#### 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

Part I	Annual Report Id	dentification Information							
For cale	For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016								
A This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this be participating employer information in accordance)									
a single-employer plan a DFE (specify)									
B This return/report is:									
		an amended return/report	a short plan ye	ear return/report (less than 12	months)	)			
C If the	plan is a collectively-barg	ained plan, check here				•			
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exte	nsion	X the	e DFVC program			
		special extension (enter description	<u> </u>						
Part II		mation—enter all requested information	on				_		
	ne of plan JNITY YOUTH SERVICE:	S HEALTH & WELFARE PLAN			1b	Three-digit plan number (PN) ▶	501		
					1c	Effective date of plants of 1/01/1977	an		
Mail	ing address (include room	er, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box) n, country, and ZIP or foreign postal code		ructions)	2b	Employer Identifica Number (EIN) 91-0859922	ation		
	NITY YOUTH SERVICES			,	2c Plan Sponsor's telephone number 360-918-7868				
	TE AVE NE A, WA 98506-3984	711 STAT OLYMPIA	E AVE NE , WA 98506-3984		2d Business code (see instructions) 624100				
Caution	: A penalty for the late o	r incomplete filing of this return/repo	rt will be assessed	unless reasonable cause is	establis	shed.			
		er penalties set forth in the instructions, ell as the electronic version of this return							
SIGN	Filed with authorized/valid	d electronic signature.	08/09/2017	WANDA MICHAEL					
HERE	Signature of plan adm	inistrator	Date	Enter name of individual sig	aning as plan administrator				
SIGN					<u> </u>	,			
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual sig	ning as	employer or plan sp	onsor		
SIGN									
HERE Signature of DFE Date Enter name of individual signin					ning as	DFE			
						telephone number			
HOLLY YOUNG						801-685-8400			
HR SERVICES, INC						001-003-0400			
9551 SOUTH 700 E SUITE 200									
SANDY, UT 84070									

Form 5500 (2016) Page **2** 

Number of participants as of the end of the plan year unless otherwise stated (welfare 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	3a	Plan administrator's name and address X Same as Plan Sponsor	<b>3b</b> Administrator's EIN		
Sponsor's name  5 Total number of participants at the beginning of the plan year  6 Number of participants as of the end of the plan year unless otherwise stated (welfare 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.  6 6a(1)  a(2) Total number of active participants at the end of the plan year.  6 6a(2)  1 8 Retired or separated participants receiving benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits and the separated participants entitled to future benefits entitled to future benefi				·	_
Sponsor's name  5 Total number of participants at the beginning of the plan year  6 Number of participants as of the end of the plan year unless otherwise stated (welfare 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.  6 6a(1)  a(2) Total number of active participants at the end of the plan year.  6 6a(2)  1 8 Retired or separated participants receiving benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits.  6 C Other retired or separated participants entitled to future benefits and the separated participants entitled to future benefits entitled to future benefi					
Total number of participants at the beginning of the plan year (sa(2), 66, 6c, and 6d).  a(1) Total number of active participants at the deginning of the plan year	4		report filed for this plan, enter the name,	4b EIN	
6 Number of participants as of the end of the plan year unless otherwise stated (welfare 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	а	Sponsor's name		4c PN	
Section   Comment   Comm	5	Total number of participants at the beginning of the plan year		5 86	6
A (2) Total number of active participants at the end of the plan year	6		d (welfare plans complete only lines 6a(1),		
B Retired or separated participants receiving benefits	a(1	Total number of active participants at the beginning of the plan year		<b>6a(1)</b>	6
C Other retired or separated participants entitled to future benefits	a(2	Total number of active participants at the end of the plan year		6a(2) 103	3
d Subtotal. Add lines 6a(2), 6b, and 6c	b	Retired or separated participants receiving benefits		6b	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	С	Other retired or separated participants entitled to future benefits		6c (	0
f Total. Add lines 6d and 6e	d	Subtotal. Add lines 6a(2), 6b, and 6c		6d 103	3
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)       6g         h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested       6h         7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)       7         8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics 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)       9b Plan benefit arrangement (check all that apply)         (1)	е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits		0
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.  7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	f	Total. Add lines <b>6d</b> and <b>6e</b>		<b>6f</b> 103	3
less than 100% vested   Senter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)   7	g			6g	_
Ba 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	h	, ,		6h	
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)	7	Enter the total number of employers obligated to contribute to the plan (only i	multiemployer plans complete this item)	7	
(1)	b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E	les from the List of Plan Characteristics Codes	s in the instructions:	
(2) Code section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor (4) General assets of the sponsor  10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Trust (4) General assets of the sponsor  b General Schedules (1) H (Financial Information) (1) H (Financial Information – Small Plan) (3) N 4 A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	<b>9</b> a			at apply)	
(3) Trust (4) General assets of the sponsor (4) General assets of the sponsor  10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) Trust General assets of the sponsor  b General Schedules (1) H (Financial Information) (1) H (Financial Information – Small Plan) (3) A (Insurance Information) (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)		H H	I — — — — — — — — — — — — — — — — — — —	insurance contracts	
(4) General assets of the sponsor  10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) SB (Single-Employer Defined Benefit Plan Actuarial  (4) General assets of the sponsor  (5) General assets of the sponsor  (6) General assets of the sponsor  (8) General assets of the sponsor  (9) General assets of the sponsor  (1) General assets of the sponsor  (2) General assets of the sponsor  (1) General assets of the sponsor  (2) General assets of the sponsor  (3) General schedules  (4) Financial Information - Small Plan  (5) C (Service Provider Information)  (6) D (DFE/Participating Plan Information)				mourance contracts	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)  a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)		H H		ponsor	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	10		<u> </u>	<u>'</u>	_
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (4) C (Service Provider Information) (5) D (DFE/Participating Plan Information)	2	Panaian Sahadulaa	b. Canaral Sahadulaa		
Purchase Plan Actuarial Information) - signed by the plan actuary  (3)  (4)  (5)  A (Insurance Information)  C (Service Provider Information)  D (DFE/Participating Plan Information)	а			mation)	
(-) (g		Purchase Plan Actuarial Information) - signed by the plan	(3) A (Insurance Infor	rmation)	
				-	

