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

2017

This Form is Open to Public Inspection

Part I Annual Report Id	lentification Information				
For calendar plan year 2017 or fisc	al plan year beginning 01/01/2017	and ending 12/31/2017	•		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking this participating employer information in accorda			ns.)
	x a single-employer plan	a DFE (specify)			
B This return/report is:	the first return/report	the final return/report			
	an amended return/report	a short plan year return/report (less than 12 n	nonths)	
C If the plan is a collectively-barga	ained plan, check here			•	
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program	
	special extension (enter description	n)			
Part II Basic Plan Inform	nation—enter all requested informati	on			
1a Name of plan COMMUNITY YOUTH SERVICES	1b	Three-digit plan number (PN) ▶	501		
			1c	Effective date of pla 01/01/1977	an
2a Plan sponsor's name (employe Mailing address (include room, City or town, state or province,	2b	2b Employer Identification Number (EIN) 91-0859922			
COMMUNITY YOUTH SERVICES			2c	Plan Sponsor's tele number 360-918-7868	phone
711 STATE AVE NE OLYMPIA, WA 98506-3984 711 STATE AVE NE OLYMPIA, WA 98506-3984		2d	Business code (see instructions) 624100	9	

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 HERE	Filed with authorized/valid electronic signature. Signature of plan administrator	07/16/2018 Date	QUONTICA CONLEY Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	07/16/2018	NICOLE BISPING Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017) v. 170203

	Form 5500 (2017)	Pag	e 2		
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Administra	tor's EIN
				3c Administra number	tor's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin	ince the lest retu	un kapat filad for this plan	4b EIN	
-	enter the plan sponsor's name, EIN, the plan name and the plan number from				
а С	Sponsor's name Plan Name			4d PN	
5	Total number of participants at the beginning of the plan year			5	103
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2) , 6b , 6c , and 6d).	d (welfare plans	complete only lines 6a(1),		
а(1) Total number of active participants at the beginning of the plan year			. 6a(1)	103
a(2) Total number of active participants at the end of the plan year			6a(2)	166
b	Retired or separated participants receiving benefits			6b	2
С	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c			6d	168
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits		. 6e	
f	Total. Add lines 6d and 6e.			6f	168
g	Number of participants with account balances as of the end of the plan year 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	
b	If the plan provides pension benefits, enter the applicable pension feature could be plan provides welfare benefits, enter the applicable welfare feature could be a 4B 4D 4E 4Q	des from the List	of Plan Characteristics Code	s in the instructio	
уа	Plan funding arrangement (check all that apply) (1)	9b Plan ben (1)	efit arrangement (check all the	at apply)	
	Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3)	insurance contra	acts
	(3) Trust (4) General assets of the sponsor	(3) (4)	Trust General assets of the s	nonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a				ee instructions)
а	Pension Schedules	b General	Schedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	I (Financial Inform	nation – Small P	an)
	Purchase Plan Actuarial Information) - signed by the plan	(3)	A (Insurance Info	•	
	actuary	(4)	C (Service Provide		
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)	D (DFE/Participat	-	
	information, orginal by the plan actually	(6)	G (Financial Trans	saction Scriedule	3)

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)

Page 3

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

			ERISA section 103(a)(2)		lion	This For	m is Open to Public Inspection
For calendar plan year 20	17 or fiscal pla	n year beginning 01/01/2017		and en	nding 12/31/2	2017	
A Name of plan COMMUNITY YOUTH SERVICES HEALTH & WELFARE PLAN					e-digit n number (PN)	•	501
C Plan sponsor's name as shown on line 2a of Form 5500 COMMUNITY YOUTH SERVICES D Employer Identification Number (E 91-0859922							
		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca STANDARD INSURANCE						D. II	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year
(6) LIN	code	identification number	policy or contract		(f) F	rom	(g) To
93-0242990	69019	753610	123		01/01/2017		12/31/2017
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, bro	okers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
3684 0					0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees w	ere paid	
GHB INC			OX 1608 MPIA, WA 98507				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
	3684	0	N/A				3
	(a) Name	and address of the agent, broke	r, or other person to whor	n commiss	sions or fees w	ere paid	
		<u>.</u>				·	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code

