Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

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

OMB Nos. 1210-0110 1210-0089

2018

Administration the in		the instruct	ions to the Form 55	ns to the Form 5500.				
Pensio	on Benefit Guaranty Corporation				This Form is Open to Public Inspection			
Part I	Annual Report	Identification Information						
For cale	ndar plan year 2018 or fi	iscal plan year beginning 01/01/2018		and ending 12/31/20	018			
A This	return/report is for:	a multiemployer plan X a single-employer plan		oloyer plan (Filers checking t mployer information in accor /)			ns.)	
D Total	and the second second second	the first return/report	the final return	/report				
B This	return/report is:	an amended return/report		ear return/report (less than 1	2 months)			
C If the	plan is a collectively-bar	rgained plan, check here				• [
D Chec	k box if filing under:	Form 5558	automatic exter	nsion	the	e DFVC program		
		special extension (enter description))					
Part II	Basic Plan Info	rmation—enter all requested information	on					
	ne of plan UNITY HOSPICE, INC.	·			1b	Three-digit plan number (PN) ▶	501	
	, , ,				1c	Effective date of pl	an	
Mail City	ing address (include roo or town, state or provinc	oyer, if for a single-employer plan) om, apt., suite no. and street, or P.O. Box) ce, country, and ZIP or foreign postal code	e (if foreign, see instr	uctions)	2b	Employer Identifica Number (EIN) 31-0970252	ation	
COMMU	NITY HOSPICE, INC.				2c	Plan Sponsor's tele number 606-329-1890		
	RTER AVENUE D, KY 41101	1480 CAR ASHLAND	TER AVENUE , KY 41101		2d	Business code (seinstructions) 621610	е	
-								
Caution	: A penalty for the late	or incomplete filing of this return/repor	t will be assessed	unless reasonable cause i	s establis	shed.		
		ther penalties set forth in the instructions, I well as the electronic version of this return						
SIGN			0.1/0.0/0.7					
HERE		alid electronic signature.	04/09/2019	SUSAN HUNT				
	Signature of plan adr	ministrator	Date	Enter name of individual s	signing as	plan administrator		
SIGN HERE								
HERE	Signature of employe	er/plan sponsor	Date	Enter name of individual s	signing as	employer or plan sp	onsor	
SIGN								

Signature of DFE

Enter name of individual signing as DFE

Page 2 Form 5500 (2018) **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN **3c** Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: 4d PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 138 5 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). 138 a(1) Total number of active participants at the beginning of the plan year 6a(1) 140 a(2) Total number of active participants at the end of the plan year 6a(2)0 Retired or separated participants receiving benefits.... 6b 0 Other retired or separated participants entitled to future benefits...... 6c 140 6d Subtotal. Add lines 6a(2), 6b, and 6c. Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... 7 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: 4B 4D 4E Plan funding arrangement (check all that apply) 9h Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance (2) Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (3) Trust (3) Trust

(4) General assets of the sponsor (4) General assets of the sponsor 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 **b** General Schedules R (Retirement Plan Information) (1) (1) H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2) X (3) 8 A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary (4) **C** (Service Provider Information) **D** (DFE/Participating Plan Information) (5) (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary **G** (Financial Transaction Schedules) (6)

Form 5500 (2018)

Page 3

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to El	RISA section 103(a)(2).				Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan COMMUNITY HOSPICE,	INC.			B Three	e-digit number (PI	N) •	501
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500			yer Identific 0970252	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
/L\ FIN	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
35-0980405	61069	99488RM	101		07/01/201	7	06/30/2018
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	l commissions paid. Lis	st in line 3	the agents,	brokers, and of	her persons in
(a) Total a	amount of comn			(b) To	otal amount	of fees paid	
		6139					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).			
	(a) Name a	nd address of the agent, broker, o	· · · · · · · · · · · · · · · · · · ·	commiss	ions or fees	were paid	
MEDLINK INC			KE POINT WAY ILLE, KY 40223				
(b) Amount of sales ar	nd base	Fees	and other commission	s paid			
commissions pai	id	(c) Amount	(1	d) Purpose	е		(e) Organization code
	5885						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commiss	ions or fees	were paid	
MEDLINK INC	,,	2001 LA	KE POINT WAY ILLE, KY 40223			·	
(b) Amount of sales ar	nd base	Fees	and other commission	s paid			
commissions pai		(c) Amount	(6	d) Purpose	Э		(e) Organization code
	254						3
F B	n Act Notice o	as the Instructions for Form Ff	-00			Caba	Iula A (Farm FE00) 2019

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Amount (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Amount (d) Purpose (e) Amount (f) Amount of sales and base commissions paid (g) Amount of sales and base commissions paid			
		From and other constitutions and	(-)
			(e) Organization
commissions paid	(C) Amount	(a) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