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)					
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)						
If "Ye	es" is checked, complete lines 11b and 11c.					
<b>11b</b> Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)					
Rece	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 ipt 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 lipt 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

2016

,		pursuant to E	RISA section 103(a)(2).	e miormai	lion		m 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	1/2016			
A Name of plan COMMUNITY YOUTH SE		B Thre-	e-digit number (PN	N) <b>•</b>	501				
C Plan sponsor's name a		e 2a of Form 5500			oyer Identifica 0859922	ation Number (	EIN)		
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:									
(a) Name of insurance ca STANDARD INSURANCE									
	(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	<b>(g)</b> To		
93-0242990	69019	753610	136		01/01/2016	6	12/31/2016		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	t in line 3	the agents,	brokers, and ot	ther persons in		
(a) Total	amount of comi			<b>(b)</b> To	otal amount	of fees paid			
		1259					0		
3 Persons receiving com		ees. (Complete as many entries							
0115.010	(a) Name a	and address of the agent, broker,	<u>'</u>	commiss	ions or fees	were paid			
GHB INC		PO BOX OLYMP	( 1608 IA, WA 98507						
(b) Amount of sales a	nd base	Fee	s and other commissions	s paid					
commissions pa		(c) Amount	(0	(d) Purpose			(e) Organization code		
	1259						3		
	(a) Name a	and address of the agent, broker,	or other person to whom	commiss	ions or fees	were paid			
(b) Amount of sales a	nd base	Fee	ees and other commissions paid						
commissions pa		(c) Amount	(0	d) Purpose	е		(e) Organization code		
For Paperwork Reduction	n Act Notice.	see the Instructions for Form 5	500.			Sched	lule A (Form 5500) 2016		

Schedule A (Form 5500) 2	2016	Page <b>2 –</b> 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	
<b>(a)</b> 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	<b>(e)</b> 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	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa,			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on 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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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

