

**SCHEDULE P
(Form 5500)**

**Annual Return of Fiduciary
of Employee Benefit Trust**

OMB No. 1210-0018

Department of the Treasury
Internal Revenue Service

▶ File as an attachment to Form 5500, 5500-C/R, or 5500EZ.
▶ For the Paperwork Reduction Notice, see page 1 of the Form 5500 Instructions.

1992

For trust calendar year 1992 or fiscal year beginning January 1, 1992, and ending December 31, 1992

1a Name of trustee or custodian
J. DUNCAN SMITH DAVID D. SMITH DAVID B. AMY

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500, 5500-C/R, or 5500EZ.)
2000 W. 41ST STREET

c City or town, state, and ZIP code
BALTIMORE MD 21211

2a Name of trust
SINCLAIR BROADCAST GROUP, INC. 401(K) PROFIT SHARING PLAN

b Trust's employer identification number
52 | 1801124

3 Name of plan if different from name of trust
SAME

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? Yes No

5 Enter the plan sponsor's employer identification number as shown on Form 5500, 5500-C/R, or 5500EZ **▶ 52 | 1494880**

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

Signature of fiduciary ▶ *David B. Amy* Date ▶ 7/13/92

Instructions

(Section references are to the Internal Revenue Code.)

Purpose of Form

You may use this schedule to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a), which is exempt from tax under section 501(a).

Who May File

1. Every trustee of a trust created as part of an employee benefit plan as described in section 401(a).
2. Every custodian of a custodial account described in section 401(f).

How To File

File Schedule P (Form 5500) for the trust year ending with or within any participating plan's plan year. Attach it to the Form 5500, 5500-C/R, or 5500EZ filed by the plan for that plan year. A separately filed Schedule P Form 5500 will not be accepted.

If the trust or custodial account is used by more than one plan, file one Schedule P (Form 5500). If a plan uses more than one trust or custodial account for

its funds, file one Schedule P (Form 5500) for each trust or custodial account.

Signature

The fiduciary (trustee or custodian) must sign this schedule. If there is more than one fiduciary, the fiduciary authorized by the others may sign.

Other Returns and Forms That May Be Required

- **Form 990-T.**—For trusts described in section 401(a), a tax is imposed on income derived from business that is unrelated to the purpose for which the trust received a tax exemption. Report such income and tax on Form 990-T, Exempt Organization Business Income Tax Return. (See sections 511 through 514 and the related regulations.)
- **Form 1099-R.**—If you made payments or distributions to individual beneficiaries of a plan, report those payments on Form 1099-R. (See sections 6041 and 6047 and the related regulations.)
- **Forms 941 or 941E.**—If you made payments of distributions to individual beneficiaries of a plan, you are required to withhold income tax from those payments unless the payee elects not to have the tax withheld. Report any withholding tax on Form 941 or 941E. (See Form 941 or 941E, and Circular E, Employer's Tax Guide (Pub. 15), for more information.)

Annual Return/Report of Employee Benefit Plan (With 100 or more participants)

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 and sections 6039D, 604(e), 6057(b), and 6058(a) of the Internal Revenue Code, referred to as the Code.

See separate instructions.

1993

This Form is Open to Public Inspection.

For the calendar plan year 1993 or fiscal plan year beginning January 1, 1993, and ending December 31, 1993

A If (1) through (4) do not apply to this year's return/report, leave the boxes unmarked. This return/report is:

For IRS Use Only EP-ID

- (1) the first return/report filed for the plan; (2) an amended return/report;

- (3) the final return/report filed for the plan; or (4) a short plan year return/report (less than 12 months).

If the preprinted information in 1a through 6d is incorrect, please correct it; if any information is missing, please add it. Be sure to include this page with your completed return/report.

- B IF YOU CORRECT ANY OF THE PREPRINTED INFORMATION OR ADD MISSING INFORMATION IN 1a THROUGH 6d, CHECK HERE. C If your plan year changed since the last return/report, check here. D If you filed for an extension of time to file this return/report, check here and attach a copy of the approved extension.

1a Name and address of plan sponsor (employer, if for a single-employer plan) (address should include room or suite no.)

SINCLAIR BROADCAST GROUP, INC. 2000 W. 41ST STREET BALTIMORE MD 21211

1b Employer identification number (EIN)

52-1494660

1c Sponsor's telephone number

(410)467-4545

1d Business code (see instructions, page 22)

4830

1e CUSIP issuer number

2a Name and address of plan administrator (if same as plan sponsor, enter "Same")

SAME

2b Administrator's EIN

2c Administrator's telephone number

3 If you are filing this page without the preprinted historical plan information and the name, address and EIN of the plan sponsor or plan administrator has changed since the last return/report filed for this plan, enter the information from the last return/report in 3a and/or 3b and complete 3c.

- a Sponsor b Administrator c If 3a indicates a change in the sponsor's name, address and EIN, is this a change in sponsorship only? (See instruction 3c on page 8 for the definition of sponsorship.) Enter "Yes" or "No."

4 ENTITY CODE. (If not shown, enter the applicable code from page 9 of the instructions.)

A

5a Name of plan SINCLAIR BROADCAST GROUP, INC. 401(K) PROFIT SHARING PLAN

5b Effective date of plan (mo., day, yr.)

01/01/88

5c Three-digit plan number 001

All filers must complete 6a through 6d, as applicable.

- 6a Welfare benefit plan 6b Pension benefit plan (If the correct codes are not preprinted below, enter the applicable codes from page 9 of the instructions in the boxes.)

Table with 7 columns and 2 rows for benefit plan codes.

6c Pension plan features. (If the correct codes are not preprinted below, enter the applicable pension plan feature codes from page 9 of the instructions in the boxes.)

Table with 7 columns and 1 row for pension plan feature codes.

6d Fringe benefit plan. Attach Schedule F (Form 5500). See instructions.