P	art	III	Welfare Benefit Contract Information If more than one contract covers the same		e same emplo	over(s) or members of t	the same er	mplovee organizati	ons(s)
			the information may be combined for report employees, the entire group of such individ	ing purposes if such conti	racts are expe	érience-rated as a unit	. Where co	ntracts cover indiv	\ <i>\</i> , ,
8	Ben	efit a	and contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d X Life insurance	e
	е	Te	emporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription	drug
	i İ	St	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity co	ntract
	m	_ _ _	ther (specify)	_	_	•		_	
_									
			ce-rated contracts:	Í					
	а		niums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	· ·			0-/4\		
	h		Earned ((1) + (2) - (3))				9a(4)		
	b		nefit charges (1) Claims paid						
		. ,	ncrease (decrease) in claim reserves				0b/2\		
			ncurred claims (add (1) and (2))				9b(3) 9b(4)		
	_	` '	Claims chargednainder of premium: (1) Retention charges (c				3D(4)		
	С		(A) Commissions	, i	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	cash, or	credited.)	9c(2)		
	d		tus of policyholder reserves at end of year: (1	_			9d(1)		
			Claim reserves				9d(2)		
		. ,	Other reserves				9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	9e		
10	No	nexp	perience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to o	arrier			10a		23289
	b		e carrier, service, or other organization incur				10b		
	Spe		nature of costs.	,	., .,			1	
Pa	art	IV	Provision of Information						
11	Die	d the	insurance company fail to provide any inform	nation necessary to compl	ete Schedule	A?	Yes	X No	
12	If t	he a	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).				Inspection
For calendar plan year 20°	18 or fiscal plan	year beginning 01/01/2018		and end	ding 12/3	1/2018	
A Name of plan COMMUNITY HOSPICE,	INC.			B Three plan	-digit number (Pl	N) •	501
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500			yer Identific 1970252	ation Number (EIN)
		ning Insurance Contract (. Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		Y, INC					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			•	ontract year
(4) =	code	identification number	policy or contract		(f)	From	(g) To
61-1237516	95120	001005860	67				06/30/2018
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	commissions paid. Li	st in line 3 t	he agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid 20959						3840	
		20939					3040
3 Persons receiving com		ees. (Complete as many entries a					
MEDLINK INC	(a) Name a		or other person to whom KE POINT WAY ILLE, KY 40223	n commission	ons or fees	were paid	
							ı
(b) Amount of sales ar			and other commission				
commissions pai	20959	(c) Amount 3840		(d) Purpose	!		(e) Organization code
		00.10					
	(a) Name a	nd address of the agent, broker, c	or other person to whom	n commission	ons or fees	were paid	
		-	·			·	
(b) Amount of sales ar	id base	Fees	and other commission	ns paid			
commissions pai	d	(c) Amount	((d) Purpose	1		(e) Organization code
For Parameter Park 1	n A a 4 N a 41 a a	and the Instructions for Form 55	****			0.1	1.10 A (Form FF00) 2049

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Amount (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Amount (d) Purpose (e) Amount (f) Amount of sales and base commissions paid (g) Amount of sales and base commissions paid			
		From and other constitutions and	(-)
			(e) Organization
commissions paid	(C) Amount	(a) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group	p of e	ses if su	ch cont	racts are	expe	erience-rated as a uni	t. Where c	ontract	s cover individual
8	Bene	efit a	and contract type (check all applicable boxes)										
	a	Н	ealth (other than dental or vision)	b	Dε	ental			CX	Vision		d	Life insurance
	еĒ	Te	emporary disability (accident and sickness)	f	∃ Lo	ng-term	disabili	ty (g∏	Supplemental unem	ployment	hΠ	Prescription drug
	ιĒ	=	op loss (large deductible)	ιĖ		MO contr			- '	PPO contract	. ,	- =	Indemnity contract
	ᆫ	_		, _L	」	vio ooniii	aot		.,⊓	11 0 contract		•п	macminty contract
	m [_ 0	ther (specify)										
a	Evne	rion	ce-rated contracts:										
•			niums: (1) Amount received					9a(1)					
			ncrease (decrease) in amount due but unpaid					_ ` _					
			ncrease (decrease) in unearned premium res						_				
		` '	Earned ((1) + (2) - (3))								. 9a(4)		
		. ,	nefit charges (1) Claims paid								, , ,		
		(2) I	ncrease (decrease) in claim reserves										
		(3) I	ncurred claims (add (1) and (2))								. 9b(3)		
		(4) (Claims charged								. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	ual basis	s)	_					
			(A) Commissions					. , ,					
			(B) Administrative service or other fees					0.74176					
			(C) Other specific acquisition costs					0./4\/F					
			(D) Other expenses					0 - /4\/F	-				
			(E) Taxes										
			(F) Charges for risks or other contingencies.					0-14116					
			(G) Other retention charges(H) Total retention								9c(1)(H	1)	
			Dividends or retroactive rate refunds. (These			_			_			'	
	d		tus of policyholder reserves at end of year: (1										
	u		Claim reserves								9d(1)		
		` '	Other reserves								9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n										
10			perience-rated contracts:						. ,	,			
			al premiums or subscription charges paid to o	carrie	r						. 10a		716889
	_	rete	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.								. 10b		
		cify r	nature of costs.	orted		arti, iiile	2 abov	е, героп	amo	u it	. 105		
P	art I	V	Provision of Information							_			
11	Did	the	insurance company fail to provide any inform	nation	ı nec	essary to	o compl	lete Sche	dule	A?	Yes	X No	0
12	lf th	ne ar	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	ovided.	>						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

