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 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

2016

This Form is Open to Public Inspection

						mspection		
Part I		dentification Information						
For caler	ndar plan year 2016 or fisc	cal plan year beginning 01/01/2016		and ending 12/31/2016	<u>; </u>			
A This return/report is for: a multiemployer plan								
		x a single-employer plan	a DFE (specify	y)				
B This r	B This return/report is: the first return/report the final return/report							
		an amended return/report	a short plan ye	ear return/report (less than 12 m	2 months)			
C If the	plan is a collectively-barg	ained plan, check here				•		
D Chec	k box if filing under:	Form 5558	automatic exte	nsion	the	e DFVC program		
		special extension (enter descripti	on)					
Part II	Basic Plan Inform	mation—enter all requested informa	ation					
	e of plan JNITY HOSPICE, INC.				1b	Three-digit plan number (PN) ▶	501	
					1c	Effective date of pl 03/01/1994	an	
Mail	ing address (include room	er, if for a single-employer plan) , apt., suite no. and street, or P.O. Bo , country, and ZIP or foreign postal co		ructions)	2b	Employer Identifica Number (EIN) 31-0970252	ation	
COMMUI	NITY HOSPICE, INC.				2c Plan Sponsor's telephone number 606-329-1890			
1480 CARTER AVENUE ASHLAND, KY 41101 1480 CARTER AVENUE ASHLAND, KY 41101				2d Business code (see instructions) 621610			е	
Caution	A penalty for the late o	r incomplete filing of this return/rep	oort will be assessed	unless reasonable cause is e	stablis	shed.		
		er penalties set forth in the instruction ell as the electronic version of this ret						
SIGN HERE	Filed with authorized/valid	d electronic signature.	05/25/2017	SUSAN HUNT				
HEKE	Signature of plan admi	nistrator	Date	Enter name of individual sign	dual signing as plan administrator			
SIGN								
HERE	Signature of employer/	plan sponsor	Date	Enter name of individual signing as employer or plan spor			onsor	
	, ,	•						
SIGN								
HERE Signature of DFE Date Enter name of individual sign			ing as	DFE				
Preparer	•	me, if applicable) and address (includ				telephone number		

Form 5500 (2016) Page **2**

3a	Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN					
		3c Administrator's telephone number					
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 for this plan, enter the name,	4b EIN 31-0970252				
а	Sponsor's name		4c PN				
5	Total number of participants at the beginning of the plan year		5 107				
6	Number of participants as of the end of the plan year unless otherwise stated 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) 107				
a(2	Total number of active participants at the end of the plan year		6a(2) 136				
b	Retired or separated participants receiving benefits		6b 0				
С	Other retired or separated participants entitled to future benefits		6c <u>0</u>				
d	Subtotal. Add lines 6a(2), 6b, and 6c		6d 136				
e	Deceased participants whose beneficiaries are receiving or are entitled to rec		6e				
f	Total. Add lines 6d and 6e		6f				
g	Number of participants with account balances as of the end of the plan year (complete this item)	6g					
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h				
7	Enter the total number of employers obligated to contribute to the plan (only related to contribute to contribute to the plan (only related to contribute to contrib	multiemployer plans complete this item)	7				
b	 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 						
9a	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 contracts				
	(3) Trust	(3) Trust					
	(4) X General assets of the sponsor	(4) X General assets of the sp	oonsor				
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and, where indicated, enter the numb	per attached. (See instructions)				
а	Pension Schedules	b General Schedules					
-	(1) R (Retirement Plan Information)	(1) H (Financial Inform	nation)				
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) I (Financial Inform (3) 8 A (Insurance Inform (4) C (Service Provide	,				
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participati (6) G (Financial Trans	ng Plan Information) saction Schedules)				
							

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
11a If the 2520	plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 1.101-2.)
lf "Y€	es" is checked, complete lines 11b and 11c.
11b Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
Rece	r the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the eipt 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 eipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
Rece	eipt Confirmation Code

Form 5500 (2016)

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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

n					n is Open to Public Inspection		
For calendar plan year 20	16 or fiscal pla	n year beginning 01/01/2016		and end	ding 12/31/201	6	
A Name of plan COMMUNITY HOSPICE,	INC.			B Three plan	e-digit number (PN))	501
C Plan sponsor's name a		ne 2a of Form 5500			yer Identification	Number (EIN)
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:				•			
(a) Name of insurance ca							
	1	1	(a) Approximate pur	nhor of	D	olicy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	 (e) Approximate number of persons covered at end of policy or contract year 		(f) Fron	-	(g) To
35-0980405	61069	99488RM	94	•	01/01/2016		12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Lis	t in line 3 t	the agents, broke	ers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
2297							
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all p	ersons).			
	(a) Name a	and address of the agent, broke	r, or other person to whom	commissi	ions or fees were	paid	
MEDLINK INC			LAKE POINT WAY SVILLE, KY 40223				
(h) Amount of color of	nd book	Fe	ees and other commission	s paid			
(b) Amount of sales an commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
2297							3
	(a) Name a	and address of the agent, broke	r, or other person to whom	commissi	ions or fees were	paid	
	\	, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,				
(b) Amount of sales a	nd base	Fe	ees and other commission	s paid			
commissions pa		(c) Amount	(0	d) Purpose	9		(e) Organization code

