Form 5500	Annual Return/Report of Employee Benefit Plan		OMB Nos. 12	10-0110 10-0089
	This form is required to be filed for employee benefit plans under sections 104			
Department of the Treasury Internal Revenue Service	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).		2013	
Department of Labor Employee Benefits Security	Complete all entries in accordance with			
Administration Pension Benefit Guaranty Corporation	the instructions to the Form 5500.	This	Form is Open to Pu	ıblic
			Inspection	
	tification Information			
For calendar plan year 2013 or fiscal		2013		
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or			
	a single-employer plan; a DFE (specify)			
B This return/report is:	the first return/report; the final return/report;			
	an amended return/report;	a a short plan year return/report (less than 12 months).		
C If the plan is a collectively-bargain	ed plan, check here.		• 🗆	
	☐ Form 5558;	_	e DFVC program;	
D Check box if filing under:			e Di VC piograffi,	
	special extension (enter description)			
Part II Basic Plan Inform	nation—enter all requested information			
1a Name of plan CAPITAL REGION ORTHOPAEDIC	ASSOCIATES PC BENEFITS PLAN	1b	Three-digit plan number (PN) ▶	510
		1c	Effective date of pla 10/01/1985	an
2a Plan sponsor's name and addres	2b Employer Identification Number (EIN) 14-1633562			
		2c	Sponsor's telephor number 518-292-2616	
1367 WASHINGTON AVENUE1367 WASHINGTON AVENUESUITE 401SUITE 401ALBANY, NY 12206ALBANY, NY 12206		2d Business code (see instructions) 621111		9

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

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

SIGN	Filed with authorized/valid electronic signature.	06/26/2014	JUDE MURPHY			
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator			
SIGN HERE	Filed with authorized/valid electronic signature.	06/26/2014	JUDE MURPHY			
	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor		
SIGN HERE						
HERE	Signature of DFE	Date	Enter name of individu	al signing as DFE		
Preparer's name (including firm name, if applicable) and address; include room or suite number. (optional) Preparer's telephone number (optional)						
For Pap	erwork Reduction Act Notice and OMB Control Numbers, see	the instructions for	- Form 5500	Form 5500 (2013)		

	Form 5500 (2013) Page 2		
3a	Plan administrator's name and address XSame as Plan Sponsor Name Same as Plan Sponsor Address	3c A	dministrator's EIN dministrator's telephone umber
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name,	4b E	
-	EIN and the plan number from the last return/report:		
а	Sponsor's name	4c P	2N 501
5	Total number of participants at the beginning of the plan year	5	207
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	6a	220
b	Retired or separated participants receiving benefits	6b	
с	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c	6d	220
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e.	6f	220
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
8a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Code	des in th	e instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4H 4F 4Q

9a	Plan fu	nding	arrangement (check all that apply)	9b	Plan ber	nefit	arra	angement (check all that apply)
	(1)	X	Insurance		(1)	X	l	nsurance
	(2)		Code section 412(e)(3) insurance contracts		(2)		C	Code section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Г	rust
	(4)		General assets of the sponsor		(4)		C	General assets of the sponsor
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	ed, and, w	her	e in	dicated, enter the number attached. (See instructions)
а	Pensio	n Scl	hedules	b	General	l Sc	hec	lules
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π		I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X	_	7 A (Insurance Information)
			actuary		(4)	X		C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary		(5)			D (DFE/Participating Plan Information)
					(6)			G (Financial Transaction Schedules)