		pursuant to EF	RISA section 103(a)(2).				Inspection
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan COMMUNITY HOSPICE,	INC.				e-digit number (PI	N) •	501
C Plan sponsor's name a COMMUNITY HOSPICE,		e 2a of Form 5500			oyer Identific 0970252	ation Number (EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		Y, INC					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nur persons covered at			Policy or co	ontract year
(b) LIN	code	identification number	policy or contract		(f)	From	(g) To
61-1237516	95120	152047	71		01/01/2018	8	12/31/2018
2 Insurance fee and come descending order of the		ation. Enter the total fees and total	l commissions paid. Lis	st in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comm			(b) To	otal amount	of fees paid	
		2054					
3 Persons receiving com		ees. (Complete as many entries a					
MEDLINK INC	(a) Name a	nd address of the agent, broker, o	or other person to whom KE POINT WAY	commiss	ions or fees	were paid	
MEDEINK INC			ILLE, KY 40223				
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai	id	(c) Amount	(d) Purpose	Э		(e) Organization code
	2054						3
	(a) Name a	nd address of the agent, broker, c	or other person to whom	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fees	and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpose	9		(e) Organization code
	- Asi Nati	the last westings for Forms 55				0.:	1.10 A (Form FF00) 2019

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Amount (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Amount (d) Purpose (e) Amount (f) Amount of sales and base commissions paid (g) Amount of sales and base commissions paid			
		From and other constitutions and	(-)
			(e) Organization
commissions paid	(C) Amount	(a) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		·	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
			Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group of employe	uch contracts are expe	erience-rated as a unit.	Where co	ontracts cover ind	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	b X Dental	С	Vision		d Life insura	nce
	е	_ Te	emporary disability (accident and sickness)	f Long-term	n disability g	Supplemental unemp	loyment	h Prescription	n drug
	i Î	_	op loss (large deductible)	j HMO cont	·	PPO contract	,	I Indemnity	
	L	_			il dot	11 0 donindor		· I Indominity	Sontiact
	m	_ 0	ther (specify)						
a	Evne	rion	ce-rated contracts:						
•	•		niums: (1) Amount received		9a(1)				
	_		ncrease (decrease) in amount due but unpai		· · · · · ·				
			ncrease (decrease) in unearned premium res						
		` '	Earned ((1) + (2) - (3))				9a(4)		
	b	. ,	efit charges (1) Claims paid			1	` /		
		(2) I	ncrease (decrease) in claim reserves		9b(2)				
		(3) I	ncurred claims (add (1) and (2))				9b(3)		
		(4) (Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (n an accrual basi	is)				
			(A) Commissions						
			(B) Administrative service or other fees		0. (4)(0)				
			(C) Other specific acquisition costs		0.(4)(D)				
			(D) Other expenses		0-(4)(5)				
			(E) Taxes						
			(F) Charges for risks or other contingencies.		9c(1)(F)				
			(G) Other retention charges(H) Total retention				9c(1)(H	1)	
			Dividends or retroactive rate refunds. (These	_		l -		7	
	А		tus of policyholder reserves at end of year: (1	L		H-	9c(2) 9d(1)		
	d		Claim reserves			<u> </u>	9d(2)		
		` '	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n			F	9e		
10			perience-rated contracts:			,			
	а		al premiums or subscription charges paid to	arrier			10a		25673
	b Spe	If th	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.	red any specific c	osts in connection with	h the acquisition or	10b		
	Spe	cify r							
Р	art l	V	Provision of Information					-	
11	Dic	the	insurance company fail to provide any inform	nation necessary	to complete Schedule	A?	Yes	X No	
			nswer to line 11 is "Yes," specify the informat		•				

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 ERISA section 103(a)(2).								
For calendar plan year 20	18 or fiscal plan	year beginning 01/01/2018		and en	ding 12/3	31/2018		
A Name of plan COMMUNITY HOSPICE,	INC.				e-digit number (Pl	N) •	501	
C Plan sponsor's name a COMMUNITY HOSPICE,	EIN)							
		ning Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca AMERICAN FIDELITY ASS		MPANY - ACCIDENT ONLY						
/I-> FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
73-0714500	60410	76564	46		07/01/201	7	06/30/2018	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	l commissions paid. Li	st in line 3	the agents,	brokers, and of	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		882						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).				
		nd address of the agent, broker, o	•	n commiss	ions or fees	were paid		
AMERICAN FIDELITY AS	SURANCE COM	MPANY PO BOX OKLAHO	. 25360 DMA CITY, OK 73125-	0360				
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid				
commissions pa	id	(c) Amount		(d) Purpos	е		(e) Organization code	
577							3	
	(a) Name a	nd address of the agent, broker, o	or other person to whor	n commiss	ions or fees	were paid		
BENEFACTOR INS GROU		2165 CA	NRTER AVE ND, KY 41101			·		
(b) Amount of sales ar	nd base	Fees	and other commission	ns paid				
commissions pa		(c) Amount	((d) Purpos	Э		(e) Organization code	
	305						3	
For Donomical Dodication	n Act Nation	as the Instructions for Form FF	200			Caba		

