Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

							inspection	
Part I		Identification Information						
For caler	ndar plan year 2016 or fi	scal plan year beginning 01/01/2	2016		and ending 12/31/	2016		
A This return/report is for: a multiemployer plan							ons.)	
		x a single-employer plan		a DFE (specify	/)			
B This r	eturn/report is:	the first return/report		the final return	/report			
		an amended return/report	t	a short plan ye	ear return/report (less than	12 months))	
C If the	plan is a collectively-bar	rgained plan, check here					• 🗌	
D Chec	k box if filing under:	X Form 5558		automatic exter	nsion	the	e DFVC program	
		special extension (enter de	scription)					
Part II	Basic Plan Info	rmation—enter all requested in	nformation	1				
1a Nam GREAT	e of plan FLOORS L.L.C. WELF	ARE BENEFIT PLAN				1b	Three-digit plan number (PN) ▶	501
						1c	Effective date of p 01/01/2005	lan
Mail	ng address (include roo	oyer, if for a single-employer plan) m, apt., suite no. and street, or P ce, country, and ZIP or foreign po	.O. Box)	(if foreign, see instr	uctions)	2b	Employer Identific Number (EIN) 82-0524095	ation
GREAT F	LOORS L.L.C.					2c	2c Plan Sponsor's telephone number 208-664-5405	
524 E. SHERMAN AVE. COEUR D ALENE, ID 83814 524 E. SHERMAN AVE. COEUR D ALENE, ID 83814				2d	2d Business code (see instructions) 442210			
Caution	A penalty for the late	or incomplete filing of this retu	ırn/report	will be assessed	unless reasonable cause	is establis	shed.	
		her penalties set forth in the instr well as the electronic version of the						
SIGN HERE	Filed with authorized/va	lid electronic signature.		10/06/2017	JIM MCGEE			
IILKL	Signature of plan adr	ministrator		Date	Enter name of individua	signing as	plan administrator	
SIGN								
HERE	Signature of employe	er/plan sponsor		Date	Enter name of individua	signing as	employer or plan sp	onsor
SIGN								
HERE Signature of DFE Date Enter name of individual signing			signing as	DFE				
Preparer	's name (including firm r	name, if applicable) and address	(include ro	om or suite numbe	r)	Preparer's	telephone number	
					-			

Form 5500 (2016) Page **2**

3a	Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN		
			3c Administrator's telephone number	
4	If the name and/or EIN of the plan sponsor has changed since the last return/r EIN and the plan number from the last return/report:	report filed for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5 251	
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	(welfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		6a(1) 251	
a(2	Total number of active participants at the end of the plan year		6a(2) 271	
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 271	
е	Deceased participants whose beneficiaries are receiving or are entitled to receiving	eive benefits	6e	
f	Total. Add lines 6d and 6e		6f	
g	Number of participants with account balances as of the end of the plan year (o complete this item)		6g	
h	Number of participants that terminated employment during the plan year with a less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only m	nultiemployer 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 4D 4E 4F 4H	es from the List of Plan Characteristics Codes	in the instructions:	
9a	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all tha(1) \overline{\text{N}} Insurance	t apply)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) i	nsurance contracts	
	(3) Trust	(3) Trust		
	(4) General assets of the sponsor	(4) General assets of the sp		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are atta	ached, and, where indicated, enter the numb	er attached. (See instructions)	
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Inform	ation – Small Plan)	
	Purchase Plan Actuarial Information) - signed by the plan	(3) S A (Insurance Inform	mation)	
	actuary 	(4) C (Service Provide		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participating G) (Financial Trans	ng Plan Information) action Schedules)	
		(manoiai mano		

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

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Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2016

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection		
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016		and en	ding 12/3	1/2016	
A Name of plan GREAT FLOORS L.L.C. V	VELFARE BEN	EFIT PLAN			B Three-digit plan number (PN) 501		
C Plan sponsor's name a GREAT FLOORS L.L.C.	s shown on line	e 2a of Form 5500		-	oyer Identific 0524095	ation Number (EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
91-0621480	47791	3831	210		09/01/2016	6	08/31/2017
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
		0					4457
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
THE MURRAY GROUP, IN	C.		AST FRONT ST., STE. 5 R D ALENE, ID 83814	02			
(b) Amount of sales ar	nd base	Fe	es and other commission	•			
commissions pai	d	(c) Amount	(d) Purpose		(e) Organization code		
4457							3
	(a) Name a	nd address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd hase	Fe	es and other commissions paid				
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
For Panerwork Reduction	n Act Notice s	see the Instructions for Form	5500			Schoo	lule A (Form 5500) 2016