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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F	Part							
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	cts with each carrier may	be treated	d as a unit for purposes of		
4	Curi	ent value of plan's interest under this contract in the general account at year	end		4			
5	Curi	Current value of plan's interest under this contract in separate accounts at year end						
6	Con	tracts With Allocated Funds:						
	а	State the basis of premium rates						
	L				Ch			
	b	Premiums paid to carrier			6b			
	c d	Premiums due but unpaid at the end of the year			6c			
	u	retention of the contract or policy, enter amount			6d			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferre	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)				
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee				
		(3) guaranteed investment (4) other						
	b	Balance at the end of the previous year			7b			
	С	Additions: (1) Contributions deposited during the year	7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		7						
		(C)Tatal additions			70/6\			
	Ч	(6)Total additions			7c(6) 7d			
		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)			7f	0		

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Р	art I	Welfare Benefit Contract Information						
•	u	If more than one contract covers the same group of em the information may be combined for reporting purpose employees, the entire group of such individual contract:	s if such contracts a	e exp	erience-rated as a un	it. Where cor	ntracts cov	
8	Bene	nefit and contract type (check all applicable boxes)		,				
	аΓ	Health (other than dental or vision)	tal	٦	Vision		d X Life	incurance
	_			_	<u>.</u>		_	
	e _	Temporary disability (accident and sickness) f Long	g-term disability		Supplemental unen	ployment		scription drug
	i L	Stop loss (large deductible) j 📙 HMC	contract	k	PPO contract		I Inde	mnity contract
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	a F	Premiums: (1) Amount received	9a(1)				
		(2) Increase (decrease) in amount due but unpaid	9a(2)				
		(3) Increase (decrease) in unearned premium reserve	9a(3)				
		(4) Earned ((1) + (2) - (3))	·····			9a(4)		
	b	Benefit charges (1) Claims paid	9b(1)				
		(2) Increase (decrease) in claim reserves	9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrua	ıl basis)	1			_	
		(A) Commissions					_	
		(B) Administrative service or other fees	-				_	
		(C) Other specific acquisition costs						
		(D) Other expenses					4	
		(E) Taxes					4	
		(F) Charges for risks or other contingencies					_	
		(G) Other retention charges	9c(1)	(G)		1		
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amounts w	ere paid in cash,	or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount he	eld to provide benefit	s after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include ar	mount entered in line	9c(2)	.)	9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		20582
	b	If the carrier, service, or other organization incurred any spec						
	0	retention of the contract or policy, other than reported in Part	I, line 2 above, repo	rt amo	ount	10b		
	Spe	ecify nature of costs.						
	Spec	ecity flature of costs.						
P	art I	IV Provision of Information						
11	Did	d the insurance company fail to provide any information neces	sary to complete Scl	<u>nedul</u> e	A?	Yes	X No	
12	If th	the answer to line 11 is "Yes," specify the information not provi	ided.					
		· · · · · · · · · · · · · · · · · · ·						

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

2016

This Form is Open to Public Inspection

For calendar plan year 20°	16 or fiscal plan	year beginning 01/01/2016		and en	ding 12/31/2016	-	
A Name of plan COMMUNITY HOSPICE,	INC.				501		
				plan number (PN)			
C Plan anangar's name a	a abour an line	20 of Form 5500		D Emplo	yer Identification Number ('EINI\	
C Plan sponsor's name as shown on line 2a of Form 5500 COMMUNITY HOSPICE, INC.					0970252	EIIN)	
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 car ANTHEM HEALTH PLANS		Y, INC					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Policy or co	ontract year	
(b) EIN	code	identification number	policy or contrac		(f) From	(g) To	
61-1237516	95120	001005860	60			12/31/2016	
2 Insurance fee and communication descending order of the		tion. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, brokers, and o	ther persons in	
(a) Total a	amount of comn	nissions paid		(b) To	otal amount of fees paid		
		20135				2052	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees were paid		
MEDLINK INC			AKE POINT WAY VILLE, KY 40223				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose		e	(e) Organization code	
	20135	2052				3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales and base		Fees and other commiss		sions paid			
commissions pai		(c) Amount		(d) Purpose	9	(e) Organization code	
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule A (Form 5500) 2016 v. 160205							

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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Part II Investment and Annuity Contract Information									
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.									
4	Curi	ent value of plan's interest under this contract in the general account at year		4					
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5				
6	Con	tracts With Allocated Funds:							
	а	State the basis of premium rates							
	L				Ch				
	b	Premiums paid to carrier			6b				
	c d	Premiums due but unpaid at the end of the year			6c				
	u	retention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferre	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)					
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			7b				
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(2) Dividends and credits	7c(2)						
		(3) Interest credited during the year	7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	7c(5)						
		7							
		(C)Tatal additions			70/6\				
	Ч	(6)Total additions			7c(6) 7d				
		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)			7f	0			