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 and statements, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of employer/plan sponsor David B. Amy

Date 6/8/94

Signature of plan administrator David B. Amy

Date 6/8/94

6e Check all applicable investment arrangements below (see instructions):

- (1) Master Trust
- (2) 103-12 investment entity
- (3) Common/collective trust
- (4) Pooled separate account

f Single-employer plans enter the tax year end of the employer in which this plan year ends ► Month 12 Day 31 Year 82
 g Is any part of this plan funded by an insurance contract described in Code section 412(f)? Yes No
 h If 6g is "Yes", was the part subject to the minimum funding standards for either of the prior 2 plan years? Yes No

7 Number of participants as of the end of the plan year (welfare plans complete only 7a(4), 7b, 7c, and 7d):		
a Active participants: (1) Number fully vested	a(1)	76
(2) Number partially vested	a(2)	113
(3) Number nonvested	a(3)	0
(4) Total	a(4)	189
b Retired or separated participants receiving benefits	b	0
c Retired or separated participants entitled to future benefits	c	26
d Subtotal (add 7a(4), 7b, and 7c)	d	215
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	e	0
f Total (add 7d and 7e)	f	215
g Number of participants with account balances (Defined benefit plans do not complete this line item.)	g	214
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	15

i (1) Was any participant(s) separated from service with a deferred vested benefit for which a Schedule SSA (Form 5500) is required to be attached? (See instructions.) Yes No
 (2) If "Yes," enter the number of separated participants required to be reported ► 3

8a Was this plan ever amended since its effective date? If "Yes," complete 8b. If the amendment was adopted in this plan year, complete 8c through 8e.
 b If 8a is "Yes," enter the date the most recent amendment was adopted ► Month 12 Day 31 Year 81
 c Did any amendment during the current plan year result in the retroactive reduction of accrued benefits for any participants?
 d During this plan year did any amendment change the information contained in the latest summary plan descriptions or summary description of modifications available at the time of amendment?
 e If 8d is "Yes," has a summary plan description or summary description of modifications that reflects the plan amendments referred to in 8d been both furnished to participants and filed with the Department of Labor?

9a Was this plan terminated during this plan year or any prior plan year? If "Yes," enter the year ► _____
 b Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of PBGC?
 c Was a resolution to terminate this plan adopted during this plan year or any prior plan year?
 d If 9a or 9c is "Yes," have you received a favorable determination letter from IRS for the termination?
 e If 9d is "No," has a determination letter been requested from the IRS?
 f If 9a or 9c is "Yes," have participants and beneficiaries been notified of the termination or the proposed termination?
 g If 9a is "Yes" and the plan is covered by PBGC, is the plan continuing to file a PBGC Form 1 and pay premiums until the end of the plan year in which assets are distributed or brought under the control of PBGC?
 h During this plan year, did any trust assets revert to the employer for which the Code section 4980 excise tax is due?
 i If 9h is "Yes," enter the amount of tax paid with your Form 5330 ► \$ _____

10a In this plan year, was this plan merged or consolidated into another plan(s), or were assets or liabilities transferred to another plan(s)? If "Yes," complete 10b through 10e. Yes No
 If "Yes," identify other plan(s) c Employer identification number(s) d Plan number(s)
 b Name of plan(s) ► _____
 e If required, has a Form 5310-A been filed? Yes No

11 Enter the plan funding arrangement code from page 11 of the instructions ► 1 12 Enter the plan benefit arrangement code from page 11 of the instructions ► 1

13a Is this a plan established or maintained pursuant to one or more collective bargaining agreements? Yes No
 b If 13a is "Yes," enter the appropriate six-digit LM number(s) of the sponsoring labor organization(s) (see instructions):
 (1) _____ (2) _____ (3) _____
 14 If any benefits are provided by an insurance company, insurance service, or similar organization, enter the number of Schedules A (Form 5500), insurance information, attached. If none, enter "-0-." ► -0-

Welfare Plans Do Not Complete Items 15 Through 24. Go To Item 25.

15a	If this is a defined benefit plan subject to the minimum funding standards for this plan year, is Schedule B (Form 5500) required to be attached? (If this is a defined contribution plan leave blank.) (See instructions.)	15a	Yes	No
b	If this is a defined contribution plan (i.e., money purchase or target benefit), is it subject to the minimum funding standard? (If a waiver was granted, see instructions) (If this is a defined benefit plan leave blank.) If "Yes," complete (1), (2), and (3) below:	b		
	(1) Amount of employer contribution required for the plan year under Code section 412	b(1)	\$	
	(2) Amount of contribution paid by the employer for the plan year Enter date of last payment by employer ▶ Month _____ Day _____ Year _____	b(2)	\$	
	(3) If (1) is greater than (2), subtract (2) from (1) and enter the funding deficiency here; otherwise, enter -0-. (If you have a funding deficiency, file Form 5330.)	b(3)	\$	
16	Has the annual compensation of each participant taken into account under the current plan year been limited to \$235,840?	16	X	
17a	(1) Did the plan distribute any annuity contracts this year? (See instructions.)	a(1)		X
	(2) If (1) is "Yes," did these contracts contain a requirement that the spouse consent before any distributions under the contract are made in a form other than a qualified joint and survivor annuity?	a(2)		N/A
b	Did the plan make distributions to participants or spouses in a form other than a qualified joint and survivor annuity (a life annuity if a single person) or qualified preretirement survivor annuity (exclude deferred annuity contracts)?	b	X	
c	Did the plan make distributions or loans to married participants and beneficiaries without the required consent of the participant's spouse?	c		X
d	Upon plan amendment or termination, do the accrued benefits of every participant include the subsidized benefits that the participant may become entitled to receive subsequent to the plan amendment or termination?	d	X	
18	Were distributions, if any, made in accordance with the requirements under Code sections 411(a)(11) and 417(e)?	18	X	
19	Have any contributions been made or benefits accrued in excess of the Code section 415 limits, as amended?	19		X
20	Is the plan administrator making an election under section 412(c)(8) for an amendment adopted after the plan year? (See instructions.)	20		N/A
21	Check if you are applying either of the following in completing items 21a through 21o (see instructions): (i) <input checked="" type="checkbox"/> Reasonable, good faith interpretation of the nondiscrimination provisions. (ii) <input type="checkbox"/> Substantiation guidelines. If you checked 21(ii), enter the first day of the plan year for which data is being submitted ▶ Month _____ Day _____ Year _____			
a	Does the employer apply the separate line of business rules of Code section 414(r) when testing this plan for the coverage and discrimination tests of Code sections 410(b) and 401(a)(4)?	21a		X
b	If 21a is "Yes," enter the total number of separate lines of business claimed by the employer ▶ _____ If more than one separate line of business, see instructions for additional information to attach.			
c	Does the employer apply the mandatory disaggregation rules under Income Tax Regulations section 1.410(b)-7(c)? If "Yes," see instructions for additional information to attach.	c	X	
d	In testing whether this plan satisfies the coverage and discrimination tests of Code sections 410(b) and 410(a), does the employer aggregate plans?	d		X
e	Does the employer restructure the plan into component plans to satisfy the coverage and discrimination tests of Code sections 410(b) and 401(a)(4)?	e		X
f	If you meet either of the following exceptions, check the applicable box to tell us which exception you meet and do NOT complete the rest of question 21: (1) <input type="checkbox"/> No highly compensated employee benefited under the plan at any time during the plan year; (2) <input type="checkbox"/> This is a collectively bargained plan that benefits only collectively bargained employees, no more than 2% of whom are professional employees.			
g	Did any leased employee perform services for the employer at any time during the plan year?	g		X
h	Enter the total number of employees of the employer. Employer includes entities aggregated with the employer under Code sections 414(b), (c), or (m). Include leased employees and self-employed individuals	h	Number	349
i	Enter the total number of employees excludable because of: (1) failure to meet requirements for minimum age and years of service; (2) collectively bargained employees; (3) nonresident aliens who receive no earned income from U. S. sources; and (4) minimum hours of service/last day rule	i		145
j	Enter the number of nonexcludable employees (subtract line 21i from line 21h)	j		204
k	Do 100% of the nonexcludable employees entered on line 21j benefit under the plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If line 21k is "Yes," do NOT complete lines 21l through 21o.			
l	Enter the number of nonexcludable employees (line 21j) who are highly compensated employees	l		
m	Enter the number of nonexcludable employees (line 21j) who benefit under the plan.	m		
n	Enter the number of employees entered on line 21m who are highly compensated employees.	n		
o	This plan satisfies the coverage requirements on the basis of (check one): (1) <input type="checkbox"/> The average benefits test (2) <input type="checkbox"/> The ratio percentage test—Enter value ▶ _____			