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

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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	Part	II Investment and Annuity Contract Information						
		Where individual contracts are provided, the entire group of such individus this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of			
		ent value of plan's interest under this contract in the general account at year		4				
		urrent value of plan's interest under this contract in separate accounts at year end						
6	Cont	ontracts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier		6b				
	C	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with the acquisition or	6d				
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma						
	а	Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee					
		(3) guaranteed investment (4) dother						
	L			71.				
	b	Balance at the end of the previous year		7b				
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
)						
		(6)Total additions		7c(6)	0			
		Total of balance and additions (add lines 7b and 7c(6))		7d				
		Deductions:	7.(4)					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2) 7e(3)					
		(3) Transferred to separate account	7e(4)					
		•	7.5(4)					
		,						
		(5) Total deductions		7e(5)	0			
	f	(5) Total deductions		76(3)				
		(00000000000000000000000000000000000000						

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Pa	art III	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individual.	group of employees of the ng purposes if such cont	racts are	expe	erience-rated as a ur	nit. Where co	ontracts	cover individual
8	Benefit	and contract type (check all applicable boxes)							
	a ∏ :	Health (other than dental or vision)	b X Dental	(С	Vision		d∏ı	Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabili	tv (g _	Supplemental uner	nplovment	h∏ı	Prescription drug
	=	Stop loss (large deductible)	j HMO contract		s _ k ∏		, ,		ndemnity contract
	=	Other (specify)	, 🗆	-	- Ц			- Ш .	
	Ц	Cirici (Specify)							
9 E	Experie	ence-rated contracts:							
		emiums: (1) Amount received		9a(1)			148580)	
) Increase (decrease) in amount due but unpaid		9a(2)			1.0000		
) Increase (decrease) in unearned premium res		9a(3)					
) Earned ((1) + (2) - (3))					9a(4)		148580
		enefit charges (1) Claims paid		9b(1)			109139)	
) Increase (decrease) in claim reserves					145255	- i	
	` ') Incurred claims (add (1) and (2))					1		254394
) Claims charged					9b(4)		
		emainder of premium: (1) Retention charges (o							
		(A) Commissions		9c(1)(A	()		4457	7	
		(B) Administrative service or other fees		9c(1)(E			19315		
		(C) Other specific acquisition costs		9c(1)(C					
		(D) Other expenses		9c(1)(D))				
		(E) Taxes		9c(1)(E	-				
		(F) Charges for risks or other contingencies		9c(1)(F					
		(G) Other retention charges		9c(1)(G					
		(H) Total retention			-		9c(1)(H))	23772
	(2	2) Dividends or retroactive rate refunds. (These	_		_				
					_				
						+			
	`	'						+	
	,	b) Other reserves					` '	+	
40		ividends or retroactive rate refunds due. (Do no	ot include amount entered	a in line 90	C(2).)	9e		
		xperience-rated contracts:					40-		
		otal premiums or subscription charges paid to c					10a	-	
		the carrier, service, or other organization incurr					406		
		etention of the contract or policy, other than report y nature of costs.	orted in Part I, line 2 abov	e, report a	amo	unt	10b		
D-	v4 I\/	Provision of Information							
	art IV	Provision of Information			_				
11		ne insurance company fail to provide any inform		lete Sched	dule	A?	Yes	X No	
12	If the	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

OMB No. 1210-0110

2016

			rm is Open to Public Inspection		
For calendar plan year 20°	16 or fiscal pla	n year beginning 01/01/2016	and er	nding 12/31/2016	
A Name of plan GREAT FLOORS L.L.C. V	VELFARE BEN	NEFIT PLAN		e-digit number (PN)	501
C Plan sponsor's name a GREAT FLOORS L.L.C.	s shown on lin	ne 2a of Form 5500	The state of the s	oyer Identification Number 0524095	(EIN)
		rning Insurance Contract A. Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca KAISER PERMANENTE	rrier				
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of	Policy or c	(g) To
91-1467158	47055	6685800	policy or contract year 342	01/01/2016	12/31/2016
2 Insurance fee and community descending order of the		ation. Enter the total fees and tota	I commissions paid. List in line 3	the agents, brokers, and o	other persons in
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid				
44901 0					
3 Persons receiving com	missions and f	ees. (Complete as many entries a	as needed to report all persons).		
		and address of the agent, broker, o	or other person to whom commiss	ions or fees were paid	
GREG HELBING BENEFIT	S CONSULTIN		. 3725 D ALENE, ID 83816		
(b) Amount of sales ar	nd base	Fees	s and other commissions paid		
commissions pai	d	(c) Amount	(d) Purpos	(e) Organization code	
	44901				3
	(a) Name a	and address of the agent, broker, of	or other person to whom commiss	ions or fees were paid	
(b) Amount of sales ar	nd base	Fees	s and other commissions paid	_	
commissions pai		(c) Amount	(d) Purpos	е	(e) Organization code
For Panerwork Reduction	n Act Notice	see the Instructions for Form 5	500	Sche	dule A (Form 5500) 2016