C Plan sponsor's name as shown on line 2a of Form 5500 CAPITAL REGION ORTHOPAEDIC ASSOCIATES PC D Employed 14-16335 Part I Information Concerning Insurance Contract Coverage, Fees, and Commi on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported 1 Coverage Information: 1 Coverage Information: (a) Name of insurance carrier METROPOLITAN LIFE INSURANCE COMPANY (b) EIN (c) NAIC code (d) Contract or identification number (e) Approximate number of persons covered at end of policy or contract year			MB No. 1210-0110
Imployee Retirement It across Security Act of 1974 (ERISA). Employee Benefits Security Administration Persion Benefit Guaranty Corporation > File as an attachment to Form 5500. Presion Benefit Guaranty Corporation > Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and endin A Name of plan B Three-d plan nu B Three-d plan nu CAPITAL REGION ORTHOPAEDIC ASSOCIATES PC BENEFITS PLAN B Three-d plan nu C Plan sponsor's name as shown on line 2a of Form 5500 D Employee CAPITAL REGION ORTHOPAEDIC ASSOCIATES PC D Employee 14-16333 Part I Information Concerning Insurance Contract Coverage, Fees, and Commin on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported 1 Coverage Information: (e) NAIC (f) Contract or identification number persons covered at end of policy or contract year 13-5531829 65978 TM05987633 239 2 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the descending order of the amount paid. (a) Name and address of the agent, broker, or other person to whom commission BROWN			2013
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712 49 SUPPLEMENTAL COMPENSATION			3

(b) Amount of sales and base	Fees and other commissions paid				
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 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	 (e) Organization code 		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Ρ	ad	e	4

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts v	irposes if such cor vith each carrier m	ntracts are experience	e-rated as a unit. Whe	re contracts	s cover individual employees,
8	Bon	efit and contract type (check all applicable boxes)					
Ŭ	г		b 🔽 Dentel	م ۲	Vision		d 🗌 Life insurance
	a	Health (other than dental or vision)	b X Dental	c	Vision		
	е	Temporary disability (accident and sickness)	f Long-term	disability g	Supplemental unemp	loyment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contra	act k	PPO contract		I Indemnity contract
	m	Other (specify)					
		_					
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received					
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res	erve				
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					_
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis				_
		(A) Commissions					_
		(B) Administrative service or other fees					-
		(C) Other specific acquisition costs		A (1)(D)			-
		(D) Other expenses					4
		(E) Taxes					-
		(F) Charges for risks or other contingencies					-
		(G) Other retention charges				a (4)(1))	
		(H) Total retention		_	-	9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These		· 🗆	-	9c(2)	
	d	Status of policyholder reserves at end of year: (1	•			9d(1)	
		(2) Claim reserves			-	9d(2)	
		(3) Other reserves			-	9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount	entered in line 9c(2))	9e	
10	_	nexperience-rated contracts:			г		
	a	Total premiums or subscription charges paid to c			-	10a	77222
	b	If the carrier, service, or other organization incurr				10b	
retention of the contract or policy, other than reported in Part I, line 2 above, report amount							

Specify nature of costs 🕨

Part IV Provision of Information

-

11	Did the 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.			

SCHEDULE		Insuranc	e Information	n		OI	MB No. 1210-0110
(Form 5500) Department of the Treas		This schedule is required	to be filed under section	on 104 of th	e	2013	
Internal Revenue Servi	ce	Employee Retirement Inc					2010
Department of Labor Employee Benefits Security Adr		File as an at	tachment to Form 55	00.			
Pension Benefit Guaranty Col	rporation		s are required to provide the information DERISA section 103(a)(2).			This Fo	rm is Open to Public Inspection
For calendar plan year 201	13 or fiscal plan	year beginning 01/01/2013		and en	Ŭ	/31/2013	
A Name of plan CAPITAL REGION ORTH	OPAEDIC ASS	OCIATES PC BENEFITS PLAN		B Threphan	e-digit number (Pl	N) 🕨	510
C Plan sponsor's name a	s shown on line	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
CAPITAL REGION ORTHO	OPAEDIC ASS	OCIATES PC		14-163	33562		
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car	rrier						
THE GUARDIAN LIFE IN	SURANCE CO	MPANY OF AMERICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu			,	contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
13-5123390 64246 00356440			90 01/01/2013		13	12/31/2013	
2 Insurance fee and comr descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
	amount of comn	nissions paid		(b) To	tal amount	of fees paid	
		942					515
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
BROWN & BROWN OF N	. /	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
	IEW FORK INC		VY, NY 12203				
(b) Amount of sales an	nd base	Fees	s and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpos	e		(e) Organization code
	932	515 CO	NTINGENCY				3
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
HOWARD J ELISA, INC		355 LE 9TH F	EXINGTON AVE				
		Foo	s and other commission	ns naid			
(b) Amount of sales an commissions pair		(c) Amount		(d) Purpose	Э		(e) Organization code
	10						3
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for F	Form 5500.		Sche	edule A (Form 5500) 2013 v. 130118

