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

2015

This Form is Open to Public Inspection

Part I	Annual Report Id	entification Information		·		•		
For cale	ndar plan year 2015 or fisc	cal plan year beginning 01/01/2015	_	and ending 12/31/2015				
A This	eturn/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or					
		x a single-employer plan;	a DFE (specify)					
B This	eturn/report is:	the first return/report;	the final return	n/report;				
		an amended return/report;	a short plan y	ear return/report (less than 12 m	onths)).		
C If the	plan is a collectively-barga	ained plan, check here				• 🗌		
D Chec	k box if filing under:	Form 5558;	automatic exte	nsion;	the	e DFVC program;		
	ŭ	special extension (enter description	n)		_			
Part	I Basic Plan Info	prmation—enter all requested inform	nation					
	ne of plan				1b	Three-digit plan	504	
COMM	JNITY HOSPICE, INC.					number (PN) ▶	501	
					1c	Effective date of pl 03/01/1994	an	
		er, if for a single-employer plan) , apt., suite no. and street, or P.O. Box)		2b	Employer Identifica Number (EIN)	ation	
City	or town, state or province	country, and ZIP or foreign postal cod		ructions)		31-0970252		
COMMU	NITY HOSPICE, INC.				2c	Plan Sponsor's tele	ephone	
						number 606-329-189	0	
1490 CA	RTER AVENUE	1480 CAE	RTER AVENUE		2d Business code (see			
	D, KY 41101		D, KY 41101			instructions)		
						621610		
Caution	· A negative for the late of	r incomplete filing of this return/repo	ort will he assessed	unlass rassonable cause is es	tablic	shad		
		er penalties set forth in the instructions,					edules.	
		ell as the electronic version of this retur						
SIGN HERE	Filed with authorized/valid	l electronic signature.	06/07/2016	SUSAN HUNT				
HEKE	Signature of plan admi	nistrator	Date	Enter name of individual signing as plan administrator				
SIGN HERE								
IILKL	Signature of employer/	plan sponsor	Date	Enter name of individual signing as employer or		employer or plan sp	onsor	
SIGN HERE								
Signature of DFE Date Enter name of individual signing								
Preparei	's name (including firm na	me, if applicable) and address (include	room or suite number	er) Prepa	arer's	telephone number		

Form 5500 (2015) Page **2**

3a	3a Plan administrator's name and address Same as Plan Sponsor					3b Adr	3b Administrator's EIN		
							ninistrator's telephone mber		
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:	/report filed fo	or this p	olan, ent	er the name,	4b EIN	N 31-0970252		
а	Sponsor's name					4c PN			
5	Total number of participants at the beginning of the plan year					5	103		
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	d (welfare pla	ns com	plete on	ly lines 6a(1),				
a(1) Total number of active participants at the beginning of the plan year					6a(1)	103		
a(2	2) Total number of active participants at the end of the plan year					6a(2)	107		
b	Retired or separated participants receiving benefits					6b	0		
С	Other retired or separated participants entitled to future benefits					6с	0		
d	Subtotal. Add lines 6a(2), 6b, and 6c.					<u>6d</u>	107		
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	3			<u>6e</u>			
f	Total. Add lines 6d and 6e					<u>6f</u>			
g	Number of participants with account balances as of the end of the plan year complete this item)				ans	6g			
h	Number of participants that terminated employment during the plan year with less than 100% vested					6h			
7	Enter the total number of employers obligated to contribute to the plan (only		-						
b	If the plan provides pension benefits, enter the applicable pension feature could be pension fea	les from the L	ist of P	lan Cha	racteristics Co	odes in the ir			
9a	Plan funding arrangement (check all that apply) (1)	9b Plan be (1)	enefit a	ırrangen İnsural	nent (check al nce	I that apply)			
	(2) Code section 412(e)(3) insurance contracts	(2)		Code	section 412(e)	(3) insurance	e contracts		
	(3) Trust (4) X General assets of the sponsor	(3) (4)	X	Trust Gener	al assets of th	e sponsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at		where				ned. (See instructions)		
а	Pension Schedules	b Gener	ral Sch	edules					
	(1) R (Retirement Plan Information)	(1)		н	(Financial In	formation)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	X	_8_ A	(Financial Int (Insurance Int (Service Pro	nformation)	,		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)			(DFE/Partici (Financial T				