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 fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(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 indivi- 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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P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual						
_		employees, the entire group of such individual contracts	with each carri	er may be	treated as a unit f	for purposes of the	nis report.
8	Bene	nefit and contract type (check all applicable boxes)		_	-		- 🗖
	а	Health (other than dental or vision) b 🗓 Denta	al	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness) f Long-	term disability	g	Supplemental u	nemployment	h Prescription drug
	ιĒ	Stop loss (large deductible) j HMO	contract	k	PPO contract		I Indemnity contract
	m	Other (specify)		_	<u>-</u>		-
	∟						
9	Expe	perience-rated contracts:					
		Premiums: (1) Amount received		9a(1)		73688	
		(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)	73688
	b	Benefit charges (1) Claims paid		9b(1)		55183	
		(2) Increase (decrease) in claim reserves		9b(2)		41	
		(3) Incurred claims (add (1) and (2))				9b(3)	55224
		(4) Claims charged				9b(4)	55224
	С	Remainder of premium: (1) Retention charges (on an accrual					
		(A) Commissions		c(1)(A)		3684	
		(B) Administrative service or other fees		c(1)(B)			_
		(C) Other specific acquisition costs	_	c(1)(C)			_
		(D) Other expenses		c(1)(D)		14149	_
		(E) Taxes	_	c(1)(E)		1474	
		(F) Charges for risks or other contingencies		c(1)(F)		1842	
		(G) Other retention charges		c(1)(G)		0-(4)(1)	
		(H) Total retention		_			21149
		(2) Dividends or retroactive rate refunds. (These amounts we		ш			
	d	Status of policyholder reserves at end of year: (1) Amount hel	•			` ` '	
		(2) Claim reserves					3222
	_	(3) Other reserves					
10		Dividends or retroactive rate refunds due. (Do not include am	nount entered in	line 9c(2)).)	9e	
10		onexperience-rated contracts:				10a	
	_	Total premiums or subscription charges paid to carrier					+
	b	If the carrier, service, or other organization incurred any speci retention of the contract or policy, other than reported in Part					
	Spe	ecify nature of costs.	i, line 2 above,	eport and	Juiit		_
	•	•					
Р	art I	IV Provision of Information					
11		id the insurance company fail to provide any information necess	sary to complete	Schedule	e A?	Yes	X No
		the answer to line 11 is "Yes," specify the information not provide		Jonodale			
. 2		and anomor to line it is ited, specify the information not provid	.ou. ,				

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

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection				
For calendar plan y	ear 2017 or fiscal p	an year beginning 01/01/2017		and e	nding <u>12/31</u>	/2017	
A Name of plan COMMUNITY YOU	JTH SERVICES HE	ALTH & WELFARE PLAN			ee-digit n number (PN) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 COMMUNITY YOUTH SERVICES D Employer Identification Number 91-0859922					tion Number	r (EIN)	
on a	separate Schedule	erning Insurance Contract A. Individual contracts grouped a					
1 Coverage Inform (a) Name of insura STANDARD INSUR	nce carrier						
			(e) Approximate nu	ımher of		Policy or o	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac	t end of	(f)	From	(g) To
93-0242990	69019	753610	139)	01/01/2017		12/31/2017
	nd commission infor	mation. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents, b	rokers, and	other persons in
(a)	Total amount of co	mmissions paid		(b) T	otal amount o	f fees paid	
		1911		` '		·	0
3 Persons receivir	ng commissions and	I fees. (Complete as many entries	as needed to report all	persons).			
	(a) Name	and address of the agent, broker,	or other person to who	m commis	sions or fees v	were paid	
GHB INC			X 1608 PIA, WA 98507				
(b) Amount of s	ales and hase	Fee	es and other commission	ns paid			
commissi		(c) Amount		(d) Purpos	se		(e) Organization code
	1911	0 N	/A				3
	(a) Name	and address of the agent, broker,	or other person to who	m commis	sions or fees v	were paid	
		<u> </u>				•	
(b) Amount of s	ales and hase	Fee	es and other commission	ns paid			
commissi		(c) Amount		(d) Purpos	se		(e) Organization code