(b) Amount of sales and base		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 poid						
(a) Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
			<u> </u>	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page 4

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees of the proses if such contracts	are experience	ce-rated as a unit. Wh	nere contrac	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	C 🗙	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabili	ity g	Supplemental unem	ployment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)			-		_
9	Expe	erience-rated contracts:					
	а	Premiums: (1) Amount received		. 9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res	erve	. 9a(3)			
		(4) Earned ((1) + (2) - (3))				. 9a(4)	
	b	Benefit charges (1) Claims paid		. 9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	Amount held to provide	benefits after	retirement		
		(2) Claim reserves	•			. 9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entere	d in line 9c(2)	.)	. 9e	
10) No	nexperience-rated contracts:		. , ,		•	
	а	Total premiums or subscription charges paid to c	arrier			. 10a	932
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo	ed any specific costs in o	connection wit	h the acquisition or		

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

SCHEDULE		Insuranc	ce Information	n		0	MB No. 1210-0110
(Form 5500 Department of the Trea	isury	This schedule is required					2013
Internal Revenue Ser	Department of Labor						
Employee Benefits Security A						This Fo	orm is Open to Public
Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 20)13 or fiscal pla	n year beginning 01/01/2013		and er	nding 12	2/31/2013	
A Name of plan CAPITAL REGION ORTH			e-digit number (P	N) 🕨	510		
C Plan sponsor's name CAPITAL REGION ORTH					oyer Identific 33562	cation Number	r (EIN)
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:		x :		•		-	
(a) Name of insurance ca		E COMPANY					
			(e) Approximate n	umber of		Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	it end of	(f)	From	(g) To
04-1590994 67598 E318		E3185758		8 01/01		013	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total	amount of com	missions paid		(b) T	otal amount	of fees paid	
		364					
3 Persons receiving con	nmissions and f	ees. (Complete as many entries	as needed to report all	persons).			
	. ,	and address of the agent, broker,	or other person to who RPORATE DR	m commiss	sions or fees	s were paid	
JAEGER & FLYNN ASS	OCIATES INC		ON PARK, NY 12065				
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	364						3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	s were paid	
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Na	me 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				
commissions paid	(c) Amount	(d) Purpose	 (e) Organization code 		
			<u> </u>		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4
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Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr			or(a) or mombors of the		Novoo organizationa(a) tha
		information may be combined for reporting put the entire group of such individual contracts v	irposes if such contracts	are experienc	e-rated as a unit. Whe	ere contract	
8	Bon	efit and contract type (check all applicable boxes)	will each camer may be			iepoit.	
Ŭ	г			م [Vision		
	a	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabil	lity g	Supplemental unemp	loyment	h Prescription drug
	i [Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
	m	Conter (specify) ► SUPPLEMENTAL PRODUC	TS				
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	l				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n 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					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention		_		9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid i	in cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	e benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entere	ed in line 9c(2) .)	9e	
10) No	nexperience-rated contracts:			-		
	а	Total premiums or subscription charges paid to c	arrier			10a	3629
	b	If the carrier, service, or other organization incurr rotantian of the contract or policy, other than room				10b	
		retention of the contract or policy, other than repo	nieu in Part I, line 2 abo	ve, report amo	นเ แ		