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

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of			
		ent value of plan's interest under this contract in the general account at year		4				
		ent value of plan's interest under this contract in separate accounts at year e	nd	5				
6	Cont	racts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier		6b				
	C	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with the acquisition or	6d				
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma						
	а	Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee					
		(3) guaranteed investment (4) dother						
	L			71.				
	b	Balance at the end of the previous year		7b				
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
)						
		(6)Total additions		7c(6)	0			
		Total of balance and additions (add lines 7b and 7c(6))		7d				
		Deductions:	7.(4)					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2) 7e(3)					
		(3) Transferred to separate account	7e(4)					
		•	7.5(4)					
		,						
		(5) Total deductions		7e(5)	0			
	f	(5) Total deductions		76(3)				
		(00000000000000000000000000000000000000						

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P	art I	Welfare Benefit Contract Information If more than one contract covers the same group of the information may be combined for reporting pur employees, the entire group of such individual con	poses if such contra	acts are exp	perience-rated as a un	it. Where con	tracts cover individu	
8	Bene	nefit and contract type (check all applicable boxes)						
	a	X Health (other than dental or vision) b	Dental	С	Vision	C	Life insurance	
	еĒ	Temporary disability (accident and sickness) f	Long-term disability	√ a l̄	Supplemental unem	nployment ľ	Prescription dr	ug
	i 📙		HMO contract		PPO contract	. ,	I Indemnity conti	
	_	Other (specify)	i iivi O contiluot	L				uot
	m	Other (specify)						
9	Evne	erience-rated contracts:						
•	•	Premiums: (1) Amount received	Γ	9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium reserve		9a(3)				
		(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)		
	-	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves	<u> </u>					
		(3) Incurred claims (add (1) and (2))	_			9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (on an ac				0.0(1)		
	•	(A) Commissions	· · · · · ·	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes	F	9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amour	nts were paid in	cash, or	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1) Amou	_	_		9d(1)		
		(2) Claim reserves	·			9d(2)		-
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not inclu-				9e		
10		onexperience-rated contracts:		•	, ,	•		
	а	Total premiums or subscription charges paid to carrier				10a		1501841
	b	If the carrier, service, or other organization incurred any	specific costs in co	nnection wi	th the acquisition or			
		retention of the contract or policy, other than reported in				10b		
	Spec	ecify nature of costs.						
P	art l'	IV Provision of Information						
		d the insurance company fail to provide any information n	ecessary to comple	te Schedul	е А?	Yes	No	
				ic ouieuul	o A:	100	1 110	
12	It th	the answer to line 11 is "Yes," specify the information not	provided. 🕨					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2016

	·			ERISA section 103(a)(2)		lion	This Fo	rm is Open to Public Inspection
For calendar	plan year 20	16 or fiscal pla	n year beginning 01/01/2016		and en	nding 12/31	/2016	
A Name of p		WELFARE BEI	NEFIT PLAN		B Thre	e-digit number (PN)	501
C Plan spon GREAT FLOO		as shown on lir	ne 2a of Form 5500		-	oyer Identifica 0524095	tion Number	(EIN)
Part I			rning Insurance Contract A. Individual contracts grouped					
1 Coverage	Information:							
(a) Name of WILLAMETTE								
(b) E	=INI	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			•	contract year
(b) E		code	identification number	policy or contrac		(f)	From .	(g) To
93-1253100		95819	ID351	93		01/01/2016		12/31/2016
		mission inform amount paid.	ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	rokers, and	other persons in
	(a) Total	amount of com	missions paid		(b) To	otal amount o	f fees paid	
	0 0							
3 Persons re	eceiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
		(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees v	vere paid	
(b) Amou	nt of sales a	nd base	Fe	ees and other commission	ns paid			
com	nmissions pa	id	(c) Amount	(d) Purpose		е		(e) Organization code
		(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	sions or fees v	vere paid	
(h) Amou	nt of sales a	nd hase	Fe	ees and other commission	ns paid			
	nmissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