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.)			
11b Is the plan	currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)		
enter the R	eceipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, eceipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure alid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)		

Form 5500 (2015)

Receipt Confirmation Code__

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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

r ension benefit dualanty of	Siporation	Insurance companies a pursuant to E	re required to provide the RISA section 103(a)(2).	einformat	tion	This Form is Open to Public Inspection			
For calendar plan year 20	15 or fiscal pla	n year beginning 01/01/2015		and en	iding 12/31	/2015			
A Name of plan COMMUNITY HOSPICE,	INC.				e-digit number (PN) •	501		
C Plan sponsor's name as shown on line 2a of Form 5500 COMMUNITY HOSPICE, INC.					D Employer Identification Number (EIN) 31-0970252				
		ning Insurance Contract C Individual contracts grouped as a							
(a) Name of insurance ca									
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate num persons covered at e policy or contract y	end of	(f)	Policy or o	(g) To		
35-0980405	61069	99488RM	84	<u> </u>	07/01/2014		06/30/2015		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List	in line 3	the agents, b	orokers, and	other persons in		
	amount of com	missions paid		(b) To	otal amount o	f fees paid			
(a) . ota	<u> </u>	2951		(3)	<u> </u>	. 1000 раза			
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all pe	ersons).					
<u> </u>		and address of the agent, broker,			ions or fees v	were paid			
MEDLINK INC		PO BO) LOUISV	X 23570 /ILLE, KY 40223						
(b) Amount of sales a	nd base	Fee	s and other commissions	paid					
commissions pa		(c) Amount	(d) Purpose	е		(e) Organization code		
	2951						3		
	(a) Name a	and address of the agent, broker,	or other person to whom	commiss	ions or fees v	were paid			
(b) Amount of sales and base Fees and other commissions paid									
commissions pa		(c) Amount	(d) Purpose				(e) Organization code		
	A . N:	LOND O 4 IN I		E E C C					

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(a) Na	me and address of the agent, broke	r, 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) No	me and address of the agent broke	r or other person to whom commissions or fees were poid	
(a) Na	ine and address of the agent, broke	r, 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	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	4.50
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
confinissions paid	(C) Amount	(u) Fulpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(2)			
(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	r, or other person to whom commissions or fees were paid	
			•
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	(-)	727	

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015		Page 4		
t III Welfare Benefit Contract Informa		e employer(s) or mem	obers of the same en	nnlovee organizations(s), the
information may be combined for reporting p the entire group of such individual contracts	ourposes if such contracts are	experience-rated as a	unit. Where contract	
Benefit and contract type (check all applicable boxes)			
Health (other than dental or vision)	b Dental	C Vision		d X Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g Supplemer	ntal unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k ☐ PPO contra		I Indemnity contract
n Other (specify)		ш		
xperience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	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)	
C Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c	c(1)(A)		
(B) Administrative service or other fees		c(1)(B)		
(C) Other specific acquisition costs		c(1)(C)		
(D) Other conserve		\(1\/D\)		

9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement...... 9d(1) 9d(2) (2) Claim reserves..... 9d(3) (3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 20496 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, 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 No

Part III

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

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

Pension Benefit Guaranty Co	orporation	Insurance companies a pursuant to E	re required to provide the RISA section 103(a)(2)				
For calendar plan year 20	15 or fiscal pla	n year beginning 01/01/2015		ar	nd ending 12/3	1/2015	
A Name of plan COMMUNITY HOSPICE,	INC.				Three-digit plan number (PN	۱) 🕨	501
							•
C Plan sponsor's name a COMMUNITY HOSPICE,	e 2a of Form 5500		D E	mployer Identific 31-0970252	ation Number	(EIN)	
		ning Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		KY, INC				Dallara	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	t end o	of	From	ontract year (g) To
61-1237516	95120	001005860	53	•			06/30/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	st in li	ne 3 the agents,	brokers, and o	other persons in
(a) Total a	amount of com	missions paid		(b) Total amount	of fees paid	
		20700	179				
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all p	persor	ns).		
	(a) Name a	and address of the agent, broker,	or other person to whor	n com	missions or fees	were paid	
MEDLINK INC		PO BO) LOUISV	< 23570 /ILLE, KY 40223				
(b) Amount of sales ar	nd hase	Fee	s and other commissior	ns paid	d		
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	18681						3
	(a) Name a	and address of the agent, broker,	or other person to whor	n com	missions or fees	were paid	
MEDLINK INC		PO BOX LOUISV	K 23570 (ILLE, KY 40223				
(b) Amount of sales and base Fees and other commissions paid				b			
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	615						3
Ear Danamuark Dadiiatia	n Aat Nation :	and OMP Control Numbers see	the inctrications for E	orm E	ENA		