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

SCHEDULE	A	Insuran	ce Informatio	n		01	/B No. 1210-0110	
(Form 5500))							
Department of the Trea Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2013	
Department of Labo Employee Benefits Security Ac		File as an attachment to Form 5500.						
Pension Benefit Guaranty C	orporation					This Fo	rm is Open to Public Inspection	
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and er	ding 12	/31/2013	-	
A Name of plan CAPITAL REGION ORTH	SOCIATES PC BENEFITS PLAN			e-digit number (Pl	N) 🕨	510		
C Plan sponsor's name a CAPITAL REGION ORTH				D Emplo 14-163		ation Number	(EIN)	
		ning Insurance Contract (Individual contracts grouped as						
1 Coverage Information:	le ochedule A.	individual contracts grouped as		can be rep				
(a) Name of insurance ca								
	(c) NAIC	c) NAIC (d) Contract or (e) Approximate number of Policy or cont				contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To	
06-0838648	70815	766963G		47	01/01/20	13	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in	
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees paid		
		1974						
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).				
BROWN & BROWN OF I		and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
			NY, NY 12203					
(b) Amount of sales a	nd base	Fee	es and other commissio	ns paid			_	
commissions pa		(c) Amount		(d) Purpos	9		(e) Organization code	
	1974						3	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales a	nd base	Fee	es and other commissio	ns paid				
commissions pa		(c) Amount	·				(e) Organization code	

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid		
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

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

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Na	me 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				
commissions paid	(c) Amount	(d) Purpose	 (e) Organization code 		
			<u> </u>		

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Page	4

li ir	Velfare Benefit Contract Informat f more than one contract covers the same gran formation may be combined for reporting pro- the entire group of such individual contracts	oup of employees of the s urposes if such contracts	are experience	ce-rated as a unit. Whe	ere contract	ployee organizations(s), the is cover individual employees,
8 Benefit ar	nd contract type (check all applicable boxes)					
a 🗌 Hei	alth (other than dental or vision)	b Dental	с	Vision		d Life insurance
e 🛛 Ter	mporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	olovment	h Prescription drug
	pp loss (large deductible)	i HMO contract	· • _	PPO contract	· · , · · ·	I Indemnity contract
			n _			
m Oth	ner (specify)					
9 Experienc	e-rated contracts:					
•	ums: (1) Amount received		9a(1)			1
	crease (decrease) in amount due but unpaid					1
(3) In	crease (decrease) in unearned premium res	serve	9a(3)			1
(4) E	arned ((1) + (2) - (3))				9a(4)	
b Bene	efit charges (1) Claims paid		9b(1)			
(2) In	crease (decrease) in claim reserves		9b(2)		1	
(3) In	curred claims (add (1) and (2))				9b(3)	
()	laims charged				9b(4)	
	ainder of premium: (1) Retention charges (c	,	a (1)(a)			4
,	A) Commissions		9c(1)(A)			4
```	B) Administrative service or other fees		9c(1)(B)			4
	C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)			
•	D) Other expenses E) Taxes		9c(1)(E)			-
```	F) Charges for risks or other contingencies					-
,	G) Other retention charges					-
	H) Total retention				9c(1)(H)	
•	Dividends or retroactive rate refunds. (These	_				
	us of policyholder reserves at end of year: (1				9d(1)	
	Claim reserves				9d(2)	
()	Other reserves				9d(3)	
e Divid	lends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	9e	
	erience-rated contracts:				·	
a Tota	I premiums or subscription charges paid to c	arrier			10a	19742
	e carrier, service, or other organization incur					
reter	ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b	

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

SCHEDULE	A	Insuran	ce Informatio	n		0	MB No. 1210-0110
(Form 5500))						
Department of the Trea Internal Revenue Service		This schedule is required Employee Retirement Ind					2013
Department of Labo Employee Benefits Security Ac		File as an a	ttachment to Form 55	600.			
Pension Benefit Guaranty C	orporation	 Insurance companies a pursuant to E 	are required to provide t RISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and er	ding 12	/31/2013	
A Name of plan CAPITAL REGION ORTH	IOPAEDIC ASS	SOCIATES PC BENEFITS PLAN			e-digit number (Pl	N) 🕨	510
C Plan sponsor's name a CAPITAL REGION ORTH				D Emplo		ation Number	(EIN)
		ning Insurance Contract (Individual contracts grouped as					
1 Coverage Information:	te ochedule A.	individual contracts grouped as		can be rep			
-							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or o	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
06-0838648	70815	766963G	35 01/01/2013		13	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	al commissions paid. L	ist in line 3	the agents,	brokers, and	other persons in
(a) Total	amount of com	missions paid		(b) To	otal amount	of fees paid	
		1908					
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
BROWN & BROWN OF I		and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	NEW TORK IN		NY, NY 12203				
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			_
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	1908						3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales a	nd base	Fee	s and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

