Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2017

Administration							
Pensio	n Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	ıblic
Part I	Annual Report Ide	ntification Information					
For caler	ndar plan year 2017 or fiscal	plan year beginning 01/01/2017		and ending 12/31/20)17		
A This r	return/report is for:	a multiemployer plan		loyer plan (Filers checking the modern information in accores.)			ns.)
		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	a short plan ye	ar return/report (less than 12	2 months))	
C If the	plan is a collectively-bargain	ned plan, check here				• []	
D Chec	k box if filing under:	Form 5558	automatic exten	sion	the	e DFVC program	
		special extension (enter description)	1				
Part II	Basic Plan Informa	ation—enter all requested informatio	n				
	ne of plan RLINE SOLUTIONS, LLC. W				1b	Three-digit plan number (PN) ▶	501
OLIVIE	ALINE GOLOTIONO, LEG. W	ZELI / INC BENEI II I E/IN			1c	Effective date of pla 03/12/2012	an
Maili City	ing address (include room, a or town, state or province, co	if for a single-employer plan) pt., suite no. and street, or P.O. Box) ountry, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b Employer Identification Number (EIN) 45-3064505		
CENTER	LINE SOLUTIONS, INC.				2c	Plan Sponsor's tele number 303-993-3293	•
16035 TABLE MOUNTAIN PKWY GOLDEN, CO 80403-1642		16035 TABLE MOUNTAIN PKWY GOLDEN, CO 80403-1642		2d	Business code (see instructions) 541512	•	
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.							
	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.						
SIGN	Filed with authorized/valid e	lectronic signature.	07/06/2018	CATHERINE NICHOLS			
HERE	Signature of plan adminis	strator	Date	Enter name of individual s	igning as	plan administrator	
	-						

Date

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

Signature of employer/plan sponsor

Signature of DFE

SIGN HERE

SIGN HERE

> Form 5500 (2017) v. 170203

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

	Form 5500 (2017)	Pa	ge 2		
3a	Plan administrator's name and address X Same as Plan Sponsor	<u> </u>		3b Administ	rator's EIN
				3c Administ	rator's telephone
				number	rator s telepriorie
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin	ince the last ret	turn/report filed for this plan	4b EIN	
•	enter the plan sponsor's name, EIN, the plan name and the plan number from				
a c	Sponsor's name Plan Name			4d PN	
5 6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated	d (welfare plan	s complete only lines 63(1)	5	403
U	6a(2), 6b, 6c, and 6d).	a (wellate plans	s complete only lines oa(1) ,		
a(1) Total number of active participants at the beginning of the plan year			6a(1)	403
				6a(2)	325
a	2) Total number of active participants at the end of the plan year			0a(2)	
b	Retired or separated participants receiving benefits			. 6b	14
С	Other retired or separated participants entitled to future benefits			. 6c	
d	Subtotal. Add lines 6a(2) , 6b , and 6c			. 6d	339
				_	
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits.		. 6e	
f	Total. Add lines 6d and 6e.			. 6f	339
g	Number of participants with account balances as of the end of the plan year			0.00	
	complete this item)			. 6g	
h	Number of participants who terminated employment during the plan year with less than 100% vested			. 6h	
7	Enter the total number of employers obligated to contribute to the plan (only			7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the L	ist of Plan Characteristics Code	es in the instru	ctions:
b	If the plan provides welfare benefits, enter the applicable welfare feature cod	des from the Lis	st of Plan Characteristics Code	s in the instruc	tions:
	4A 4B 4D 4E 4F 4H 4L 4Q				
9a	Plan funding arrangement (check all that apply)		enefit arrangement (check all the	at apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) (2)	Insurance Code section 412(e)(3)	insurance con	tracts
	(3) Trust	(3)	Trust		
10	(4) General assets of the sponsor	(4)	General assets of the s	•	(See instructions)
	Check all applicable boxes in 10a and 10b to indicate which schedules are a			ber allached. ((See instructions)
а	Pension Schedules (1) R (Retirement Plan Information)	D Genera (1)	al Schedules H (Financial Inform	mation)	
		(2)	I (Financial Inform	,	Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Info	rmation)	
	actuary	(4)	C (Service Provide	er Information)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participat	ing Plan Inform	nation)
	Information) - signed by the plan actuary	(6)	G (Financial Trans	saction Schedu	ules)