(a) Name	and address of the agent, broker	r, or other person to whom commissions or fees were paid	I
MEDLINK	PO BO	DX 23570 SVILLE, KY 40223	
(b) Amount of sales and base	ŀ	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	179		
		r, or other person to whom commissions or fees were paid	1
THOMPSON-FLETCHER INSURANCE A	GENCY 505 W BARD	/ STEPHEN FOSTER AVE STOWN, KY 40004	
(b) Amount of sales and base	ļ	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
1404			
(a) Name	and address of the agent, broker	r, or other person to whom commissions or fees were paid	ı
(b) Amount of sales and base	ı	ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent, broke	r, or other person to whom commissions or fees were paid	 I
(4)	and again, sions.	, 0. 0 релости и пот соптисовано от 1000 и от раз	
(b) Amount of sales and base	F	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent, broken	r, or other person to whom commissions or fees were paid	1
(b) Amount of sales and base		ees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Schedule A (Form 5500) 2015

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015	Page 4
	of the same employer(s) or members of the same employee organizations(s), the ntracts are experience-rated as a unit. Where contracts cover individual employed hay be treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes)	
Health (other than dental or vision) b Dental	c ☒ Vision d ☐ Life insurance
Temporary disability (accident and sickness) f Long-term	disability g Supplemental unemployment h Prescription drug
Stop loss (large deductible) j HMO contra	ract k PPO contract I Indemnity contract
Other (specify)	
(4)/	
erience-rated contracts:	
Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	9a(3)
(4) Earned ((1) + (2) - (3))	
Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	9b(3)
(4) Claims charged	
Remainder of premium: (1) Retention charges (on an accrual basis	s)
(A) Commissions	
(B) Administrative service or other fees	9c(1)(B)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

527357

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

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

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

Experience-rated contracts:

Part III

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

Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions..... (B) Administrative service or other fees

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

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

(H) Total retention

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

(2) Claim reserves

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

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

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

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

9c(1)(C)

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

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

Tension benefit duaranty of	Siporation	pursuant to E	re required to provide the information (2).	'	This Form is Open to Public Inspection
For calendar plan year 20	15 or fiscal pla	n year beginning 01/01/2015	and e	nding 12/31/2015	5
A Name of plan COMMUNITY HOSPICE,	, INC.			ee-digit n number (PN)	501
C Plan sponsor's name a	as shown on lin	e 2a of Form 5500	D Empl	oyer Identification N	Number (EIN)
COMMUNITY HOSPICE,	INC.		31	-0970252	
		ning Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca		KY, INC			
	(c) NAIC	(d) Contract or	(e) Approximate number of	Po	olicy or contract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
61-1237516	95120	152047	59	01/01/2015	12/31/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	Il commissions paid. List in line 3	3 the agents, broker	rs, and other persons in
(a) Total	amount of com	missions paid	(b) T	otal amount of fees	s paid
		1467			
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons).		
	(a) Name a	and address of the agent, broker, o	or other person to whom commis	sions or fees were	paid
MEDLINK INC		PO BOX LOUISV	(23570 ILLE, KY 40223		
		Face	s and other commissions paid		
(b) Amount of sales a commissions pa		(c) Amount	(d) Purpos	(e) Organization code	
1467			(4)		3
	(a) Name a	and address of the agent, broker,	or other person to whom commis	sions or fees were	naid
	(u) Hamo a	and address of the agent, broker, t	or carer percent to whem comme	0.01.0 01 1000 11010	para
(b) Amount of sales a	nd hase	Fees	s and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code

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Schedule A (Form 5500) 2015 (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 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015		Page 4		
If more than one contract covers the same einformation may be combined for reporting the entire group of such individual contracts	group of employees of the sar ourposes if such contracts are	e experience-rated as a	unit. Where contrac	
Benefit and contract type (check all applicable boxes	;)			
a Health (other than dental or vision)	b X Dental	c Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g Suppleme	ntal unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k PPO contr		I Indemnity contract
m ☐ Other (specify) ▶	, 🗆	L		
The Other (Specify)				
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)		_
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	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))				
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges				
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		_
(C) Other specific acquisition costs	P	9c(1)(C)		
(D) Other expenses		9c(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