FORM 5500 (1993)

Attachment to Q.21(a-o)

Plan Name : SINCLAIR BROADCAST GROUP, INC.
 401(K) PROFIT SHARING PLAN
 EIN/PN : 52-1494660/001
 Group Name: SINCLAIR BROADCAST GROUP, INC. 401(k) - DEFFERAL

21 Check if you are applying either of the following in completing items 21a through 21o (see instructions):

(i) Reasonable, good faith interpretation of the nondiscrimination provisions.

(ii) Substantiation guidelines.

If you checked 21(ii), enter the first day of the plan year for which data is being submitted ▶ Month Day Year

a Does the employer apply the separate line of business rules of Code section 414(r) when testing this plan for the coverage and discrimination tests of Code sections 410(b) and 401(a)(4)?

b If 21a is "Yes," enter the total number of separate lines of business claimed by the employer ▶
 If more than one separate line of business, see instructions for additional information to attach.

c Does the employer apply the mandatory disaggregation rules under Income Tax Regulations section 1.410(b)-7(c)?
 If "Yes," see instructions for additional information to attach.

d In testing whether this plan satisfies the coverage and discrimination tests of Code sections 410(b) and 401(a), does the employer aggregate plans?

e Does the employer restructure the plan into component plans to satisfy the coverage and discrimination tests of Code sections 410(b) and 401(a)(4)?

f If you meet either of the following exceptions, check the applicable box to tell us which exception you meet and do NOT complete the rest of question 21:

(1) No highly compensated employee benefited under the plan at any time during the plan year;

(2) This is a collectively bargained plan that benefits only collectively bargained employees, no more than 2% of whom are professional employees.

g Did any leased employee perform services for the employer at any time during the plan year?

h Enter the total number of employees of the employer. Employer includes entities aggregated with the employer under Code section 414(b), (c), or (m). Include leased employees and self-employed individuals.

i Enter the total number of employees excludable because of: (1) failure to meet requirements for minimum age and years of service; (2) collectively bargained employees; (3) nonresident aliens who receive no earned income from U.S. sources; and (4) minimum hours of service/last day rule

j Enter the number of nonexcludable employees (subtract line 21i from line 21h)

k Do 100 percent of the nonexcludable employees entered on line 21j benefit under the plan? Yes No
 If line 21k is "Yes," do NOT complete lines 21l through 21o.

l Enter the number of nonexcludable employees (line 21j) who are highly compensated employees

m Enter the number of nonexcludable employees (line 21j) who benefit under the plan.

n Enter the number of employees entered on line 21m who are highly compensated employees

o This plan satisfies the coverage requirements on the basis of (check one):

(1) The average benefits test (2) The ratio percentage test—Enter value ▶

	Yes	No
21a		X
b		
c		X
d		X
e		X
f		
g		X
h	Number 363	
i	145	
j	218	
k	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
l		
m		
n		
o		

FORM 5500 (1993)

Attachment to Q.21(a-o)

Plan Name : SINCLAIR BROADCAST GROUP, INC.
 401(K) PROFIT SHARING PLAN
 EIN/PN : 52-1494660/001
 Group Name: SINCLAIR BROADCAST GROUP, INC. 401(k) - MATCH

21 Check if you are applying either of the following in completing items 21a through 21o (see instructions):

(i) Reasonable, good faith interpretation of the nondiscrimination provisions.

(ii) Substantiation guidelines.

If you checked 21(ii), enter the first day of the plan year for which data is being submitted ► Month Day Year

a Does the employer apply the separate line of business rules of Code section 414(r) when testing this plan for the coverage and discrimination tests of Code sections 410(b) and 401(a)(4)?

b If 21a is "Yes," enter the total number of separate lines of business claimed by the employer ►
 If more than one separate line of business, see instructions for additional information to attach.

c Does the employer apply the mandatory disaggregation rules under Income Tax Regulations section 1.410(b)-7(c)?
 If "Yes," see instructions for additional information to attach.

d In testing whether this plan satisfies the coverage and discrimination tests of Code sections 410(b) and 401(a), does the employer aggregate plans?

e Does the employer restructure the plan into component plans to satisfy the coverage and discrimination tests of Code sections 410(b) and 401(a)(4)?

f If you meet either of the following exceptions, check the applicable box to tell us which exception you meet and do NOT complete the rest of question 21:

(1) No highly compensated employee benefited under the plan at any time during the plan year;

(2) This is a collectively bargained plan that benefits only collectively bargained employees, no more than 2% of whom are professional employees.

g Did any leased employee perform services for the employer at any time during the plan year?

h Enter the total number of employees of the employer. Employer includes entities aggregated with the employer under Code section 414(b), (c), or (m). Include leased employees and self-employed individuals.

i Enter the total number of employees excludable because of: (1) failure to meet requirements for minimum age and years of service; (2) collectively bargained employees; (3) nonresident aliens who receive no earned income from U.S. sources; and (4) minimum hours of service/last day rule

j Enter the number of nonexcludable employees (subtract line 21i from line 21h)

k Do 100 percent of the nonexcludable employees entered on line 21j benefit under the plan? Yes No
 If line 21k is "Yes," do NOT complete lines 21l through 21o.

l Enter the number of nonexcludable employees (line 21j) who are highly compensated employees

m Enter the number of nonexcludable employees (line 21j) who benefit under the plan.

n Enter the number of employees entered on line 21m who are highly compensated employees

o This plan satisfies the coverage requirements on the basis of (check one):

(1) The average benefits test (2) The ratio percentage test—Enter value ►

	Yes	No
21a		x
b		
c		x
d		x
e		x
f		
g		x
h	Number 363	
i	145	
j	218	
k		
l		
m		
n		
o		

22a Is it or was it ever intended that this plan qualify under Code section 401(a)? If "Yes," complete 22b and 22c

b Enter the date of the most recent IRS determination letter ▶ Month _____ Year _____

c Is a determination letter request pending with IRS?