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)			
11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)				
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)			
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt 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 pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)			
Rece	ipt Confirmation Code			

Form 5500 (2017)

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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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2017

This Form is Open to Public

					поросион
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017	and .	d ending 12/31/2017	
A Name of plan CENTERLINE SOLUTIONS, LLC. WELFARE BENEFIT PLAN				hree-digit blan number (PN)	501
C Plan sponsor's name a	s shown on line	e 2a of Form 5500	D En	nployer Identification Number	er (EIN)
CENTERLINE SOLUTION	NS, INC.			45-3064505	, ,
			ct Coverage, Fees, and Cas a unit in Parts II and III can be		
1 Coverage Information:					
(a) Name of insurance ca	rrier				
CIGNA HEALTH AND LIFE		COMPANY			
		1	(e) Approximate number of	f Policy o	r contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year		(g) To
59-1031071	67369	00608911		01/01/2017	12/31/2017
2 Insurance fee and come descending order of the		ation. Enter the total fees and to	otal commissions paid. List in lin	e 3 the agents, brokers, and	d other persons in
(a) Total a	amount of comr	missions paid	(b) Total amount of fees paid	
		58686			1991
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all persons	s).	
	(a) Name a	nd address of the agent, broke	r, or other person to whom comm	nissions or fees were paid	
EXCALIBUR FINANCIAL (GROUP		NIGHTS RUN #110 PA, FL 33602		
(b) Amount of sales ar	nd base		ees and other commissions paid		
commissions pai		(c) Amount	(d) Pur	(e) Organization code	
	31185	0			3
	(a) Name a	nd address of the agent, broke	r, or other person to whom comn	nissions or fees were naid	<u> </u>
LOCKTON COMPANIES L			OX 173850	ilosions of fees were paid	
		DENV	/ER, CO 80217		
(h) Amount of colors	nd book	Fe	ees and other commissions paid		
(b) Amount of sales ar commissions pai		(c) Amount	(d) Pur	oose	(e) Organization code
	44822	₂₅₃₂ I	NCENTIVE FEE		3
For Panerwork Reduction	n Act Notice.	see the Instructions for Form	5500.	Scl	hedule A (Form 5500) 2017

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

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts 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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			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 termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for report	group of employees of the ting purposes if such cont	e same empl racts are exp	loyer(s) or members of perience-rated as a un	the same e it. Where co	mployee organizations(s), ontracts cover individual
		employees, the entire group of such individ	dual contracts with each ca	arrier may be	treated as a unit for p	urposes of t	his report.
8	Ben	efit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision)	b X Dental	C	X Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g [Supplemental unem	ployment	h Prescription drug
	i İ	Stop loss (large deductible)	j HMO contract		PPO contract		I X Indemnity contract
	m	Other (specify)	<i>•</i> 🗆	L			<u> </u>
	[
9	Expe	erience-rated contracts:					
•		Premiums: (1) Amount received	l	9a(1)			
		(2) Increase (decrease) in amount due but unpai		9a(2)			
		(3) Increase (decrease) in unearned premium re		9a(3)			
		(4) Earned ((1) + (2) - (3))	•	• • •		9a(4)	
	b	Benefit charges (1) Claims paid	i	9b(1)			
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (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					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				. 9c(1)(H))
		(2) Dividends or retroactive rate refunds. (Thes	e amounts were 🗌 paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits afte	r retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				. 9d(3)	
	е	Dividends or retroactive rate refunds due. (Do r	not include amount entered	d in line 9c(2)) .)	9e	
10	No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to	carrier			. 10a	
	b	If the carrier, service, or other organization incur	, .		•		
	Cna	retention of the contract or policy, other than repair patters of contract	orted in Part I, line 2 abov	e, report am	ount	10b	
	Spe	cify nature of costs.					
P	art	V Provision of Information					
				aka Oalisid I	- 42	Yes	X No
11		I the insurance company fail to provide any inform		ete Schedule	e A?	162	NU INU
12	12 If the answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to EF	RISA section 103(a)(2).			Inspection
For calendar plan year 20	17 or fiscal plan	year beginning 01/01/2017		and ending	12/31/2017	
A Name of plan CENTERLINE SOLUTION	ARE BENEFIT PLAN	В	B Three-digit plan number (PN) 501		501	
C Plan sponsor's name a CENTERLINE SOLUTION		2a of Form 5500	D	Employer Ider 45-3064505	ntification Number (5	EIN)
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca CIGNA HEALTH AND LIFE		COMPANY				
	(c) NAIC	(d) Contract or	(e) Approximate number		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end policy or contract yea		(f) From	(g) To
59-1031071	67369	0608911	235	01/01/	2017	12/31/2017
2 Insurance fee and composite descending order of the		tion. Enter the total fees and total	commissions paid. List in	line 3 the age	nts, brokers, and o	ther persons in
(a) Total a	amount of comn	nissions paid		(b) Total amo	unt of fees paid	
		17320				541
3 Persons receiving com	missions and fe	es. (Complete as many entries a	s needed to report all pers	ons).		
	(a) Name a	nd address of the agent, broker, o	or other person to whom co	mmissions or f	ees were paid	
LOCKTON COMPANIES L	LC	PO BOX DENVER	. 173850 R, CO 80217			
(b) Amount of sales ar	nd base	Fees	and other commissions pa	aid		
commissions pai		(c) Amount		(d) Purpose		(e) Organization code
10516		0				3
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
LOCKTON COMPANIES, I		РО ВОХ	. 173850 R, CO 80217			
(b) Amount of sales and base Fees and other commissions paid						
commissions pai		(c) Amount	(d) F	Purpose		(e) Organization code
	0	541 GA	PMT			3