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 fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(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 indivi- 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)				
	_			. \Box		
	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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F	art l							
		If more than one contract covers the same the information may be combined for repor employees, the entire group of such individual to the contract of the same that the coverage of the covera	ting purposes if such cont	racts are exp	perience-rated as a u	init. Where co	ontracts cover individual	
8	Bene	efit and contract type (check all applicable boxes)						
	аГ	Health (other than dental or vision)	b Dental	сГ	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabili	ь, а Г	Supplemental une	mnlovment	h Prescription drug	
	: [- 5		imployment		
	'	Stop loss (large deductible)	j HMO contract	r [PPO contract		I Indemnity contract	
	m	Other (specify) ►AD&D						
_								_
9		erience-rated contracts:		2 (1)				
		Premiums: (1) Amount received		9a(1)		12740		
		(2) Increase (decrease) in amount due but unpai				-676		
		(3) Increase (decrease) in unearned premium res (4) Earned ((1) + (2) - (3))			<u> </u>	9a(4)	120	16/
	_	Benefit charges (1) Claims paid				3a(4)		0-
	~	(2) Increase (decrease) in claim reserves		(-)		 521		
		(3) Incurred claims (add (1) and (2))			1			21
		(4) Claims charged				9b(4)	5	2
	С	Remainder of premium: (1) Retention charges (c	on an accrual basis)			,		
		(A) Commissions		9c(1)(A)		1911		
		(B) Administrative service or other fees		9c(1)(B)		C		
		(C) Other specific acquisition costs		9c(1)(C)		()	
		(D) Other expenses				2108	3	
		(E) Taxes				241		
		(F) Charges for risks or other contingencies.				965		
		(G) Other retention charges				6319		4
		(H) Total retention					115	44
		(2) Dividends or retroactive rate refunds. (These	_					
	d	Status of policyholder reserves at end of year: (1	•			` ` `	0.4	(
		(2) Other reserves					24	1
	е	(3) Other reserves Dividends or retroactive rate refunds due. (Do n						
10		nexperience-rated contracts:	ot include amount entered	2 111 11111E 3C(2	<i>j.</i>)	36		Ì
		Total premiums or subscription charges paid to	carrier			10a		_
	b	If the carrier, service, or other organization incur						_
	~	retention of the contract or policy, other than rep			•	10b		
	Spe	cify nature of costs.						
P	art I	V Provision of Information						_
11	Did	I the insurance company fail to provide any inforn	nation necessary to compl	ete Schedule	e A?	Yes	X No	
		ne answer to line 11 is "Yes," specify the informat			_			
		, , ,	•					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 2017 or fiscal plan year beginning 01/01/2017				and en	ding 12/3	1/2017		
A Name of plan COMMUNITY YOUTH SE	ERVICES HEAL	TH & WELFARE PLAN		B Three	e-digit number (PN	N) •	501	
C Plan sponsor's name a COMMUNITY YOUTH SE			yer Identific 0859922	ation Number (EIN)			
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:								
(a) Name of insurance ca NATIONAL GUARDIAN LI		E COMPANY/SUPERIOR VISIO	N PLAN					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
39-0493780	66583	31425	145		01/01/2017	7	12/31/2017	
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	st in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of comr			(b) To	otal amount	of fees paid		
		0					0	
3 Persons receiving com	missions and fe	ees. (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	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	s and other commission	s paid				
commissions pa		(c) Amount	(d) Purpose				(e) Organization code	
	0						3	
	(a) Name a	nd address of the agent, broker,	or other person to whon	n commiss	ions or fees	were paid		
						·		
(b) Amount of sales ar	nd base	Fee	s and other commission	s paid		_		
commissions pa		(c) Amount	((d) Purpose	9		(e) Organization code	
	A 4 NI 41						/= =====	

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 fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(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 indivi- 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)				
	_			. \Box		
	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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P	Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members the information may be combined for reporting purposes if such contracts are experience-rated as a employees, the entire group of such individual contracts with each carrier may be treated as a unit for					erience-rated as a unit	. Where co	ontracts cover individual
8	Bone	ofit o	nd contract type (check all applicable boxes)		iner may be i	ireated as a unit for po	iiposes oi i	шіз тероп.
O	_	_	, , , , , , , , , , , , , , , , , , , ,	. \square	. .	\/:-:		d 🗆 1 % in a company
	a [=	alth (other than dental or vision)	b Dental	_	Vision		d ☐ Life insurance
	е	Те	mporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	oloyment	h Prescription drug
	i	Sto	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Ot	her (specify)					
9	Expe	erienc	ce-rated contracts:					
	а	Prem	iums: (1) Amount received		9a(1)			
		(2) Ir	ncrease (decrease) in amount due but unpai	t				
			ncrease (decrease) in unearned premium res					
	_		arned ((1) + (2) - (3))				9a(4)	
			efit charges (1) Claims paid					
			ncrease (decrease) in claim reserves				01- (0)	
			ncurred claims (add (1) and (2))				9b(3)	
		` '	claims charged(1) Patentian sharges (9b(4)	
	С		nainder of premium: (1) Retention charges (c		9c(1)(A)			
			A) Commissions B) Administrative service or other fees					
			C) Other specific acquisition costs		0 (4)(0)			
			D) Other expenses		0 (4)(5)			
			E) Taxes		9c(1)(E)			
			(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
			(H) Total retention				9c(1)(H)
		(2) [Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Stat	us of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) (Claim reserves				9d(2)	
		(3) (Other reserves				9d(3)	
			dends or retroactive rate refunds due. (Do n	ot include amount entered	I in line 9c(2) .)	. 9e	
10) No	nexp	erience-rated contracts:					
	а	Tota	I premiums or subscription charges paid to o	arrier			10a	987
	b	rete	e carrier, service, or other organization incurnation of the contract or policy, other than reporture of costs				10b	
D	Spe		Provision of Information					
					-1- 0 ! !!		Voc	V No.
11			insurance company fail to provide any inforn		ete Schedule	A?	Yes	X No
12	2 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