Part III

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

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

(2) Claim reserves

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

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

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

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

9c(1)(E)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2015

This Form is Open to Public

		pursuant to EF	RISA section 103(a)(2).			11110 1 011	Inspection	
For calendar plan year 20	15 or fiscal plar	year beginning 01/01/2015		and en	ding 12/3	31/2015	•	
A Name of plan COMMUNITY HOSPICE,	INC.				e-digit number (Pl	N) •	501	
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500			yer Identific 0970252	cation Number (EIN)	
		ing Insurance Contract C Individual contracts grouped as a						
1 Coverage Information:								
(a) Name of insurance ca		MPANY - ACCIDENT ONLY						
(L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	contract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
73-0714500	60410	76564	8		07/01/201	4	06/30/2015	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	l commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of com			(b) To	otal amount	of fees paid		
		165						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).				
		nd address of the agent, broker, o		commiss	ions or fees	were paid		
BENEFACTOR INS GROU	IP INC		ARTER AVE ND, KY 41101					
(b) Amount of sales ar	nd hasa	Fees	and other commissions	s paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
95							3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commiss	ions or fees	were paid		
AMERICAN FIDELITY ASS		MPANY PO BOX			10110 01 1000	wore paid		
(b) Amount of sales and base Fees and other commissions paid								
commissions pai		(c) Amount	(d) Purpose				(e) Organization code	
	70						3	
	A 4 N 4	101100 1 111 1						

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Schedule A (Form 5500) 2015 (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 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015	Page 4	
information may be combined for reporting purp	up of employees of the same employer(s) or members of the same employee o coses if such contracts are experience-rated as a unit. Where contracts cover the each carrier may be treated as a unit for purposes of this report.	
Benefit and contract type (check all applicable boxes)		
a Health (other than dental or vision)	Dental C Vision d ☐ Li	fe insurance
e X Temporary disability (accident and sickness)	F Long-term disability $\mathbf{g} \square$ Supplemental unemployment $\mathbf{h} \square$ Pr	rescription drug
i Stop loss (large deductible)		demnity contract
m ☐ Other (specify) ▶		•
III Guilla (opcony)		
Experience-rated contracts:		
a Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reser	ve	
(4) Earned ((1) + (2) - (3))	9a(4)	1888
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)	
c Remainder of premium: (1) Retention charges (on	an accrual basis)	
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees		
(C) Other specific acquisition costs	9c(1)(C)	

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

1888

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

10 Nonexperience-rated contracts:

Part III

(D) Other expenses.....

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

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

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier

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

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

Part	V Provision of Information			
11 D	d the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(D)

9c(1)(E)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to EF	RISA section 103(a)(2).		Inspection
For calendar plan year 20	15 or fiscal plar	year beginning 01/01/2015	and er	nding 12/31/2015	•
A Name of plan COMMUNITY HOSPICE, INC.				e-digit number (PN)	501
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500	-	oyer Identification Number 0970252	(EIN)
		ing Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca		MPANY - CANCER			
/I.A. EIAI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
73-0714500	60410	76564	55	07/01/2014	06/30/2015
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	ther persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid				
		790			
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees were paid	
AMERICAN FIDELITY ASS	SURANCE COM		25360 DMA CITY, OK 73125-0360		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	(e) Organization code	
203			3		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees were paid	
BENEFACTOR INS GROU		2165 CA	RTER AVE ID, KY 41101		
(b) Amount of sales ar	nd hase	Fees	and other commissions paid		
commissions pai		(c) Amount	(d) Purpose		(e) Organization code
	326				3
For Denominant Bodinatio	n Act Notice c	nd OMP Control Numbers see	the instructions for Form FEOD		1