		• -	
Schedule A (Form 5500) 2017		Page 2 – 1	
(a) Name	and address of the agent broker	, or other person to whom commissions or fees were paid	
EXCALIBUR FINANCIAL GROUP	302 K	NIGHTS RUN #110 A, FL 33602	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
6805	0		3
(a) Name	and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name	and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid		(//	code
(a) Name	and address of the agent, broken	, or other person to whom commissions or fees were paid	
(a) Name	and address of the agent, broker	, or other person to whom commissions or rees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Name	and address of the agent, broker	, or other person to whom commissions or fees were paid	

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts 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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			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 termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

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Р	Part III Welfare Benefit Contract Information						
		If more than one contract covers the same the information may be combined for repo	rting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	ntracts cover individual
		employees, the entire group of such indivi		arrier may be	treated as a unit for p	ourposes of the	nis report.
8	Ben	efit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision)	b X Dental	C	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	ployment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contract	- 5	PPO contract		I Indemnity contract
	m	Other (specify)	, I illie seriada	•• [I M machinity contract
		Cities (specify)					
a	Evn	rience-rated contracts:					
3		Premiums: (1) Amount received	!	9a(1)			_
	u	(2) Increase (decrease) in amount due but unpa		9a(2)			_
		(3) Increase (decrease) in unearned premium re					_
		(4) Earned ((1) + (2) - (3))	•		l	9a(4)	
	b	Benefit charges (1) Claims paid	i				
		(2) Increase (decrease) in claim reserves					_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (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					_
		(E) Taxes					
		(F) Charges for risks or other contingencies					
		(G) Other retention charges		9c(1)(G)		1	
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in	cash, or	credited.)	·· 9c(2)	
	d	Status of policyholder reserves at end of year: (<u>9d(1)</u>	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
4.0	<u>e</u>	Dividends or retroactive rate refunds due. (Do	not include amount entered	d in line 9c(2) .)	9e	
10	_	nexperience-rated contracts:				40-	
	а	Total premiums or subscription charges paid to				<u>10a</u>	
	b	If the carrier, service, or other organization incuretention of the contract or policy, other than rep			•	10b	
	Spe	cify nature of costs.	onted in Part I, line 2 abov	e, report am	ourit	100	
	•	•					
Р	art	V Provision of Information					
11	Dic	the insurance company fail to provide any infor	mation necessary to compl	ete Schedule	e A?	Yes	X No
12		ne answer to line 11 is "Yes," specify the informa					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 20°	17 or fiscal plar	year beginning 01/01/2017		and en	ding 12/31/2017	•		
A Name of plan			E	B Three-digit				
CENTERLINE SOLUTION	NS, LLC. WELF	ARE BENEFIT PLAN		plan	number (PN)	501		
C Plan sponsor's name a	s shown on line	e 2a of Form 5500	[D Emplo	yer Identification Numb	er (EIN)		
CENTERLINE SOLUTION	NS, INC.			45-	3064505			
Part I Informat on a separa	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca	rrier							
PAUL REVERE LIFE INSU	JRANCE COMF	PANY						
	(-) NAIO	(A) Octoberation	(e) Approximate num	nber of	Policy o	contract year		
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at e		(f) From	(g) To		
04-1590994	67598	CENTERLINE	3		01/01/2017	12/31/2017		
2 Insurance fee and communication descending order of the		ntion. Enter the total fees and total	al commissions paid. List	in line 3	the agents, brokers, and	d other persons in		
	amount of comr	nissions paid		(b) To	tal amount of fees paid			
		496				65		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all pe	ersons).				
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees were paid			
LOCTON COMPANIES			UNION AVE #700 ER, CO 80337					
(b) Amount of sales ar	nd base	Fee	es and other commissions	paid				
commissions pai		(c) Amount		(d) Purpose		(e) Organization code		
	195	0				3		
	(a) Name a	nd address of the agent, broker,	or other person to whom	commiss	ions or fees were paid			
PARRISH J PEACHTREE	(2)	136 NC	ORTH UNION STREET					
		WEST	FIELD, IN 46074					
						_		
(b) Amount of sales ar	nd base	Fee	es and other commissions	paid				
commissions pai		(c) Amount	(d)) Purpose	9	(e) Organization code		
	14	0				3		
For Paperwork Reductio	n Act Notice,	see the Instructions for Form 5	5500.		Sc	nedule A (Form 5500) 2017 v. 170203		