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).						Inspection		
For calendar plan year 20	year beginning 01/01/2017	and ending 12/31/2017						
A Name of plan COMMUNITY YOUTH SE	RVICES HEAL	TH & WELFARE PLAN			e-digit number (PI	N) •	501	
					oyer Identific 0859922	ation Number (EIN)	
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca		DF WASHINGTON OPTIONS, IN	С					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			•	ontract year	
(5) 2	code	identification number	policy or contract		(f)	From	(g) To	
91-1467158	47055	6584700	116	5	01/01/201	7	12/31/2017	
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	al commissions paid. Li	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of comr	<u> </u>		(b) To	otal amount	of fees paid	0	
		23771						
3 Persons receiving com		ees. (Complete as many entries						
GHB INC	(a) Name a	nd address of the agent, broker, PO BOX OLYMP	•	n commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose			(e) Organization code	
	23771	0 N/a	A				3	
	(a) Name a	nd address of the agent, broker,	or other person to whor	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code	
Fan Damamuanlı Danlıyatla	n Act Nation	see the Instructions for Form F	F00			Cabaa	Iula A (Farm FEOO) 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 fees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(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 indivi- 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)				
	_			. \Box		
	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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P	art I	III Welfare Benefit Contract Informa	tion					
		If more than one contract covers the same of the information may be combined for reportional employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a uni	t. Where co	ontracts cover individual),
8	Bene	efit and contract type (check all applicable boxes)		-	<u> </u>		·	
	a 🔀	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	늗	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	<u></u>	nlovmont	h Prescription drug	
	e [<u></u>	·	Supplemental unem	pioyinent		
	'	Stop loss (large deductible)	j HMO contract	KX	PPO contract		I Indemnity contract	į
	m	Other (specify)						
		erience-rated contracts:		- (1)				
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	· ·			00(4)		
	_	(4) Earned ((1) + (2) - (3))				9a(4)		
		(2) Increase (decrease) in claim reserves		(-)				
		(3) Incurred claims (add (1) and (2))	· ·			9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (or				0.0(1)		
		(A) Commissions	·	9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•			9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
40		Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2)	.)	. 9e		
10		nexperience-rated contracts:	a wei a w			100		00000
	_	Total premiums or subscription charges paid to ca				10a		82328
	_	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo	, ,		•	. 10b		
	_	• • • • • •	, ,		•	. 10b		_
P	art l	IV Provision of Information						
			otion managements as	oto Cole a delle	. До П	Yes	X No	
		d the insurance company fail to provide any informa		ete Schedule	A?	169	^ INU	
12	If th	he answer to line 11 is "Yes," specify the information	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		- Parsuant to	ETTIOA SCCIIOTI TOS(a)(Z)	·			Inspection
For calendar plan year 20°	17 or fiscal plan	year beginning 01/01/2017		and en	ding 12/31/201	7	
A Name of plan COMMUNITY YOUTH SE	RVICES HEAL	TH & WELFARE PLAN			e-digit number (PN)	•	501
C Plan sponsor's name a COMMUNITY YOUTH SE		e 2a of Form 5500		-	oyer Identification 0859922	Number (EIN)
COMMONTT TOOTTISE	KVICES			31-	0033322		
		ning Insurance Contract. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance car FIRST CHOICE HEALTH E		SISTANCE PROGRAM					
41 EIN	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	1	(g) To
91-1272766			166	;	01/01/2017		12/31/2017
2 Insurance fee and common descending order of the		tion. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, broke	rs, and o	ther persons in
(a) Total a	mount of comn	nissions paid		(b) To	otal amount of fee	s paid	
							0
3 Persons receiving com	missions and fe	es. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	nd address of the agent, broke	r, or other person to whor	n commiss	ions or fees were	paid	
(b) Amount of sales an	id base	Fe	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose	e		(e) Organization code
							3
	(a) Name a	nd address of the agent, broke	r, or other person to whor	m commiss	ions or fees were	paid	
(b) Amount of sales an	nd base	Fe	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(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 indivi- 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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Pa	art I	Welfare Benefit Contract Informat	ion				
		If more than one contract covers the same grund the information may be combined for reporting employees, the entire group of such individual	oup of employees of the g purposes if such contra	acts are exp	erience-rated as a uni	t. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)			·		<u> </u>
	а Г	=	Dental	с	Vision		d Life insurance
	-	」	. 📙	<u> </u>	<u></u>		
	e _		Long-term disability	′ g <u> </u>	Supplemental unem	ployment	h Prescription drug