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Pa	art I	II	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract of the c	group of employees of th ting purposes if such con	tracts are expe	erience-rated as a uni	it. Where c	ontracts (cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)						
	a	Не	ealth (other than dental or vision)	b Dental	c X	Vision		d ☐ Li	ife insurance
	еĪ	Te	emporary disability (accident and sickness)	f Long-term disabil	ity g	Supplemental unem	ployment	h □ P	rescription drug
	ιĖ	_	op loss (large deductible)	j HMO contract	· <u> </u>	PPO contract	. ,	- =	demnity contract
	m [_	ther (specify)	, []e seas.	🗀			- Ш	aciminy contides
9 E	Expe	rieno	ce-rated contracts:						
	a [.] F	rem	iums: (1) Amount received		9a(1)			_	
		(2) Ir	ncrease (decrease) in amount due but unpai	d	9a(2)				
			ncrease (decrease) in unearned premium res						
		(4) E	Earned ((1) + (2) - (3))				9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
			ncurred claims (add (1) and (2))				9b(3)		
			Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (on an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies.		9c(1)(F)				
		((G) Other retention charges		9c(1)(G)				
		((H) Total retention				9c(1)(H)	
		(2) [Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or 🗌 d	credited.)	9c(2)		
	d		us of policyholder reserves at end of year: (1				9d(1)		
			Claim reserves				9d(2)		-
		` '	Other reserves				9d(3)		-
	е	` '	dends or retroactive rate refunds due. (Do n				9e		-
10			erience-rated contracts:			,	1		
			al premiums or subscription charges paid to	carrier			10a		476619
	_		e carrier, service, or other organization incur						
			ntion of the contract or policy, other than rep				10b		
	Spe				,				
	Spe		ntion of the contract of policy, other than replicature of costs.	orted in Part I, line 2 abov	ve, report amo	unt	100		
	art I		Provision of Information		data Oak 12	A2 🗆	Voc	V NI-	
			insurance company fail to provide any inforn		nete Schedule	A!	Yes	X No	
12	If th	ne ar	nswer to line 11 is "Yes," specify the informat	ion 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).			nspection
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016	and er	nding 12/31/201	16	•
A Name of plan COMMUNITY HOSPICE,	INC.			ee-digit n number (PN)	•	501
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500		oyer Identification 0970252	Number (E	EIN)
		ning Insurance Contract (. Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		Y, INC				
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of	Р	olicy or co	ntract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	n	(g) To
61-1237516	95120	152047	64	01/01/2016		12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, broke	ers, and otl	her persons in
(a) Total	amount of comr		(b) ⊤	otal amount of fee	es paid	
		1653				
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	•	sions or fees were	paid	
MEDLINK INC			KE POINT WAY LLE, KY 40223			
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos		(e) Organization code	
	1653				3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees were	paid	
	,	V	·		•	
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	(d) Purpose		(e) Organization code
For Donomicals Desired	an Aat Nation	see the Instructions for Form FF	00		Caba d	ulo A /Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page 2 – 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, bro	sker, 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	
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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Part II Investment and Annuity Contract Information									
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.									
4	Curi	ent value of plan's interest under this contract in the general account at year		4					
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5				
6	Con	tracts With Allocated Funds:							
	а	State the basis of premium rates							
	L				Ch				
	b	Premiums paid to carrier			6b				
	c d	Premiums due but unpaid at the end of the year			6c				
	u	retention of the contract or policy, enter amount			6d				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferre	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)					
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee					
		(3) guaranteed investment (4) other							
	b	Balance at the end of the previous year			7b				
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(2) Dividends and credits	7c(2)						
		(3) Interest credited during the year	7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	7c(5)						
		7							
		(C)Tatal additions			70/6\				
	Ч	(6)Total additions			7c(6) 7d				
		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)			7f	0			

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P	art II							
		If more than one contract covers the same group of the information may be combined for reporting purp employees, the entire group of such individual contract.	oses if such contr	acts are expe	rience-rated as a unit	. Where con	tract	s cover individual
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	ental	с	Vision	C	i 🗌	Life insurance
	e 🗀		ong-term disabilit	v a □	Supplemental unem	olovment ľ	า⊟ี	Prescription drug
	i F		MO contract	- =	PPO contract		브	Indemnity contract
	m	Other (specify)	We dominate	<u> </u>	TT O contidor		- Ш	machinity contract
	m _	Other (specify) •						
9	Evne	erience-rated contracts:						
		Premiums: (1) Amount received	[9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
	,	(3) Increase (decrease) in unearned premium reserve	I	9a(3)				
	,	(4) Earned ((1) + (2) - (3))	_	· · · ·		. 9a(4)		
		Benefit charges (1) Claims paid	Г	9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)				
	,	(3) Incurred claims (add (1) and (2))	L			9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an acc	rual 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	F	9c(1)(F)				
		(G) Other retention charges	<u>-</u>	9c(1)(G)		0-(4)(11)		
		(H) Total retention		_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amount	_			9c(2)		
		Status of policyholder reserves at end of year: (1) Amoun	·			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3) 9e		
10		nexperience-rated contracts:	e amount entered	III IIIIE 30(2).)	36		
		Total premiums or subscription charges paid to carrier				10a		22844
		If the carrier, service, or other organization incurred any s						22011
		retention of the contract or policy, other than reported in F	•		•	10b		
		cify nature of costs.	•	•				
Pa	art I	IV Provision of Information						
11	Did	d the insurance company fail to provide any information ne	cessary to comple	ete Schedule	А?	Yes	No)
		he answer to line 11 is "Yes," specify the information not p			Ц			
		no anomo, to mile i i to i co, specify the information not p	oriaca. F					