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

P	art	III	Welfare Benefit Contract Informatif more than one contract covers the same		a como omplo	over(a) or members of t	the same om	anlovae organizationa(a)			
	the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.										
8	Ben	efit a	and contract type (check all applicable boxes)								
	а	H	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance			
	е	X Te	emporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	oloyment I	h Prescription drug			
	i [op loss (large deductible)	j HMO contract	, b □	PPO contract	•	I Indemnity contract			
	m	0	ther (specify)	- Ц	_	1		ь -			
_											
			ce-rated contracts:	İ	0-(4)			-			
	а		niums: (1) Amount received		9a(1)		6091	_			
			ncrease (decrease) in amount due but unpaid								
			ncrease (decrease) in unearned premium res Earned ((1) + (2) - (3))			=	9a(4)	609			
	b		nefit charges (1) Claims paid				3a(4)	000			
			ncrease (decrease) in claim reserves					-			
		. ,	ncurred claims (add (1) and (2))				9b(3)				
			Claims charged				9b(4)				
	С	` '	mainder of premium: (1) Retention charges (c				0.0(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		9c(1)(D)						
			(E) Taxes		9c(1)(E)						
			(F) Charges for risks or other contingencies		9c(1)(F)						
			(G) Other retention charges		9c(1)(G)						
			(H) Total retention				9c(1)(H)				
		(2)	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)				
	d	Sta	tus of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)				
		(2)	Claim reserves				9d(2)				
		(3)	Other reserves				9d(3)				
	е	Divi	dends or retroactive rate refunds due. (Do n	ot include amount entered	l in line 9c(2) .	.)	9e				
10	No	nexp	perience-rated contracts:			,					
	а	Tota	al premiums or subscription charges paid to o	arrier			10a				
	b Spe	rete	e carrier, service, or other organization incur- ention of the contract or policy, other than rep- nature of costs.				10b				
Pa	art	IV	Provision of Information								
11	Die	d the	insurance company fail to provide any inform	nation necessary to compl	ete Schedule	A?	Yes	X No			
12	If t	he a	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.

OMB No. 1210-0110

•			s are required to provide the ERISA section 103(a)(2).	e morman	ion	This For	m is Open to Public Inspection		
For calendar plan year 20	18 or fiscal pla	an year beginning 01/01/2018		and en	ding 12/3	1/2018			
A Name of plan COMMUNITY HOSPICE,	INC.			B Three plan	e-digit number (PN	l) >	501		
C Plan sponsor's name a COMMUNITY HOSPICE,		ne 2a of Form 5500			yer Identifica 0970252	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		DMPANY - CANCER							
	(c) NAIC	(d) Contract or	(e) Approximate nui			Policy or c	ontract year		
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	mation for each contract e.A. contract year (g) To 06/30/2018		
73-0714500	60410	76564	80		07/01/2017	7	06/30/2018		
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. Lis	st in line 3	the agents, I	brokers, and c	ther persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid									
		1612							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all p	ersons).					
	(a) Name	and address of the agent, broke	er, or other person to whom	commissi	ons or fees	were paid			
AMERICAN FIDELITY AS:	SURANCE CO		SOX 25360 AHOMA CITY, OK 73125-0	0360					
(b) Amount of sales a	nd base	F	ees and other commission	s paid					
commissions pa	id 944	(c) Amount	(1	d) Purpose	9				
					3				
	(a) Name	and address of the agent, broke	er, or other person to whom	commissi	ons or fees	were paid			
BENEFACTOR INS GROU	JP INC	2165 ASHI	CARTER AVE LAND, KY 41101						
(b) Amount of sales a	nd base	F	ees and other commission	s paid					
commissions pa		(c) Amount	(0	d) Purpose	9		(e) Organization code		
	540						3		
							1		

Schedule A	(Form	5500	2018
Scriedule A	(1 01111	5500	/ 2010

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

F KY

800 DIEDERICH BLVD
RACELAND, KY 41169

INSURANCE SOLUTIONS OF KY

		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code 3 (e) Organization code Organization code	
128				
()))				
(a) Nar	ne and address of the agent, broker	, 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	
commissions paid	· · · · · · · · · · · · · · · · · · ·	, ,	code	
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid		
	Fees and other commissions paid	(e)		
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(-)	(4)	code	
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization	
commissions paid	(e) / illioani	(4) 1 3.15000	code	
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(6)	
(b) Amount of sales and base	(c) Amount	(d) Purpose	(e) Organization	
commissions paid	(o) / allount	(a) : dipose	code	