Calaaduda A	/ C	FF00)	2045
Schedule A	(- 01111	5500	1 ZU 13

Page **2** - 1

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
INSURANCE SOLUTIONS OF KY	SURANCE SOLUTIONS OF KY 800 DIEDERICH BLVD RACELAND, KY 41169				
(b) Amount of sales and base	ļ	Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
261			3		
(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	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	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	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	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	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, cl	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015		Pa	ge 4	
rt III Welfare Benefit Contract Info If more than one contract covers the sa information may be combined for repor the entire group of such individual cont	me group of employees of the sating purposes if such contracts at	re experienc	e-rated as a unit. Where contra	
Benefit and contract type (check all applicable b	oxes)			
a Health (other than dental or vision)	b Dental	С	Vision	d Life insurance
e Temporary disability (accident and sickne	ess) f X Long-term disability	g	Supplemental unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k	PPO contract	I Indemnity contract
m ☐ Other (specify) ▶	, L	<u> </u>		
The Curier (specify)				
Experience-rated contracts:				
a Premiums: (1) Amount received		9a(1)	1008	39
(2) Increase (decrease) in amount due but	unpaid	9a(2)		
(3) Increase (decrease) in unearned premiu	ım reserve	9a(3)		
(4) Earned ((1) + (2) - (3))	<u>.</u>		9a(4)	10089
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)	
c Remainder of premium: (1) Retention char	ges (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs		9c(1)(C)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

10089

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

10 Nonexperience-rated contracts:

Part III

(D) Other expenses.....

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

(H) Total retention

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

(2) Claim reserves

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

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

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

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

9c(1)(D)

9c(1)(E)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

			RISA section 103(a)(2).	I his For	m is Open to Public Inspection
For calendar plan year 20	15 or fiscal plan	year beginning 01/01/2015	and en	nding 12/31/2015	
A Name of plan COMMUNITY HOSPICE,	INC.			e-digit number (PN)	501
C Plan sponsor's name a COMMUNITY HOSPICE,	INC.		31-	oyer Identification Number 0970252	. ,
on a separat		ing Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca AMERICAN FIDELITY ASS		MPANY - LTD			
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
73-0714500	60410	76564	52	07/01/2014	06/30/2015
2 Insurance fee and compute descending order of the		tion. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and c	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid					
		4486			
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all persons).		
		nd address of the agent, broker, o		ions or fees were paid	
BENEFACTOR INS GROU	P INC		RTER AVE ID, KY 41101		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pai		(c) Amount	(d) Purpose	(e) Organization code	
3029			3		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
AMERICAN FIDELITY ASS	SURANCE COM	MPANY PO BOX OKLAHO	. 25360 DMA CITY, OK 73125-0360		
(h) Amount of colors	d book	Fees	and other commissions paid		
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose		(e) Organization code
·	1457				3
For Panerwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500		

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Schedule A (Form 5500) 2015 (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 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, cl	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015	Page 4		
Welfare Benefit Contract Information			
If more than one contract covers the same group of employee information may be combined for reporting purposes if such countries the entire group of such individual contracts with each carrier in	ontracts are experience-rated as a	unit. Where contracts cover in	
and contract type (check all applicable boxes)			_
ealth (other than dental or vision) b Dental	c Vision	d 🗌 Life	e insurance
emporary disability (accident and sickness) $\mathbf{f} \ \overline{\overline{\mathbb{X}}}$ Long-term	n disability $\mathbf{g} \overline{\square}$ Supplemen	ital unemployment h 🗍 Pre	escription drug
top loss (large deductible) j 📗 HMO cont	tract k PPO contra	act I Ind	emnity contract
Other (specify)			
nce-rated contracts:			
niums: (1) Amount received	9a(1)	60561	
Increase (decrease) in amount due but unpaid	9a(2)		
Increase (decrease) in unearned premium reserve	9a(3)		
Earned ((1) + (2) - (3))		9a(4)	60561
nefit charges (1) Claims paid	9b(1)		
Increase (decrease) in claim reserves	9b(2)		
Incurred claims (add (1) and (2))	·····	9b(3)	
Claims charged		9b(4)	
mainder of premium: (1) Retention charges (on an accrual basi			
(A) Commissions			
(B) Administrative service or other fees			
` '	• • • • • • • • • • • • • • • • • • • •		

10b

(2) Increase (decrease) in amount due but unpaid...... (3) Increase (decrease) in unearned premium reserve..... (4) Earned ((1) + (2) - (3)) Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) (4) Claims charged..... Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs..... 9c(1)(C) (D) Other expenses 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies 9c(1)(F) (H) Total retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement...... 9d(1) (2) Claim reserves 9d(2) 9d(3) (3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 60561 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.....