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 Be	enerit Guaranty Co	orporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Fo	This Form is Open to Public Inspection	
For calendar	plan year 20	16 or fiscal pl	an year beginning 01/01/2016		a	and ending 12/	31/2016	
A Name of COMMUNIT	plan Y HOSPICE,	INC.			В	Three-digit plan number (F	PN) •	501
•	nsor's name a Y HOSPICE,		ine 2a of Form 5500		D	Employer Identif 31-0970252	ication Number	(EIN)
Part I			erning Insurance Contract A. Individual contracts grouped as					
1 Coverage	Information:							
` '	insurance ca		DMPANY - ACCIDENT ONLY				Daliana	
(b)	EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a	t end	of (4	Policy or o	contract year (g) To
73-0714500		60410	76564	policy or contrac		07/01/201	15	06/30/2016
		mission inforr amount paid	nation. Enter the total fees and total.	al commissions paid. Li	ist in	line 3 the agents	s, brokers, and o	other persons in
	(a) Total	amount of cor	nmissions paid			(b) Total amoun	t of fees paid	
			357					
3 Persons	receiving com	missions and	fees. (Complete as many entries	as needed to report all	perso	ons).		
			and address of the agent, broker,		m cor	mmissions or fee	s were paid	
AMERICAN F	IDELITY ASS	SURANCE CO		X 25360 OMA CITY, OK 73125-	0360			
(b) Amou	unt of sales a	nd base	Fee	es and other commission	ns pa	id		
cor	mmissions pa		(c) Amount	(d) Purpose				(e) Organization code
		240						3
		(a) Name	and address of the agent, broker,	or other person to who	m cor	nmissions or fee	s were paid	
BENEFACTO	R INS GROL	JP INC	2165 C/ ASHLAI	ARTER AVE ND, KY 41101				
(h) Amor	unt of sales a	nd hase	Fee	es and other commission	ns pa	id		
` '	nmissions pa		(c) Amount	•		(d) Purpose		(e) Organization code
		117						3
For Donorus	ork Boductic	n Act Notice	see the Instructions for Form F	:500			Coho	dula A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page 2 – 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, bro	sker, 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	
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L				Ch	
	b	Premiums paid to carrier			6b	
	c d	Premiums due but unpaid at the end of the year			6c	
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		7				
		(C)Tatal additions			70/6\	
	Ч	(6)Total additions			7c(6) 7d	
		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)			7f	0

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Pa	ırt II	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	roup of employees of the ng purposes if such cont	racts are expe	erience-rated as a unit	. Where co	ontracts	cover individual
8	3ene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d 🗌 I	Life insurance
(e X	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unemp	oloyment	h∏⊓	Prescription drug
	i F	Stop loss (large deductible)	j	· - <u>-</u>	PPO contract	•	- 🗀	ndemnity contract
	m	Other (specify)	, []	[1		- Ш -	
9 E	хре	erience-rated contracts:						
i		Premiums: (1) Amount received		9a(1)		2326	<u>; </u>	
		(2) Increase (decrease) in amount due but unpaid					4	
		(3) Increase (decrease) in unearned premium rese						
	_ `	(4) Earned ((1) + (2) - (3))				. 9a(4)	_	2326
		Benefit charges (1) Claims paid					4	
		(2) Increase (decrease) in claim reserves				05/2)		
		(3) Incurred claims (add (1) and (2))				9b(3)	+	
	,	(4) Claims charged				9b(4)		
	С	(A) Commissions	· ·	9c(1)(A)			4	
		(B) Administrative service or other fees		9c(1)(B)			4	
		(C) Other specific acquisition costs		9c(1)(C)			4	
		(D) Other expenses		9c(1)(D)			4	
		(E) Taxes		9c(1)(E)			7	
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		0-(4)(0)				
		(H) Total retention				9c(1)(H)	,	
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid ir	cash, or	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1)				9d(1)		
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	d in line 9c(2).	.)	9e		
10		nexperience-rated contracts:		, ,	•			
	a	Total premiums or subscription charges paid to ca	rrier			10a		2326
	b	If the carrier, service, or other organization incurre	d any specific costs in c	onnection with	h the acquisition or			
		retention of the contract or policy, other than repor				10b		
	Spec	cify nature of costs.						
Pa	rt I	IV Provision of Information						
11	Did	d the insurance company fail to provide any informa	tion necessary to comp	ete Schedule	A?	Yes	X No	
		he answer to line 11 is "Yes," specify the informatio			<u>—</u>			