F	Part I	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individual	group of employees of th ing purposes if such cont	racts are ex	perience-rated as a uni	t. Where contr	acts cover individual
8	Bene	fit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	d	X Life insurance
	еĒ	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	plovment <b>h</b>	Prescription drug
	i F	Stop loss (large deductible)	j HMO contract	, S	=		Indemnity contract
			, I ilwo contract	*	_ 110 contract	• 1	Indemnity contract
	m _	Other (specify)					
9	Evne	rience-rated contracts:					
3	•	remiums: (1) Amount received		9a(1)		8394	
		(2) Increase (decrease) in amount due but unpaid		· · · · ·		1148	
		(3) Increase (decrease) in unearned premium res		9a(3)		0	
		(4) Earned ( <b>(1) + (2) - (3)</b> )				9a(4)	9542
	-	Benefit charges (1) Claims paid				10000	
	(	(2) Increase (decrease) in claim reserves		9b(2)		1954	
		(3) Incurred claims (add (1) and (2))				9b(3)	11954
	(	(4) Claims charged				9b(4)	11954
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)		T		
		(A) Commissions		9c(1)(A)		1259	
		(B) Administrative service or other fees		9c(1)(B)		0	
		(C) Other specific acquisition costs		9c(1)(C)		3668	
		(D) Other expenses		9c(1)(D) 9c(1)(E)		1949	
		(E) Taxes(F) Charges for risks or other contingencies		9c(1)(F)		191	
		(G) Other retention charges		0 (4)(0)		763	
		(H) Total retention				9c(1)(H)	7830
		(2) Dividends or retroactive rate refunds. (These				9c(2)	(
		Status of policyholder reserves at end of year: (1)	_	_		9d(1)	(
		(2) Claim reserves	•			9d(2)	1954
		(3) Other reserves				9d(3)	(
		Dividends or retroactive rate refunds due. (Do no				9e	(
1(	-	nexperience-rated contracts:		,			
	а	Total premiums or subscription charges paid to c	arrier			10a	
	b	If the carrier, service, or other organization incurr	ed any specific costs in o	onnection w	ith the acquisition or		
	_	retention of the contract or policy, other than repo	orted in Part I, line 2 abov	e, report am	ount	10b	
	Spec	ify nature of costs.					
F	Part I	V Provision of Information					
		the insurance company fail to provide any inform	ation necessary to some	lata Sahadul	ь А2	Yes	No
	םוט ו	the mourance company rail to provide any inform	anon necessary to comp	iere ochedu	€ ∧ :	100	110

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 YOUTH SERVICES HEALTH & WELFARE PLAN				B Three-digit				
OSMINIONI FOSTI OLIVIOLO NENENEN A WELLTING FERMI				plan	number (PN)	301		
C Plan sponsor's name a COMMUNITY YOUTH SE		2a of Form 5500			oyer Identification Number	(EIN)		
COMMUNITY YOUTH SE	RVICES			91-0	0009922			
	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 STANDARD INSURANCE								
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			ontract year I		
(b) Liiv	code	identification number	policy or contract		(f) From	<b>(g)</b> To		
93-0242990	69019	753610	115		01/01/2016	12/31/2016		
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total a	amount of comn			<b>(b)</b> To	otal amount of fees paid			
		3287				0		
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).				
	(a) Name ar	nd address of the agent, broker,	•	m commiss	ions or fees were paid			
GHB INC			X 1608 PIA, WA 98507					
(b) Amount of sales ar	d base		es and other commission	ns paid				
commissions pai		(c) Amount	(d) Purpose		e	(e) Organization code		
	3287	0				3		
	(a) Name ar	nd address of the agent, broker,	, or other person to whor	m commiss	ions or fees were paid			
			·					
(b) Amount of sales and base Fees and other commissions paid								
commissions paid		(c) Amount		(d) Purpose	e	(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 <b>2 –</b> 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	
<b>(a)</b> 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	<b>(e)</b> 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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ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on 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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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

