligible indirect compensation. Complete as many entries as neede		ne service providers who
(b) Enter name and EIN or address of person who provide	ded you disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or address of person who provide	ded you disclosure on eligible indirect con	npensation
(b) Enter name and EIN or address of person who provid	lad vou diaglacurae en elimible indirect es	manastica
(b) Enter name and Envior address or person who provide	ed you disclosures on eligible mallect col	препѕаноп
(b) Enter name and EIN or address of person who provid	led you disclosures on eligible indirect co	mpensation

Schedule C (Form 5500) 2012	Pa	age 2- 1	
(b) Enter name and FIN or a	address of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	address of person who provided yo	ou disclosures on eligible indirect co	mpensation
	<u></u>	-	<u>·</u>
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	u disclosures on eligible indirect cor	mpensation
(h) =			
(D) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation

	_			
Page	3	-	1	

answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			a) Enter name and EIN or	addraga (aga inatrustiana)		
DELTA DE	NTAL OF NEW YORK		a) Enter name and EIN or	address (see instructions)		
DELTA DE	INTAL OF NEW YORK	· ·				
11-198021	8					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	CONTRACT ADMINISTRATOR	27273	Yes No X	Yes No 🗵		Yes No X
			a) Enter name and EIN or	address (see instructions)		
	E INSURANCE	`	, =			
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service
Code(s)	employer, employee organization, or person known to be a party-in-interest	compensation paid by the plan. If none, enter -0	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	provider give you a formula instead of an amount or estimated amount?
13	CONTRACT ADMINISTRATOR	351534	Yes No X	Yes 📗 No 🛚	0	Yes No X
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	3	-	2
-age	J	-	12

answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
			,			
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
<u> </u>		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens	ation, by a service provider, and th	ne service provider is a fiduciary
or provides contract administrator, consulting, custodial, investment advisory, investment mar questions for (a) each source from whom the service provider received \$1,000 or more in indi provider gave you a formula used to determine the indirect compensation instead of an amou many entries as needed to report the required information for each source.	nagement, broker, or recordkeepin irect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(coo mendency)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Page 5-

[
Part II Service Providers Who Fail or Refuse to Provide Information				
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.				
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		

Page	6-
------	----

Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)				
а	Name:	(complete as many entries as needed)	b EIN:		
C	Positio		B EIIV.		
d	Addres		e Telephone:		
•	/ ladio		С госраново.		
Ex	olanatio):			
			I		
<u>a</u>	Name:		b EIN:		
d d	Position Address		e Telephone:		
u	Addies	.5.	е тегерпопе.		
Ex	olanatio	n:			
а	Name:		b EIN:		
<u>C</u>	Positio				
d	Addres	SS:	e Telephone:		
Exi	olanatio				
а	Name:		b EIN:		
С	Positio	n:			
d	Addres	ss:	e Telephone:		
	Explanation:				
ᄓ	piariatio	i.			
а	Name:		b EIN:		
C	Positio				
d	Addres		e Telephone:		
Ex	olanatio	1:			