23a Does the plan hold any assets that have a fair market value that is not readily determinable on an established market? (If "Yes," answer 23b) (See instructions)

b Were all the assets referred to in 23a valued for the 1993 plan year by an independent third-party appraiser?

c If 23b is "No," enter the value of the assets that were not valued by an independent third-party appraiser for the 1993 plan year. ▶ _____

d Enter the most recent date the assets in 23c were valued by an independent third-party appraiser. (If more than one asset, see instructions.) ▶ Month _____ Day _____ Year _____ (If this plan does not have ESOP features leave 23e blank and go to item 24.)

e If dividends paid on employer securities held by the ESOP were used to make payments on ESOP loans, enter the amount of the dividends used to make the payments. [23e]

24 Does the employer/sponsor listed in 1a of this form maintain other qualified pension benefit plans? If "Yes," enter the total number of plans, including this plan ▶

	Yes	No
22a	X	
b		X
23a	X	
b		X
c		
d		
e		
24		X

25a Did any person who rendered services to the plan receive directly or indirectly \$5,000 or more in compensation from the plan during the plan year (except for employees of the plan who were paid less than \$1,000 in each month)? If "Yes," complete Part I of Schedule C (Form 5500).

b Did the plan have any trustees who must be listed in Part II of Schedule C (Form 5500)?

c Has there been a termination in the appointment of any person listed in 25d below?

d If 25c is "Yes," check the appropriate box(es), answer 25e and 25f, and complete Part III of Schedule C (Form 5500): (1) Accountant (2) Enrolled actuary (3) Insurance carrier (4) Custodian (5) Administrator (6) Investment manager (7) Trustee

e Have there been any outstanding material disputes or matters of disagreement concerning the above termination?

f If an accountant or enrolled actuary has been terminated during the plan year, has the terminated accountant/actuary been provided a copy of the explanation required by Part III of Schedule C (Form 5500) with a notice advising them of their opportunity to submit comments on the explanation directly to DOL?

g Enter the number of Schedules C (Form 5500) that are attached. If none, enter -0- ▶ 1

	Yes	No
25a	X	
b	X	
c		X
d		
e		N/A
f		N/A
g		

26a Is this plan exempt from the requirement to engage an independent qualified public accountant? (see instructions)

b If 26a is "No," attach the accountant's opinion to this return/report and check the appropriate box. This opinion is: (1) Unqualified (2) Qualified/disclaimer per Department of Labor Regulations 29 CFR 2520.103-8 and/or 2520.103-12(d) (3) Qualified/disclaimer other (4) Adverse (5) Other (explain) _____

c If 26a is "No," does the accountant's report, including the financial statements and/or notes required to be attached to this return/report disclose (1) errors or irregularities; (2) illegal acts; (3) material internal control weaknesses; (4) a loss contingency indicating that assets are impaired or a liability incurred; (5) significant real estate or other transactions in which the plan and (A) the sponsor, (B) the plan administrator, (C) the employer(s), or (D) the employee organization(s) jointly involved; (6) that the plan has participated in any related party transactions; or (7) any unusual or infrequent events or transactions occurring subsequent to the plan year and that might significantly affect the usefulness of the financial statements in assessing the plan's present or future ability to pay benefits?

d If 26c is "Yes," provide the total amount involved in such disclosure ▶

	Yes	No
26a		X
b		
c		X
d		

27 If 26a is "No," complete the following questions. (You may NOT use "N/A" in response to item 27): If 27a, 27b, 27c, 27d, 27e, or 27f is checked "Yes," schedules of these items in the format set forth in the instructions are required to be attached to this return/report. Schedule G (Form 5500) may be used as specified in the instructions. During the plan year:

a Did the plan have assets held for investment?

b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible?

c Were any leases to which the plan was a party in default or classified during the year as uncollectible?

d Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets?

e Do the notes to the financial statements accompanying the accountant's opinion disclose any nonexempt transactions with parties-in-interest?

f Did the plan engage in any nonexempt transactions with parties-in-interest not reported in 27e?

g Did the plan hold qualifying employer securities that are not publicly traded?

h Did the plan purchase or receive any nonpublicly traded securities that were not appraised in writing by an unrelated third party within 3 months prior to their receipt?

i Did any person manage plan assets who had a financial interest worth more than 10% in any party providing services to the plan or receive anything of value from any party providing services to the plan?

	Yes	No
27a	X	
b		X
c		X
d	X	
e		X
f		X
g		X
h		X
i		X

28	Did the plan acquire individual whole life insurance contracts during the plan year?	28	Yes	No
29	During the plan year:			
a	(1) Was this plan covered by a fidelity bond? If "Yes," complete 29a(2) and 29a(3)	29a(1)	X	
	(2) Enter amount of bond ▶ \$			
	(3) Enter the name of the surety company ▶			
b	(1) Was there any loss to the plan, whether or not reimbursed, caused by fraud or dishonesty?	b(1)		X
	(2) If 29b(1) is "Yes," enter amount of loss ▶ \$			

30a Is the plan covered under the Pension Benefit Guaranty Corporation termination insurance program?
 Yes No Not determined

b If 30a is "Yes" or "Not determined," enter the employer identification number and the plan number used to identify it.
 Employer identification number ▶ Plan number ▶

31 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of the plan assets held in more than one trust. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions. Do not enter the value of that portion of an insurance contract that guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar; any other amounts are subject to rejection. Plans with no assets at the beginning and the end of the plan year, enter -0- on line 31f.