P	art II	Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	group o ing purp	poses if such cont	racts are	exp	erience-rated as a unit	. Where co	ntrac	ts cover individual
8	Bene	fit and contract type (check all applicable boxes)								
	а	Health (other than dental or vision)	b 🗶 I	Dental		С	Vision		d 🗌	Life insurance
	е	Temporary disability (accident and sickness)	f 🗌 ı	Long-term disabili	ty	g	Supplemental unemp	oloyment	h	Prescription drug
	iΠ	Stop loss (large deductible)	j∏ı	HMO contract		kΓ	PPO contract		ıΠ	Indemnity contract
	m	Other (specify)	- 🗀			<u> </u>	1			·
	∟	Carlot (Openity)								
9	Exper	ience-rated contracts:								
	<b>a</b> P	remiums: (1) Amount received			9a(1	)		65732		
	(	2) Increase (decrease) in amount due but unpaid	l		9a(2	)		0		
	(	3) Increase (decrease) in unearned premium res	erve		9a(3	)		0		
		4) Earned ( <b>(1) + (2) - (3)</b> )						. 9a(4)		65732
		Benefit charges (1) Claims paid						51996	-1	
		2) Increase (decrease) in claim reserves						3181		
		3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )						9b(3)		55177
	,	4) Claims charged				•••••		9b(4)		55177
	С	Remainder of premium: (1) Retention charges (or (A) Commissions			9c(1)(	Δ١		3287	_	
		(B) Administrative service or other fees			9c(1)(			<u>3207</u>	_	
		(C) Other specific acquisition costs			9c(1)(			0	-	
		(D) Other expenses			9c(1)(	_		13037	_	
		(E) Taxes			9c(1)(			1315	7	
		(F) Charges for risks or other contingencies			9c(1)(	F)		1644	<b>-</b>	
		(G) Other retention charges			9c(1)(	G)		0		
		(H) Total retention						9c(1)(H)		19283
	(	2) Dividends or retroactive rate refunds. (These	amoun	its were 🗌 paid in	cash, o	r 🛮 (	credited.)	9c(2)		(
	d :	Status of policyholder reserves at end of year: (1)	) Amou	nt held to provide	benefits	after	retirement	9d(1)		(
	(	2) Claim reserves						9d(2)		3181
	(	3) Other reserves						9d(3)		(
		Dividends or retroactive rate refunds due. (Do no	ot includ	de amount entered	d in line 9	c(2)	.)	9e		(
10		experience-rated contracts:						40		
		Total premiums or subscription charges paid to ca						10a		
		f the carrier, service, or other organization incurre						10b		
		etention of the contract or policy, other than repo ify nature of costs.	nteu III	rait i, iiile 2 abov	е, тероп	anic	June	100		
Р	art I\	Provision of Information								
_11	Did	the insurance company fail to provide any inform	ation n	ecessary to compl	ete Sche	edule	A?	Yes	X N	0

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

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2). Inspection					Inspection		
For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016		and en	nding 12/3	1/2016	
A Name of plan COMMUNITY YOUTH SE	RVICES HEAL	TH & WELFARE PLAN			e-digit number (PN	N) <b>•</b>	501
C Plan sponsor's name a COMMUNITY YOUTH SE		e 2a of Form 5500			oyer Identific 0859922	ation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca NATIONAL GUARDIAN LIF		E COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
39-0493780	66583	31425	131		01/01/2016	5	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents,	brokers, and of	ther persons in
(a) Total	amount of comr	missions paid		<b>(b)</b> To	otal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	ions or fees	were paid	
		<b>y</b> , ,	·			·	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	se <b>(e)</b> Orga		(e) Organization code

Schedule A (Form 5500) 2016		Page <b>2 –</b> 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
<b>(a)</b> 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	<b>(e)</b> 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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ay		•

F	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on 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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

