# Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### 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

2017

Pension Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	blic			
Part I	Annual Report Idea	ntification Information							
For calenda	ar plan year 2017 or fiscal	plan year beginning 07/01/2017	and ending 06/30/20	)18					
A This ret	urn/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in according to the participating employer information in according to the participating employer plan (Filers checking the participating employer em			ns.)			
		X a single-employer plan	a DFE (specify)						
<b>B</b> This ret	urn/report is:	the first return/report	the final return/report						
		an amended return/report	a short plan year return/report (less than 12	2 months)					
C If the pla	an is a collectively-bargain	ed plan, check here			•				
<b>D</b> Check b	oox if filing under:	Form 5558	automatic extension	the	e DFVC program				
		special extension (enter description							
Part II	Basic Plan Informa	ation—enter all requested information	on						
1a Name	of plan	RE CENTER FLEXIBLE BENEFIT PI		1b	Three-digit plan number (PN) ▶	502			
				<b>1c</b> Effective date of plan 07/01/1995		ın			
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) 61-0663787				
MOUNTAIN	I COMPREHENSIVE CAR	E CENTER, INC		2c Plan Sponsor's telephone number 606-886-8572		phone			
	H FRONT AVENUE SBURG, KY 41653		TH FRONT AVENUE ISBURG, KY 41653	2d	Business code (see instructions) 621330	)			
Caution: A	Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.								
	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.								
	·	·	1		·				

SIGN HERE	Filed with authorized/valid electronic signature.  Signature of plan administrator	07/03/2019 Date	KATHY GOBLE  Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017) v. 170203

	Form 5500 (2017)	Page <b>2</b>		
3a	Plan administrator's name and address Same as Plan Sponsor		<b>3b</b> Administrato	
MC	UNTAIN COMPREHENSIVE CARE CENTER	3c Administrato		
	SOUTH FRONT AVENUE ESTONSBURG, KY 41653		number 606-886	·
4	If the name and/or EIN of the plan sponsor or the plan name has changed sir		4b EIN	
a c	enter the plan sponsor's name, EIN, the plan name and the plan number from Sponsor's name Plan Name	n the last return/report:	4d PN	
5	Total number of participants at the beginning of the plan year		5	1088
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	(welfare plans complete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year		6a(1)	1088
a(	2) Total number of active participants at the end of the plan year		6a(2)	1202
b	Retired or separated participants receiving benefits		6b	
С	Other retired or separated participants entitled to future benefits		6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d	1202
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	6e		
f	Total. Add lines 6d and 6e	6f		
g	Number of participants with account balances as of the end of the plan year (complete this item)	6g		
	Number of participants who terminated employment during the plan year with less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer plans complete this item)	7	
	If the plan provides pension benefits, enter the applicable pension feature code.  If the plan provides welfare benefits, enter the applicable welfare feature code.  4A 4B 4C 4D 4E	es from the List of Plan Characteristics Coo	les in the instruction	
Эа	Plan funding arrangement (check all that apply)  (1)	9b Plan benefit arrangement (check all to the check all the check all to the check all		ts
	(4) X 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 at	ttached, and, where indicated, enter the nur	mber attached. (See	instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Info	ormation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) I (Financial Info (3) 8 A (Insurance Inf (4) C (Service Prov	,	٦)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participal	ating Plan Information	

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	If "Yes" 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.)					
11c Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 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.)						
Rece	eipt Confirmation Code					

Form 5500 (2017)

Page 3

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

2017

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2).				Inspection
For calendar plan year 20°	17 or fiscal plan	year beginning 07/01/2017		and en	ding 06/3	0/2018	
A Name of plan MOUNTAIN COMPREHE	LAN	B Three-digit plan number (PN) ▶		502			
C Plan sponsor's name a MOUNTAIN COMPREHE					yer Identific 0663787	ation Number (	EIN)
		ning Insurance Contract  Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f)	From	<b>(g)</b> To
35-0980405	61069	00202661	872		07/01/2017	7	06/30/2018
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comn			<b>(b)</b> To	otal amount	of fees paid	
		7501					1949
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all p	persons).			
		nd address of the agent, broker,		n commiss	ions or fees	were paid	
ASSUREDPARTNERS NL	LLC		IVER ROAD /ILLE, KY 40206				
(b) Amount of sales ar	nd base	Fee	s and other commission	ıs paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
	7501	1949					3
	(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	s paid			
commissions pai		(c) Amount	(	(d) Purpose			(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention 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)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(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	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