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

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Stop loss (large deductible)

Other (specify)

Experience-rated contracts:

Specify nature of costs

Part III

a Premiums: (1) Amount received......

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to EF	RISA section 103(a)(2).				Inspection
For calendar plan year 20	15 or fiscal plar	year beginning 01/01/2015		and en	ding 12/3	31/2015	
A Name of plan COMMUNITY HOSPICE, INC. B Three- plan r			e-digit number (PI	N) •	501		
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500			yer Identific 0970252	cation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		MPANY - MEDICAL INDIV					
/I.A. EIAI	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To
73-0714500	60410	76564	2		07/01/201	4	06/30/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. List	in line 3	the agents,	brokers, and of	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
34							
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	is needed to report all pe	ersons).			
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ons or fees	were paid	
BENEFACTOR INS GROU	JP INC		RTER AVE ID, KY 41101				
(b) Amount of sales ar	nd base	Fees	and other commissions	paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	34						3
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commissi	ions or fees	were paid	
		•	·				
(b) Amount of sales ar	nd hase	Fees	and other commissions	paid			
commissions pa		(c) Amount	(d) Purpose	e		(e) Organization code
For Donomicarly Dodicatio	n Act Notice o	nd OMB Central Numbers and	the instructions for Fo	rm EEOO		•	

Page 2 - 1	
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Schedule A (Form 5500) 2015 (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 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Pa	art I	I Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi	dual contrac	ts with each carrier may be	treate	d as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end		4	
		rent value of plan's interest under this contract in the general accounts at year er			5	
		tracts With Allocated Funds:				<u> </u>
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		•	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	dannuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, cl	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	•			
	а			on guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(b) guaranteed investment (i) all ellies y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
	_	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account	- (4)			
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions		7	c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			4
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions		7	e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		7f	0

Schedule A (Form 5500) 2015		Page 4		
If more than one contract covers the same goinformation may be combined for reporting the entire group of such individual contracts	roup of employees of the sa ourposes if such contracts a	re experience-rated a	as a unit. Where contrac	
Benefit and contract type (check all applicable boxes)			
a Health (other than dental or vision)	b Dental	c Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disability	g ☐ Supple	mental unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k PPO co		I Indemnity contract
	, rime contract	и 🗆	Antidot	
m ☑ Other (specify) ▶OTHER				
Experience-rated contracts:				
Premiums: (1) Amount received		9a(1)	68	8
(2) Increase (decrease) in amount due but unpa	id	9a(2)		
(3) Increase (decrease) in unearned premium re	serve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	68
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)	
c Remainder of premium: (1) Retention charges (,			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs		9c(1)(C)		
(D) Other expenses		9c(1)(D)		

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

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

10 Nonexperience-rated contracts:

Part III

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

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

(2) Claim reserves

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

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

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

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

9c(1)(E)

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2015

This Form is Open to Public

		pursuant to EF	RISA section 103(a)(2).			11110 1 011	Inspection
For calendar plan year 20	15 or fiscal plar	year beginning 01/01/2015		and en	ding 12/3	31/2015	•
A Name of plan COMMUNITY HOSPICE,	Name of plan MMUNITY HOSPICE, INC. B Three-digit plan number (PN) 501			501			
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500			yer Identific 0970252	cation Number (EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		MPANY - STD					
41 \ FINI	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
73-0714500	60410	76564	6		07/01/201	4	06/30/2015
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		470					
3 Persons receiving com		ees. (Complete as many entries a					
DENIES ACTOR INC. OR OL		nd address of the agent, broker, o		commiss	ions or fees	were paid	
BENEFACTOR INS GROU	IP INC		RTER AVE ID, KY 41101				
(b) Amount of sales ar	nd hasa	Fees	and other commissions	s paid			
commissions pai		(c) Amount	(0	(d) Purpose			(e) Organization code
	240		(4) - 4		3		
	(a) Name a	nd address of the agent, broker, c	or other person to whom	commiss	ions or fees	were paid	
AMERICAN FIDELITY ASS		MPANY PO BOX				word pand	
(la) Amazon (- 1	- d b	Fees	and other commissions	s paid			
(b) Amount of sales ar commissions pai		(c) Amount		d) Purpose			(e) Organization code
-1	230		`	•			3
	A (N ()	10170 1 111 1					