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Pa	ırt I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract covers the same the information may be combined for report employees, the entire group of such individual to the contract covers the covers the contract covers the covers t	group of employees of th	tracts are expe	erience-rated as a uni	t. Where co	ontracts	cover individual
<b>8</b> E	3ene	efit aı	nd contract type (check all applicable boxes)						
;	а	He	alth (other than dental or vision)	<b>b</b> Dental	c 🛚	Vision		d∏∟	ife insurance
	e 🗆	Te	mporary disability (accident and sickness)	f Long-term disabil	ity $\mathbf{g}$	Supplemental unem	ployment	h∏p	rescription drug
i	:		op loss (large deductible)	j  HMO contract	· - =	PPO contract		- =	ndemnity contract
	m [	_	her (specify)	, I have contract	⊓	TT O continuot		•□ "	identification of the contract
<b>9</b> E	xne	rienc	ce-rated contracts:						
_	•		iums: (1) Amount received		9a(1)			7	
			ncrease (decrease) in amount due but unpai					$\dashv$	
			ncrease (decrease) in unearned premium res					_	
			arned ((1) + (2) - (3))				9a(4)		
	_	. ,	efit charges (1) Claims paid						
		(2) Ir	ncrease (decrease) in claim reserves					_	
			ncurred claims (add (1) and (2))				9b(3)		
			laims charged				9b(4)		
	С	Rem	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 .					_	
		(	(G) Other retention charges		9c(1)(G)		•		
		(	(H) Total retention	<u></u>	·····		9c(1)(H	)	
		(2) [	Dividends or retroactive rate refunds. (These	e amounts were paid i	n cash, or 📗 c	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (	Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line <b>9c(2)</b> .	.)	9e		
10	Nor	nexp	erience-rated contracts:						
	а	Tota	I premiums or subscription charges paid to o	carrier			10a		7212
			e carrier, service, or other organization incur						
			ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	ve, report amo	unt	10b		
			ature of costs.						
Pa	rt I	V	Provision of Information						
11	Did	the	insurance company fail to provide any inforn	nation necessary to comp	lete Schedule	A?	Yes	X No	
12	If th	ne an	swer 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.

OMB No. 1210-0110

2016

			ERISA section 103(a)(2)		lion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	16 or fiscal pla	in year beginning 01/01/2016		and en	nding 12/31/	2016	
A Name of plan COMMUNITY YOUTH SERVICES HEALTH & WELFARE PLAN					e-digit number (PN)	<b>,</b>	501
C Plan sponsor's name a COMMUNITY YOUTH SE	RVICES			91-0	oyer Identifica 0859922		
on a separa		rning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca KAISER FOUNDATION HE	ALTH PLAN (	OF WASHINGTON OPTIONS, I	NC (e) Approximate nu	umbor of	T	Policy or o	contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f) F	From	(g) To
91-1467158	47055	6584700	106		01/01/2016		12/31/2016
2 Insurance fee and coming descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	rokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		21805					
3 Persons receiving com	missions and f	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees v	vere paid	
GHB INSURANCE			OX 1608 IPIA, WA 98507				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code
	21805						
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees v	vere paid	
<b>(b)</b> Amount of sales ar			ees and other commission			-	
commissions pai	a	(c) Amount	1	(d) Purpose	e		(e) Organization code

Schedule A (Form 5500) 2016		Page <b>2 –</b> 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
<b>(a)</b> 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	<b>(e)</b> 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	art	II Investment and Annuity Contract Information				
·	u. c	Where individual contracts are provided, the entire group of such individual this report.	idual contrac	ets with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year e			5	
_		racts With Allocated Funds:			<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 co retention of the contract or policy, enter amount			6d	
		Specify nature of costs		!	'	
	е	Type of contract: (1)  individual policies (2)  group deferre	d annuity			
	•		a aa			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	aintained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participati	on 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)			
		<b>•</b>				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		i	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)			
		<b>&gt;</b>	• • •			
		(E) T + 1 1 1 4			70/F)	
		(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	ane	Δ