Pa	пe	4

F	art	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such conti	racts are expe	erience-rated as a unit	t. Where co	ontracts cover individual	,
8	Ber	efit a	nd contract type (check all applicable boxes)						
	а	Пне	ealth (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> X Life insurance	
	е	_	emporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental unem	nlovment	h Prescription drug	
		_		<u> </u>	: :=	<u>.</u>	pioyment		
	Ī		op loss (large deductible)	j HMO contract	K_	PPO contract		I Indemnity contract	
	m	Ot	her (specify)						
_									
9			ce-rated contracts:	!	- (1)				
	а		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	•			0.(4)		
	L	. ,	farned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid					_	
			ncrease (decrease) in claim reserves				01- (0)		
			ncurred claims (add (1) and (2))						
	_	` '	Claims charged(1) Betarties absence (2)				. 9b(4)		
	С		nainder of premium: (1) Retention charges (c	, i	00/41/41			_	
			(A) Commissions		9c(1)(A) 9c(1)(B)				
			(B) Administrative service or other fees		9c(1)(C)				
			(C) Other specific acquisition costs(D) Other expenses						
			(E) Taxes		A (4)(=)				
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges		0 (4)(0)				
			(H) Total retention				9c(1)(H	)	
			Dividends or retroactive rate refunds. (These	_					
	d		us of policyholder reserves at end of year: (1	<u>—</u>					
	u		Claim reserves				9d(1)		
		` '	Other reserves						
	е	` '	dends or retroactive rate refunds due. (Do n						
10			erience-rated contracts:	st molado amoditi ontoro	<b></b>	.,	.,		
	а		al premiums or subscription charges paid to o	arrier			. 10a		55989
	b		e carrier, service, or other organization incur						
		rete	ntion of the contract or policy, other than representative of costs.	, .		•	. 10b		
F	Part '	IV	Provision of Information						
11				nation necessary to comple	ata Sahadula	ΛΔ2 Π	Yes	X No	
			insurance company fail to provide any inform		ete Schedule	A f	169	^ NO	
12	2 If t	ne an	nswer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2)			11110 1 011	Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 07/01/2017		and en	ding 06/3	0/2018	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE (	CENTER FLEXIBLE BENEFIT P	LAN	B Three-digit plan number (PN) ▶ 5		502	
C Plan sponsor's name a MOUNTAIN COMPREHE				-	oyer Identific 0663787	ation Number (	EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca		ΥY					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
61-1237516	95120	001003753	870	)	07/01/2017	7	06/30/2018
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr	,		<b>(b)</b> To	otal amount	of fees paid	
		23348					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
ASSUREDPARTNERS NL	.LLC		IVER ROAD /ILLE, KY 40206				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	23348						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		<u> </u>				·	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	A 4 N 4 4 .		E00		· ·		

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,		code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention 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)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(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	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

F	art	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the	racts are expe	erience-rated as a unit	t. Where co	ontracts cover indiv	
8	Ber	efit a	nd contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> Life insuran	ce
	е	_	emporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	nlovment	h Prescription	
	i				: :=	<u>.</u>	pioyinon		ŭ
	- !	_	op loss (large deductible)	j   HMO contract	K_	PPO contract		I Indemnity co	ontract
	m	Ot	her (specify)						
_	_								
9			ce-rated contracts:	İ	0=/4)				
	а		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid ncrease (decrease) in unearned premium res						
			arned ((1) + (2) - (3))	•			9a(4)		
	b	, ,	efit charges (1) Claims paid				- 3α( <del>+</del> )		
	~		ncrease (decrease) in claim reserves						
			ncurred claims (add (1) and (2))				. 9b(3)		
			Claims charged				(.)		
	С	` '	nainder of premium: (1) Retention charges (c						
		(	(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						
			(E) Taxes						
		(	(F) Charges for risks or other contingencies.						
		(	(G) Other retention charges		9c(1)(G)				
			(H) Total retention				9c(1)(H	)	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1						
		` '	Claim reserves				. 9d(2)		
		` '	Other reserves				_ ` _		
41	<u>е</u>		dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	.)	. 9e		
10	_		erience-rated contracts:				100		00000
	a		al premiums or subscription charges paid to c				. 10a		283034
	<b>b</b> Spe	rete	e carrier, service, or other organization incurintion of the contract or policy, other than replature of costs.	, .		•	. 10b		
P	Part	IV	Provision of Information						
11				nation necessary to comple	ata Schadula	Λ2 Π	Yes	X No	
			insurance company fail to provide any inform		ete Schedule	: A ?	169	^ INO	
12	2 If t	ne an	nswer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).				This For	m is Open to Public Inspection		
For calendar plan year 20	17 or fiscal pla	an year beginning 07/01/2017		and en	nding 06/30	/2018	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	CENTER FLEXIBLE BENEFIT	PLAN		e-digit n number (PN)	<b>)</b>	502
C Plan sponsor's name as shown on line 2a of Form 5500  MOUNTAIN COMPREHENSIVE CARE CENTER, INC  D Employer Identification 61-0663787							
on a separa	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		CKY					
(L) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number		persons covered at end of policy or contract year		From	<b>(g)</b> To
61-1237516	95120	001003753	663		07/01/2017		03/30/2018
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	rokers, and c	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
5477 0					0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees v	vere paid	
ASSUREDPARTNERS NL	LLC		RIVER ROAD SVILLE, KY 40206				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
5477							3
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees v	vere paid	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention 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)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(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	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purposes if such conti	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	·	-	i
	а	Health (other than dental or vision)	<b>b</b> Dental	c	X Vision		<b>d</b> Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	_	Supplemental unen	anloymont	h Prescription drug
						ipioyment	
	וי	Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
9		erience-rated contracts:	!	- (1)	1		_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_
		(3) Increase (decrease) in unearned premium res	•	9a(3)		00(4)	
	b	(4) Earned ((1) + (2) - (3))		9b(1)	······	9a(4)	
	D	(2) Increase (decrease) in claim reserves					_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c			•••••		
	-	(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					
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention					-
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	·· 9c(2)	
	d	Status of policyholder reserves at end of year: (1				9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				· · · · ·	
4.0	<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2	<u>).)</u>	9e	
10	_	nexperience-rated contracts:				100	0700
	a	Total premiums or subscription charges paid to c				<u>10a</u>	6786
	b	If the carrier, service, or other organization incurrent retention of the contract or policy, other than report				10b	
	Spe	cify nature of costs.	, , , , , , , , , , , , , , , , , , , ,	, ,			
Р	art	IV Provision of Information					
			nation necessary to come	oto Cobodiil	۰ ۸2	Yes	X No
11		d the insurance company fail to provide any inform		ete Scheaul	e A?	103	N 140
12	12 If the answer to line 11 is "Yes," specify the information not provided. ▶						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