Assets		(a) Beginning of year	(b) End of Year
a	Total noninterest-bearing cash	0	0
b	Receivables: (1) Employer contributions		
	(2) Participant contributions		
	(3) Income	0	0
	(4) Other	0	0
	(5) Less allowance for doubtful accounts	0	0
	(6) Total. Add lines 31b(1) through 31b(4) and subtract line 31b(5) ▶		
c	General investments: (1) Interest-bearing cash (including money market funds)		
	(2) Certificates of deposit	0	0
	(3) U.S. Government securities		
	(4) Corporate debt instruments (A) Preferred	0	0
	(B) All other		
	(5) Corporate stocks: (A) Preferred	0	0
	(B) Common		
	(6) Partnership/joint venture interests		
	(7) Real estate: (A) Income-producing	0	0
	(B) Nonincome-producing	0	0
	(8) Loans (other than to participants) secured by mortgages: (A) Residential	0	0
	(B) Commercial	0	0
	(9) Loans to participants: (A) Mortgages	0	0
	(B) Other		
	(10) Other loans	0	0
	(11) Value of interest in common/collective trusts	0	0
	(12) Value of interest in pooled separate accounts	0	0
	(13) Value of interest in master trusts	0	0
	(14) Value of interest in 103-12 investment entities	0	0
	(15) Value of interest in registered investment companies	0	0
	(16) Value of funds held in insurance company general account (unallocated contracts)	0	0
	(17) Other ▶	0	0
	(18) Total. Add lines 31c(1) through 31c(17) ▶		
d	Employer-related investments: (1) Employer securities	0	0
	(2) Employer real property	0	0
e	Buildings and other property used in plan operation	0	0
f	Total assets. Add lines 31a, 31b(6), 31c(18), 31d(1), 31d(2), and 31e ▶		
Liabilities			
g	Benefit claims payable	0	0
h	Operating payables	0	0
i	Acquisition indebtedness	0	0
j	Other liabilities	0	0
k	Total liabilities. Add lines 31g through 31j ▶	0	0
Net Assets			
l	Subtract line 31k from line 31f ▶		

32 Plan income, expenses, and changes in net assets for the plan year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s), and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar; any other amounts are subject to rejection.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable from:			
(A) Employers	a(1)(A)		
(B) Participants	(B)		
(C) Others	(C)		
(2) Noncash contributions	(2)	0	
(3) Total contributions. Add lines 32a(1)(A), (B), (C) and line 32a(2)	(3)		
b Earnings on Investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market funds)	b(1)(A)		
(B) Certificates of deposit	(B)	0	
(C) U.S. Government securities	(C)		
(D) Corporate debt instruments	(D)		
(E) Mortgage loans	(E)	0	
(F) Other loans	(F)		
(G) Other interest	(G)		
(H) Total interest. Add lines 32b(1)(A) through (G)	(H)		
(2) Dividends: (A) Preferred stock	b(2)(A)	0	
(B) Common stock	(B)		
(C) Total dividends. Add lines 32b(2)(A) and (B)	(C)		
(3) Rents	(3)		0
(4) Net gain (loss) on sale assets: (A) Aggregate proceeds	(4)(A)		
(B) Aggregate carrying amount (see instructions)	(B)	0	
(C) Subtract (B) from (A) and enter result	(C)		
(5) Unrealized appreciation (depreciation) of assets	(5)		
(6) Net investment gain (loss) from common/collective trusts	(6)		0
(7) Net investment gain (loss) from pooled separate accounts	(7)		0
(8) Net investment gain (loss) from master trusts	(8)		0
(9) Net investment gain (loss) from 103-12 investment entities	(9)		0
(10) Net investment gain (loss) from registered investment companies	(10)		0
c Other income	c		0
d Total income. Add all amounts in column (b) and enter total	d		
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries	e(1)		
(2) To insurance carriers for the provision of benefits	(2)	0	
(3) Other	(3)	0	
(4) Total payments. Add lines 32e(1) through 32e(3)	(4)		
f Interest expense	f		0
g Administrative expenses: (1) Salaries and allowances			
(2) Accounting fees	g(2)	0	
(3) Actuarial fees	(3)	0	
(4) Contract administrator fees	(4)	0	
(5) Investment advisory and management fees	(5)		
(6) Legal fees	(6)	0	
(7) Valuation/appraisal fees	(7)	0	
(8) Trustees fees/expenses (including travel, seminars, meeting, etc.)	(8)	0	
(9) Other	(9)		
(10) Total administrative expenses. Add lines 32g(1) through 32g(9)	(10)		
h Total expenses. Add lines 32e(4), 32f, and 32g(10)	h		
i Net income (loss). Subtract line 32h from line 32d	i		
j Transfers to (from) the plan (see instructions)	j		0
k Net assets at beginning of year (line 31l, column (a))	k		
l Net assets at end of year (line 31l, column (b))	l		

Yes	No
	x

33 Did any employer sponsoring the plan pay any of the administrative expenses of the plan that were not reported in line 32g?

**SCHEDULE C
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Service Provider and Trustee Information

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

► File as an attachment to Form 5500.
Additional Schedules C (Form 5500) may be used, if needed, to provide additional information for Parts I, II, and/or III.

OMB No. 1510-0018

1993

**This Form is
Open to Public
Inspection**

For the calendar year 1993 or fiscal plan year beginning January 1, 1993, and ending December 31, 1993

Name of plan sponsor as shown on line 1a of Form 5500
SINCLAIR BROADCAST GROUP, INC. Employer identification number
52 | 1494660

Name of plan **SINCLAIR BROADCAST GROUP, INC.**
401(K) PROFIT SHARING PLAN Three-digit plan number ► **0 | 0 | 1**

Part I Service Provider Information (see instructions)

1 Enter the total dollar amount of compensation paid by the plan to all persons receiving less than \$5,000 during the plan year							1	0.00
2	(a) Name	(b) Employer identification number (see instructions)	(c) Official plan position	(d) Relationship to employer, employee organization, or person known to be a party-in-interest	(e) Gross salary or allowances paid by plan	(f) Fees and commissions paid by plan	(g) Nature of service code (see instructions)	
(1)			Contract administrator		0.00	0.00	12	
(2)	PSA CAPITAL MANAGEMENT	52 1588935	asset manager	NONE	0.00		21	
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								
(11)								
(12)								
(13)								
(14)								
(15)								
(16)								
(17)								
(18)								
(19)								
(20)								
(21)								
(22)								
(23)								
(24)								
(25)								
(26)								
(27)								
(28)								
(29)								
(30)								
(31)								
(32)								
(33)								
(34)								
(35)								
(36)								
(37)								
(38)								
(39)								
(40)								

Part II Trustee Information Enter the name and address of all trustees who served during the plan year. If more space is required to supply this information, attach additional Schedules C (Form 5500).

Name J. DUNCAN SMITH Address 2000 W. 41st STREET BALTO. MD 21211	Name DAVID D. SMITH Address 2000 W. 41st STREET BALTO. MD 21211
Name DAVID B. AMY Address 2000 W. 41st STREET BALTO. MD 21211	Name Address
Name Address	Name Address
Name Address	Name Address
Name Address	Name Address
Name Address	Name Address
Name Address	Name Address
Name Address	Name Address

Part III Termination Information (see instructions)

(a) Name	(b) EIN	(c) Position	(d) Address	(e) Telephone No.