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	•	pursuant to ERISA section 103(a)(2).			This For	This Form is Open to Public Inspection	
For calendar plan year	2016 or fiscal p	lan year beginning 01/01/2016		and ending 12/	/31/2016		
A Name of plan COMMUNITY HOSPIC	E, INC.		В	Three-digit plan number (l	PN) •	501	
C Plan sponsor's nam COMMUNITY HOSPIC		ine 2a of Form 5500	D	Employer Identif 31-0970252	ication Number	(EIN)	
		erning Insurance Contract A. Individual contracts grouped as					
1 Coverage Informatio	n:						
(a) Name of insurance AMERICAN FIDELITY A		OMPANY - CANCER					
/L\	(c) NAIC	(d) Contract or	(e) Approximate numb		Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at en policy or contract ye		f) From	(g) To	
73-0714500	60410	76564	59	07/01/20	15	06/30/2016	
2 Insurance fee and co		mation. Enter the total fees and total	I commissions paid. List in	line 3 the agents	s, brokers, and c	other persons in	
(a) Tot	al amount of co	mmissions paid		(b) Total amour	nt of fees paid		
		1197					
3 Persons receiving co	ommissions and	fees. (Complete as many entries a	as needed to report all pers	sons).			
		e and address of the agent, broker, o	or other person to whom co	ommissions or fee	es were paid		
AMERICAN FIDELITY A	SSURANCE C		. 25360 DMA CITY, OK 73125-036	0			
(b) Amount of sales	and base	Fees	s and other commissions p	aid			
commissions	paid	(c) Amount	(d)	(e) Organization code			
	555					3	
	(a) Name	e and address of the agent, broker, of	or other person to whom co	ommissions or fee	es were paid		
BENEFACTOR INS GRO	OUP INC		RTER AVE ND, KY 41101				
(b) Amount of sales	and base	Fees	s and other commissions p	aid			
commissions		(c) Amount	(d)	Purpose		(e) Organization code	
	381					3	
For Department Deduc	tion Act Notice	soo the Instructions for Form El	E00		Caha	dula A (Form 5500) 2016	

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Schedule A	(Form	5500)	2016

Page 2 –	1	
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(a)	Name and address of the a	gent, broker, or o	other person to	whom con	nmissions or f	ees were	paid
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INSURANCE SOLUTIONS OF KY

800 DIEDERICH BLVD RACELAND, KY 41169

	Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
261			3		
(a) Nar	ne and address of the agent, broke	r, or other person to whom commissions or fees were paid			
(a) Hai	no and address of the agent, broke	1, or other person to whom commissions or rece were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	ne and address of the agent broke	r, or other person to whom commissions or fees were paid	-		
(a) Ivai	ne and address of the agent, broke	i, of other person to whom commissions of fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
·					
(a) Nar	ne and address of the agent broke	r, or other person to whom commissions or fees were paid	-		
(a) Ivai	ne and address of the agent, broke	i, of other person to whom commissions of fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	no and address of the agent broke	r, or other person to whom commissions or fees were paid	"		
(a) Nai	ne and address of the agent, broke	i, of other person to whom commissions of fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		

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F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L				Ch	
	b	Premiums paid to carrier			6b	
	c d	Premiums due but unpaid at the end of the year			6c	
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		7				
		(C)Tatal additions			70/6\	
	Ч	(6)Total additions			7c(6) 7d	
		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)			7f	0