Page 2 - 1	
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Schedule A (Form 5500) 2015 (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 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 Fees and other commissions paid (e) Organization (b) Amount of sales and base 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 Fees and other commissions paid (b) Amount of sales and base (e) Organization commissions paid (c) Amount (d) Purpose code

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Pa	art I	I Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contract	s with each carrier may be treate	ed as a unit for purposes of
4	Cur	this report. rent value of plan's interest under this contract in the general account at year of	end	4	
		rent value of plan's interest under this contract in the general accounts at year er			
		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
		Specify nature of costs •			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, ch	neck here	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai		<u> </u>	
	а		te participation		
		(3) guaranteed investment (4) other		ŭ	
		(b) guaranteed investment (i) all ellies y			
	b	Balance at the end of the previous year		7b	
	C	Additions: (1) Contributions deposited during the year		10	
	_	(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year			
		(4) Transferred from separate account	- (4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			
	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)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	<u></u>		0

Schedule A (Form 5500) 2015		Page	4		
Welfare Benefit Contract Information If more than one contract covers the same goinformation may be combined for reporting pothe entire group of such individual contracts.	roup of employees of the same ourposes if such contracts are ex	perience	rated as a unit. Where contra		
efit and contract type (check all applicable boxes)	ı				
Health (other than dental or vision)	b Dental	c 🗌 ,	/ision	d	Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g 🗌 :	Supplemental unemployment	h 🗌	Prescription drug
Stop loss (large deductible)	j HMO contract	k □	PPO contract	ΙŪ	Indemnity contract
Other (specify)					
erience-rated contracts:					
Premiums: (1) Amount received	9a	(1)	479	36	
(2) Increase (decrease) in amount due but unpai	d 9a	(2)			
(3) Increase (decrease) in unearned premium res		(3)			
(4) Earned ((1) + (2) - (3))			9a(4)		4796
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 (c	on an accrual basis)				
(A) Commissions	9c(*	1)(A)			
(B) Administrative service or other fees	9c(*	1)(B)			
		1)(0)			

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

4796

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

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

a Health (other than dental or vision)

Experience-rated contracts:

Part III

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

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

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

(H) Total retention

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

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier

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

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

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

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

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

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), 6047(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

2015

This Form is Open to Public Inspection

Part I Ann	Part I Annual Report Identification Information					
For calendar plan	year 2015 or fiscal	plan year beginning		and ending		
A This return/re	port is for:	a multiemployer plan;			g this box must attach a list o cordance with the form instruc	
B This return/re	port is:	x a single-employer plan: the first return/report; an amended return/report;	a DFE (specify) the final return/re a short plan year		12 months).	
D Check box if f	iling under:	ned plan, check here Form 5558; special extension (enter desc	automatic extens	ion;	► ☐ the DFVC program;	
Part II Bas	ic Plan Informa	ation—enter all requested infor	mation			
1a Name of plan	HOSPICE, INC	3.			1b Three-digit plan number (PN) ▶ 1c Effective date of plan	501
*1					03/01/1994	
Mailing addre	ss (include room, ap tate or province, co	if for a single-employer plan) ot., suite no. and street, or P.O. B untry, and ZIP or foreign postal c		uctions)	2b Employer Identification Number (EIN) 31-0970252	
COMMUNITY	HOSPICE, INC	2.			2c Plan Sponsor's telephonumber 606-329-1890	one
1480 CARTE	R AVENUE	SEE	STATEMENT		2d Business code (see instructions) 621610	
ASHLAND		KY 41101				
Caution: A penal	ty for the late or in	complete filing of this return/r	eport will be assessed	d unless reasonable c	ause is established.	
Under penalties of pe	rjury and other penaltie	es set forth in the instructions, I declare electronic version of this return/report,	that I have examined this re	eturn/report, including accor	mpanying schedules,	
SIGN HERE	Usenflu	nt	04/14/2016	SUSAN HUNT		
Signature	of plan administr	ator	Date	Enter name of individ	lual signing as plan administr	ator
SIGN HERE Signature	of employer/plan	sponsor	Date	Enter name of individual	signing as employer or plan spons	sor
SIGN						
HERE Signature	of DFE		Date	Enter name of individ	ual signing as DFE	
Preparer's name (i	ncluding firm name	, if applicable) and address (inclu	de room or suite numbe	:r)	Preparer's telephone numb	er