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

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
		where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of			
		ent value of plan's interest under this contract in the general account at year		4				
		ent value of plan's interest under this contract in separate accounts at year e	nd	5				
6	Cont	racts With Allocated Funds:						
	а	State the basis of premium rates •						
	b	Premiums paid to carrier		6b				
	C	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with the acquisition or	6d				
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate						
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma						
	а	Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee					
		(3) guaranteed investment (4) dother						
	L			71.				
	b	Balance at the end of the previous year		7b				
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)					
		(3) Interest credited during the year	7c(3)					
		(4) Transferred from separate account	7c(4)					
		(5) Other (specify below)	7c(5)					
)						
		(6)Total additions		7c(6)	0			
		Total of balance and additions (add lines 7b and 7c(6))		7d				
		Deductions:	7.(4)					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
		(2) Administration charge made by carrier	7e(2) 7e(3)					
		(3) Transferred to separate account	7e(4)					
		•	7.5(4)					
		,						
		(5) Total deductions		7e(5)	0			
	f	(5) Total deductions		76(3)				
		(00000000000000000000000000000000000000						

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P	art II	Welfare Benefit Contract Information	tion						
	ai t ii	If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of the	racts are	expe	erience-rated as a ur	it. Where co	ntracts cove	anizations(s), r individual
8	Benef	fit and contract type (check all applicable boxes)						<u> </u>	
	а П		b X Dental		с	Vision		d ☐ Life in	surance
						1		블	
	е 📙	Temporary disability (accident and sickness)	f Long-term disabili	ty	g	<u> </u>	nployment		ription drug
	ί	Stop loss (large deductible)	j HMO contract		k	PPO contract		I Indem	nity contract
	m	Other (specify)							
		·							
9	Exper	ience-rated contracts:							
	a P	remiums: (1) Amount received		9a(1))		38569		
	(2	2) Increase (decrease) in amount due but unpaid		9a(2))				
	(:	3) Increase (decrease) in unearned premium rese	rve	9a(3))				
	(-	4) Earned ((1) + (2) - (3))					9a(4)		38569
	b i	Benefit charges (1) Claims paid					42041	_	
	,	2) Increase (decrease) in claim reserves							
	(:	3) Incurred claims (add (1) and (2))					9b(3)		42041
	,	4) Claims charged					9b(4)		
	C	Remainder of premium: (1) Retention charges (on	an accrual basis)					_	
		(A) Commissions		9c(1)(/			1157	i	
		(B) Administrative service or other fees		9c(1)(I			4243		
		(C) Other specific acquisition costs		9c(1)(0				_	
		(D) Other expenses		9c(1)(I				_	
		(E) Taxes		9c(1)(I			32		
		(F) Charges for risks or other contingencies		0 (4)(4					
		(G) Other retention charges					9c(1)(H)		5432
	,	(H) Total retention(These of the return do (These of the return do (Thes						<u> </u>	3432
		(2) Dividends or retroactive rate refunds. (These a			_		• •		
		Status of policyholder reserves at end of year: (1)	•				` '		
	,	(2) Claim reserves					9d(2)		
	,	(3) Other reserves					· · · ·		
10		Dividends or retroactive rate refunds due. (Do not	include amount entered	a in line 9	C(2).	.)	9e		
10		experience-rated contracts:	rrior				10a		
	_	Total premiums or subscription charges paid to ca					IVa		
		If the carrier, service, or other organization incurre retention of the contract or policy, other than repor					10b		
		ify nature of costs.	ted iii i ait i, iiile 2 abov	o, report	anio	· · · · · · · · · · · · · · · · · · ·	100		
	•	,							
P	art I\	/ Provision of Information							
11	Did	the insurance company fail to provide any informa	tion necessary to comp	lete Sche	dule	A?	Yes	X No	
		e answer to line 11 is "Yes," specify the information					_		
			p						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

		F				mspection
For calendar plan year 20°	16 or fiscal plan	year beginning 01/01/2016		and er	nding 12/31/2016	
A Name of plan GREAT FLOORS L.L.C. V	VELFARE BEN	EFIT PLAN			e-digit number (PN)	501
C Plan sponsor's name a	s shown on line	2a of Form 5500		D Emplo	oyer Identification Number	(EIN)
GREAT FLOORS L.L.C.				82-	0524095	
		ning Insurance Contract Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance car	rrier					
UNITED HERITAGE LIFE I						
	(c) NAIC	(d) Contract or	(e) Approximate nu	mber of	Policy or c	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		(g) To
82-0123320	63983	GL-3119	153		01/01/2016	12/31/2016
2 Insurance fee and commodescending order of the		tion. Enter the total fees and tot	al commissions paid. Lis	st in line 3	the agents, brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		(b) To	otal amount of fees paid	
		5210				0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all p	persons).		
	(a) Name a	nd address of the agent, broker,	, or other person to whon	n commiss	sions or fees were paid	
GREG HELBING BENEFIT	S CONSULTIN		OX 3725 R D ALENE, ID 83816-25	529		
			,			
(b) Amount of sales ar	nd base	Fee	es and other commission	s paid		
commissions pai		(c) Amount	(d) Purpose			(e) Organization code
	5210					3
					. ,	
	(a) Name a	nd address of the agent, broker,	, or other person to whon	n commiss	sions or fees were paid	
		Fe	es and other commission	s naid		
(b) Amount of sales and base commissions paid		(c) Amount		d) Purpos	e	(e) Organization code
- 1			,			, , 5
For Paperwork Reductio	n Act Notice. s	ee the Instructions for Form	5500.		Sche	dule A (Form 5500) 2016