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

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

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

(b) Amount of sales and base		(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			

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
			<u> </u>	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

	Ρ	age	4
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Pa	rt III	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 s urposes if such contracts	are experienc	e-rated as a unit. Wh	ere contract	
8	Bene	fit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f 🛛 Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription drug
	i [Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)					
9 E	Expe	rience-rated contracts:					
i	a F	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid	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 (c	on an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			_
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			_
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves	· · · · · · · · · · · · · · · · · · ·			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2) .	.)	9e	
10		nexperience-rated contracts:				•	
		Total premiums or subscription charges paid to o	carrier			10a	19084
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	red any specific costs in c	onnection wit	h the acquisition or	10b	

Specify nature of costs

Part IV Provision of Information

11	Did the 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.			

SCHEDULE		Insuranc	e Information		ON	<i>I</i> B No. 1210-0110
(Form 5500) Department of the Treasu	ry		to be filed under section 104		2013	
Internal Revenue Service Department of Labor	e		ome Security Act of 1974 (E	RISA).		
Employee Benefits Security Adm Pension Benefit Guaranty Corp			tachment to Form 5500.		This Fo	rm is Open to Public
			re required to provide the inf RISA section 103(a)(2).	ormation		Inspection
For calendar plan year 2013	3 or fiscal plan	year beginning 01/01/2013		ÿ	2/31/2013	
A Name of plan CAPITAL REGION ORTHO	PAEDIC ASS	OCIATES PC BENEFITS PLAN	В	Three-digit plan number (P	N) 🕨	510
C Plan sponsor's name as CAPITAL REGION ORTHO				Employer Identific 4-1633562	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a				
Coverage Information:						
a) Name of insurance carr	ier					
METROPOLITAN LIFE IN	SURANCE CC	OMPANY				
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or contract year	
(b) EIN	code	identification number	persons covered at end policy or contract year	(T)	From	(g) To
13-5581829	65978	TM05987633	239	01/01/20)13	12/31/2013
		tion. Enter the total fees and tota	I commissions paid. List in I	line 3 the agents,	brokers, and o	other persons in
descending order of the a descending order at the a	mount of comn	nissions paid		(b) Total amount	of fees paid	
		2313				23
3 Persons receiving comm		ees. (Complete as many entries a				
BROWN & BROWN OF NE		nd address of the agent, broker, of 6 TOW	or other person to whom con	nmissions or fees	s were paid	
		ALBAN	NY, NY 12203			
(b) Amount of sales and			s and other commissions pai			_
commissions paid	1960	(c) Amount 229 SU	(d) Po PPLEMENTAL COMPENSA	ATION		(e) Organization code
ROWLANDS & BARRANC		nd address of the agent, broker, o	or other person to whom con	nmissions or fees	were paid	
	AGENCTIN		VY, NY 12203			
(b) Amount of sales and			s and other commissions pai	d		_
commissions paid		(c) Amount	. ,			(e) Organization code
	353	9 SU	PPLEMENTAL COMPENSA	A LION		3
	Act Notice a					

(b) Amount of sales and base		(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					
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

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

(b) Amount of sales and base		(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						