	i L	Stop loss (large deductible)	HMO contract	k _	PPO contract		I Indemnity contract
	m 🛚	Other (specify) MENTAL HEALTH COUNSEL	ING - MORE THAN REF	ERRALS			
	_	_					
9 E	хре	erience-rated contracts:					
;	a P	Premiums: (1) Amount received		9a(1)			
	((2) Increase (decrease) in amount due but unpaid		9a(2)			
	((3) Increase (decrease) in unearned premium reser	ve	9a(3)			
	((4) Earned ((1) + (2) - (3))	<u>.</u>			. 9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
	((2) Increase (decrease) in claim reserves		9b(2)			
	((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	<u> </u>	9c(1)(C)			
		(D) Other expenses	<u> </u>	9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges				0.747711	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention				. 9c(1)(H)
		(2) Dividends or retroactive rate refunds. (These a	_				
		Status of policyholder reserves at end of year: (1) A	•				
		(2) Claim reserves				. 9d(2)	
		(3) Other reserves				. 9d(3)	
40		Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2)	.)	. 9e	
10		nexperience-rated contracts:				40	
		Total premiums or subscription charges paid to car				. <u>10a</u>	4288
		If the carrier, service, or other organization incurred				10h	
	Snec	retention of the contract or policy, other than report cify nature of costs.	ed in Part I, line 2 above	, report amo	ount	. 10b	
,	Орсс	sity flattice of costs.					
Г.	and P	Dravisian of Information					
	rt l'						П.,
		I the insurance company fail to provide any informat		te Schedule	: A?X	Yes	No
12	If th	he answer to line 11 is "Yes," specify the information	n 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°	17 or fiscal pla	an year beginning 01/01/2017		and en	iding 12/31/201	7	
A Name of plan		y			e-digit		
COMMUNITY YOUTH SE	RVICES HEA	ALTH & WELFARE PLAN			number (PN)	•	501
				piari	Trainion (FTV)	<u> </u>	
C Di		0 (5 5500		D = .	11 (2)		EIL!)
C Plan sponsor's name a COMMUNITY YOUTH SE		ne 2a of Form 5500		-	oyer Identification 0859922	Number (EIN)
COMMONITY TOUTH SE	KVICES			31-	0039922		
		rning Insurance Contra A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance car	rrier						
TELADOC, INC.							
	(-) NIAIO	(4) Ocational an	(e) Approximate no	umber of	Po	olicy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	it end of	(f) From		(g) To
20-1020949			143	3	01/01/2017		12/31/2017
2 Insurance fee and com	nission inform	nation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents, broke	rs, and of	ther persons in
descending order of the			· -				
(a) Total a	mount of con	nmissions paid		(b) To	otal amount of fee	s paid	
3 Persons receiving com	missions and	fees. (Complete as many entri	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were	paid	
(b) Amount of sales an	d boss	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees were	paid	
(b) Amount of sales an	Fees and other commissions paid						
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or fees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(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 indivi- 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						
		If more than one contract covers the same gro the information may be combined for reporting employees, the entire group of such individual	purposes if such contr	acts are ex	perience-rated as a uni	t. Where cor	ntracts cover individual
8	Bene	efit and contract type (check all applicable boxes)			·		•
	а	_	Dental	С	Vision		d Life insurance
	е		Long-term disabilit		□ Supplemental unem	nlovment	h Prescription drug
	: [HMO contract	່ ອຸ k	=	pioyment	
	' <u> </u>	Stop loss (large deductible)	HIMO contract	Λ,	PPO contract		I Indemnity contract
	m	Other (specify) TELEMEDICINE					
0							
9	•	erience-rated contracts: Premiums: (1) Amount received	Г	9a(1)			_
		(2) Increase (decrease) in amount due but unpaid		9a(1) 9a(2)			_
		(3) Increase (decrease) in unearned premium reserv	To the second se	9a(3)			
		(4) Earned ((1) + (2) - (3))	-			. 9a(4)	
	_	Benefit charges (1) Claims paid	F	9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				. 9b(3)	
		(4) Claims charged				. 9b(4)	
	С	Remainder of premium: (1) Retention charges (on a	n accrual basis)		T		
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees	l l	9c(1)(B)			
		(C) Other specific acquisition costs	To the second se	9c(1)(C)			
		(D) Other expenses	 	9c(1)(D) 9c(1)(E)			
		(E) Charges for risks or other contingencies	i i	9c(1)(E)			
		(F) Charges for risks or other contingencies (G) Other retention charges	The state of the s	9c(1)(G)			_
		(H) Total retention	-			9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These an					
	d	Status of policyholder reserves at end of year: (1) A	_	_			
	_	(2) Claim reserves	•			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not in	nclude amount entered	in line 9c(2	2) .)		
10) No	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carr	ier			. 10a	
	b	If the carrier, service, or other organization incurred	any specific costs in co	onnection w	ith the acquisition or		
	Cno	retention of the contract or policy, other than reporte	ed in Part I, line 2 above	e, report am	nount	10b	
	Spe	cify nature of costs.					
P	art I	V Provision of Information					
11	Dic	I the insurance company fail to provide any information	on necessary to comple	ete Schedu	le A?	Yes	No
		he answer to line 11 is "Yes," specify the information				L	
			•				