Schedule A (Form 5500)	2017	Page 2 –	1	
			<u> </u>	
	ne and address of the agent, broker	•	mmissions or fees were paid	
MICHAEL BLOCK		S PINE CREEK DRIVE PORT, IL 60441		
		(e)		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions	Organization code	
9	0			3
(a) Nar	ne and address of the agent, broker	, or other person to whom co	mmissions or fees were paid	
OPTIO LLC		E ARAPAHOE RD ER, CO 80112		
		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	((d) Purpose	Organization code
21	0			3
(a) Nar	ne and address of the agent, broker	, or other person to whom co	mmissions or fees were paid	
SARA SORENSEN-CONNICK		E ARAPAHOE ER, CO 80112		
(b) Amount of color and boss		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(Organization code	
111	14	BONUS		3
(a) Nar	ne and address of the agent, broker	, or other person to whom co	mmissions or fees were paid	•
MELISSA A KOLL	216 C DILON	LIMAX DR N, CO 80435		
		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	Organization code
5	0			3
(a) Nar	ne and address of the agent, broker	, or other person to whom co	mmissions or fees were paid	
HOWARD HOROWITZ	2610	ALCOTT STREET MEL, IN 46032		
		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	((d) Purpose	Organization code

BONUS

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts 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 cor				
	<u>.</u>	retention of the contract or policy, enter amount			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 termin				
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		7.0	
		(2) Dividends and credits	7c(1)			
			7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 10(3)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))	<u></u>		7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		•				
					_ /=\	
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

F	Part	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individuals.	group of employees of the ting purposes if such cont	racts are exp	erience-rated as a uni	t. Where co	ontracts cover inc	
8	Ben	efit a	nd contract type (check all applicable boxes)			<u>'</u>	<u> </u>	•	
_	а	_	ealth (other than dental or vision)	b Dental	сГ	Vision		d Life insura	ance
	L	=		_ H	_	<u>-</u> -	nlaumant	_ H	
	e	_	mporary disability (accident and sickness)	=	· - <u>-</u>	=	pioyment	h Prescription	•
	1 [_	op loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity	contract
	m	X Ot	her (specify) VOLUNTARY ACCIDENT,C	RITICAL ILLNESS					
_									
9			ce-rated contracts:		2 (1)				
	a		iums: (1) Amount received						
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res				00(4)		
	b	. ,	arned ((1) + (2) - (3))efit charges (1) Claims paid				. 9a(4)		
			ncrease (decrease) in claim reserves						
			ncurred claims (add (1) and (2))				. 9b(3)		
			Claims charged				9b(4)		
	С	` '	nainder of premium: (1) Retention charges (c				.1 0.0(1)		
	_		(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees						
			(C) Other specific acquisition costs		0 (4)(0)				
		((D) Other expenses						
		((E) Taxes						
		((F) Charges for risks or other contingencies.						
		((G) Other retention charges		9c(1)(G)		1		
			(H) Total retention	_			. 9c(1)(H))	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1	•			• •		
		` '	Claim reserves				. 9d(2)		
	_	` '	Other reserves						
11			dends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2)	<u>)</u>	9e		
10	_		erience-rated contracts:	porrior			. 10a		1020
	a		Il premiums or subscription charges paid to o				. 10a		1038
	b Sne	rete	e carrier, service, or other organization incurintion of the contract or policy, other than replature of costs				. 10b		
			ature of costs.						
F	art	IV	Provision of Information						
11	Dic	the	insurance company fail to provide any inform	ation necessary to comp	lete Schedule	e A?	Yes	X No	
12	2 If t	he ar	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