(1) Explanation:

.....

.....

.....

.....

(a) Name	(b) EIN	(c) Position	(d) Address	(e) Telephone No.

(2) Explanation:

.....

.....

.....

.....

(a) Name	(b) EIN	(c) Position	(d) Address	(e) Telephone No.

(3) Explanation:

.....

.....

.....

.....

**SCHEDULE P
(Form 5500)**

Department of the Treasury
Internal Revenue Service

**Annual Return of Fiduciary
of Employee Benefit Trust**

▶ File as an attachment to Form 5500, 5500-C/R, or 5500-EZ.
▶ For the Paperwork Reduction Notice, see page 1 of the Form 5500 instructions.

OMB No. 1210-0018

1993

This Form is Open to
Public Inspection

For trust calendar year 1993 or fiscal year beginning January 1, 1993, and ending December 31, 1993

Please type or print	1a Name of trustee or custodian J. DUNCAN SMITH DAVID D. SMITH DAVID B. AMY
	b Number, street, and room or suite no. (if a P.O. box, see the instructions for Form 5500, 5500-C/R, or 5500-EZ.) 2000 W. 41ST STREET
	c City or town, state, and ZIP code BALTIMORE MD 21211
2a Name of trust SINCLAIR BROADCAST GROUP, INC. 401(K) PROFIT SHARING PLAN	b Trust's employer identification number 52 1801124
3 Name of plan if different from name of trust SAME	
4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
5 Enter the plan sponsor's employer identification number as shown on Form 5500, 5500-C/R, or 5500-EZ. ▶	52 1494660

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

Signature of fiduciary ▶ *David B. Amy* Date ▶ 6/8/94

Instructions

(Section references are to the Internal Revenue Code.)

Purpose of Form

You may use this schedule to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a), which is exempt from tax under section 501(a).

Who May File

1. Every trustee of a trust created as part of an employee benefit plan as described in section 401(a).
2. Every custodian of a custodial account described in section 401(f).

How To File

File Schedule P (Form 5500) for the trust year ending with or within any participating plan's plan year. Attach it to the Form 5500, 5500-C/R, or 5500-EZ filed by the plan for that plan year. A separately filed Schedule P (Form 5500) will not be accepted.

If the trust or custodial account is used by more than one plan, file one Schedule P (Form 5500). If a plan uses more than one trust or custodial account for its funds, file one Schedule P (Form 5500) for each trust or custodial account.

Trust's Employer Identification Number

Enter the trust employer identification number (EIN) assigned to the employee benefit trust or custodial account, if one has been issued to you. The trust EIN should be used for transactions conducted for the trust. If you do not have a

trust EIN, enter the EIN you would use on Form 1099-R to report distributions from employee benefit plans and on Form 941 or 941E to report withheld amounts of income tax from those payments.

Note: Trustees who do not have an EIN may apply for one on Form SS-4, Application for Employer Identification Number. You must be consistent and use the same EIN for all trust reporting purposes.

Signature

The fiduciary (trustee or custodian) must sign this schedule. If there is more than one fiduciary, the fiduciary authorized by the others may sign.

Other Returns and Forms That May Be Required

- **Form 990-T.**—For trusts described in section 401(a), a tax is imposed on income derived from business that is unrelated to the purpose for which the trust received a tax exemption. Report this income and tax on Form 990-T, Exempt Organization Business Income Tax Return. (See sections 511 through 514 and the related regulations.)
- **Form 1099-R.**—If you made payments or distributions to individual beneficiaries of a plan, report those payments on Form 1099-R. (See the instructions for Forms 1099, 1098, 5498, and W-2G.)
- **Forms 945.**—If you made payments of distributions to individual beneficiaries of a plan, you may be required to withhold income tax from those payments. Form 945, Annual Return of Withheld Federal Income Tax is new and will be used to report taxes withheld from nonpayroll items effective January 1994. Do not use Form 941 or 941E for amounts withheld after the fourth quarter of 1993 for nonpayroll items. (See Circular E, Employer's Tax Guide (Pub. 15), for more information.)

SINCLAIR BROADCAST GROUP, INC.
SUMMARY OF TRANSACTIONS BY SOURCE
Account : TRUST FUND
- FOR THE YEAR ENDING 12/31/93 -

FUNDS SOURCE	PRIOR BALANCE	FUND CONTRIB	FORFEIT. ALLOCAT.	PAYOUT/ DISTRIB	GAIN/ LOSS	LOANS OUTSTAND	ENDING BALANCE	VESTED PERCENT BALANCE VESTED	NONVESTED SUSPENSE
289 SMITH, DAVID D		Active		SSN : 213-54-1652		IDM : SBG-0180	Annual Comp.:		
EMPLOYER DI		0.00		0.00		0.00		100	0.00
PENSION ROL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDU			0.00	0.00		0.00		100	0.00
EMPLOYER MA				0.00		0.00		100	0.00
SUBTOTALS..				0.00		0.00			0.00
290 SMITH, FREDERICK G.		Active		SSN : 213-54-1651		IDM : SBG-0180	Annual Comp.:		
EMPLOYER DI		0.00		0.00		0.00		60	0.00
PENSION ROL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDU			0.00	0.00		0.00		100	0.00
EMPLOYER MA				0.00		0.00		60	0.00
SUBTOTALS..				0.00		0.00			0.00
291 SMITH, J DUNCAN		Active		SSN : 212-62-5979		IDM : SBG-0180	Annual Comp.:		
EMPLOYER DI		0.00		0.00		0.00		100	0.00
PENSION ROL		0.00	0.00	0.00		0.00		100	0.00
SALARY REDU			0.00	0.00		0.00		100	0.00
EMPLOYER MA				0.00		0.00		100	0.00
SUBTOTALS..				0.00		0.00			0.00
292 SMITH, ROBERT E		Active		SSN : 215-92-3389		IDM : SBG-0180	Annual Comp.:		
EMPLOYER DI		0.00		0.00		0.00		100	0.00
PENSION ROL		0.00	0.00	0.00		0.00		100	0.00
SALARY REDU			0.00	0.00		0.00		100	0.00
EMPLOYER MA				0.00		0.00		100	0.00
SUBTOTALS..				0.00		0.00			0.00
293 AMY, DAVID B.		Active		SSN : 191-42-6231		IDM : SBG-0180	Annual Comp.:		
EMPLOYER DI		0.00		0.00		0.00		100	0.00
PENSION ROL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDU			0.00	0.00		0.00		100	0.00
EMPLOYER MA				0.00		0.00		100	0.00
SUBTOTALS..				0.00		0.00			0.00
294 SHAPIRO, DARREN J		Active		SSN : 115-60-2624		IDM : SBG-0180	Annual Comp.:		
EMPLOYER DI		0.00		0.00		0.00		60	0.00
PENSION ROL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDU	0.00		0.00	0.00		0.00		100	0.00
EMPLOYER MA				0.00		0.00		60	0.00
SUBTOTALS..				0.00		0.00			0.00
295 EGGER, HELEN RUTH		Active		SSN : 084-36-3481		IDM : SBG-0180	Annual Comp.:	22757.68	
EMPLOYER DI		0.00		0.00		0.00		60	0.00
PENSION ROL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00