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group ting pu	of e	ses if	f such of	contra	cts are	expe	erience-rated as a un	it. Where c	ontrac	ts cover individual
8	Ben	efit a	nd contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b	Dε	ental				С	Vision		d	Life insurance
	е	Te	emporary disability (accident and sickness)	f X	Lo	ona-te	erm disa	ability		g☐	Supplemental unen	nplovment	h∏	Prescription drug
	ιĖ	=	op loss (large deductible)	iΓ	_	-	ontract	-		- 느	PPO contract	. ,	ᅩ片	Indemnity contract
	L	_		, _□]		omiaot			.,⊓	1 1 0 communi		- □	machinity contract
	m	_ 0	ther (specify)											
9	Exne	rien	ce-rated contracts:											
Ŭ	•		niums: (1) Amount received						9a(1)			1274		
	_		ncrease (decrease) in amount due but unpaid					_	9a(2)			1217	_	
			ncrease (decrease) in unearned premium res						9a(3)	_				
		` '	Earned ((1) + (2) - (3))									9a(4)		12740
	b	. ,	efit charges (1) Claims paid						9b(1)					
		(2) lı	ncrease (decrease) in claim reserves						9b(2))				
			ncurred claims (add (1) and (2))									9b(3)		
		(4) (Claims charged									9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an a	accr	rual ba	asis)	_						
			(A) Commissions						9c(1)(/	_				
			(B) Administrative service or other fees						9c(1)(I					
			(C) Other specific acquisition costs						9c(1)(0					
			(D) Other expenses					_ 	9c(1)(I	_				
			(E) Taxes						0c(1)(E					
			(F) Charges for risks or other contingencies		•••••				2c(1)(1	3))				
			(G) Other retention charges(H) Total retention									9c(1)(H	ı)	
			Dividends or retroactive rate refunds. (These							_			'	
	٨		rus of policyholder reserves at end of year: (1									. ,		
	d		Claim reserves											
		` '	Other reserves											
	е	` '	dends or retroactive rate refunds due. (Do n											
10			erience-rated contracts:			-				- (-/-	,			
	а		al premiums or subscription charges paid to d	arrier	f							10a		
	b Spe	rete	e carrier, service, or other organization incurrention of the contract or policy, other than repeature of costs.									10b		
D	art l	V	Provision of Information											
									- 0 '	4		1 voc	V NI	
			insurance company fail to provide any inform					mplet	e Sche	dule	A?	Yes	X N	0
12	lf t	ne ar	nswer to line 11 is "Yes," specify the informat	on no	ot pro	ovide	ed. 🕨							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

Tension benefit duaranty o	pursuant to ERISA section 103(a)(2).						This Form is Open to Public Inspection		
For calendar plan year 20	018 or fiscal pla	n year beginning 01/01/2018	ı	and en	ding 12/31	/2018	1		
A Name of plan COMMUNITY HOSPICE	, INC.				e-digit number (PN) •	501		
C Plan sponsor's name COMMUNITY HOSPICE		ne 2a of Form 5500			yer Identifica 0970252	tion Number	(EIN)		
on a sepa	rate Schedule /	rning Insurance Contract A. Individual contracts grouped as							
1 Coverage Information:									
(a) Name of insurance ca		MPANY - LTD							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			•	contract year		
(b) LIIV	code	identification number	policy or contract		(f)	From	(g) To		
73-0714500	60410	76564	64 07/01/2				06/30/2018		
2 Insurance fee and condescending order of the		ation. Enter the total fees and total	I commissions paid. Lis	st in line 3	the agents, b	orokers, and	other persons in		
	missions paid		(b) To	otal amount o	f fees paid				
•		5924				•			
3 Persons receiving con	nmissions and	fees. (Complete as many entries a	as needed to report all r	ersons).					
		and address of the agent, broker,			ions or fees v	were paid			
BENEFACTOR INS GRO		2165 CA	ARTER AVE ND, KY 41101			·			
(b) Amount of sales a	nd base	Fees	s and other commission	s paid					
commissions pa		(c) Amount	(d) Purpose	е		(e) Organization code		
	2965						3		
	(a) Name	and address of the agent, broker,	or other person to whon	commiss	ions or fees v	were paid			
AMERICAN FIDELITY AS	• •	MPANY PO BOX							
(b) Amount of sales a	and hase	Fee:	s and other commission	s paid					
commissions pa		(c) Amount		d) Purpose	9		(e) Organization code		
	2959						3		

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0,1	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