Form 5500

Department of the Treasury Internal Revenue Service

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 autrice in accordance

OMB Nos. 1210-0110 1210-0089

E	mployee Benefits Security Administration		all entries in accorda uctions to the Form 5			
Pensio	n Benefit Guaranty Corporation				This Form is Open to Pu Inspection	ıblic
Part I		Identification Information				
For caler	ndar plan year 2017 or f	iscal plan year beginning 01/01/2017		and ending 12/31/2	2017	
A This r	eturn/report is for:	a multiemployer plan	_ participating e	employer information in acco	this box must attach a list of ordance with the form instructio	ns.)
		X a single-employer plan	a DFE (specif	• • • • • • • • • • • • • • • • • • • •	•	٠
B This r	eturn/report is:	the first return/report	the final return	•		
		an amended return/report	lud.	ear return/report (less than 1	· _ ·	
C If the	plan is a collectively-ba	rgained plan, check here				
D Chec	k box if filing under:	Form 5558	automatic exte	nsion	the DFVC program	
		special extension (enter descript	ion)		_	
Part II	Basic Plan Info	rmation—enter all requested inform	ation			
	e of plan JNITY YOUTH SERVIC	ES HEALTH & WELFARE PLAN			1b Three-digit plan number (PN) ▶	501
		•			1c Effective date of plants	an
Maili City	ng address (include roo or town, state or provin	oyer, if for a single-employer plan) om, apt., suite no. and street, or P.O. Bo ce, country, and ZIP or foreign postal co		ructions)	2b Employer Identifica Number (EIN) 91-0859922	ation
COMMUI	NITY YOUTH SERVICE	S			2c Plan Sponsor's tele number 360-918-7868	•
	TE AVE NE A, WA 98506-3984		ATE AVE NE PIA, WA 98506-3984		2d Business code (see instructions) 624100	е
Caution	A penalty for the late	or incomplete filing of this return/re	port will be assessed	unless reasonable cause	is established.	
Under pe statemer	enalties of perjury and o nts and attachments, as	ther penalties set forth in the instruction well as the electronic version of this re	ns, I declare that I have turn/report, and to the t	examined this return/report pest of my knowledge and be	, including accompanying sche elief, it is true, correct, and con	dules, nplete.
SIGN HERE	Quant	as Conly	7/14/18	Quontica	Conley	
	Signature of plan ad	ministrator 0	Date	Enter name of individual	signing as plan administrator	
SIGN	ent 6	Bure	7/16/18	Hicole Bio	Spirk	
HERE	Signature of employe	er/plan sponsor	Date		signing as employer or plan sp	onsor
SIGN						
HERE	Signature of DFE		Date	Enter name of individual	signing as DFE	

	Form 5500 (2017)	Pag	je 2		
3a	Plan administrator's name and address X Same as Plan Sponsor			3b Administrat	or's EIN
				3c Administrate	or's telephone
				No. 27 (Springer Company)	ROSE AND LOSS OF THE SECOND
			/ / / / / / / / / / / / / / / / / / /	4b EIN	
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from	nce the last return the last return	urn/report filed for this plan, n/report:		
a c	Sponsor's name Plan Name			4d PN	
	Total number of participants at the beginning of the plan year		-	5	103
$\frac{5}{6}$	Number of participants as of the end of the plan year unless otherwise stated	d (welfare plans	complete only lines 6a(1),		
	6a(2), 6b, 6c, and 6d).				
a	1) Total number of active participants at the beginning of the plan year	***************************************		6a(1)	103
a	2) Total number of active participants at the end of the plan year			6a(2)	145
b	Retired or separated participants receiving benefits			6b	2
·	Other retired or separated participants entitled to future benefits			1	
	Subtotal. Add lines 6a(2), 6b, and 6c				147
d					
е	Deceased participants whose beneficiaries are receiving or are entitled to rec				147
f	Total. Add lines 6d and 6e.			6f	147
g	Number of participants with account balances as of the end of the plan year complete this item)	(only defined co	ontribution plans	6g	
h					
_	less than 100% vested			6h	
$\frac{7}{2}$	If the plan provides pension benefits, enter the applicable pension feature co				one:
	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E 4Q	les from the Lis	t of Plan Characteristics Code	es in the instruction	
9a	(m)	9b Plan ber (1)	nefit arrangement (check all ti X Insurance	hat apply)	
	(1) X Insurance (2) Code section 412(e)(3) Insurance contracts	(2)	Code section 412(e)(3) insurance contra	cts
	(3) Trust	(3)	Trust		
	(4) General assets of the sponsor	(4)	General assets of the		n (notwictions)
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	ittached, and, w	/nere indicated, enter the num	nperallached. (Se	e instructions)
8	Pension Schedules		I Schedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Info	•	nn)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)	<u>'</u>	rmation – Small Pla ormation)	311 <i>)</i>
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) (4)	A (Insurance Info	•	
	, prej	(5)	<u></u>	ating Plan Informati	ion)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(6)		nsaction Schedule	