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Pa	art	Ш	Welfare Benefit Contract Informa				f the come o	malau	voo organizations(s)
			If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual.	ng purposes if such contr	acts are exp	erience-rated as a ur	nit. Where co	ontract	ts cover individual
8	Ben	efit a	and contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d	Life insurance
	e [= Te	emporary disability (accident and sickness)	f X Long-term disabilit	у д [Supplemental unen	nployment	h∏	Prescription drug
	iΪ	_	op loss (large deductible)	j HMO contract	·	PPO contract			Indemnity contract
	m		ther (specify)		<u> </u>	_			
9 E	Ехре	erien	ce-rated contracts:	,					
	a	Prem	niums: (1) Amount received		9a(1)		10998	3	
		(2) l	ncrease (decrease) in amount due but unpaid		9a(2)				
		(3) I	ncrease (decrease) in unearned premium res	erve	9a(3)		_		
		(4) E	Earned ((1) + (2) - (3))				9a(4)		10998
	b	Ben	nefit charges (1) Claims paid		9b(1)				
		(2) l	ncrease (decrease) in claim reserves		9b(2)		1		
		(3) I	ncurred claims (add (1) and (2))				9b(3)		
		٠,,	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (o	n an accrual basis)		1			
			(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	l	9c(1)(D)			_	
			(E) Taxes	ŀ	9c(1)(E)			_	
			(F) Charges for risks or other contingencies		9c(1)(F)				
			(G) Other retention charges	ı	9c(1)(G)		0-(4)(11)		
			(H) Total retention	_	_		9c(1)(H)	<u>' </u>	
	_		Dividends or retroactive rate refunds. (These	_					
	d		tus of policyholder reserves at end of year: (1)	•					
		` '	Claim reserves						
		` '	Other reserves				_ ` /		
40	е		dends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2)	(.)	9e		
10	_		perience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to c	arrier			10a		10998
	b C	rete	e carrier, service, or other organization incurrention of the contract or policy, other than repo				10b		
	Spe	city r	nature of costs.						
Pa	rt	IV	Provision of Information						
11	Dic	d the	insurance company fail to provide any inform	ation necessary to comple	ete Schedule	e A?	Yes	X N	0
12	If t	he ar	nswer to line 11 is "Yes " specify the informati	on 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 Fol	rm is Open to Public Inspection	
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016	and en	nding 12/31/2016		
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)	
		ning Insurance Contract (Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		MPANY - LTD				
/h) [IN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or o	contract year	
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To	
73-0714500	60410	76564	55	07/01/2015	06/30/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
		5363				
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	is needed to report all persons).			
		nd address of the agent, broker, o	· · · · · · · · · · · · · · · · · · ·	ions or fees were paid		
BENEFACTOR INS GROU	P INC		RTER AVE D, KY 41101			
(b) Amount of sales ar	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	(e) Organization code		
2996					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	SURANCE COM	MPANY PO BOX OKLAHO	25360 MA CITY, OK 73125-0360			
(b) Amount of color or	nd base	Fees	and other commissions paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code	
·	2367				3	
For Panerwork Reduction	n Act Notice	see the Instructions for Form 55	500.	Sche	dule A (Form 5500) 2016	

Schedule A (Form 5500) 2	2016	Page 2 – 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, bro	sker, 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	
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L				Ch	
	b	Premiums paid to carrier			6b	
	c d	Premiums due but unpaid at the end of the year			6c	
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		7				
		(C)Tatal additions			70/6\	
	Ч	(6)Total additions			7c(6) 7d	
		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)			7f	0

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Pa	art I							
		If more than one contract covers the same group of employed the information may be combined for reporting purposes if substitution employees, the entire group of such individual contracts with	uch contrac	ts are expe	rience-rated as a uni	t. Where cor	itracts cov	• • • • • • • • • • • • • • • • • • • •
8	Bene	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) b Dental		С	Vision		d Life i	nsurance
	еĒ	Temporary disability (accident and sickness) f 🐰 Long-term	n disability	g∏	Supplemental unem	plovment I	h Pres	cription drug
	iΕ	Stop loss (large deductible)	-		PPO contract			nnity contract
	· _		liaci	ν.	11 O contract			illility contract
	m	Other (specify)						
ο .		-vi v-tdtt						
		erience-rated contracts:		00/4)		50040	1	
		Premiums: (1) Amount received		9a(1) 9a(2)		59910	1	
		(3) Increase (decrease) in amount due but unpaid		9a(2)			1	
		(4) Earned ((1) + (2) - (3))				9a(4)		59910
	_	Benefit charges (1) Claims paid		9b(1)		1 04(.)		
		(2) Increase (decrease) in claim reserves		9b(2)			1	
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (on an accrual bas						
		(A) Commissions	9	c(1)(A)				
		(B) Administrative service or other fees		c(1)(B)				
		(C) Other specific acquisition costs		c(1)(C)			_	
		(D) Other expenses		c(1)(D)			_	
		(E) Taxes	_	c(1)(E)			1	
		(F) Charges for risks or other contingencies	_	c(1)(F)			4	
		(G) Other retention charges	<u> </u>	c(1)(G)		0o/1\/U\		
		(H) Total retention	_			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amounts were	_			9c(2)		
		Status of policyholder reserves at end of year: (1) Amount held to	•			9d(1)		
		(2) Claim reserves				9d(2) 9d(3)		
		(3) Other reserves				9e		
10		onexperience-rated contracts:	it entered in	III 16 3C(2).)	36		
		Total premiums or subscription charges paid to carrier				10a		59910
	_	If the carrier, service, or other organization incurred any specific c						00010
		retention of the contract or policy, other than reported in Part I, lin				10b		
		ecify nature of costs.		•			•	
	·							
Pa	art l'	IV Provision of Information						
		d the insurance company fail to provide any information necessary	to complete	Schedule	А? П	Yes	No	
				, Joneaule	/ \ :	. 00	1	
14	if th	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).	Inis Fo	rm is Open to Public Inspection			
For calendar plan year 20	16 or fiscal plar	n year beginning 01/01/2016	and en	iding 12/31/2016				
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		D Employer Identification Number (EIN) 31-0970252				
	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		MPANY - MEDICAL INDIV						
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	contract year			
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To			
73-0714500	60410	76564	2	07/01/2015	06/30/2016			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents, brokers, and o	other 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	as needed to report all persons).					
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid				
BENEFACTOR INS GROU	IP INC		RTER AVE ID, KY 41101					
(b) Amount of sales a	nd base	Fees	and other commissions paid					
commissions pa	id	(c) Amount	(d) Purpose	(e) Organization code				
	34			3				
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	ions or fees were paid				
(b) Amount of sales a	nd base	Fees	and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code			
For Panerwork Reduction	n Act Notice	see the Instructions for Form 55	500	Sche	dule A (Form 5500) 2016			