v. 170203

		pursuant to	_1(10A 3cction 103(a)(2).				Inspection	
For calendar plan year 2017	7 or fiscal plan	year beginning 07/01/2017		and en	ding 06/30/201	18		
A Name of plan MOUNTAIN COMPREHEN	ISIVE CARE C	ENTER FLEXIBLE BENEFIT F	PLAN		e-digit number (PN)	•	502	
C Plan sponsor's name as					yer Identification	Number (	(EIN)	
MOUNTAIN COMPREHEN	ISIVE CARE C	EENTER, INC		61-	0663787			
		ning Insurance Contraction						
1 Coverage Information:								
(a) Name of insurance carr AFLAC	ier							
4) 511	(c) NAIC	(d) Contract or	(e) Approximate nur		Policy or contract year		ontract year	
<b>(b)</b> EIN	code	identification number	persons covered at policy or contract		(f) From	า	<b>(g)</b> To	
82-2723296	60380	ZY056	72		07/01/2017		06/30/2018	
2 Insurance fee and comm descending order of the a		tion. Enter the total fees and tot	al commissions paid. Lis	st in line 3	the agents, broke	ers, and of	ther persons in	
(a) Total an	nount of comm	nissions paid		<b>(b)</b> To	otal amount of fee	s paid		
	18398 2043							
3 Persons receiving comm	issions and fe	es. (Complete as many entries	as needed to report all p	ersons).				
	(a) Name ar	nd address of the agent, broker,	or other person to whom	commiss	ions or fees were	paid		
ASSUREDPARTNERS NL L	LC		E GALBRAITH RD STE 50 NNATI, OH 45236	000				
(b) Amount of sales and	l base	Fee	es and other commissions	s paid				
commissions paid		(c) Amount	(c) Amount			(d) Purpose (e) C		
	6868						3	
	(a) Name ar	nd address of the agent, broker,	or other person to whom	commiss	ions or fees were	paid		
THOMAS A MORRIS AND ASSOC INC  2322 PATCHEN WILKES DR LEXINGTON, KY 40509								
(b) Amount of sales and	l hase	Fee	es and other commissions	s paid				
commissions paid		(c) Amount	(0	d) Purpose	Э		(e) Organization code	
	4784	508					3	
For Paperwork Reduction	Act Notice, s	ee the Instructions for Form	5500.			Sched	dule A (Form 5500) 2017	

Schedule A (Form 5500)	2017	Page <b>2</b> – 1	
, , , , , , , , , , , , , , , , , , ,			
(a) Nar LAWRENCE TODD FUGATE	2352 l	r, or other person to whom commissions or fees were paid HARTLAND PARKSIDE DR NGTON, KY 40515	
		Fees and other commissions paid	(0)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
1955			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
CAREN OSTROWSKI		CUSTER DR STE 104 NGTON, KY 40517	
400		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1250	431		3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	·
LAURA BETH KELLER		EXECUTIVE DR STE 204 IGTON, KY 40505	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
965	338		3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	·
TYLER DECKER	4325 (	COBBLESTONE KNOLL DR IGTON, KY 40515	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
830	273		3
(a) Nar	ne and address of the agent broker	r, or other person to whom commissions or fees were paid	
DEBRA SMART	605 A	UTUMNWOOD DRIVE MOND, KY 40475	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