Federal Communications Commission

Docket No. 93-94 Exhibit No. 76 TAB 12

Presented by Scupper Howard

Disposition { Identified 9/13/94
Received 9/13/94
Rejected _____

Reporter P. McNulty

Date 9/13/94

SINCLAIR BROADCAST GROUP, INC.
SUMMARY OF TRANSACTIONS BY SOURCE
Account : TRUST FUND
- FOR THE YEAR ENDING 12/31/92 -

FUNDS SOURCE	PRIOR BALANCE	FUND CONTRIB	FORFEIT. ALLOCAT.	PAYOUT/ DISTRIB	GAIN/ LOSS	LOANS OUTSTAND	ENDING BALANCE	VESTED BALANCE	PERCENT VESTED	NONVESTED SUSPENSE
326 SMITH, DAVID D		Active		SSN : 213-54-1652	IDM : SBG-0180	Annual Comp.:				
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
325 SMITH, FREDERICK G.		Active		SSN : 213-54-1651	IDM : SBG-0180	Annual Comp.:				
EMPLOYER DISC		0.00		0.00		0.00			40	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			40	0.00
SUBTOTALS....				0.00		0.00				0.00
326 SMITH, J DUNCAN		Active		SSN : 212-62-5979	IDM : SBG-0180	Annual Comp.:				
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO		0.00	0.00	0.00		0.00			100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC			160.99	0.00		0.00			100	0.00
SUBTOTALS....			176.26	0.00		0.00				0.00
412 SMITH, JERRUD C		Vest T. - 2		SSN : 522-82-3811	IDM : TTE-0450	Annual Comp.:		0.00		
EMPLOYER DISC		0.00		0.00		0.00	0.00	0.00	80	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT		0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
EMPLOYER MATC		0.00		0.00	0.00	0.00	0.00	0.00	80	0.00
SUBTOTALS....		0.00		0.00	0.00	0.00	0.00	0.00		0.00
316 SMITH, LISA MARIE		Vest T. - 2		SSN : 165-58-4660	IDM : PTT-0348	Annual Comp.:		0.00		
EMPLOYER DISC		0.00		0.00	0.00	0.00	0.00	0.00	40	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
EMPLOYER MATC		0.00		0.00	0.00	0.00	0.00	0.00	40	0.00
SUBTOTALS....		0.00		0.00	0.00	0.00	0.00	0.00		0.00
327 SMITH, ROBERT E		Active		SSN : 215-92-3389	IDM : SBG-0180	Annual Comp.:				
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO		0.00	0.00	0.00		0.00			100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
146 SMITH, WILLIAM PERRY		Term. - 2		SSN : 245-50-6114	IDM : BFF-0670	Annual Comp.:		0.00		
EMPLOYER DISC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT		0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00

SINCLAIR BROADCAST GROUP, INC.
SUMMARY OF TRANSACTIONS BY SOURCE
Account : TRUST FUND
- FOR THE YEAR ENDING 12/31/91 -

FUNDS SOURCE	PRIOR BALANCE	FUND CONTRIB	FORFEIT. ALLOCAT.	PAYOUT/ DISTRIB	GAIN/ LOSS	LOANS OUTSTAND	ENDING BALANCE	VESTED BALANCE	PERCENT VESTED	NONVESTED SUSPENSE
1 AMY, DAVID B.		Active		SSN : 191-42-6231		IDN : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
2 EGGER, HELEN RUTH		Active		SSN : 084-36-3481		IDN : SBG-0180	Annual Comp.:			
EMPLOYER DISC	0.00	0.00		0.00	0.00	0.00			20	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
EMPLOYER MATC	0.00	0.00		0.00	0.00	0.00			20	0.00
SUBTOTALS....	0.00	0.00		0.00	0.00	0.00				0.00
3 REDMILES, MARGARET D.		Active		SSN : 215-40-1196		IDN : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO		0.00	0.00	0.00		0.00			100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
4 REYNOLDS, LEILONI M		Active		SSN : 214-38-8059		IDN : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
5 SHAPIRO, DARREN J		Active		SSN : 115-60-2624		IDN : SBG-0180	Annual Comp.:			
EMPLOYER DISC	0.00	0.00		0.00	0.00	0.00			20	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
EMPLOYER MATC	0.00	0.00		0.00	0.00	0.00			20	0.00
SUBTOTALS....	0.00	0.00		0.00	0.00	0.00				0.00
6 SMITH, DAVID D		Active		SSN : 213-54-1652		IDN : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00

SINCLAIR BROADCAST GROUP, INC.
 SUMMARY OF TRANSACTIONS BY SOURCE
 Account : TRUST FUND
 - FOR THE YEAR ENDING 12/31/91 -

FUNDS SOURCE	PRIOR BALANCE	FUND CONTRIB	FORFEIT. ALLOCAT.	PAYOUT/ DISTRIB	GAIN/ LOSS	LOANS OUTSTAND	ENDING BALANCE	VESTED BALANCE	PERCENT VESTED	NONVESTED SUSPENSE
7 SMITH, FREDERICK G.		Active		SSN : 213-54-1651		IDM : SBG-0180	Annual Comp.:			
EMPLOYER DISC	0.00	0.00		0.00	0.00	0.00			20	0.00
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT	0.00		0.00	0.00		0.00			100	0.00
EMPLOYER MATC	0.00			0.00	0.00	0.00			20	0.00
SUBTOTALS....	0.00			0.00		0.00				0.00
8 SMITH, J DUNCAN		Active		SSN : 212-62-5979		IDM : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO		0.00	0.00	0.00		0.00			100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
9 SMITH, ROBERT E		Active		SSN : 215-92-3389		IDM : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			100	0.00
PENSION ROLLO		0.00	0.00	0.00		0.00			100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			100	0.00
SUBTOTALS....				0.00		0.00				0.00
10 TIPTON, MYRA K		Active		SSN : 215-96-3541		IDM : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00		0.00		0.00			60	0.00
PENSION ROLLO		0.00	0.00	0.00		0.00			100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC				0.00		0.00			60	0.00
SUBTOTALS....				0.00		0.00				0.00
11 LAZARUS, ART S.		Vest T. - 1		SSN : 212-84-1763		IDM : SBG-0180	Annual Comp.:			
EMPLOYER DISC		0.00	0.00	0.00		0.00			40	
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT			0.00	0.00		0.00			100	0.00
EMPLOYER MATC			0.00	0.00		0.00			40	
SUBTOTALS....			0.00	0.00		0.00				
12 SMITH CAROLYN C.		Vest T. - 1		SSN : 092-20-0627		IDM : SBG-0180	Annual Comp.:		0.00	
EMPLOYER DISC		0.00	0.00	0.00		0.00			40	
PENSION ROLLO	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
SALARY REDUCT	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100	0.00
EMPLOYER MATC		0.00	0.00	0.00		0.00			40	
SUBTOTALS....		0.00	0.00	0.00		0.00				