Pa	art	Ш	Welfare Benefit Contract Informa	ation					
			If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ing purposes if such cont	racts are expe	erience-rated as a uni	t. Where co	ontracts cover individual	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	Не	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	e [=	emporary disability (accident and sickness)	f \ Long-term disabili	_	Supplemental unem	nlovment	h Prescription drug	1
	, [=	op loss (large deductible)	j HMO contract	· - <u>-</u>	PPO contract	p.0,	I Indemnity contra	
	' [[I I I I I I I I I I I I I I I I I I I	κ	FFO contract		I Indemnity Contra	Cl.
	m	0	ther (specify)						
0 1	=vn/	orion	ce-rated contracts:						
			ce-rated contracts: liums: (1) Amount received		00/1)		50000	<u>. </u>	
	а		ncrease (decrease) in amount due but unpaid		9a(1) 9a(2)		59286	<u>) </u>	
			ncrease (decrease) in unearned premium res		1 1				
			Earned ((1) + (2) - (3))				. 9a(4)		59286
	b	. ,	efit charges (1) Claims paid				-1(-)		
			ncrease (decrease) in claim reserves						
		(3) li	ncurred claims (add (1) and (2))				. 9b(3)		
		(4) C	Claims charged				. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs					_	
			(D) Other expenses						
			(E) Taxes		9C(1)(E)			_	
			(F) Charges for risks or other contingencies		9c(1)(F)				
			(G) Other retention charges				. 9c(1)(H)	1	
			(H) Total retention Dividends or retroactive rate refunds. (These					/	
	a								
	d		rus of policyholder reserves at end of year: (1 Claim reserves				. 9d(1) . 9d(2)		
		` '	Other reserves				9d(3)		
	е	` '	dends or retroactive rate refunds due. (Do n						
10	_		erience-rated contracts:			,	1		
	а		al premiums or subscription charges paid to d	arrier			. 10a		
	b	If th	e carrier, service, or other organization incur	ed any specific costs in c	onnection witl	h the acquisition or			
		rete	ntion of the contract or policy, other than rep			•	. 10b		
	Spe	cify r	nature of costs.						
Pa	art	IV	Provision of Information						
11	Dio	d the	insurance company fail to provide any inform	ation necessary to compl	ete Schedule	Α? Π	Yes	X No	
			nswer to line 11 is "Yes," specify the informat						
_			, ,,						

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

•			ERISA section 103(a)(2).	le imomiai	IOH	This Fo	rm is Open to Public Inspection
For calendar plan year 20	18 or fiscal pla	n year beginning 01/01/2018		and en	ding 12/3	1/2018	
A Name of plan COMMUNITY HOSPICE,	INC.				e-digit number (PN	ı) >	501
C Plan sponsor's name a COMMUNITY HOSPICE,	INC.			31-	0970252	ation Number	
		rning Insurance Contrac A. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca AMERICAN FIDELITY ASS		MPANY - MEDICAL INDIV				Dellares	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered at policy or contract	end of	(f)	From	(g) To
73-0714500	60410	76564	2	your	07/01/2017	,	06/30/2018
2 Insurance fee and com- descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis	st in line 3	the agents, I	orokers, and	other persons in
	amount of com	missions paid		(b) To	otal amount o	of fees paid	
, ,		31		, ,		•	
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all p	ersons).			
		and address of the agent, broker			ions or fees	were paid	
BENEFACTOR INS GROU		2165 (CARTER AVE AND, KY 41101				
(b) Amount of sales ar	nd base	Fe	es and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose	е		(e) Organization code
	31						3
	(a) Name a	and address of the agent, broker	r, or other person to whom	n commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	s paid			
commissions pa	id	(c) Amount	(d) Purpose	9		(e) Organization code

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

Р	art I	II	Welfare Benefit Contract Informatif more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group	of e	ses if	such co	ontracts	are exp	eri	ience-rated as a uni	t. Where	contrac	ts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)												
	а	Не	ealth (other than dental or vision)	b	D€	ental			С	٦,	Vision		d□	Life insurance	
	е	_	emporary disability (accident and sickness)	f	ב בור	na-tei	rm disa	hility	g	Ī.	Supplemental unem	nlovment	h∏	Prescription drug	
	i [, ,	:	_	-	ontract	Unity			PPO contract	pioymoni			
	L	_	op loss (large deductible)) [] П	VIO CO	milaci		r.	ַ '	PPO CONTIACT		'⊔	Indemnity contract	
	m	O	ther (specify) DOTHER												
<u> </u>	F.,,,,		an rate discrete.												
9			ce-rated contracts:						2/1)	T		00	14		
			iiums: (1) Amount received ncrease (decrease) in amount due but unpaid						a(1) a(2)	-		63	51		
			ncrease (decrease) in unearned premium res						a(2)						
		` '	Earned ((1) + (2) - (3))									. 9a(4)			631
		. ,	efit charges (1) Claims paid						b(1)	Ī		.,(.)			
			ncrease (decrease) in claim reserves						• •						
			ncurred claims (add (1) and (2))									. 9b(3)			
		(4) C	Claims charged									. 9b(4)			
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	rual ba	asis)					•			
			(A) Commissions					9c	1)(A)						
			(B) Administrative service or other fees						1)(B)						
			(C) Other specific acquisition costs						1)(C)						
			(D) Other expenses					0-1	1)(D)	-					
			(E) Taxes						1)(E)	-					
			(F) Charges for risks or other contingencies	•••••				90	1)(F) 1)(G)	-					
			(G) Other retention charges									9c(1)(H	1/		
			(H) Total retention Dividends or retroactive rate refunds. (These				_								
	٨		rus of policyholder reserves at end of year: (1												
	d		Claim reserves									. 9d(1) . 9d(2)			
		` '	Other reserves												
	е	` '	dends or retroactive rate refunds due. (Do n												
10			erience-rated contracts:							, ,		.,			
			al premiums or subscription charges paid to d	arrier	r							. 10a			
	_	rete	e carrier, service, or other organization incurrention of the contract or policy, other than repeature of costs.									. 10b			
P	art I	V	Provision of Information												
						20000	ny to oo	nnloto C	obodul-	^ ^	. п	Yes	X N	lo.	
			insurance company fail to provide any inform					nplete S	chedule	e A	Λ?	res	ΛN	IU	
12	If th	ne ar	nswer to line 11 is "Yes," specify the informat	on no	ot pro	ovided	d. ▶								

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

2018

This Form is Open to Public

pursuant to ERISA section 103(a)(2).						Inspection	
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018	T	and en	ding 12/3	1/2018	
A Name of plan COMMUNITY HOSPICE,	INC.			B Three	e-digit number (PN	N) •	501
•	Plan sponsor's name as shown on line 2a of Form 5500 COMMUNITY HOSPICE, INC.					ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca AMERICAN FIDELITY ASS		мРАNY - STD					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To
73-0714500	60410	76564	5	07/01/2017		06/30/2018	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and tota	I commissions paid. Lis	st in line 3	the agents,	brokers, and of	her persons in
(a) Total a	amount of comm			(b) To	tal amount	of fees paid	
		209					
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).			
		nd address of the agent, broker, o		n commiss	ions or fees	were paid	
BENEFACTOR INS GROU	JP INC		ARTER AVE ND, KY 41101				
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid			
commissions pai	id	(c) Amount	(d) Purpose	Э		(e) Organization code
	259						3
	(a) Name a	nd address of the agent, broker, o	or other person to whom	n commissi	ions or fees	were paid	
AMERICAN FIDELITY ASS	SURANCE COM		(25360 OMA CITY, OK 73125-0)360			
(b) Amount of sales ar	nd base	Fees	s and other commission	s paid	-	_	
commissions pai		(c) Amount	(d) Purpose				(e) Organization code
	-50						3

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
•			
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

F	Part				
		Where individual contracts are provided, the entire group of such individual this report.	dual contracts with e	each carrier may be treated as a unit fo	or 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			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check he	re 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate	accounts)	
	а	Type of contract: (1) deposit administration (2) immedia	ite participation guar	antee	
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	. 7c(5)		
		>			
		(6)Total additions		7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6)).	<u></u>	7d	
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	. 7e(2)		
		(3) Transferred to separate account	. 7e(3)		
		(4) Other (specify below)	. 7e(4)		
		>			
		(5) Total deductions		7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			C
	_				

P	art	Ш	Welfare Benefit Contract Inform			()			,
			If more than one contract covers the same the information may be combined for report						5),
			employees, the entire group of such individ		arrier may be	treated as a unit for pu	irposes of th	nis report.	
8	Ben	efit a	nd contract type (check all applicable boxes)	_		_		_	
	а	Не	ealth (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	X Te	emporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	oloyment	h Prescription drug	
	i İ	St	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	ct
	m	_ o	ther (specify)	_		•			
	ľ								
9	Ехр	erien	ce-rated contracts:						
	а	Prem	iums: (1) Amount received		9a(1)		5180		
		(2) I	ncrease (decrease) in amount due but unpaid	t					
			ncrease (decrease) in unearned premium res	· ·					
			Earned ((1) + (2) - (3))				9a(4)		5180
	b		efit charges (1) Claims paid						
		. ,	ncrease (decrease) in claim reserves				01- (0)		
			ncurred claims (add (1) and (2))				9b(3)		
	_	٠,	Claims charged				9b(4)		
	С		nainder of premium: (1) Retention charges (c	, i	0c/1)/A)			-	
			(A) Commissions (B) Administrative service or other fees		9c(1)(A) 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	cash, or	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)		
		(3)	Other reserves				9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do n	ot include amount entered	l in line 9c(2) .	.)	9e		
10	No	nexp	erience-rated contracts:			1			
	а	Tota	al premiums or subscription charges paid to o	arrier			10a		
	b		e carrier, service, or other organization incur				401		
	Sn.		ntion of the contract or policy, other than rep	orted in Part I, line 2 abov	e, report amo	ount	10b		
	Spe	city i	nature of costs.						
Pa	art	IV	Provision of Information						
11	Die	d the	insurance company fail to provide any inform	nation necessary to compl	ete Schedule	A?	Yes	X No	
12	If t	he ar	nswer to line 11 is "Yes," specify the informat	on 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