Form 5500 (2017)	Page 3
Part III Form M-1 Compliance Info	rmation (to be completed by welfare benefit plans)
11a If the plan provides welfare benefits, was the 2520.101-2.)	_
11b is the plan currently in compliance with the	Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
11c Enter the Receipt Confirmation Code for the Receipt Confirmation Code for the most rec Receipt Confirmation Code will subject the it	e 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the ent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	ERISA SOCIION TUS(a)(2)				Inspection
For calendar plan year :	2017 or fiscal pla	an year beginning 01/01/2017		and er	iding 12/31/20	17	
A Name of plan		ALTH & WELFARE PLAN		B Thre	e-digit number (PN)	>	501
	i i						
C Plan sponsor's name COMMUNITY YOUTH		ne 2a of Form 5500			oyer Identification 0859922	Number	(EIN)
Part I Inform	ation Conce	rning Insurance Contract A. Individual contracts grouped a	t Coverage, Fees, is a unit in Parts II and I	and Con	nmissions Proported on a single	ovide info e Schedt	ormation for each contract ule A.
1 Coverage Informatio	n:						
(a) Name of insurance ELADOC, INC.	carrier	·					
	· · · · · · · · · · · · · · · · · · ·		(e) Approximate n	umber of	T F	Policy or o	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f) From		(g) To
0-1020949			143	3	01/01/2017		12/31/2017
2 Insurance fee and co		nation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents, broke	ers, and	other persons in
	al amount of cor			(b) To	otal amount of fee	es paid	
3 Persons receiving or	ommissions and	fees. (Complete as many entries	as needed to report all	persons).			
	(a) Name	and address of the agent, broker,	, or other person to who	m commiss	sions or fees were	e paid	
		·					,
(b) Amount of sales	and hase	Fee	es and other commissio	ns paid			
commissions		(c) Amount	·····	(d) Purpos	e		(e) Organization code
THE STATE OF THE STATE OF THE STATE OF	Sec. sectors re-	and address of the agent, broker	or other person to who	m commiss		e paid	en belleveren bereitstell terringe
	(a) Name	and address of the agont, broker	, or outer percent to tene				•
(b) Amount of sales	and hase	Fe	es and other commissio	ns paid			
commissions		(c) Amount		(d) Purpos	e		(e) Organization code

Schedule A (Form 5500) 2017

_	•	$\overline{}$
Page	Z	 1

(a) Na				
(a) Na	me and address of the agent, broke	er, 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	
Services Services				
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	The state of the s	
	,			
		Fees and other commissions paid		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization	
commissions paid	(d) / miles in	(d) i dipose	code	
Paris 2 1. 22 - D. Chings and D. China		AND SECTION OF THE PROPERTY OF		
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
		Fees and other commissions paid		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid		
	<u> </u>			
(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, broke	er, 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	
		<u> </u>		

P	ad	е	3

	Investment and Appuity Contract Information	- 		
Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier ma	y be treated as a	unit for purposes of
	this report.		1 . 1	,
	rent value of plan's interest under this contract in the general account at year			
	rent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 Cor	ntracts With Allocated Funds:			
а	State the basis of premium rates			
l.	D. A. was well be assured	•	6b	
b	Premiums paid to carrier Premiums due but unpaid at the end of the year		· · · · · · · · · · · · · · · · · · ·	
۲ C	If the carrier, service, or other organization incurred any specific costs in co	nnection with the acquisition or	····	
d	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)			
	(b) Could (obodity)			
£	If contract purchased, in whole or in part, to distribute benefits from a termin	pating plan, check here		
f				
	ntracts With Unallocated Funds (Do not include portions of these contracts ma	ate participation guarantee		
а	- 1 7 1 1 1 1 1 1 1 1 1			
	(3) ☐ guaranteed investment (4) ☐ other ▶	•	-	
	•			
b	Balance at the end of the previous year		7b	ethe sedil Albumbana.
C	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits	- /->		
	(3) Interest credited during the year			
	(4) Transferred from separate account		1, 17, 17, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	
	(5) Other (specify below)			
	•			
			- (2)	
	(6)Total additions		7c(6)	
	Total of balance and additions (add lines 7b and 7c(6))	Prince of community and the reserving	7d	o au na sagapaga zem eu galega
е	Deductions:	ファイイン ファイイン		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	7e(4)	The decision of the control of the c	
	•			
	(5) Total deductions		7e(5)	
	Belance at the end of the current year (subtract line 7e/5) from line 7d)		7f	•