320

Page <b>2</b> -	2	

		, or other person to whom commissions or fees were paid	
LINDSEY HOSKINS		ERMILLION PEAK PASS IGTON, KY 40515	
	LEXIN	IGTON, KT 40515	
		Fees and other commissions paid	(0)
(b) Amount of sales and base		1	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
415	129		3
		, or other person to whom commissions or fees were paid	
CREECH & STAFFORD INS AGENC		SIR BARTON WAY STE 400 IGTON, KY 40509	
	LEXIII	1010N, KT 40303	
		Fees and other commissions paid	(e)
(b) Amount of sales and base		'	Organization
commissions paid	(c) Amount	(d) Purpose	code
175			3
())			
		, or other person to whom commissions or fees were paid	
VONDA BLANCETT		NILLOW SPG GTON, KY 40509	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
58	26		3
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
LESLIE K KIMBROUGH	PO BC	OX 273488	
	BOCA	RATON, FL 33427	
	Γ		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
50			3
<b>(a)</b> Nar		, or other person to whom commissions or fees were paid	
JONATHAN JONES	468 KF	ECK CHURCH RD , KY 40734	
	OKAT	, 101 40754	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(e) Amount	(u) i uipose	code 3
50			3
	, ·		l l

Scriedule A (Form 5500)	2017	rage Z = 3				
<b>(a)</b> Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid				
LAURA J NEWMAN-SUTER		HINOE RD NGTON, KY 40502				
	22/11	101, 11 1000 <u>1</u>				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
42			3			
		r, or other person to whom commissions or fees were paid				
VICTORIA KENLEY		FORKLAND RD TION CITY, KY 40440				
			,			
(b) Amount of color and hace		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
28	13		3			
		r, or other person to whom commissions or fees were paid				
TYLER DECKER		NGINEER ST BIN, KY 40701				
			T			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
30			3			
(a) Nov	no and address of the agent broken	ar other nersen to whom commissions or feed were noid				
LINDSEY HOSKINS		r, or other person to whom commissions or fees were paid  AMMOCK OAK LN				
	LEXIN	NGTON, KY 40515				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base			Organization			
commissions paid 30	(c) Amount	(d) Purpose	code			
30			3			
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid				
RAYE ANN THOMAS	1600	JACKS CREEK PIKE				
	LEXIN	NGTON, KY 40515				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization			
commissions paid	(o) / anount	(a) i diposo	code			

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
16			3

**DEBORAH MCGREGOR ADDESSI** 

1488 LEESTOWN RD LEXINGTON, KY 40511

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
14			3	

<b>(a)</b> Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
DALE I DAVIS		TRAVELLER RD IGTON, KY 40504	
		Face and allow accessing and	(2)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization code
12			3
<b>(a)</b> Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
RUEANN EMERSON	1017 A WILMI	ASHES DR STE 106 INGTON, NC 28405	
	·	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
10			3
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	<u>.</u>
BRIAN S MARTIN	3280 E	BLAZER PARKWAY STE 201 IGTON, KY 40509	
(b) Amount of sales and base	F	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
10			3
(a) Nar	me and address of the agent, broker.	, or other person to whom commissions or fees were paid	
SUSAN M HINKLE	283 H	YDE PARK LN IIN, KY 40701	
	ı	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
10			3
(a) Nar	me and address of the agent, broker,	, or other person to whom commissions or fees were paid	
KRISTIANNA J FLY	PO BO	DX 206 TH MIDDLETOWN, KY 40357	
#NA	ſ	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
5			3
		L	<u> </u>

Page <b>2</b> –	6	
i aye 🚣	O	

(a) Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
CLIFFORD FRANKLIN BROOKS		SHELBYVILLE ROAD STE 605	
	LOUIS	SVILLE, KY 40222	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
5			3
(a) No.	me and address of the agent broker	, or other person to whom commissions or fees were paid	
BRADLEY L ELLIS		BEVILLE RD STE 606 # 327	
BRADLET E ELLIS	DAYT	ONA BEACH, FL 32114	
		Fees and other commissions paid	(0)
(b) Amount of sales and base		rees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
4			3
		, or other person to whom commissions or fees were paid	
DAVID A EMERSON	11551	NUCKOLS RD STE P	
	GLEN	ALLEN, VA 23059	
	T		
45.4		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
3	, ,	`,' .	3
3			3
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
DAVID A EMERSON	1017	ASHES DR STE 106	
	WILM	INGTON, NC 28405	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
1			3
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Hai	The aria address of the agent, broker	, or other person to when commissions or rose were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<u> </u>			
	•		•

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts wit	th each carrier may be trea	ted as a unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	rent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			•
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the	acquisition or	
		retention 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)			
		(c) [ cirior (opcomy) /			
	£	If anythrough anythrough in sub-plant in most to distribute boundite from a town-in-	-ti	h	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin			
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation gu	uarantee	
		(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	) 0
	٦	(6)Total additions and additions (add lines <b>7b</b> and <b>7a(6)</b> )			,
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )			
	е	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		_
			7e(1)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	. /e(4)		_
		•			
		(5) Total deductions		7e(5	0
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			