2017

This Form is Open to Public Inspection

For calendar plan year 20°	7 or fiscal plan	year beginning 01/01/2017		and en	ding 12/31/2017			
A Name of plan CENTERLINE SOLUTION	ARE BENEFIT PLAN			e-digit number (PN)	501			
					,			
C Plan sponsor's name as shown on line 2a of Form 5500 CENTERLINE SOLUTIONS, INC. D Employer Identification Number (EIN) 45-3064505								
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.								
1 Coverage Information:								
(a) Name of insurance car COLONIAL ACCIDENT INS		MPANY						
/L\	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or co	ontract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	(g) To		
57-0144607	62049	E4553442	42	!	01/01/2017	12/31/2017		
2 Insurance fee and commodescending order of the		tion. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents, brokers, and o	ther persons in		
(a) Total a	mount of comn	nissions paid		(b) To	otal amount of fees paid			
		5236				2497		
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commiss	ions or fees were paid			
LOCTON COMPANIES LL	C		E UNION AVE #700 ER, CO 80337					
(b) Amount of sales an	d base	Fe	es and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose		(e) Organization code		
	2004	411 B	ONUS			3		
	(a) Name a	nd address of the agent, broker	or other person to whor	n commiss	ions or fees were paid			
PARISH J PEACHEE	(a) Hame an	136 No	ORTH UNION STREET FIELD, IN 46074		o. 1000 11010 paid			
(h) Amazzat at a al-	46	Fe.	es and other commission	ns paid				
(b) Amount of sales an commissions pai		(c) Amount	(d) Purpose		(e) Organization code			
	23	0				3		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule A (Form 5500) 2017 v. 170203								

	,	Page 2 – 1		
		er, or other person to whom commissions or fees were paid		
ICHAEL BLOCK		9 S. PINECREEK DR KPORT, IL 60411		
(b) Amount of sales and base		Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	Organization code	
2	1	BONUS	3	
(a) Name ar	d address of the agent, broke	er, or other person to whom commissions or fees were paid		
PITO LLC		7 E ARAPAHOE RD ENWOOD VILLAGE, CO 80112		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
96	79	BONUS	3	
(a) Name ar	nd address of the agent, broke	er, or other person to whom commissions or fees were paid		
3 SOLUTIONS LLC		N GRANT ST VER, CO 80203		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization	
commissions paid 49	3	(d) Purpose	Organization code	
commissions paid 49	ad address of the agent, broke	(d) Purpose	Organization code	
commissions paid 49 (a) Name ar	ad address of the agent, broke	(d) Purpose BONUS er, or other person to whom commissions or fees were paid MIDDLE DARLEEN	Organization code 3	
commissions paid 49 (a) Name ar	ad address of the agent, broke	(d) Purpose BONUS er, or other person to whom commissions or fees were paid B MIDDLE DARLEEN NDER, TX 78641	Organization code	
(a) Name ar CQUELINE MARIE STUEMKY	ad address of the agent, broke	(d) Purpose BONUS BONUS BET, or other person to whom commissions or fees were paid BET, TX 78641 Fees and other commissions paid (d) Purpose	Organization code 3 (e) Organization	
(a) Name ar CQUELINE MARIE STUEMKY (b) Amount of sales and base commissions paid	d address of the agent, broke 1020 LEAN (c) Amount 0 ad address of the agent, broke	(d) Purpose BONUS BONUS BET, or other person to whom commissions or fees were paid BET, TX 78641 Fees and other commissions paid (d) Purpose	Organization code 3 (e) Organization code	