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

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such individus this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of
		ent value of plan's interest under this contract in the general account at year		4	
		ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Cont	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate			
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee		
		(3) guaranteed investment (4) dother			
	L			71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))		7d	
		Deductions:	7.(4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2) 7e(3)		
		(3) Transferred to separate account	7e(4)		
		•	7.5(4)		
		,			
		(5) Total deductions		7e(5)	0
	f	(5) Total deductions		76(3)	
		(00000000000000000000000000000000000000			

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P	art II	II	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 individ	ing purposes if such con	tracts are expe	erience-rated as a uni	t. Where cor	ntract	ts cover individual
8	Bene	efit ar	nd contract type (check all applicable boxes)						
	а	Не	alth (other than dental or vision)	b Dental	С	Vision		d X	Life insurance
	e X	Te	mporary disability (accident and sickness)	f X Long-term disabil	itv a 🗀	Supplemental unem		_ =	Prescription drug
	i F	J	pp loss (large deductible)	j HMO contract	· <u> </u>	PPO contract	,	느	Indemnity contract
		_) [] Timo contract	ν_	1170 contract		•⊔	macming contract
	m _	Ot	her (specify)						
9	Evno	riona	a rated contractor						
	•		e-rated contracts: ums: (1) Amount received		9a(1)				
			crease (decrease) in amount due but unpaid					┪	
		` '	crease (decrease) in unearned premium res					-	
		` '	arned ((1) + (2) - (3))				9a(4)		
	_	. ,	efit charges (1) Claims paid				<u>, ou(+)</u>		
			crease (decrease) in claim reserves		21 (2)			1	
		` '	curred claims (add (1) and (2))				9b(3)		
			laims charged				9b(4)		-
		` '	ainder 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		9c(1)(E)			_	
		(F) Charges for risks or other contingencies .					_	
		,	G) Other retention charges				- 40.00		
		,	H) Total retention	_	_		9c(1)(H)		_
			Dividends or retroactive rate refunds. (These	_			9c(2)		
	d	Stati	us of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		` '	Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
10			dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2).	.)	9e		
10		•	erience-rated contracts:	orrior.			10a		24725
			I premiums or subscription charges paid to c				IUa		34735
			e carrier, service, or other organization incurnation of the contract or policy, other than rep	, ,		•	10b		
			ature of costs.	orted in rait i, into 2 abo	vo, roport arrio		100	<u> </u>	
	•	,							
_	n w 4 11	· /	Draviaian of Information						
	art I		Provision of Information				., F	7 .	
			nsurance company fail to provide any inform		lete Schedule	A?	Yes	× N	0
12	If th	ie an	swer 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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 201	6 or fiscal plan	year beginning 01/01/2016		and er	nding 12/31/2016	
A Name of plan GREAT FLOORS L.L.C. WELFARE BI				B Three-digit plan number (PN) 501		
C Plan sponsor's name as shown on line 2a of Form 5500 GREAT FLOORS L.L.C. D Employer Identification Number (EIN) 82-0524095						
		ning Insurance Contrac . Individual contracts grouped a				
1 Coverage Information:						
(a) Name of insurance car UNITED HERITAGE LIFE IN						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		Policy or o	ontract year
(b) EIN	code	identification number	policy or contrac		(f) From	(g) To
82-0123320	63983	GV-3119	256	i	01/01/2016	12/31/2016
2 Insurance fee and commodescending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and o	other persons in
(a) Total a	mount of comr	missions paid		(b) To	otal amount of fees paid	
1366 0					0	
3 Persons receiving comm	nissions and fe	ees. (Complete as many entries	as needed to report all	persons).		
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees were paid	
GREG HELBING BENEFITS	S CONSULTIN		OX 3725 R D ALENE, ID 83816-2	529		
			es and other commission	no noid		
(b) Amount of sales and commissions paid		(c) Amount		(d) Purpos	e	(e) Organization code
1366		(o) / uniodin	(d) Purpose		3	
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	sions or fees were paid	
(b) Amount of sales and	d hase	Fe	es and other commission	ns paid		
commissions paid		(c) Amount		(d) Purpos	e	(e) Organization code
For Paperwork Reduction	n Act Notice.	see the Instructions for Form	5500.		Sche	dule A (Form 5500) 2016