ı	Page	4

P	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual.	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					<u> </u>
•	a [	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	L	<u>-</u>	<b>=</b>	L	<b>=</b>		
	e	Temporary disability (accident and sickness)	f Long-term disabilit		Supplemental unen	npioyment	h Prescription drug
	i	Stop loss (large deductible)	j  HMO contract	<b>k</b> [	PPO contract		I Indemnity contract
	m	X Other (specify) ▶SUPPLEMENTAL					
9	Exp	erience-rated contracts:					_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	b	9a(2)			_
		(3) Increase (decrease) in unearned premium res	•				
		(4) Earned ((1) + (2) - (3))	i			9a(4)	
	b	Benefit charges (1) Claims paid					_
		(2) Increase (decrease) in claim reserves				T	
		(3) Incurred claims (add (1) and (2))					
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (c	•	0 (4)(4)			_
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)			_
		(D) Other expenses		0 (4)(5)			_
		(E) Taxes(F) Charges for risks or other contingencies.					_
		(G) Other retention charges					
		(H) Total retention	•			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	٦		_	_		• • •	
	d	Status of policyholder reserves at end of year: (1 (2) Claim reserves	•			` ` `	
		(3) Other reserves				9d(2) 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n					
10	_	nexperience-rated contracts:	of include amount entered	2 111 11111E 3C(2	· <b>J</b> ··)······	<u>Je</u>	
	a	Total premiums or subscription charges paid to	earrier			10a	5868
	b	If the carrier, service, or other organization incur					0000
	D	retention of the contract or policy, other than rep	, ,		•	10b	
	Spe	cify nature of costs.	, , , , , , , , , , , , , , , , , , , ,	, , ,			
Р	art	IV Provision of Information					
11		the insurance company fail to provide any inform	nation necessary to compl	ete Schedul	е А?	Yes	X No
				CIE OCHEUUN	ол:	1	<u></u>
14	. If t	he answer 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 E	RISA section 103(a)(2)	).			Inspection
For calendar plan year 20°	17 or fiscal plar	n year beginning 07/01/2017		and en	ding 06/3	0/2018	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE (	CENTER FLEXIBLE BENEFIT PL	_AN		e-digit number (PN	N) <b>•</b>	502
C Plan sponsor's name as shown on line 2a of Form 5500  MOUNTAIN COMPREHENSIVE CARE CENTER, INC  D Employer Identification Number (EIN) 61-0663787					EIN)		
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance car COLONIAL LIFE & ACCID		ICE CO					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or co	ntract year
(b) EIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To
57-0144607	62049	E7817000	45	5	07/01/2017	7	06/30/2018
2 Insurance fee and compute descending order of the		ation. Enter the total fees and tota	ıl commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid						
2251 0							
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
MARY DUFF			CHMOND RD TON, KY 40502				
(b) Amount of sales ar	nd hase	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	946						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
BB&T INSURANCE SERV	ICES INC		LLIMORE ROAD SBORO, NC 27409				
(b) Amount of sales ar	nd base	Fees	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	493						3
For Donomicals Doductio	n Act Nation	see the Instructions for Form F	F00			Calaa	lulo A (Earm FEOO) 2017

Schedule A (Form 5500)	2017	Page <b>2</b> – 1	
(a) Nan MCGOHAN BRABENDER AGY	3931	r, or other person to whom commissions or fees were paid S DIXIE DRIVE ON, OH 45439	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization code
200			3
(a) Nan	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
DARRELL L. PATTON	PO BO	OX 925 STONBURG, KY 41653	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
152			3
(a) Nan	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
DEE ANN SLADE	104 P FRAN	OTOMAC COURT IKFORT, KY 40601	
(h) Amount of color and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
110			J
(a) Nan	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
ANNE OWENS	550 D MIDW	AVISTOWN RD /AY, KY 40357	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
85			3
(a) Nan	ne and address of the agent. broker	r, or other person to whom commissions or fees were paid	
LVI BENEFITS SERVICES LLC	2985	SURREY RIDGE ROAD KSVILLE, TN 37043	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
69			3

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
28			3

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

KAREN TOBIAS

1366 DUNRAVEN DR MURFREESBORO, TN 37128

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
3			3

Page	2 –	3

<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
CAROL LAMB		OX HARBOUR DRIVE	
	LEXIN	IGTON, KY 40517	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) Fulpose	code
3	!		3
	1		
(a) No.	me and address of the agent broken	or other nersen to whom commissions or feet were noid	
ROBERT C RUSSELL		, or other person to whom commissions or fees were paid  HWY 500	
ROBERT C ROSSELE		NSBORO, KY 42301	
	T		
(h) Amount of color and book	ļ ļ	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
2			3
	1		
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	,	Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(e) / une and	(a) : siposo	code
	1		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Nai	The drie address of the agent, broker,	, or other person to whom commissions or rees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
	1		
	1		
<b>(a)</b> Naı	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 commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	code
	1		