(3)

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

COMMU	NITY HOSPICE, INC. 31-09	70252		
	Form 5500 (2015)	Page 2		
3a Plan a	administrator's name and address X Same as Plan Sponsor		3b Administrat	tor's EIN
			3c Administrat	tor's telephone
			number	
			REPORT OF STREET	585 S. C. Selling 5.75 K
4 If the	name and/or EIN of the plan sponsor has changed since the last re	turn/report filed for this plan, enter the name	4b EIN	
	nd the plan number from the last return/report:	terms open means and plant, enter the name,	31-0970	0252
a Spons	sor's name		4c PN	
	number of participants at the beginning of the plan year		5	10
6 Numb	per of participants as of the end of the plan year unless otherwise st	ated (welfare plans complete only lines 6a(1),		
6a(2),	, 6b , 6c , and 6d).			
a(1) To	Otal number of active participants at the beginning of the plan year		C-(4)	
۵(۱)	otal number of active participants at the beginning of the plan year	•••••	6a(1)	10
a(2) To	otal number of active participants at the end of the plan year		6a(2)	10
			04(2)	
b Retire	d or separated participants receiving benefits		6b	
C Other	retired or separated participants entitled to future benefits	***************************************	6c	
d Cubia	tol Add lines Ca(2). Ch. and Ca			00029
u Subio	tal. Add lines 6a(2), 6b, and 6c		6d	10
e Decea	ased participants whose beneficiaries are receiving or are entitled to	receive honofits	6e	
	to are entitled to	receive benefits	06	
f Total.	Add lines 6d and 6e		6f	
	er of participants with account balances as of the end of the plan ye			
comple	ete this item)	***************************************	6g	
	er of participants that terminated employment during the plan year v	ith accrued benefits that were	Ch	
	the total number of employers obligated to contribute to the plan (on	ly multiamployer plans complete this item)	6h	
	plan provides pension benefits, enter the applicable pension feature		es in the instruction	ne:
	, , , , , , , , , , , , , , , , , , , ,	source from the blot of Fran Characteristic Cour	es in the mstructio	1115.
b If the p	lan provides welfare benefits, enter the applicable welfare feature of	odes from the List of Plan Characteristic Codes	s in the instruction	s:
4A	4B 4D 4E			
411	4B 4D 4E			
9a Plan fu	unding arrangement (check all that apply)	9b Plan benefit arrangement (check all that	ot control	
(1)	X Insurance	(1) X Insurance	ат арріу)	
(2)	Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) ins	surance contracts	
(3)	Trust	(3) Trust		
(4)	X General assets of the sponsor	(4) X General assets of the spo	nsor	
10 Check	k all applicable boxes in 10a and 10b to indicate which schedules are attached,	and, where indicated, enter the number attached. (See	instructions)	
3 D	sion Cabadulas	The superior control of the superior of the su		
(1)	sion Schedules R (Retirement Plan Information)	b General Schedules		
(2)	MB (Multiemployer Defined Benefit Plan and Certain Mone	(1) H (Financial Info		
\-/	Purchase Plan Actuarial Information) - signed by the plan		rmation - Small Pl	an)
	actuary	——————————————————————————————————————	ormation) der Information)	

(4)

(5)

(6)

С

D

(Service Provider Information)

(DFE/Participating Plan Information)

(Financial Transaction Schedules)

COMMUNITY HOSPICE,	INC.
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Form 5500 (2015)		Page 3	
Part III Form M-1 Compliance Informati	ion (to be completed by welf	are benefit plans)	
11a If the plan provides welfare benefits, was the plan 2520.101-2.)	n subject to the Form M-1 filing require $oldsymbol{X}$ No	ements during the plan year? (See instru	ctions and 29 CFR
If "Yes" is checked, complete lines 11b and 11c.			
11b Is the plan currently in compliance with the Form	M-1 filing requirements? (See instruc	tions and 29 CFR 2520.101-2.)	Yes N
11c Enter the Receipt Confirmation Code for the 201s enter the Receipt Confirmation Code for the mos to enter a valid Receipt Confirmation Code will se	st recent Form M-1 that was required to	be filed under the Form M-1 filing requi	
Receipt Confirmation Code			