Pa	art II	III Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportin employees, the entire group of such individu	roup of employees of the	racts are expe	erience-rated as a uni	t. Where co	ontracts cover in					
8	Bene	enefit and contract type (check all applicable boxes)										
	a X	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insu	rance				
	e 🗆	Temporary disability (accident and sickness)	f Long-term disabili	ty <b>g</b>	Supplemental unem	ployment	h Prescrip	tion drug				
	ιĖ	Stop loss (large deductible)	j  HMO contract	· - <u>-</u>	PPO contract	,	I Indemnit	_				
	m [	Other (specify)	, I ime somace	🗀	11100011111001			y contract				
9 E	Expe	erience-rated contracts:										
;	a Þ	Premiums: (1) Amount received		9a(1)			7					
	(	(2) Increase (decrease) in amount due but unpaid										
	(	(4) Earned ((1) + (2) - (3))				9a(4)						
	b			9b(1)								
	(	(2) Increase (decrease) in claim reserves		9b(2)								
		(3) Incurred claims (add (1) and (2))				9b(3)						
		(4) Claims charged			T .	9b(4)						
	С	Remainder of premium: (1) Retention charges (or	an accrual basis)									
		(A) Commissions	9c(1)(A)									
		(B) Administrative service or other fees		9c(1)(B)								
		(C) Other specific acquisition costs		9c(1)(C)								
		(D) Other expenses		9c(1)(D)								
		(E) Taxes	9c(1)(E)									
		(F) Charges for risks or other contingencies										
		(G) Other retention charges	9c(1)(G)									
		(H) Total retention	9c(1)(H)	)								
		(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)										
	d	Status of policyholder reserves at end of year: (1)	9d(1)									
		(2) Claim reserves		9d(2)								
		(3) Other reserves										
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	d in line <b>9c(2)</b> .	.)	9e						
10	Nor	onexperience-rated contracts:										
	а	Total premiums or subscription charges paid to ca	10a		543605							
	b	If the carrier, service, or other organization incurre	ed any specific costs in o	onnection with	h the acquisition or							
		retention of the contract or policy, other than repo				10b						
,	Spec	ecify nature of costs.										
Pa	rt I	IV Provision of Information										
							<u> </u>					
		d the insurance company fail to provide any informa		lete Schedule	A?	Yes	X No					
12	If th	he answer to line 11 is "Yes," specify the information	n 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 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		
Part		dentification In	formation				Inspection		
For ca	lendar plan year 2016 or fis				and endi	ng 12/31/2016			
	s return/report is for:	x a single-empl x the first return	pyer plan  a multiple-employer plan (Filers checking the participating employer information in accordance)  a DFE (specify)				this box must attach a list of		
_		an amended	,	a short pl	an year return/report	(less than 12 m	nonths)		
C If th	e plan is a collectively-barg	jained plan, check h	ere				_		
D Che	eck box if filing under:								
Part	I Racic Plan Infor		on (enter description						
7777	II Basic Plan Informe of plan	mation-enter all	requested information	tion					
COMMUNITY YOUTH SERVICES HEALTH & WELFARE PLAN							<b>1b</b> Three-digit plan number (PN) ▶ 501		
2a Pla	n sponsor's name (employ		1c Effective date of plan 01/01/1977						
Ma Cit	iling address (include room y or town, state or province JNITY YOUTH SERVICES		2b Employer Identification Number (EIN) 91-0859922						
711 CT	TE AME NO		*				2c Plan Sponsor's telephone number 360-918-7868		
711 STATE AVE NE OLYMPIA, WA 98506-3984			711 STATE AVE NE OLYMPIA, WA 98506-3984				2d Business code (see instructions) 624100		
•									
	n: A penalty for the late or renalties of perjury and other ents and attachments, as we						stablished.  udlng accompanying schedules, it is true, correct, and complete.		
SIGN HERE	Manda	Mich	all	08.09.	L Dest of thy knowle	da M	it is true, correct, and complete.		
	Signature of plan administrator			Date	Enter name of	Enter name of individual signing as plan administrator			
SIGN	Marsa Mici		all	08.09.1		a Mi	chael		
	Signature of employer/	plan sponsor		Date	Enter name of	individual signir	ng as employer or plan sponsor		
SIGN HERE		·					s as employer of plair sportsor		
	Signature of DFE			Date	Enter name of	individual signir	OC OC DELL		
Prepare	r's name (including firm nar	ne, if applicable) and	nd address (include room or suite number)			Prepa	Preparer's telephone number		
	YOUNG RVICES, INC						801-685-8400		
	OUTH 700 E						. 001-000-0400		
SUITE ?									
Ear D-	anneal D. J.								
ror Pap	erwork Reduction Act No	tice, see the Instru	ctions for Form 5	500					