Schedule A (Form 5500) 2	2016	Page 2 – 1		
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid		
(a) Nai	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nar	me and address of the agent, bro	sker, 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	
	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid		

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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F	Part					
		Where individual contracts are provided, the entire group of such individual this report.	idual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end		4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L				Ch	
	b	Premiums paid to carrier			6b	
	c d	Premiums due but unpaid at the end of the year			6c	
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferre	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		7				
		(C)Tatal additions			70/6\	
	Ч	(6)Total additions			7c(6) 7d	
		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)			7f	0

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Pa	art	Ш	Welfare Benefit Contract Informa			(a) an managabana			
			If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual of the contract of the contract covers the same of the covers the covers the covers the same of the covers the covers the same of the covers the covers the same of the covers the cov	ing purposes if such conti	acts are exp	erience-rated as a un	it. Where co	ontract	ts cover individual
8	Ben	efit ar	nd contract type (check all applicable boxes)						
	а	He	alth (other than dental or vision)	b Dental	С	Vision		d	Life insurance
	е	Ter	mporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unen	ployment	h∏	Prescription drug
	ί	Sto	op loss (large deductible)	j HMO contract	_	PPO contract		ıΠ	Indemnity contract
	m	X Otl	ner (specify) DTHER		_	_			
9 1	Ехре	erienc	e-rated contracts:						
	a	Premi	ums: (1) Amount received		9a(1)		688	3	
		(2) In	crease (decrease) in amount due but unpaid		9a(2)				
		(3) In	crease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		688
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) In	crease (decrease) in claim reserves		9b(2)				
		(3) In	curred claims (add (1) and (2))				9b(3)		
		(4) C	laims charged				9b(4)		
	С	Rem	ainder 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) D	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Statu	us of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) C	Claim reserves				9d(2)		
		(3) C	Other reserves				9d(3)		
	е	Divid	lends or retroactive rate refunds due. (Do no	ot include amount entered	I in line 9c(2)).)	9e		
10	No	nexpe	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to c	arrier			10a		688
	b		e carrier, service, or other organization incurr ntion of the contract or policy, other than repo				10b		
	Spe		ature of costs.	,	, ,				
Pa	rt	IV	Provision of Information						
11	Dio	d the i	nsurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X N	lo
			swer to line 11 is "Yes " specify the informati						

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 Foi	m is Open to Public Inspection
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016	and en	iding 12/31/2016	
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)
		ning Insurance Contract (. Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca		MPANY - STD			
/h) [IN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or c	ontract year
(b) EIN	code	identification number	policy or contract year	(f) From	(g) To
73-0714500	60410	76564	5	07/01/2015	06/30/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and c	other persons in
(a) Total a	amount of comr		(b) To	otal amount of fees paid	
-		289			
3 Persons receiving com	missions and fe	ees. (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 D, KY 41101		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions paid		(c) Amount	(d) Purpose		(e) Organization code
	178				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	SURANCE COM	MPANY PO BOX OKLAHO	25360 MA CITY, OK 73125-0360		
(b) Amount of sales ar	nd book	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code
·	111				3
For Panerwork Reduction	n Act Notice	see the Instructions for Form 55	500.	Scho	dule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) No.	me and address of the agent bro	lker, er ether person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, bio	oker, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, bro	sker, 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) Nar	me and address of the agent, bro	ker, 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) Nar	me and address of the agent, bro	ker, 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
	me and address of the agent, bro	ker, or other person to whom commissions or fees were paid	

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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F	Part							
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.							
4	Curi	Current value of plan's interest under this contract in the general account at year end						
5	Curi	ent value of plan's interest under this contract in separate accounts at year e	nd		5			
6	Con	tracts With Allocated Funds:						
	а	State the basis of premium rates						
	L				Ch			
	b	Premiums paid to carrier			6b			
	c d	Premiums due but unpaid at the end of the year			6c			
	u	retention of the contract or policy, enter amount			6d			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferre	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, c	check here				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)				
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	ion guarantee				
		(3) guaranteed investment (4) other						
	b	Balance at the end of the previous year			7b			
	С	Additions: (1) Contributions deposited during the year	7c(1)					
		(2) Dividends and credits	7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
		7						
		(C)Tatal additions			70/6\			
	Ч	(6)Total additions			7c(6) 7d			
		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)			7f	0		