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

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

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	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such individus this report.	idual contracts with each carrier may	be treated	d as a unit for purposes of
		ent value of plan's interest under this contract in the general account at year		4	
		ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Cont	racts With Allocated Funds:			
	а	State the basis of premium rates •			
	b	Premiums paid to carrier		6b	
	C	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate			
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma			
	а	Type of contract: (1) \square deposit administration (2) $\underline{\square}$ immedia	ate participation guarantee		
		(3) guaranteed investment (4) dother			
	L			71.	
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
)			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines 7b and 7c(6))		7d	
		Deductions:	7.(4)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	7e(2) 7e(3)		
		(3) Transferred to separate account	7e(4)		
		•	7.5(4)		
		,			
		(5) Total deductions		7e(5)	0
	f	(5) Total deductions		76(3)	
		(00000000000000000000000000000000000000			

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Pa	ırt I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual to the contract covers the same the information may be combined for report employees, the entire group of such individual to the contract covers the covers the contract covers the covers t	group of employees of th	tracts are expe	erience-rated as a uni	t. Where co	ontracts	cover individual
8 E	3ene	efit a	nd contract type (check all applicable boxes)						
;	а	He	alth (other than dental or vision)	b Dental	c 🛚	Vision		d □L	ife insurance
	e 🗆	Te	mporary disability (accident and sickness)	f Long-term disabil	ity \mathbf{g}	Supplemental unem	ployment	h∏F	Prescription drug
i	ιĖ		op loss (large deductible)	j HMO contract	- =	PPO contract		- =	ndemnity contract
	m [_	her (specify)	, I have contract	⊓	11 0 contract		.⊓	identification of the contract
9 E	xne	rienc	ce-rated contracts:						
_	•		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpai						
			ncrease (decrease) in unearned premium res						
			arned ((1) + (2) - (3))				. 9a(4)		
	_	. ,	efit charges (1) Claims paid						
		(2) Ir	ncrease (decrease) in claim reserves						
			ncurred claims (add (1) and (2))				9b(3)		
			laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (on an accrual basis)					
		((A) Commissions		9c(1)(A)				
		((B) Administrative service or other fees		9c(1)(B)				
		((C) Other specific acquisition costs		9c(1)(C)				
		((D) Other expenses		9c(1)(D)				
		((E) Taxes		9c(1)(E)				
		((F) Charges for risks or other contingencies .						
		((G) Other retention charges		9c(1)(G)		1		
		((H) Total retention	<u></u>	·····		9c(1)(H)	
		(2) [Dividends or retroactive rate refunds. (These	e amounts were paid i	n cash, or 📗 c	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
		(2) (Claim reserves				9d(2)		
		` '	Other reserves				9d(3)		
			dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .	.)	9e		
10	Nor	nexp	erience-rated contracts:						
	а	Tota	Il premiums or subscription charges paid to o	carrier			10a		27317
			e carrier, service, or other organization incur						
			ntion of the contract or policy, other than rep ature of costs.	orted in Part I, line 2 abov	ve, report amo	unt	10b		
Pa	rt I	V	Provision of Information						
<u>1</u> 1	Did	the	insurance company fail to provide any inforn	nation necessary to comp	lete Schedule	A?	Yes	X No	
12	If th	ne an	swer to line 11 is "Yes," specify the informat	ion not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

Service Provider Information

File as an attachment to Form 5500.

OMB No. 1210-0110

2016

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation	Inspection.
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016	and ending 12/31/2016
A Name of plan	B Three-digit
GREAT FLOORS L.L.C. WELFARE BENEFIT PLAN	plan number (PN) 501
	prantiamoer (i i i)
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
GREAT FLOORS L.L.C.	82-0524095
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information re	
or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which	
answer line 1 but are not required to include that person when completing the remainder of	
1 Information on Persons Receiving Only Eligible Indirect Compensat	ion
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the	
indirect compensation for which the plan received the required disclosures (see instructions	for definitions and conditions)
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing	
received only eligible indirect compensation. Complete as many entries as needed (see ins	tructions).
(b) Enter name and EIN or address of person who provided you dis	
(b) Enter name and Env or address or person who provided you dis	sclosures on engible matrect compensation
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
41.7—	
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
1-7 provided you die	

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(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on clinible indirect compensation
(6)	Enter hame and Env or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation

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i age o		

answered	"Yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation		
		((a) Enter name and EIN or	address (see instructions)				
DELTA DE	NTAL OF IDAHO			OX 2870 ID 83701				
82-029943	1							
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	Enter direct compensation paid by the plan. If none, enter -0 Did service provider receive indirect compensation, for which the other than plan or plan plan received the required plan indirect compensation. Did indirect compensation include eligible indirect compensation for which the plan received the required provider excluding plan received the required plan indirect compensation include eligible indirect compensation for which the plan received the required provider excluding provider excluding provider excluding plan received the required plan indirect compensation include eligible indirect compensation paid of the plan indirect compensation include eligible indirect compensation paid indirect compensation include eligible indirect compensation paid indirect			Did service provider receive indirect compensation include eligible indirect compensation, for which the plan received the required		(h) Did the service provider give you a formula instead of an amount or estimated amount?
3	ADM. SVC. PROVIDER	19315	Yes No 🗵	Yes No		Yes No		
		(a) Enter name and EIN or	address (see instructions)				
(b) Service	(c)	(d)	(e)	(f)	(g)	(h)		
Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	receive indirect compensation? (sources other than plan or plan sponsor)	sation? (sources compensation, for which the nan plan or plan plan received the required service provider excluding eligible indirect		Did the service provider give you a formula instead of an amount or estimated amount?		
		Yes		Yes No				
		(:	a) Enter name and EIN or	address (see instructions)				
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	receive indirect compensation? (sources other than plan or plan of plan received the required of the plan received by service provider excluding of the plan received the required of the plan received by service provider excluding of the plan received the required of the plan received by service provider excluding the plan received b			(h) Did the service provider give you a formula instead of an amount or estimated amount?		
Yes								

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answered	2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).								
=		((a) Enter name and EIN or	r address (see instructions)					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	relationship to leading to bloyer, employee ganization, or son known to be leading to the plan. If none, on the leading to the plan is on the							
			Yes No	Yes No		Yes No			
			(a) Enter name and EIN or	address (see instructions)					
				(0)					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	ship to Enter direct compensation paid include eligible indirect compensation received by the plan. If none, wn to be enter -0 Did service provider include eligible indirect compensation provider include eligible indirect compensation for which the other than plan or plan plan received the required eligible indirect				(h) Did the service provider give you a formula instead of an amount or estimated amount?			
	Yes								
		((a) Enter name and EIN or	address (see instructions)					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	oloyee compensation paid n, or by the plan. If none, to be enter -0 receive indirect compensation? (sources other than plan or plan		(h) Did the service provider give you a formula instead of an amount or estimated amount?					
			Yes No	Yes No No		Yes No			

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Schedule C (Form 5500) 2016

Part I Service Provider Information (continued) If you reported on line 2 receipt of indirect compensation, other than

If you reported on line 2 receipt of indirect compensation, other than eligible indirect competer provides contract administrator, consulting, custodial, investment advisory, investment magnestions for (a) each source from whom the service provider received \$1,000 or more in information grave you a formula used to determine the indirect compensation instead of an amount and entries as needed to report the required information for each source.	anagement, broker, or recordkeepir	ng services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	,	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibilit the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibilit the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	t compensation, including any e the service provider's eligibilit the indirect compensation.

Part	Service Providers Who Fail or Refuse to Provide Information						
	Provide, to the extent possible, the following information for each his Schedule.	ch service provide	r who failed or refused to provide the information necessary to complete				
(8	Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide				
(8	Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
(a	Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
(8	Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
(8	Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				
(8	Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide				

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Schedule C (Form 5500) 2016

Pa	art III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)					
а	Name:		b EIN:			
С	Position					
d	Address		e Telephone:			
<u> </u>	71001000	•	Telephone.			
	planation:					
LX	piariatiori.					
a	Name:		b EIN:			
С	Position					
d	Address	:	e Telephone:			
Ex	planation:					
a	Name:		b EIN:			
С	Position					
d	Address	:	e Telephone:			
Ex	planation:					
	Nome		b EIN:			
<u>a</u>	Name:		D EIN.			
C	Position		A.T. I.			
d	Address	;	e Telephone:			
Ex	planation:					
а	Name:		b EIN:			
С	Position					
d	Address		e Telephone:			
-						
	nlone#!=:					
ĽΧ	planation:					