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each	n carrier may be treated as a u	unit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the acquis	ition or	
		retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) x group deferred	d annuity		
		(3) other (specify)			
		(c) [ Strict (choosily)			
	£	If a cuture to combine and the color of the force of the	-4:	<b>▶</b> □	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>	<u> </u>	
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation guarante	ee	
		(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>			
		(C)Total additions		7c(6)	0
	d	(6)Total additions			
		Deductions:		/u	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(3)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	. , 5(7)		
		•			
		(5) Total deductions		7e(5)	0
	_f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

ı	Page	4

F	art	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 the ing purposes if such contr	acts are ex	perience-rated as a u	unit. Where co	entracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> X Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k		Jp.10 J	I Indemnity contract
	'		I I IIVIO contract	K			I I Indemnity contract
	m	Other (specify)					
^							
9		erience-rated contracts:	[	00(1)	1		
	а	Premiums: (1) Amount received(2) Increase (decrease) in amount due but unpaid	•	9a(1) 9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(2)			
		(4) Earned ((1) + (2) - (3))	-			9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		54(+)	
	-	(2) Increase (decrease) in claim reserves	•	9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (o					
		(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)		T	
		(H) Total retention					
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide I	penefits after	er retirement	9d(1)	
		(2) Claim reserves					
		(3) Other reserves					
4.	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2	<b>2)</b> .)	9e	
1(	_	nexperience-rated contracts:				40	
	а	Total premiums or subscription charges paid to c					37107
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than reposits potus of costs.					
		cify nature of costs.					
P	art	V Provision of Information					_
11	l Di	the insurance company fail to provide any inform	ation necessary to comple	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the informati	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		paradantio	LINIOA 30011011 103(a)(2)	•			Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 07/01/2017		and en	iding 06/30/201	8	
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE	CENTER FLEXIBLE BENEFIT F	PLAN		e-digit number (PN)	<b>)</b>	502
C Plan sponsor's name a MOUNTAIN COMPREHE				-	oyer Identification I	Number (	(EIN)
MOONTAIN COMPREHE	NSIVE CARE	CENTER, INC		01-	0003707		
		rning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		MPANY					
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	l 	<b>(g)</b> To
13-5581829	65978	1095113	55	i	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. Li	st in line 3	the agents, broke	rs, and o	ther persons in
(a) Total a	amount of comr	missions paid		<b>(b)</b> To	otal amount of fee	s paid	
		0					0
3 Persons receiving com		ees. (Complete as many entries					
	(a) Name a	and address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount	· ·	(d) Purpose	e		(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) Amount of sales ar	nd base	Fe	es and other commissior	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>,                                      </u>	code
(1)				
( <b>a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part				
		Where individual contracts are provided, the entire group of such indivi- this report.	dual contracts with each carri	er 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 e	end	4	327964
		ent value of plan's interest under this contract in separate accounts at year er			961510
		tracts With Allocated Funds:			
	а	State the basis of premium rates			
		'			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in conretention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) x group deferred	annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminal	ating plan, check here	П	
7		tracts With Unallocated Funds (Do not include portions of these contracts mai			
•	a		te participation guarantee		
	а		to participation guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶			
	b	Balance at the end of the previous year		7b	343354
	С	Additions: (1) Contributions deposited during the year			
		(2) Dividends and credits	7c(2)	0722	
		(3) Interest credited during the year	7c(3)	9722	
		(4) Transferred from separate account	7c(4)	11175	
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	20897
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	364251
	е	Deductions:			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	36027	
		(2) Administration charge made by carrier	7e(2)	260	
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	7e(4)		
		<b>&gt;</b>			
		(5) Total deductions		7e(5)	36287
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )			327964

ı	Page	4

Р	art	Welfare Benefit Contract Inform	ation				
		If more than one contract covers the same the information may be combined for repo employees, the entire group of such indivi	rting purposes if such cont	racts are exp	perience-rated as a unit	t. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes			·	<u> </u>	<u> </u>
Ĭ	a	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> X Life insurance
	L I	<u>-</u>	불	L			<b>=</b>
	e	Temporary disability (accident and sickness)	f Long-term disabili	- L	Supplemental unem	pioyment	h Prescription drug
	1	Stop loss (large deductible)	j HMO contract	ĸ	PPO contract		I Indemnity contract
	m	Other (specify)					
9	Exp	erience-rated contracts:			T		_
	а	Premiums: (1) Amount received		9a(1)			_
		(2) Increase (decrease) in amount due but unpa					_
		(3) Increase (decrease) in unearned premium re				T - (1)	
	L	(4) Earned ((1) + (2) - (3))			 T	. 9a(4)	
	b	Benefit charges (1) Claims paid					_
		(2) Increase (decrease) in claim reserves				01- (0)	
		(3) Incurred claims (add (1) and (2))				9b(3)	
	_	(4) Claims charged				. 9b(4)	
	С	, , , ,	•	9c(1)(A)			_
		(A) Commissions(B) Administrative service or other fees		- (1)(T)			
		(C) Other specific acquisition costs		0 (4)(0)			
		(D) Other expenses		0 (4)(5)			_
		(E) Taxes		0 (4)(5)			
		(F) Charges for risks or other contingencies					_
		(G) Other retention charges					_
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid ir	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (	_	_		. 9d(1)	
		(2) Claim reserves	•			. 9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do	not include amount entered	d in line <b>9c(2</b> )	<b>)</b> .)	. 9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to	carrier			. 10a	
	b	If the carrier, service, or other organization incu			•		
	Sno	retention of the contract or policy, other than rep cify nature of costs.	oorted in Part I, line 2 abov	e, report am	ount	10b	
	Opc	sity flature of costs.					
Р	Part IV Provision of Information						
11	Di	I the insurance company fail to provide any infor	mation necessary to compl	lete Schedule	е А?	Yes	X No
		he answer to line 11 is "Yes," specify the informa					<u></u>
. 4	12 If the driswer to line 11 is 1 es, specify the information hot 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