REC	COMPANY CODE	COMPANY NAME	PAY DATE	WTR NO	BATCH NO
WDP		SINCLAIR BROADCAST	092493	38	1128

AUTOPAY PAYROLL REGISTER



REC	COMPAN - 0008
WDP	

0510

OMNI 009

PAGE 001

PRE NUMBER	NAME			HOURS				EARNINGS				GROSS PAY	STATUTORY DEDUCTIONS			VOLUNTARY DEDS.		CHECK NO.	NET PAY			
	DEPT NUMBER	CLOCK NO	PERIOD	RATE	REGULAR	OVT	HOURS	CD	REGULAR	OVERTIME	EARNINGS		CD	EARNINGS	CD	FEDERAL TAX	SOC SEC TAX			STATUTORY TAX	AMOUNT	CD
01010	AMY, DAVID B																					380001 .00
01101	EGGER, HELEN RUTH																					380002 .00
01184	HORST, BETH LIANE																					3598239
01270	HEDMILES, MARGARET D																					380003 .00
01272	REYNOLDS, LEILONI M																					380004 .00
01303	SMITH, DAVID D																					380005 .00
01304	SMITH, FREDERICK G.																					380006 .00
01305	SMITH, J DUNCAN																					380007 .00
01309	SMITH, ROBERT E																					380008 .00
01351	TYPTON, MYRA K																					3598240 380009
01275	TROTTER JR., BRUCE A																					380010 .00
01352	ZARUBA, MICHAEL G.																					380011 .00

FJC0010

Federal Communications Commission

Docket No. 93-94 Exhibit No. 40TAB13

Presented by Scupper Howard

Disposition { Identified 9/13/94
Received 9/13/94
Rejected _____

Reporter P. Mc Mulley

Date 9/13/94

REG		COMPANY NAME		PAY DATE	WEEK NO	BATCH NO
WDP	SINCLAIR BROADCAST	123192	52	4424		

AUTOPAY PAYROLL REGISTER



REG	COMPANY CODE
WDP	

0254

OMNI 009

PAGE 001

PRE NUMBER	NAME	HOURS	EARNINGS					GROSS PAY	STATUTORY DEDUCTIONS				VOLUNTARY DEDS.		CHECK NO.	NET PAY		
			REGULAR 1	QTY 2	HOURS 3&4	CD	REGULAR 1		OVERTIME 2	EARNINGS 3&4	CD	EARNINGS 5	CD	FEDERAL TAX			SOC SEC TAN MED TAX 1&2 501	STATUTORY TAX AMOUNT 1
01010	AMY, DAVID B																	
180	1219																	
01101	EGGER, HELEN RUTH																	520001.00
180	1219																	
01270	REDMILES, MARGARET D																	
180	1219																	
01272	REYNOLDS, LEILONI M																	520003.00
180	1219																	
01254	SHAPIRO, DARREN J.																	
180	1219																	
01363	SMITH, DAVID D																	ADJUST. 1423
180	1219																	
01363	SMITH, DAVID D																	ADJUST. 1423
180	1219																	

FJC0011

REG	EMPLOYEE NAME	PAY DATE	WEEK NO	DATE
WDP	SINCLAIR BROADCAST	122081	51	2184

AUTOPAY PAYROLL REGISTER



REG	EMPLOYEE NAME
WDP	

1888

OMNI 000

PAGE 001

EMP NUMBER	EMP NAME	HOURS				EARNINGS				GROSS PAY	STATUTORY DEDUCTIONS				VOLUNTARY DEDS.		CHECK NO.	NET PAY
		REGULAR	OT	VACATION	COMB	REGULAR	OVERTIME	SALARIES	BONUSES		FEDERAL TAX	STATE TAX	STATEMENT TAX	AMOUNT	AMOUNT			
01010	AMY, DAVID B																	
180	1207																	
01101	EGGER, HELEN RUTH																510001	.00
180	1207																	
01167	LAZARUS, ARTHUR S.																510003	.00
180	1207																	
01270	WEDMILES, MARGARET D																510004	.00
180	1207																	
01272	REYNOLDS, LEILONI M																510005	.00
180	1207																	
01284	SHAPIRO, DARREN J.																510006	.00
180	1207																	
01363	SMITH, DAVID D																510007	.00
180	1207																	
01363	SMITH, DAVID D																510008	.00
180	1207																	
01364	SMITH, FREDERICK G.																	
180	1207																	
186																		
180	1207																3015888	510009

FJC0013

REG

REG	COMPANY CODE	COMPANY NAME	PAY DATE	WEEK NO	PERIOD
WDP		SINCLAIR BROADCAST	122091	51	2184

AUTOPAY PAYROLL REGISTER



REG	EMPLOYEE CODE
WDP	

1888

OMNI 008

PAGE 002

EMP NUMBER	DEPT	NAME	HOURS				EARNINGS				GROSS PAY	STATUTORY DEDUCTIONS			VOLUNTARY DEDS.		CHECK NO.	✓			
			REGULAR	OT	HOLIDAY	CB	REGULAR	OVERTIME	SUBSIDY	CB		FEDERAL TAX	SEC DEC TAX	STATE TAX	AMOUNT	CB			AMOUNT	CB	NET PAY
01304	180	SMITH, FREDERICK Q.																		3015869-510010	
01305	180	SMITH, J DUNCAN																		ADJUST. VOID	.00
01308	180	SMITH, J DUNCAN																		510011	.00
01308	180	SMITH, J DUNCAN																		510012	.00
01309	180	SMITH, ROBERT E																		510013	.00
01309	180	SMITH, ROBERT E																		510014	.00
01351	180	TIPTON, MYRA K																		3015870-510015	
TOTAL FOR DEPT.																					PAYS 18
EARNINGS ANALYSIS																					
REDUCTION ANALYSIS																					

FJC0014

REG