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Pa	art I	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individua	oup of employees of the gurposes if such cont	racts are e	xpe	rience-rated as a unit	Where co	ontracts	s cover individual
8	Bene	efit and contract type (check all applicable boxes)							-
	аГ	_	b Dental	c	: П	Vision		d∏	Life insurance
	e >	d d	f Long-term disabilit		=	Supplemental unemp	lovmont		Prescription drug
	. r		_ 📛	_	_		noyment		
	ַ י	Stop loss (large deductible)	HMO contract	K	· 🗌	PPO contract		IШ	Indemnity contract
	m	Other (specify)							
	•	erience-rated contracts:						4	
		Premiums: (1) Amount received		9a(1)			3563	<u>-</u>	
		(2) Increase (decrease) in amount due but unpaid						_	
		(3) Increase (decrease) in unearned premium rese							
	_	(4) Earned ((1) + (2) - (3))			·····		9a(4)		3563
		Benefit charges (1) Claims paid						_	
		(2) Increase (decrease) in claim reserves							
		(3) Incurred claims (add (1) and (2))					9b(3)		
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on		0.(4)(4)				4	
		(A) Commissions		9c(1)(A				-	
		(B) Administrative service or other fees		9c(1)(B				-	
		(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)	_			4	
		(D) Other expenses		9c(1)(E)				-	
		(E) Taxes.		9c(1)(F)	_				
		(F) Charges for risks or other contingencies							
		(G) Other retention charges					9c(1)(H)		
		(H) Total retention	_	_	_			<u>' </u>	
		(2) Dividends or retroactive rate refunds. (These a	_	<u> </u>			9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•				9d(1)		
		(2) Claim reserves					9d(2)		
	_	(3) Other reserves					9d(3)		
10		Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c	(2) .)		9e		
10		nexperience-rated contracts:					100		2500
		Total premiums or subscription charges paid to ca					10a		3563
	b	If the carrier, service, or other organization incurre	d any specific costs in c	onnection	with	the acquisition or	10b		
	Spe	retention of the contract or policy, other than report cify nature of costs.	teu iii Fait i, iiile 2 abov	е, тероп а	HIOC	JIII	100		
P	rt l	IV Provision of Information							
			tion noonoon, to occur	oto Coba-l	ulc		Yes	X No	
		d the insurance company fail to provide any informa		ete Sched	uie /	A!	169	^ INC	1
12	If th	he answer to line 11 is "Yes." specify the information	n not provided. 🕨						

rm 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 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

2016

This Form is Open to Public Inspection

Part I Annual Report	Identification Information	4			
For calendar plan year 2016 or fi	scal plan year beginning		and ending		
A This return/report is for:	a multiemployer plan			ng this box must attach a list occordance with the form instru	
B This return/report is:	a single-employer plan the first return/report an amended return/report	a DFE (specify) the final return/i a short plan yea		n 12 months)	
C If the plan is a collectively-baD Check box if filing under:	rgained plan, check here Form 5558 special extension (enter de	automatic exten	sion	the DFVC program	
Part II Basic Plan Infor	mation-enter all requested info	ormation			
1a Name of plan COMMUNITY HOSPICE,	INC.			1b Three-digit plan number (PN) ► 1c Effective date of plan	501
				03/01/1994	
City or town, state or province	n, apt., suite no. and street, or P.O. I , country, and ZIP or foreign postal		ructions)	2b Employer Identification Number (EIN) 31-0970252	
COMMUNITY HOSPICE, I	NC.			2c Plan Sponsor's telephonumber 606-329-1890	one
1480 CARTER AVENUE		STATEMENT	,	2d Business code (see instructions) 621610	CONTRACTOR ST. CO.
ASTLAND	KY 41101				
Caution: A penalty for the late of	r incomplete filing of this return/	renort will be assessed	d unless reasonable o	ausa is actablished	
Under penalties of perjury and other penalties and attachments, as well as t	alties set forth in the instructions, I declare	that I have examined this re	eturn/report, including accor	mpanying schedules.	
SIGN JUNAN	Yurd	05/04/2017			
Signature of plan adminis	itrator	Date	Enter name of individ	ual signing as plan administra	itor
Signature of employer/pla	n sponsor	Date	Enter name of individual	signing as employer or plan sponso	or
ERE Signature of DFE		Data		1	
Preparer's name (including firm nam	ne if applicable) and address (inclu	Date	Enter name of individ		
, so the second	e, i applicable) and address (inclu	de room of suite numbe	()	Preparer's telephone number	: r
				7.1	

31-0970252

Form 5500 (2016)

Page 2

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report. 5 Total number of participants at the beginning of the plan year. 6 Number of participants at the beginning of the plan year unless otherwise stated (wolfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year unless otherwise stated (wolfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the end of the plan year unless otherwise stated (wolfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). b Restred or separated participants at the end of the plan year (all year). c Other retired or separated participants entitled to future benefits (but of the plan year (all year)) and benefits (c) benefits (Plan administrator's name and address [X] Same as Plan Sponsor	,	3b Administrator's EIN
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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 filling requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)

Yes X No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filling requirements? (See instructions and 29 CFR 2520.101-2.)

Yes No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 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 filling requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filling to rejection as incomplete.)

Receipt Confirmation Code