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
			<u> </u>	

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

Pag	e 4

Pa	art II	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same gr					
		information may be combined for reporting put the entire group of such individual contracts w					s cover maividual employees,
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	с	Vision		d 🛛 Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemp		h Prescription drug
	i		j HMO contract	, s_ k∏	PPO contract	lo y mont	
		Stop loss (large deductible)		n _	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Fyne	erience-rated contracts:					
J		Premiums: (1) Amount received	Г	9a(1)			-
		(2) Increase (decrease) in amount due but unpaid					1
		(3) Increase (decrease) in unearned premium res		9a(3)			1
		(4) Earned ((1) + (2) - (3))				9a(4)	
	-	Benefit charges (1) Claims paid	-				
		(2) Increase (decrease) in claim reserves					1
		(3) Incurred claims (add (1) and (2))	-			9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				
		(A) Commissions		9c(1)(A)			7
		(B) Administrative service or other fees		9c(1)(B)			7
		(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	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide b	penefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	in line 9c(2).	.)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to c	arrier			10a	15220
		If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b	

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	Х	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE		Insuranc	e Information	n		ON	/IB No. 1210-0110
(Form 5500) Department of the Treasu Internal Revenue Servic	ıry	This schedule is required Employee Retirement Inc					2013
Department of Labor			ttachment to Form 55	,).		
Employee Benefits Security Adm Pension Benefit Guaranty Corp		 Insurance companies al 			ion	This Fo	rm is Open to Public
			RISA section 103(a)(2)		1011		Inspection
For calendar plan year 201							
A Name of plan CAPITAL REGION ORTHO	OPAEDIC ASS	OCIATES PC BENEFITS PLAN			e-digit number (Pl	N) 🕨	510
C Plan sponsor's name as CAPITAL REGION ORTHO				D Emplo	-	ation Number	(EIN)
on a separate		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance carr HEALTHNOW NEW YOR		LUE CROSS BLUE SHIELD OF	WESTERN NEW YOR				
		(d) Contract or	(e) Approximate nu	umber of		Policy or c	ontract year
(b) EIN (c) NAIC code		identification number	persons covered at end of policy or contract year		(f)	From	(g) To
16-1105741	55204	00968908	220		01/01/20	13	12/31/2013
2 Insurance fee and comm descending order of the a		tion. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and c	other persons in
	mount of comn	nissions paid		(b) To	otal amount	of fees paid	
		32535					
3 Persons receiving comm		es. (Complete as many entries a					
BROWN & BROWN OF N		nd address of the agent, broker, o	or other person to who VFR PI	m commiss	ions or fees	were paid	
BROWN & BROWN OF N	EW TORK INC	,	NY, NY 12203				
(b) Amount of sales and	d base	Fees	s and other commission	ns paid			
commissions paid	b	(c) Amount	(d) Purpose		е		(e) Organization code
32535					3		
	(a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
		Fee	s and other commission	ns paid			
(b) Amount of sales and commissions paid		(c) Amount	Fees and other commissions paid (d) Purpose				(e) Organization code

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

Schedule A (Form 5500) 2013 v. 130118

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

 (b) Amount of sales and base commissions paid
 Fees and other commissions paid
 (e) Organization code

 (c) Amount
 (d) Purpose
 code

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

(b) Amount of sales and base		(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					

(b) Amount of sales and base commissions paid		(e) Organization	
	(c) Amount	(d) Purpose	code
			<u> </u>

(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent 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 the general accounts at year			
-	tracts 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 co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