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

➤ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210 - 0110 1210 - 0089

2016

This Form is Open to Public Inspection

Part I Annual Report Identification	Information				
For calendar plan year 2016 or fiscal plan year b	eginning 01/01/2	2016 and ending	9 12/31/2016		
A This return/report is for: a multiemploy	1 8V (M 194 ,		lers checking this box must attach a list of mation in accordance with the form instr.)		
X a single-emplo		OFE (specify)	_		
B This return/report is: the first return	Acceptance of the control of the con	e final return/report			
an amended r	10.1-10.00 1.10 1.00 1.00 1.00 1.00 1.00	short plan year return/rep	ort (less than 12 months)		
C If the plan is a collectively-bargained plan, check Check box if filing under: X Form 5558	au	tomatic extension	the DFVC program		
Part II Basic Plan Information - enter	ion (enter description)				
1a Name of plan GREAT FLOORS L.L.C. WELFAR		N	1b Three-digit plan number (PN) ► 501		
			1c Effective date of plan 01/01/2005		
Plan sponsor's name (employer, if for a single-employ Mailing address (include room, apt., suite no. and stre			2b Employer Identification Number (EIN) 82-0524095		
City or town, state or province, country, and ZIP or fo GREAT FLOORS L.L.C.	reign postal code (if foreign, se	ee instructions)	2c Plan Sponsor's telephone number 208-664-5405		
			2d Business code (see instructions) 442210		
COEUR D' ALENE ID Caution: A penalty for the late or incomplete filing Under penalties of perjury and other penalties set forth in the instruction	g of this return/report will	Sec. As an Inches 10 years	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
as the electronic version of this return/report, and to the best of my kn			parlying scriedules, statements and attachments, as wen		
SIGN HERE	10-6-17	JIM MCGEE			
Signature of plan administrator	Date	Enter name of individua	al signing as plan administrator		
SIGN HERE	10-6-17	JIM MCGEE			
Signature of employer/plan sponsor	Date	Enter name of individua	al signing as employer or plan sponsor		
SIGN					
HERE Signature of DFE	Date	Enter name of individua	al signing as DFE		
Preparer's name (including firm name, if applicable)		200 00 00	Preparer's telephone number		
For Paperwork Reduction Act Notice, see the Ins	tructions for Form 5500.		Form 5500 (2016		

v. 160205

	Form 5500 (2016)	Page 2							
3a	Plan administrator's name and address 🛮 Same as Plan Sponsor	3b Administr					rator's EIN		
4	If the name and/or EIN of the plan sponsor has changed since the last re EIN and the plan number from the last return/report:	eturn/report	filed for	this pla	n, ent	er the na	me,	4b EIN 4c PN	
а	Sponsor's name								
5	Total number of participants at the beginning of the plan year						5		251
6	Number of participants as of the end of the plan year unless otherwise s	stated (welfa	re plans	comple	ete on	ly lines			
	6a(1), 6a(2), 6b, 6c, and 6d).						60/1		251
	(1) Total number of active participants at the beginning of the plan year						6a(1) 6a(2)		25 <u>1</u> 271
	(2) Total number of active participants at the end of the plan year						6b	-	<u> </u>
	Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits						6c		\top
	Subtotal. Add lines 6a(2), 6b, and 6c						6d		271
e	Deceased participants whose beneficiaries are receiving or are entitled t	to receive be	nefits				6e		
f	Total. Add lines 6d and 6e						6f		
g	the state of the second belonger as of the and of the plan year (anly defined contribution plans					ans			
·	complete this item)						6g	<u> </u>	_
h	Number of participants that terminated employment during the plan year	ar with accrud	ed bene	efits that	were	less thar	6h		
	100% vested						OII		
7	Enter the total number of employers obligated to contribute to the plan						7		
8a	complete this item)	re codes fro	m the L	ist of Pl	an Ch	aracteris	tics Coc	les in the instructi	ons:
oa	If the plan provides pension benefits, onto the approache pension reals	., • • • • • • • • • • • • • • • • • • •							
b 4A	If the plan provides welfare benefits, enter the applicable welfare feature $4B4D4E4F4H$	e codes from	n the Lis	st of Plar	n Cha	racteristic	cs Code	s in the instruction	ns:
9a	Plan funding arrangement (check all that apply)	9b Plan b		ırrangem	nent (d	check all	that app	oly)	
	(1) X Insurance	(1)		urance					
	(2) Code section 412(e)(3) insurance contracts	(2)	_		on 412	2(e)(3) ins	urance	contracts	
	(3) Trust	(3)	∐ Tru		oto o	f the spoi	noor		
40	(4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules	are attached						ber attached.	
10	(See instructions)	are arraorroo	, and,		aioai	, o, iii			
а	Pension Schedules	b Gene	eral Sch	nedules					
_	(1) R (Retirement Plan Information)	(1)		Н	(Fir	nancial In	formatio	on)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money		Ц	ı	•			on - Small Plan)	
	Purchase Plan Actuarial Information) - signed by the plan	(3)	<u>x</u> _	<u>5</u> A		surance I			
	actuary	` '	X	C	•			formation)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	Н	D	•			Plan Information)	
	Information) - signed by the plan actuary	(6)	Ш	G	(1-11	ianciai II	ansacti	on Schedules)	