2017

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 2017 or fiscal plan year beginning 07/01/2017 and ending 06/30/2018							
A Name of plan MOUNTAIN COMPREHE	NSIVE CARE (	CENTER FLEXIBLE BENEFIT P	LAN	<b>B</b> Three plan	e-digit number (PN	N) <b>•</b>	502
C Plan sponsor's name a MOUNTAIN COMPREHE					yer Identific 0663787	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							
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
35-0980405	61069	00202661	129	)	07/01/2017	7	06/30/2018
2 Insurance fee and come descending order of the		ation. Enter the total fees and tota	al commissions paid. Li	st in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comr	·		<b>(b)</b> To	tal amount	of fees paid	
		3530					917
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
ASSUREDPARTNERS NL	LLC		IVER ROAD VILLE, KY 40206				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount	(	(d) Purpose			(e) Organization code
	3530	917					3
	(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 pai		(c) Amount		(d) Purpose			(e) Organization code
	A 4 NI 41					_ <del>.</del>	/

Schedule A (Form 5500)	2017	Page <b>2 –</b> [	1	
(a) No.			aminaiana ar fana wara naid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	(0	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	Г			1
(b) Amount of sales and base		Fees and other commissions p		(e) Organization
commissions paid	(c) Amount	((	d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base	(c) Amount		d) Purpose	Organization
commissions paid	(0)	,		code
<b>(a)</b> Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each	carrier may be treated as a u	nit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the acquisi	tion or	
		retention 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)			
		(c) [ Strict (choosily)			
	£	If a cuture to combine and the color of the force of the	ation along about home	<b>▶</b> □	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin		<u> </u>	
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation guarante	e	
		(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>			
		(C)Total additions		7c(6)	0
	d	(6)Total additions			
		Deductions:		7 d	
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(3)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	. 76(4)		
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

ı	Page	4

F	art	III Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reportified employees, the entire group of such individual	group of employees of the ing purposes if such conti	acts are ex	perience-rated as a u	unit. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental une	employment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	, s k		ompioymoni	I Indemnity contract
	' [		I I IIVIO contract	K			I Indemnity contract
	m	Other (specify)					
^	F						
9		erience-rated contracts:	[	00(1)			
	а	Premiums: (1) Amount received(2) Increase (decrease) in amount due but unpaid	ŀ	9a(1) 9a(2)			
		(3) Increase (decrease) in unearned premium resi		9a(2)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)		Ju(+)	
		(2) Increase (decrease) in claim reserves	l	9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (or					
		(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)		T	
		(H) Total retention	_	_			
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits afte	er retirement	9d(1)	
		(2) Claim reserves					
		(3) Other reserves				· · · · ·	
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	l in line 9c(2	2).)	9e	
1(	_	nexperience-rated contracts:				40	
	а	Total premiums or subscription charges paid to ca					2635
	b Sno	If the carrier, service, or other organization incurred retention of the contract or policy, other than repocify nature of costs.					
P	art	IV Provision of Information					
11	Die	the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the information	on not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