2018

This Form is Open to Public Inspection

Par	t I Annual Report lo	entification Information		*************************************		<i>7</i> 11	
For	calendar plan year 2018 or fisc			and ending			
Α	This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instruction				
_		X a single-employer plan	a DFE (spe	ecify)			
В	This return/report is:	the first return/report	the final ret		A 50 15 15 20 22 1 150 10		
С	If the plan is a collectively-barg	an amended return/report		n year return/report (les	NOTE OF THE POST O		
	Check box if filing under:	Form 5558 special extension (enter des	automatic e	atic extension the DFVC program			
Part	II Basic Plan Inforn	nation—enter all requested infor	mation		# ************************************		
	Name of plan MMUNITY HOSPICE, I				1b Three-digit plan number (PN) ▶	501	
	***************************************				1c Effective date of plan 03/01/1994	1	
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 31-0970252		
COMMUNITY HOSPICE, INC.					2c Plan Sponsor's telephone number 606-329-1890		
1480 CARTER AVENUE SEE			STATEMENT		2d Business code (see instructions) 621610		
ASH	LAND	KY 41101					
Caut	ion: A penalty for the late or i	ncomplete filing of this return/re	eport will be asse	ssed unless reasonal	ele cause is established.		
staten	penalties of perjury and other penal nents and aftachments, as well as Jh	ties set forth in the instructions, I declare e electronic version of this return/report,	that I have examined and to the best of my	I this return/report, including knowledge and belief, it is	g accompanying schedules, true, correct, and complete.		
SIGN	Supantic	M	6/5/19	SUSAN HUNT			
HERE	Signature of plan administ	rator	Date /	Enter name of in	Enter name of individual signing as plan administra		
SIGN							
IERE	Signature of employer/plan	sponsor	Date	Enter name of indiv	vidual signing as employer or plan spo	nsor	
SIGN							
HERE	Signature of DFE		Date	Enter name of in	dividual signing as DFE		

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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3a Plan administrator's name and address X Same as Plan Sponsor					3b Administra	ator's EIN
					3c Administr	ator's telephone
4 If the name and/or EIN of the plan sponsor or the plan name has changed					4b EIN	
enter the plan sponsor's name, EIN, the plan name and the plan number for a Sponsor's name	rom the la	ast retur	n/repo	rt:	4d PN	
C Plan Name					40 PN	
5 Total number of participants at the beginning of the plan year					5	138
6 Number of participants as of the end of the plan year unless otherwise states 6a(2), 6b, 6c, and 6d).	led (welfa	are plan	s com	olete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year					6a(1)	138
a(2) Total number of active participants at the end of the plan year					6a(2)	140
b Retired or separated participants receiving benefits					6b	<u>C</u>
C Other retired or separated participants entitled to future benefits				*****	6c	0
d Subtotal. Add lines 6a(2), 6b, and 6c					6d	140
e Deceased participants whose beneficiaries are receiving or are entitled to r	eceive be	enefits			6e	
f Total. Add lines 6d and 6e		tana nan			6f	· · · · · · · · · · · · · · · · · · ·
g Number of participants with account balances as of the end of the plan year complete this item)	r (only de	efined co	ontribu	tion plans	6g	
h Number of participants who terminated employment during the plan year wi	th accrue	ed bene	fits tha	t were		**************************************
less than 100% vested 7 Enter the total number of employers obligated to contribute to the plan (only					6h 7	
 8a If the plan provides pension benefits, enter the applicable pension feature con b If the plan provides welfare benefits, enter the applicable welfare feature con 4A 4B 4D 4E 						
93 Class (undies and a final state of the st				***************************************		
9a Plan funding arrangement (check all that apply) (1) X Insurance				ngement (check all tha	it apply)	
(2) Code section 412(e)(3) insurance contracts	(1) (2)	Α.	Insu			
(3) Trust	(3)		Trus	e section 412(e)(3) ins	surance contracts	5
(4) X General assets of the sponsor	(4)	x	Gen	eral assets of the spon	nsor	
10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, an	nd, where i	ndicated	enter t	he number attached. (See	e instructions)	
a Pension Schedules		neral Se			,	
(1) R (Retirement Plan Information)	(1)	iciai 30	neau	H (Financial Infor	mation)	
193.20	101				mation) mation - Small P	lan)
(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	x	8	A (Insurance Info		
actuary	(4)			C (Service Provid		
(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)				ing Plan Informa	tion)
Information) - signed by the plan actuary	(6)				saction Schedule	

16475000A 06/04/7019 9 COMMUNITY	HOSPICE.	INC
COLMICITIES	most red,	TITLE

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31-0970252

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Part III	Form M-1 Compliance Information	(to be completed by welfare	e benefit plans)	
252	ne plan provides welfare benefits, was the plan su 20.101-2.) Yes Yes" is checked, complete lines 11b and 11c.			and 29 CFR
11b Is th	ne plan currently in compliance with the Form M-	filing requirements? (See instruction	ns and 29 CFR 2520.101-2.)	Yes No
Rece	er the Receipt Confirmation Code for the 2018 Form M-1 a eipt Confirmation Code for the most recent Form M-1 that eipt Confirmation Code will subject the Form 5500 filing to	was required to be filed under the Form M-		
Rec	eipt Confirmation Code			