Fees and other commissions paid

(d) Purpose

(c) Amount

0

(b) Amount of sales and base commissions paid

37

(e) Organization code

Page	2 –	2

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

ABIGAL LEIGH CONNICK

10408 RUTLEDGE ST PARKER, CO 80134

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
391	122	BONUS	3	

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

SHARLA LEARY

18284 TENNYSON LANE PARKER, CO 80134

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
296	124	BONUS	3	

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

MARY CATHERINE WILLIAMS

16319 E TENNESSEE AVE AURORA, CO 80017

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
49	7	BONUS	3	

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

ALL ABOUT YOU WELLNESS LLC

8999 APACHE PLUME DR PARKER, CO 80134

	Fees and other commissions paid		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
10	0		3

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

SARA SORENSEN-CONNICK

8547 E ARAPAHOE GREENWOOD VILLAGE, CO 80112

		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1371	1583	BONUS	3
			<u> </u>

Page 2 –	3	

	-		
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
MELISSA A KOLL		LIMAX DR	
	DILON	N, CO 80435	
	F	Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid			code
657	106	BONUS	3
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
RACHEL S SPORLEDER	18869	E WHITAKER CR	
	CENT	ENIAL, CO 80015	
	F	Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	1 1	(u) i dipose	code
95	0		3
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
HOWARD HOROWITZ		ALCOTT STREET	
	CARM	IEL, IN 46032	
	F	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
143	62	(.)	3
143	02		3
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
			
(b) Amount of sales and base	ļ F	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
())			
(a) Nar	ne and address of the agent, broker,	, or other person to whom commissions or fees were paid	
	,	Face and other commissions not	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
•			

F	Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	ts with each carrier may	be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:				
•	а	State the basis of premium rates				
	_	otato ano suoto di promisimi attori				
	b	Premiums paid to carrier		[6b	
	C	Premiums due but unpaid at the end of the year		ŀ	6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participati	on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(*) 🗋 3***********************************				
	b	Palance at the end of the provious year		i	7b	
	C	Balance at the end of the previous year	7c(1)		7.0	
	•	(2) Dividends and credits	7c(1)			
		• •	7c(2)			
		(3) Interest credited during the year	7c(4)			
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
		•				
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	_
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•	- (- /			
		,				
		(5) Total deductions		Ī	7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

ı	Page	4

F	art	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repoi employees, the entire group of such individ	group of employees of the rting purposes if such cont	racts are ex	perience-rated as a	unit. Where co	entracts cover individual
8	Ben	efit and contract type (check all applicable boxes)				
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	tv a	Supplemental ur	nemployment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	, s k	H	iompioymoni	I Indemnity contract
	m						I I Indominity contract
	m	Other (specify) VOLUNTARY ACCIDENT,	CRITICAL ILLNESS				
a	Evn	erience-rated contracts:					
9		Premiums: (1) Amount received	į	9a(1)			
	а	(2) Increase (decrease) in amount due but unpai					
		(3) Increase (decrease) in unearned premium re					
		(4) Earned ((1) + (2) - (3))	· ·			9a(4)	
	b	Benefit charges (1) Claims paid				34(+)	
	~	(2) Increase (decrease) in claim reserves		a. (a)			
		(3) Incurred claims (add (1) and (2))	· ·			9b(3)	
		(4) Claims charged					
	С	Remainder of premium: (1) Retention charges (
	·	(A) Commissions	•	9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges					
		(H) Total retention			·	9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These			_		
	d	Status of policyholder reserves at end of year: (_		•	· · ·	
	u	(2) Claim reserves	·			` '	
		(3) Other reserves				2 1(2)	
	е	Dividends or retroactive rate refunds due. (Do r					
10		nexperience-rated contracts:	lot inolade amount entered	2 III III IO 30 (2	- / · / · · · · · · · · · · · · · · · · ·		
•	a	Total premiums or subscription charges paid to	carrier			10a	1239
	-	, , ,					1200
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep					
		Drovision of Information					
F	art					п.	П
11	Di	the insurance company fail to provide any inform	nation necessary to compl	ete Schedu	le A?	Yes	X No
12	2 If t	he answer to line 11 is "Yes," specify the informa	tion not provided.				