	Page	4
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Ра	rt III	III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the							
		information may be combined for reporting p the entire group of such individual contracts						ts cover	individual employees,
8	Bene	fit and contract type (check all applicable boxes)							
	a 🗴	Health (other than dental or vision)	b	Dental	c	Vision		d 🗌 Li	fe insurance
	еГ	Temporary disability (accident and sickness)	f	1	ty g	Supplemental unem	plovment	h 🛛 P	rescription drug
	- -	Stop loss (large deductible)		HMO contract	-, 9_ k	PPO contract	programme		demnity contract
	' _		1		ĸ			•□ "'	
	m	Other (specify)							
9	Ехреі	ience-rated contracts:							
		remiums: (1) Amount received			9a(1)		856187	7	
	(2) Increase (decrease) in amount due but unpai	db						
		3) Increase (decrease) in unearned premium res							
	(4) Earned ((1) + (2) - (3))					. 9a(4)		856187
	b	Benefit charges (1) Claims paid			9b(1)		718477	'	
	(2) Increase (decrease) in claim reserves			9b(2)				
	(3) Incurred claims (add (1) and (2))					. 9b(3)		718477
	(4) Claims charged					. 9b(4)		
	С	Remainder of premium: (1) Retention charges (c	on an a	accrual basis)					
		(A) Commissions			9c(1)(A)				
		(B) Administrative service or other fees			9c(1)(B)		103462	2	
		(C) Other specific acquisition costs							
		(D) Other expenses			9c(1)(D)				
		(E) Taxes							
		(F) Charges for risks or other contingencies.					25686	6	
		(G) Other retention charges					8562		
		(H) Total retention		_			. 9c(1)(H))	137710
		(2) Dividends or retroactive rate refunds. (These	e amoi	unts were paid in	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amc	ount held to provide	benefits after	r retirement	. 9d(1)		
		(2) Claim reserves					. 9d(2)		
	(3) Other reserves						. 9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot incl	ude amount entere	d in line 9c(2)) .)	. 9e		
10	Nor	experience-rated contracts:							
	a	Total premiums or subscription charges paid to o	carrier				. 10a		
		If the carrier, service, or other organization incur retention of the contract or policy, other than rep					. 10b		

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	Х	No	
12 If the	answer to line 11 is "Yes," specify the information not provided.				

SCHEDULE C	Service Provider	Information		OMB No. 1210-0110		
(Form 5500)		2013				
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under Retirement Income Security A					
Department of Labor Employee Benefits Security Administration	File as an attachment	t to Form 5500.	This F	Form is Open to Public Inspection.		
Pension Benefit Guaranty Corporation For calendar plan year 2013 or fiscal pla	an year beginning 01/01/2013	and ending 12/31	/2013			
A Name of plan CAPITAL REGION ORTHOPAEDIC AS		B Three-digit plan number (PN)	•	510		
C Plan sponsor's name as shown on lir CAPITAL REGION ORTHOPAEDIC AS		D Employer Identification Number (EIN) 14-1633562				
Part I Service Provider Info	rmation (see instructions)					
 a Check "Yes" or "No" to indicate wheth indirect compensation for which the p b If you answered line 1a "Yes," enter received only eligible indirect compensation 	ceiving Only Eligible Indirect Com her you are excluding a person from the remain an received the required disclosures (see ins the name and EIN or address of each person historia. Complete as many entries as needed me and EIN or address of person who provide	inder of this Part because they rece tructions for definitions and condition providing the required disclosures d (see instructions).	ns)	☐ Yes ⊠ No ce providers who		
(b) Enter na	me and EIN or address of person who provide	ed you disclosure on eligible indirec	t compensa	tion		
(b) Enter nar	me and EIN or address of person who provide	ed you disclosures on eligible indirec	t compensa	ition		

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

		(a) Enter name and EIN or	address (see instructions)				
BROWN &	BROWN OF NEW YO	ORK INC DBA	6 TOWER	IDS AND BARRANCA AGENC` ₹ PL NY 12203	(INC			
58-151047	7							
(b) Service Code(s)	(c) 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?		
14	PLAN ADMINISTRATOR	8562	Yes 🗌 No 🛛	Yes 🗌 No 🕅		Yes 🗌 No 🗙		
	•	(a) Enter name and EIN or	address (see instructions)	•			
	_							
(b) Service Code(s)	(c) 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 🗌		
		(a) Enter name and EIN or	address (see instructions)				
(b) Service Code(s)	(C) 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 🗌		

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	(C) 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 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(C) 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 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) 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 🗌

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
		compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any
	formula used to determine t	the service provider's eligibility le indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any the service provider's eligibility
	for or the amount of th	ie indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect conformula used to determine to	he service provider's eligibility
	for or the amount of th	e indirect compensation.

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P	Part II Service Providers Who Fail or Refuse to Provide Information				
4	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		

Pa	art III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)		
а	Name		b EIN:
С	Positio	n:	
d	Addre	3S:	e Telephone:
Ex	planatio	1.	

Name:	b EIN:
Position:	
Address:	e Telephone:
	Position:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation: