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

2014

This Form is Open to Public Inspection

Part I	Annual Report Ide	entification Information						
For caler	For calendar plan year 2014 or fiscal plan year beginning 07/01/2014 and ending 06/30/2015							
A This	return/report is for:	a multiemployer plan;		ployer plan (Filers checki employer information in ac	-		ons); or	
		x a single-employer plan;	a DFE (speci	fy)				
B This r	eturn/report is:	the first return/report;	the final retur	n/report;				
	·	an amended return/report;	a short plan y	ear return/report (less that	an 12 months	s).		
C If the	plan is a collectively-bargai	ined plan, check here				→ □		
	k box if filing under:	Form 5558;	automatic ext					
2 01.00	K BOX II IIIIII g GIIGOI.	special extension (enter description	_	,		, ,		
Part	I Basic Plan Info	rmation—enter all requested informa	ation					
1a Nam	ne of plan	ARE CENTER FLEXIBLE BENEFIT PL			1b	Three-digit plan number (PN) ▶	502	
					1c	Effective date of pla 07/01/1995	an	
	sponsor's name and addre	ess; include room or suite number (emp ARE CENTER, INC	oloyer, if for a single-	employer plan)	2b	Employer Identifica Number (EIN) 61-0663787	ation	
	JTH FRONT AVENUE		TH FRONT AVENUE		2c Plan Sponsor's telephone number 606-886-8572			
PRESTO	DNSBURG, KY 41653	PRESTOR	NSBURG, KY 41653		2d Business code (see instructions) 621330			
Caution	A penalty for the late or	incomplete filing of this return/repor	rt will be assessed	unless reasonable caus	se is establis	shed.		
Under pe	enalties of perjury and other	r penalties set forth in the instructions, I Il as the electronic version of this return	I declare that I have	examined this return/repo	ort, including	accompanying sche		
SIGN	Filed with authorized/valid	electronic signature.	04/18/2016	KATHY GOBLE				
HERE	Signature of plan admin	istrator	Date	Enter name of individua	al signing as	plan administrator		
SIGN	о. у				<u></u>			
HERE	Signature of employer/p	olan sponsor	Date	Enter name of individua	al signing as	employer or plan sp	onsor	
SIGN								
HERE	Signature of DFE		Date	Enter name of individua	al signing as	DFE		
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Preparer's telephone number								
WILLIAM G. CARROLL (optional)								
STROTHMAN & COMPANY PSC 502-585-1600								
	MAIN ST. SUITE 1600 LLE, KY 40202-4251							

Form 5500 (2014) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor		3b Adminis	
MC	OUNTAIN COMPREHENSIVE CARE CENTER		61-060	
	4 SOUTH FRONT AVENUE ESTONSBURG, KY 41653		numbe	strator's telephone r 3-886-8572
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	n/report filed for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5	692
6	Number of participants as of the end of the plan year unless otherwise state 6a(2) , 6b , 6c , and 6d).	d (welfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	692
a(2	Total number of active participants at the end of the plan year		6a(2)	724
b	Retired or separated participants receiving benefits		6b	
С	Other retired or separated participants entitled to future benefits		. 6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.		. 6d	724
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits	. 6e	
f	Total. Add lines 6d and 6e.		. 6f	
g	Number of participants with account balances as of the end of the plan year complete this item)		. 6g	
h	Number of participants that terminated employment during the plan year witl 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	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits, enter the applicable welfare feature could be plan at the plan provides welfare benefits.	des from the List of Plan Characteristics Code	s in the instru	
9 а	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all that (1) Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance co	ntracts
	(3) Trust	(3) Trust		
10	(4) X General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are a	(4) General assets of the s	<u>' </u>	(See instructions)
		_	ber attaoried.	(Occ mondono)
а	Pension Schedules (1) R (Retirement Plan Information)	b General Schedules (1) H (Financial Inform	mation)	
	(2) Departure Defined Departure Departure Manage		,	II Dian)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2) I (Financial Inform		ıı Plan)
	actuary	(4) C (Service Provide		n)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participati	_	
-	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Sched	dules)

Form 5500 (2014) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Yes" is checke	If "Yes" is checked, complete lines 11b and 11c.					
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)						
Receipt Confirmation Code						

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

2014

This Form is Open to Public

pursuant to ERISA section 103(a)(2).			inspection				
For calendar plan year 20°	14 or fiscal pla	an year beginning 07/01/2014		and en	ding 06	5/30/2015	
A Name of plan MOUNTAIN COMPREHEI	NSIVE CARE	CENTER FLEXIBLE BENEFIT F	PLAN	B Three plan	e-digit number (P	N) •	502
C Plan sponsor's name as shown on line 2a of Form 5500 MOUNTAIN COMPREHENSIVE CARE CENTER, INC D Employer Identification Number (Electron Company) 61-0663787						EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca	rrier						
ANTHEM HEALTH PLAN	IS OF KENTU	ICKY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(D) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
61-1237516	95120	001003753	50	07/01/2014		014	06/30/2015
2 Insurance fee and complete descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents,	, brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
	536						
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
		and address of the agent, broke			ions or fees	s were paid	
CREECH AND STAFFOR	RD INS AGCY		S SIR BARTON WAY ST INGTON, KY 40509	≣ 300			
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
536						3	
	(a) Name	and address of the agent, broke	r, or other person to who	n commissi	ions or fees	s were paid	
	(a) Hamo	and dedicate of the agont, protect	, or other percent to when		10110 01 1000	s word paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(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 paid					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year		-	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, checl	k here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) media immedia (3) guaranteed investment (4) other	ate participation g	guarantee		
	b	Balance at the end of the previous year		[7b	
	С	Additions: (1) Contributions deposited during the year		Į.		
		(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		F	7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(4)			
		(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) 7e(4)			
		(4) Other (specify below)	<i>1</i>			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

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e experienc		ere contracts	loyee organizations(s), the cover individual employees,
c [g [k [Vision Supplemental unemp PPO contract	_	Life insurance Prescription drug I Indemnity contract
9a(1)			
9a(2)			
9a(3)			
		9a(4)	
9b(1)			
0h/2\			

Pá	art II	I 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 surposes if such contracts a	are experienc	ce-rated as a unit. Wi	here contracts	
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision	(X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д 🗍	Supplemental unem	nployment i	Prescription drug
	ίĪ	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Other (specify)	<i>,</i>		I		<u> </u>
	L						
9	Ехре	rience-rated contracts:					
	a	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))	г			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))					
	_	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	· · · · · · · · · · · · · · · · · · ·	0 (4)(4)			
		(A) Commissions	•	9c(1)(A)			
		(B) Administrative service or other fees	•	9c(1)(B) 9c(1)(C)			
		(C) Other specific acquisition costs	•	9c(1)(C)			
		(D) Other expenses		9c(1)(E)			
		(E) Charges for risks or other continuous		9c(1)(F)			
		(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	_	_			
	d		— •				
	u	Status of policyholder reserves at end of year: (1 (2) Claim reserves	•			9d(1) 9d(2)	
		(3) Other reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no					
10		nexperience-rated contracts:	A morado amount ontereu	JC(2)	.,	36	
	a	Total premiums or subscription charges paid to c	arrier			10a	43730
	b	If the carrier, service, or other organization incurr					10100
		retention of the contract or policy, other than repo	, ,		'	10b	
	Sp	ecify 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.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public

r ension benefit Guaranty of	прогацоп	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				Inspection	
For calendar plan year 20	14 or fiscal pl	an year beginning 07/01/2014		and ending	06/30/2015		
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	CENTER FLEXIBLE BENEFIT F	PLAN	Three-digit plan numbe	r (PN)	502	
C Plan sponsor's name a MOUNTAIN COMPREHE		D	Employer Ider 61-0663787	ntification Numbe	er (EIN)		
		rning Insurance Contract A. Individual contracts grouped as					
(a) Name of insurance ca		JCKY	(a) Approximate gumb	or of	Policy or	contract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate numb persons covered at en policy or contract ye	id of	(f) From	(g) To	
61-1237516	95120	001003753	0	07/0	1/2014	06/30/2015	
2 Insurance fee and com descending order of the		mation. Enter the total fees and to	otal commissions paid. List in	n line 3 the age	nts, brokers, and	other persons in	
		mmissions paid		(b) Total amo	ount of fees paid		
		2303			•	0	
3 Persons receiving com	missions and	I fees. (Complete as many entries	s as needed to report all per	sons).			
		and address of the agent, broker			fees were paid		
CREECH AND STAFFO		Y INC 2416	5 SIR BARTON WAY STE 30 INGTON, KY 40509		·		
(b) Amount of sales a	nd base	Fe	es and other commissions p	aid			
commissions pa		(c) Amount	(d)	(d) Purpose		(e) Organization code	
	2303						
	(a) Name	and address of the agent, broker	r or other person to whom o	ommissions or	fees were naid		
	(a) Name	and address of the agont, protein	, or other person to whom or		iodo wore para		
(b) Amount of sales a	nd base	Fe	es and other commissions p	aid			
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code	

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(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 paid					
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts w	ith each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year		-	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, checl	k here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) media immedia (3) guaranteed investment (4) other	ate participation g	guarantee		
	b	Balance at the end of the previous year		[7b	
	С	Additions: (1) Contributions deposited during the year		Į.		
		(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		F	7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(4)			
		(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) 7e(4)			
		(4) Other (specify below)	<i>1</i>			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

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experience	rer(s) or members of the same en ce-rated as a unit. Where contraction init for purposes of this report.		
c g k	Vision Supplemental unemployment PPO contract	d [h [I	Life insurance Prescription drug Indemnity contract
a(1)			

Pa	art III	If more than one contract covers the same gr information may be combined for reporting puthe entire group of such individual contracts v	roup of employees of the saurposes if such contracts a	re experienc	e-rated as a unit. Wh	ere contracts	
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	b Dental	С	Vision	(d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	, g	Supplemental unemp	oloyment I	h Prescription drug
	ιĒ	Stop loss (large deductible)	j HMO contract	~ =	PPO contract	·	I Indemnity contract
	m [Other (specify)	, .		l.		· ·
9	Expe	rience-rated contracts:					
	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))	<u>.</u>			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)			1
		(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	enefits after	retirement	9d(1)	
		(2) Claim reserves	' '			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	
10		nexperience-rated contracts:		(-/-	,		
		Total premiums or subscription charges paid to c	arrier			10a	185966
	_	If the carrier, service, or other organization incurr					100000
	~	retention of the contract or policy, other than repo				10b	

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

Specify nature of costs >

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2014

This Form is Open to Public

			ERISA section 103(a)(2).	nomation		Inspection	
For calendar plan year 20	14 or fiscal pla	n year beginning 07/01/2014		and ending 0	6/30/2015		
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	CENTER FLEXIBLE BENEFIT F	PLAN	Three-digit plan number (F	PN) •	502	
C Plan sponsor's name as shown on line 2a of Form 5500 MOUNTAIN COMPREHENSIVE CARE CENTER, INC D Employer Identification Number (EIN) 61-0663787							
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:		-					
(a) Name of insurance ca	rrier						
ANTHEM HEALTH PLAN	IS OF KENTU	CKY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate numbersons covered at en		Policy or c	ontract year	
(b) EIN	code	identification number	policy or contract year	/1) From	(g) To	
61-1237516	95120	001003753	484	07/01/2	014	06/30/2014	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. List ir	n line 3 the agents	, brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
		2089				0	
3 Persons receiving com	missions and t	fees. (Complete as many entries	s as needed to report all pers	sons).			
		and address of the agent, broker			s were paid		
CREECH AND STAFFOR	RD INS AGCY		S SIR BARTON WAY STE 30 NGTON, KY 40509	00			
(b) Amount of sales ar	nd base	Fe	es and other commissions p	aid			
commissions pa		(c) Amount	(d) F	Purpose		(e) Organization code	
	2089						
	(a) Name -	and address of the second burling	or other person to what	mmionione auto-	o wore r = : -!	•	
	(a) Name	and address of the agent, broker	, or other person to whom co	ommissions or tee	s were paid		
(b) Amount of sales ar commissions pa		(c) Amount	es and other commissions p	aid Purpose		(e) Organization code	
		(-)	(4)	· F		()/ = -3	

Schedule A (Form 5500) 2014 Page 2 - 1								
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
	-							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
	T							
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts w	ith each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year		-	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, checl	k here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) media immedia (3) guaranteed investment (4) other	ate participation g	guarantee		
	b	Balance at the end of the previous year		[7b	
	С	Additions: (1) Contributions deposited during the year		Į.		
		(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		F	7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(4)			
		(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) 7e(4)			
		(4) Other (specify below)	<i>1</i>			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	age 4		
e experienc		ere contracts	loyee organizations(s), the cover individual employees,
c [g [k [Vision Supplemental unemp PPO contract	_	d ☐ Life insurance ☐ ☐ Prescription drug ☐ ☐ Indemnity contract
9a(1)			
9a(2)			
9a(3)		9a(4)	
9b(1)		- σα(+ <i>)</i>	
			1

Pa	art II	II	If more than one contract covers the same gr information may be combined for reporting puthe entire group of such individual contracts v	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contrac	, , ,	· //
8	Ben	efit	and contract type (check all applicable boxes)						
	а	ı	Health (other than dental or vision)	b X Dental	С	Vision		d Life insurance	е
	е	1	Temporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental unem	oloyment	h Prescription of	drug
	i] ;	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity cor	ntract
	m		Other (specify)	_				_	
9	Expe	erie	ence-rated contracts:	_					
	а	Pre	emiums: (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	В	enefit 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	R	emainder 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	2) Dividends or retroactive rate refunds. (These	amounts were ☐ paid in	cash. or	credited.)			
	d		tatus of policyholder reserves at end of year: (1	_					
	_		2) Claim reserves	•			9d(2)		
		`	3) Other reserves				9d(3)		
		(3	, other recorded				34(3)	+	

10	Nonexperience-rated contracts:		
	a Total premiums or subscription charges paid to carrier	10a	16
	b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount	10b	
	Specify nature of costs		

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

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

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public

r ension benefit dualarity oc	riporation		s are required to provide the ERISA section 103(a)(2).		ion		Inspection
For calendar plan year 20	14 or fiscal pl	an year beginning 07/01/2014	1	and en	ding 06/	30/2015	
A Name of plan	•	CENTER FLEXIBLE BENEFIT	PLAN		e-digit number (PN	l) >	502
C Plan sponsor's name a MOUNTAIN COMPREHE				D Emplo		ation Number	(EIN)
		rning Insurance Contract Lindividual contracts grouped a					
(a) Name of insurance ca		JCKY				Dalimon	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f)	From	(g) To
61-1237516	95120	001003753	37		01/01/201	14	12/31/2014
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. Lis	st in line 3	the agents, I	brokers, and o	other persons in
(a) Total a	amount of cor	nmissions paid		(b) To	otal amount o	of fees paid	
		428					0
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all p	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whon	n commiss	ions or fees	were paid	
CREECH AND STAFFOR	RD INS AGC		6 SIR BARTON WAY STE (INGTON, KY 40509	300			
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	е		(e) Organization code
	428						
	(a) Name	and address of the agent, broke	er or other person to whon	n commiss	ions or fees	were paid	
	(a) Hame	and address of the agont, broke	n, or care, person to when	<u> </u>	10110 01 1000	word paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	9		(e) Organization code

Schedule A (Form 5500)	2014	Page 2 - 1	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts w	ith each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				1
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year		-	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, checl	k here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) media immedia (3) guaranteed investment (4) other	ate participation g	guarantee		
	b	Balance at the end of the previous year		[7b	
	С	Additions: (1) Contributions deposited during the year		Į.		
		(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		F	7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(4)			
		(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) 7e(4)			
		(4) Other (specify below)	<i>1</i>			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Page 4	
ployer(s) or members of rience-rated as a unit. W a unit for purposes of the	Vhere contracts co

Part III	Welfare	Benefit	Contr
	Schedule A	(Form 55	00) 2014

Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same eminformation may be combined for reporting purposes if such contracts are experienced. vee organizations(s), the over individual employees

		the entire group of such individual contracts v					is cover marviadar employees,
3	Benefit	and contract type (check all applicable boxes)					
	a 🗌	Health (other than dental or vision)	b Dental	c 🛚	Vision		d Life insurance
	е 🗌	Temporary disability (accident and sickness)	f Long-term disability	y g 🗌	Supplemental unemp	oloyment	h Prescription drug
	i ∏:	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract
	m \Box	Other (specify)	- 🗖	_			
	Ш						
)	Experie	ence-rated contracts:					
	a Pre	emiums: (1) Amount received		9a(1)			
	(2)	Increase (decrease) in amount due but unpaid	l	9a(2)			
	(3)	Increase (decrease) in unearned premium res	erve	9a(3)			
	(4)) Earned ((1) + (2) - (3))	<u>.</u>			9a(4)	
	b B	enefit 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)	
	C R	emainder 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	L	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)	1
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	redited.)	9c(2)	
	d St	tatus 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)	
	e D	ividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).)	9e	
0	None	xperience-rated contracts:					
	a To	otal premiums or subscription charges paid to c	arrier			10a	35751
		the carrier, service, or other organization incurr	, ,				
	re	tention of the contract or policy, other than repo	orted in Part I, line 2 above	e, report amo	unt	10b	
	Spec	ify 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.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

For calendar plan year 20°	14 or fiscal plar	year beginning 07/01/2014		and end	ding 06/30/2015	
A Name of plan MOUNTAIN COMPREHEN	NSIVE CARE C	ENTER FLEXIBLE BENEFIT PL	_AN	B Three	e-digit number (PN)	502
C Plan sponsor's name a MOUNTAIN COMPREHEN				D Employ 61-066	yer Identification Number 3787	(EIN)
		ing Insurance Contract (Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance cal	rrier					
AFLAC						
<u> </u>	(c) NAIC	(d) Contract or	(e) Approximate nun		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	(g) To
58-0663085	60380	ZY056	20)	07/01/2015	06/30/2015
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	t in line 3 t	the agents, brokers, and o	ther persons in
(a) Total a	amount of comr	missions paid		(b) To	tal amount of fees paid	
		1785				128
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all pe	ersons).		
		nd address of the agent, broker,			ons or fees were paid	
THOMAS A MORRIS AN	D ASSOC INC		EXECUTIVE DR SUITE : NGTON, KY 40505	204		
		Fee	es and other commissions	s naid		
(b) Amount of sales ar commissions pai		(c) Amount		d) Purpose)	(e) Organization code
•	449	81	,			3
	(a) Name a	nd address of the agent, broker,	or other person to whom	commissi	ons or fees were paid	
CREECH AND STAFFOR			SIR BARTON WAY STE		one or rece were paid	
		LEXIN	NGTON, KY 40509			
(b) Amount of sales ar	nd base	Fee	s and other commissions	s paid		
commissions pai	d	(c) Amount	(0	d) Purpose	9	(e) Organization code
	406	0				3
						•

(a) Name a		ا		
(a) Name at thomas a Morris and Assoc Inc			r, or other person to whom commissions or fees were paid THUNDERSTRUCK DR STE 1104	
THOMAS A MORRIS AND ASSOCING			GTON, KY 40505	
		-	Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code
	(C) Amount	10	(a) Fulpose	3
263		13		3
	<u> </u>		r, or other person to whom commissions or fees were paid	
THOMAS A MORRIS			CRUSADERS AY	
	L	-EXIIN	GTON, KY 40509	
(b) Amount of sales and base		<u> </u>	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
208		0		3
(a) Name a	nd address of the agent,	broker	r, or other person to whom commissions or fees were paid	
LESLIE K KIMBROUGH	2	2220 E	XECUTIVE DR SUITE 204	
	L	EXIN	GTON, KY 40505	
(b) Amount of sales and base		F	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
100		16		3
(a) Name a	nd address of the agent	hrokei	r, or other person to whom commissions or fees were paid	
LESLIE K KIMBROUGH			0X 273488	
LEGEIE K KIMBKOOOT			RATON, FL 33427	
(In) Agreement of a place and because		F	Fees and other commissions paid	(-) ()
(b) Amount of sales and base commissions paid	(c) Amount	i	(d) Purpose	(e) Organization code
94	(b) / linount	0	(4)1 (1)0000	3
34		Ŭ		· ·
,		1		•
			r, or other person to whom commissions or fees were paid	
KEITH FRIZZELL	1	1795 A	LYSHEBA WAY STE 1204 GTON, KY 40509	
	_		O1011, 101 40000	
(b) Amount of sales and base		<u> </u>	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
68		0		3

Page **2 -** 1

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		or other person to whom commissions or fees were pa	id
R. AARON WRIGHT	9200 SH LOUISVI	ELBYVILLE RD, SUITE 605 LLE, KY 40222	
			T
(b) Amount of sales and base —		es and other commissions paid	(e) Organization
commissions paid 52	(c) Amount	(d) Purpose	code 3
52	10		3
(a) Name	e and address of the agent, broker, o	or other person to whom commissions or fees were pa	id
LAURA NEWMAN-SUTTER	414 CHIN LEXINGT	NOE RD TON, KY 40502	
		and other commissions naid	
(b) Amount of sales and base commissions paid	(c) Amount	es and other commissions paid (d) Purpose	(e) Organization code
49	(c) Amount	(d) i dipose	3
	e and address of the agent, broker, o	or other person to whom commissions or fees were pa	id
LAURA J NEWMAN-SUTER	414 CHINGT	IOE RD ON, KY 40502	
	Fe	es and other commissions paid	
(b) Amount of sales and base		es and other commissions paid (d) Purpose	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	es and other commissions paid (d) Purpose	(e) Organization code
commissions paid 39	(c) Amount	(d) Purpose	code 3
commissions paid 39 (a) Name	(c) Amount 0 e and address of the agent, broker, or	(d) Purpose or other person to whom commissions or fees were pa	code 3
commissions paid 39 (a) Name	e and address of the agent, broker, o	(d) Purpose	code 3
commissions paid 39 (a) Name	e and address of the agent, broker, of the agent Alexander Alexand	(d) Purpose or other person to whom commissions or fees were pa	id code
commissions paid 39 (a) Name	e and address of the agent, broker, of the agent Alexander Alexand	(d) Purpose or other person to whom commissions or fees were particles and the person to whom commissions or fees were particles and the person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to whom commissions or fees were particles and the person to whom commissions or fees were particles. The person to t	code 3
commissions paid 39 (a) Name RUEANN EMERSON (b) Amount of sales and base	e and address of the agent, broker, of the agent AL	(d) Purpose or other person to whom commissions or fees were particles and the person to whom commissions or fees were particles and other commissions paid	id (e) Organization
(a) Name RUEANN EMERSON (b) Amount of sales and base commissions paid 21	(c) Amount 0 e and address of the agent, broker, c 4820 LAR GLEN AL Fee (c) Amount 0	(d) Purpose or other person to whom commissions or fees were particles and the person to whom commissions or fees were particles and other commissions paid	id (e) Organization code 3

Fees and other commissions paid

(d) Purpose

(c) Amount

0

(e) Organization code

3

(b) Amount of sales and base commissions paid

17

Schedule A	(Form 5500) 2014	Page 2 - 3

281 LINCOLN AVE STE 100 LEXINGTON, KY 40502 **CURTIS SCHWARTZ ENTERPRISES INC** Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code 10 2 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid CAREN OSTROWSKI 100 CLAY AVE GEORGETOWN, KY 40324 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code 5 0 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid LAWRENCE TODD FUGATE 2352 HARTLAND PARKSIDE DR LEXINGTON, KY 40515 Fees and other commissions paid (e) Organization (b) Amount of sales and base (c) Amount commissions paid (d) Purpose code 4 0 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (b) Amount of sales 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 Fees and other commissions 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

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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts w	ith each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				1
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year		-	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, checl	k here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) media immedia (3) guaranteed investment (4) other	ate participation g	guarantee		
	b	Balance at the end of the previous year		[7b	
	С	Additions: (1) Contributions deposited during the year		Į.		
		(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		F	7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(4)			
		(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) 7e(4)			
		(4) Other (specify below)	<i>1</i>			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2014		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 sar ourposes if such contracts are	e experienc	ce-rated as a unit. Wh	ere contrac	
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 Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
X Other (specify) ▶SUPPLEMENTAL			'		–
erience-rated contracts:	_	•			
Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpai	d	9a(2)			
(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
(4) Earned ((1) + (2) - (3))				9a(4)	
Benefit charges (1) Claims paid		9b(1)			
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))				9b(3)	
(4) Claims charged				9b(4)	
Remainder of premium: (1) Retention charges (on an accrual basis)				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
(C) Other enecific acquisition costs		0c(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:

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

Experience-rated contracts:

m X Other (specify) ▶SUPPLEMENTAL

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

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees..... (C) Other specific acquisition costs (D) Other expenses.....

(E) Taxes.....

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

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

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

(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

Part III

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

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

9c(1)(F)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2014

This Form is Open to Public

, , , , , , , , , , , , , , , , , , , ,			ERISA section 103(a)(2).		ION		Inspection	
For calendar plan year 20	For calendar plan year 2014 or fiscal plan year beginning 07/01/2014 and ending 06/30/2015							
A Name of plan MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT I			PLAN	B Three plan	e-digit number (PN	N) •	502	
	C Plan sponsor's name as shown on line 2a of Form 5500 MOUNTAIN COMPREHENSIVE CARE CENTER, INC D Employer Identification Number (E 61-0663787						r (EIN)	
		ning Insurance Contract Individual contracts grouped as						
1 Coverage Information:	te deficació A.	maividual contracts grouped as	a dilicili i atta ii and iii c	an be repe	orted off a 3i	ingic ocheda	io A.	
(a) Name of insurance ca	arrier							
COMPANION LIFE INSU		DANIV						
COMI ANION EN E INSC			(e) Approximate nu	mber of		Policy or	contract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at policy or contract	end of	(f)	From	(g) To	
57-0523959	77828	77828	39	8	07/01/20	14	06/30/2015	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis	st in line 3 t	the agents,	brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
9720								
3 Persons receiving com	missions and fo	ees. (Complete as many entries	s as needed to report all p	ersons).				
	· · ·	and address of the agent, broker		n commissi	ions or fees	were paid		
NORTH AMERICA ADM	INISTRATORS		ELM HILL PIKE HVILLE, TN 37210					
(b) Amount of sales an commissions pa		(c) Amount	es and other commission	s paid d) Purpose			(e) Organization code	
oominiosiono pa	9720	(O) / anount	<u>(a)</u> 1 dipose			3		
	(a) Name a	and address of the agent, broker	, or other person to whom	n commissi	ions or fees	were paid		
(b) Amount of sales a	nd base		es and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose)		(e) Organization code	

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	-				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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ay	v	•

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts w	ith each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				1
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year		-	6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, checl	k here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) media immedia (3) guaranteed investment (4) other	ate participation g	guarantee		
	b	Balance at the end of the previous year		[7b	
	С	Additions: (1) Contributions deposited during the year		Į.		
		(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		F	7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:	70(4)			
		(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) 7e(4)			
		(4) Other (specify below)	<i>1</i>			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	age 4			
e experienc	ver(s) or members of the ce-rated as a unit. Whe unit for purposes of this	ere contract		e organizations(s), the er individual employees,
c [g [k [Vision Supplemental unemp PPO contract		d <mark>⊠</mark> h [] I []	Life insurance Prescription drug Indemnity contract
9a(1)			_	
9a(2)				
9a(3)				
		9a(4)		
9b(1)				

		information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts a	are experienc	e-rated as a unit. Who	ere contract		
8	Bene	efit and contract type (check all applicable boxes)	-					
	а	Health (other than dental or vision)	b Dental	с	Vision		d X Life insurance	ce
	еĒ		f Long-term disability	y g	Supplemental unemp		h Prescription	
	. =		j HMO contract	·	PPO contract	olo y i i lorit	<u> </u>	•
	i L	Stop loss (large deductible)	I HIVIO contract	ĸ_	PPO contract		I Indemnity co	ntract
	m	Other (specify)						
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)			7	
		(2) Increase (decrease) in amount due but unpaid	d	• • • •			_	
		(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	F	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	L	9c(1)(G)		6 (4)(1)		
		(H) Total retention	_	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	<u>—</u>			9c(2)		
		Status of policyholder reserves at end of year: (1	, I			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
4.0		Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:				40		
		Total premiums or subscription charges paid to d				10a		184584
		If the carrier, service, or other organization incur retention of the contract or policy, other than rep			•	10b		
	Sp	ecify nature of costs						

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

Schedule A (Form 5500) 2014

Part III

Welfare Benefit Contract Information

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

		•				
For calendar plan year 20	14 or fiscal plan	year beginning 07/01/2014	and e	nding 06/30/2015		
A Name of plan			B Thr			
MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT PLAN			AN pla	n number (PN)	502	
C Plan sponsor's name a	as shown on line	e 2a of Form 5500	D Emp	oyer Identification Number	r (EIN)	
MOUNTAIN COMPREHE				663787	,	
		ing Insurance Contract C Individual contracts grouped as a				
1 Coverage Information:		Ŭ i		<u> </u>		
(a) Name of insurance ca	rrier					
()						
COLONIAL LIFE & ACCI	DENT INSURA	NCE CO				
/b) [IN]	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
57-0144607	62049	E7817000	60	07/01/2014	06/30/2015	
2 Insurance fee and com	mission informa	ition. Enter the total fees and tota	I commissions paid. List in line	3 the agents, brokers, and	other persons in	
descending order of the	amount paid.					
(a) Total amount of commissions paid (b) Total amount of fees paid						
		3246			0	
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees were paid		
MARY DUFF			ASADENA DRIVE GTON, KY 40503			
		LLXIIV	GTON, KT 40303			
(b) Amount of sales ar	nd hase	Fees	s and other commissions paid			
commissions pa		(c) Amount	(d) Purpo	(e) Organization code		
	1205				3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	sions or fees were paid		
BB&T INSURANCE SER	VICES	414 G	ALLIMORE ROAD NSBORO, NC 27409			
		GREE	NSBORO, NC 27409			
(b) Amount of colon or	ad book	Fees	s and other commissions paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpo	se	(e) Organization code	
	594		, , ,		3	
For Donorwork Doductio	n Act Notice c	nd OMB Control Numbers, see	the instructions for Earn EEO	1		
	ACT MOTICE 3		THE RESIDENCE TO FORD SOUR			

Schedule A (Form 5500) 2	014	Page 2 - 1	
(a) Nam	e and address of the agent, broke	er, or other person to whom commissions or fees were pa	nid
MCGOHAN BRABENDER AGY	3931	S DIXIE DRIVE ON, OH 45439	
(h) Assessed of soles and have		Fees and other commissions paid	(-) (
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
243			3
(a) Nam	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	iid
DARRELL PATTON		DX 925 TONBURG, KY 41653	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
203			3
(a) Nam	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	iid
CREECH AND STAFFORD INS AGCY	INC 210 M LEXIN	ALABU DRIVE IGTON, KY 40502	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
196			3
(a) Nam	e and address of the agent, broke	r, or other person to whom commissions or fees were pa	nid
FINCH INSURANCE GROUP		HYDE PARK DRIVE IGTON, KY 40503	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
171	(c) Amount	(u) Fulpose	3
	e and address of the agent, broke	er, or other person to whom commissions or fees were pa	l
DEE ANN SLADE	104 P	OTOMAC COURT KFORT, KY 40601	
		Fees and other commissions paid	1
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
122			3
		<u> </u>	

Schedule A (Form 5500)	2014	Page 2 - 2	
(a) Nar	ne and address of the agent broke	er, or other person to whom commissions or fees were pai	d
ASSURED NEACE LUKENS INSURA	NCE AGEN 2416	SIR BARTON WAY STE 300 NGTON, KY 40509	u
(b) Amount of color and base		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
120	.,		3
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were pai	l
ANNE OWENS		DEAR LAKE DRIVE NGTON, KY 40515	
(b) Amount of sales and base		Fees and other commissions paid	(a) Organization
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
103			3
(a) Nar	ne and address of the agent broke	er, or other person to whom commissions or fees were pai	d
LERMAN VENTURES		SURREY RIDGE ROAD RKSVILLE, TN 37043	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
99			3
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were pai	d
LISA R GRAVES		GLENNS CREEK RD IKFORT, KY 40601	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
68			3
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were pai	d
BART GAUNT	4021 LOUI	ST GERMAINE CT SVILLE, KY 40207	
(b) Amount of a little		Fees and other commissions paid	(2) 0
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code

45

(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
MARK HOLLAND	PO BC	DX 38366 ANTOWN, TN 38183		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code	
34			3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	•	
BENJAMIN B GAUNT	6923 F LOUIS	FALLEN LEAF CIRCLE VILLE, KY 40241		
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid	(e) Organization	
commissions paid 26	(C) Amount	(d) Purpose	3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
CATHY M LERMAN		SURREY RIDGE ROAD KSVILLE, TN 37043		
(b) Amount of sales and base Fees and other commissions paid		•	(e) Organization	
commissions paid 10	(c) Amount	(d) Purpose	code 3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
KAREN TOBIAS	1366 E	DUNRAVEN DR REESBORO, TN 37128		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid 4	(c) Amount	(d) Purpose	code 3	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
CAROL LAMB	309 FC LEXIN	DX HARBOUR DRIVE GTON, KY 40517		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization code 3 (e) Organization code 3 (e) Organization code	
commissions paid 2	(c) Amount	(d) Purpose		

Page **2 -** 3

(b) Amount of sales and base

commissions paid

(b) Amount of sales and base

commissions paid

Page **2 -** 4

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MICHAEL J BOONE 1302 CLEAR SPRINGS TRACE LOUISVILLE, KY 40223 Fees and other commissions paid (e) Organization (b) Amount of sales and base commissions paid (c) Amount (d) Purpose code 1 3 (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid Fees and other commissions paid (b) Amount of sales 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base code commissions paid (c) Amount (d) Purpose

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

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

(c) Amount

(c) Amount

Fees and other commissions paid

Fees and other commissions paid

(d) Purpose

(d) Purpose

(e) Organization

code

(e) Organization

code

		•
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ay	v	•

Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts w	ith each carrier may b	e treate	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:				ı
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.	nnection with the	acquisition or	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	nating plan, check	here •		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separ	ate accounts)		
	а	Type of contract: (1) deposit administration (2) mmedia (3) guaranteed investment (4) other	ate participation g	uarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		>				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		>				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	ige 4			
are experienc	rer(s) or members of the ce-rated as a unit. Whe unit for purposes of this	ere contrac		e organizations(s), the er individual employees,
c	Vision		d X	Life insurance
у g [Supplemental unemp	loyment	h 🗌	Prescription drug
k	PPO contract		I	Indemnity contract
_	-			
9a(1)				
9a(2)				
9a(3)				
		9a(4)		
9b(1)			_	
9b(2)				
		9b(3)	_	
		9b(4)		
0c(1)(A)			-	
9c(1)(A)			-	

Pa	art II	Welfare Benefit Contract Informat	on					-
		If more than one contract covers the same gro						
		information may be combined for reporting put the entire group of such individual contracts w					s cover in	dividual employees,
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life	insurance
	еĒ	Temporary disability (accident and sickness)	f \(\sum_{\text{Long-term disabilit}} \)	v a∏	Supplemental unemp	olovment	h ☐ Pre	scription drug
	i È	Stop loss (large deductible)	j HMO contract	, s∟ k□	PPO contract	, .,		emnity contract
	. L	Other (specify)] I iiwo contract	., _	11 0 contract		· 🗆a	Simility Contract
	m	Other (specify)						
9	Expe	rience-rated contracts:						
_		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium res		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 (or	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)		0-(4)(11)		
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	_	_				
	d	Status of policyholder reserves at end of year: (1)	· ·			9d(1)		
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2)	.)	9e		
10		nexperience-rated contracts:				40-		
		Total premiums or subscription charges paid to ca				10a		46320
		If the carrier, service, or other organization incurreretention of the contract or policy, other than repo			•	10b		
	Sp	ecify 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.