					Inspection			
For calendar plan ye	For calendar plan year 2017 or fiscal plan year beginning 07/01/2017					ding 06/3	30/2018	
A Name of plan MOUNTAIN COMPREHENSIVE CARE CENTER FLEXIBLE BENEFIT			CENTER FLEXIBLE BENEFIT PL	AN		e-digit number (PI	N) •	502
C Plan sponsor's na MOUNTAIN COMPI					-	oyer Identific 0663787	ation Number	(EIN)
			ning Insurance Contract Individual contracts grouped as					
1 Coverage Informa	ation:							
(a) Name of insuran		SURANCE	COMPANY					
<b>/b</b> ) <b>F</b>   <b>N</b>	(c)	) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	,	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To
57-0514130	7173	30	0000009988	20	)	07/01/201	7	06/01/2018
2 Insurance fee and descending order			tion. Enter the total fees and tota	I commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) <sup>-</sup>	Total amour	nt of comm	nissions paid		<b>(b)</b> To	otal amount	of fees paid	
			146					0
3 Persons receiving	g commissio	ons and fe	es. (Complete as many entries a	as needed to report all	persons).			
	(a	ı) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
KERRY D KIMBROU	JGH		PO BOX LEXING	( 23582 TON, KY 40523				
(b) Amount of sa	ales and has	se	Fees	and other commission	ns paid			
commissio			(c) Amount		(d) Purpose			(e) Organization code
		86					3	
	(a	a) Name ar	nd address of the agent, broker, o	or other person to who	m commiss	ions or fees	were paid	
LESLIE K KIMBROU		•	PO BOX	( 623557 ), FL 32762				
(b) Amount of sa	ales and had	se L	Fees	and other commission	ns paid			
commissio			(c) Amount		(d) Purpose	e		(e) Organization code
		24						3
For Donorwork Don	luction Act	Notice :	so the Instructions for Form Fl	-00			Caha	dulo A (Form 5500) 2017

Schedule A (Form 5500)	2017	Page <b>2</b> – 1			
(a) Non	and address of the agent broke	ar other nersen to whom commissions or focus	ro noid		
SARAH K BARDELL	381	er, or other person to whom commissions or fees we S UPPER ST #1 NGTON, KY 40508	ге раю		
(b) Amount of sales and base commissions paid					
20			3		
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees we	re paid		
RUEANN M EMERSON	225	SOMERSLY PLACE NGTON, KY 40515			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
10			3		
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees we	re paid		
POWELL ENTERPRISES LLC	125 MAC	PLANTATOIN CENTRE DR #900B ON, GA 31210			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
4			3		
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees we	re paid		
KRISTIANNA J FLY		BOX 206 TH MIDDLETOWN, KY 40357			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
1			3		
(a) Nan	ne and address of the agent, broke	er, or other person to whom commissions or fees we	re paid		
BRIAN S MARTIN		BLAZER PARKWAY STE 201 NGTON, KY 40509			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
1			3		

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts with each	carrier may be treated as a u	nit for purposes of
4	Curi	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curi	ent value of plan's interest under this contract in separate accounts at year el	nd	5	
_		tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nnection with the acquisi	tion or	
		retention 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)			
		(c) [ Strict (choosily)			
	£	If a cuture to combine and the color of the force of the	ation along about home	<b>▶</b> □	
7	f	If contract purchased, in whole or in part, to distribute benefits from a termin		<u> </u>	
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		te participation guarante	e	
		(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>			
		(C)Total additions		7c(6)	0
	d	(6)Total additions			
		Deductions:			
	C	(1) Disbursed from fund to pay benefits or purchase annuities during year	70(1)		
			7e(1)		
		(2) Administration charge made by carrier	7e(3)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	. 76(4)		
		•			
		(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			

ı	Page	4

F	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 employees of the	racts are exp	erience-rated as a unit	t. Where co	ontracts cover individual	
8	Ber	efit a	nd contract type (check all applicable boxes)						
	а	Пне	alth (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
	е	_	mporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental unem	nlovment	h Prescription drug	
		_				<u>.</u>	pioyment	를 · · · ·	
	i		op loss (large deductible)	j HMO contract	K_	PPO contract		I Indemnity contract	ct
	m	Ot	her (specify)						
_									
9	Exp	erienc	ce-rated contracts:						
	а		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	· ·			0 (1)		
		. ,	arned ((1) + (2) - (3))				9a(4)		
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				21 (2)		
			ncurred claims (add (1) and (2))				(.)		
	_	` '	laims charged				. 9b(4)		
	С		nainder of premium: (1) Retention charges (o	, i	0 (4)(4)				
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)				
			(D) Other expenses		A (4)(=)				
			E) Taxes						
			(F) Charges for risks or other contingencies.		0 (4)(0)				
			(G) Other retention charges				9c(1)(H)	١	
			H) Total retention		_			/	
	اہ		Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1	•					
		` '	Claim reserves				9d(2)		
	_	` '	Other reserves				_ ` _		
10	<u>e</u>		dends or retroactive rate refunds due. (Do n erience-rated contracts:	ot include amount entered	in line 9c(2)	.)	. 9e		
1	_		enence-rated contracts. Il premiums or subscription charges paid to c	oorrior			. 10a		1600
	a						iua		1693
	<b>b</b> Sne	rete	e carrier, service, or other organization incurnation of the contract or policy, other than repretature of costs.	, ,		•	. 10b		
P	Part	IV	Provision of Information						
				nation necessary to comp	ata Sahadula	ΛΔ2 Π	Yes	X No	
11			insurance company fail to provide any inform		ete Schedule	A /	162	^ INU	
12	2 If	the an	swer to line 11 is "Yes," specify the informat	ion not provided.					