~		/-		~~ -
Schedule	A.	(⊢orm	5500)	2017

12 If the answer to line 11 is "Yes," specify the information not provided. ▶ NO INFORMATION WAS PROVIDED

Page 4

Part III Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repo employees, the entire group of such indivi	group of employees of the	tracts are exp	erience-rated as a unit. `	Where con	ifracts cover individual
8 Benefit and contract type (check all applicable boxes)		\-\-\-\-\-\-\-\-\-\-\-\-\-\-\-\-\-\-\-		
a Health (other than dental or vision)	b Dental	сГ	Vision		d Life insurance
e Temporary disability (accident and sickness)	f T Long-term disabil	ity g	Supplemental unemplo	vment I	h Prescription drug
i Stop loss (large deductible)	j HMO contract	•	PPO contract	,	Indemnity contract
m ☑ Other (specify) ▶TELEMEDICINE	, 🗆]		- I indentity contract
The state (epoolity) is the state of the sta					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)	· · · · · · · · · · · · · · · · · · ·		
(2) Increase (decrease) in amount due but unpa					
(3) Increase (decrease) in unearned premium re	serve	9a(3)			
(4) Earned ((1) + (2) - (3))				9a(4)	
b Benefit charges (1) Claims paid	***************************************	9b(1)			
(2) Increase (decrease) in claim reserves	***************************************	9b(2)			
(3) Incurred claims (add (1) and (2))				9b(3)	
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (•				
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees					
(C) Other specific acquisition costs					
(D) Other expenses					
(E) Taxes					
(F) Charges for risks or other contingencies					
(G) Other retention charges				0 (4)(1)	
(H) Total retention				9c(1)(H)	
(2) Dividends or retroactive rate refunds. (Thes				9c(2)	
d Status of policyholder reserves at end of year: (9d(1)	
(2) Other reserves				9d(2)	
(3) Other reserves				9d(3)	
 e Dividends or retroactive rate refunds due. (Do i 10 Nonexperience-rated contracts; 	iot iriciude amount entere	a in line 9c(2)	l.)	9e	A Maria Maria di Araba Maria
a Total premiums or subscription charges paid to	carrior		<u> </u> -	10a	
			-	TUA	
b If the carrier, service, or other organization incurrent enterior of the contract or policy, other than reg	red any specific costs in conted in Part I. line 2 above	connection with	th the acquisition or	10b	
Specify nature of costs.	ortod iii i dirti, iiilo 2 abo	o, roport and	, di ita	100	l
·					
Part IV Provision of Information					
11 Did the insurance company fail to provide any inform	nation necessary to comp	loto Sobodula	\A2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	es [1 No

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).					This F	This Form is Open to Public Inspection	
For calendar plan year	r 2017 or fiscal pl	an year beginning 01/01/2017		and er	nding 12/31/2017		
A Name of plan		ALTH & WELFARE PLAN		B Thre	e-digit number (PN)	501	
			,				
C Plan sponsor's nar COMMUNITY YOUTH		ine 2a of Form 5500			oyer Identification Numb 0859922	er (EIN)	
Part I Inform	mation Conce eparate Schedule	erning Insurance Contrac A. Individual contracts grouped a	t Coverage, Fees, as a unit in Parts II and I	and Cor Il can be re	nmissions Provide in ported on a single Sche	formation for each contract dule A.	
1 Coverage informati	lon:						
(a) Name of insurance STANDARD INSURAN							
	(c) NAIC	(d) Contract or	(e) Approximate r		Policy of	r contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To	
3-0242990	69019	753610	13	9	01/01/2017	12/31/2017	
2 Insurance fee and descending order o		mation. Enter the total fees and to	otal commissions paid. I	ist in line 3	the agents, brokers, and	d other persons in	
	otal amount of co			(b) To	otal amount of fees paid		
		1911				0	
3 Persons receiving		l fees. (Complete as many entries					
	(a) Name	and address of the agent, broker		m commiss	sions or fees were paid		
GHB INC			OX 1608 1PIA, WA 98507		·		
#1.3 A		Fe	es and other commission	ns paid			
(b) Amount of sale commission		(c) Amount		(d) Purpos	e	(e) Organization code	
	1911	10	N/A			3	
<u>, 1808-7828 700 8 40 18</u>	(a) Name	and address of the agent, broker	r, or other person to who	m commiss	sions or fees were paid	ह जीवन - रहाक्ष्मकुन्याः, चन्द्राम्बद्धार्थन्याः व्रोहरू	
	(a) Itamic	and address of the agent project					
/h\	and been	. Fe	ees and other commission	ns paid			
(b) Amount of sale commission		(c) Amount		(d) Purpos	ө	(e) Organization code	
		1					

Schedule A (Form 5500) 2017 Page 2 – 1				
(a) Nam	e and address of the agent, br	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	
taga and assault of any assaultage	magaaga kaasa da da laga da sa sa sa da ka sa sa sa sa		र कार के प्रोक्षक है। इस कार की उन्हों की	
(a) Nam	e and address of the agent, br	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) Nam	e and address of the agent, br	oker, or other person to whom commissions or fees were paid		
(a) Hain	o arra dadreeo or are agorig or	oner, or early person to whom commissions of foce were paul		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Nam		oker, or other person to whom commissions or fees were paid	्राप्ति । अपन्तिस्थान क्षा कि स्वाह्म विश्वस	
(h) Amount of colon and have		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
ACOUST TO THE STATE OF THE STAT				
(a) Nam	e and address of the agent, br	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	
		I .		

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3000	- 4
- auc	v

D.	Part II Investment and Annuity Contr	act Information				
F	Part II Investment and Annuity Contr Where individual contracts are provided,	the entire group of such indiv	idual contra	cts with each carrier ma	ay be treated a	is a unit for purposes of
	this report.					
4 (Current value of plan's interest under this contract i	the general account at year	end		4	
	Current value of plan's interest under this contract i	n separate accounts at year e	nd		3	
3 (Contracts With Allocated Funds:					
•	a State the basis of premium rates	•				
	and the same of th				6b	
	b Premiums paid to carrier c Premiums due but unpaid at the end of the ye	or				
		urred any specific costs in co	nnection wit	h the acquisition or		
•	d If the carrier, service, or other organization inc retention of the contract or policy, enter amou	nt			6d	
	Specify nature of costs	•				
	. ,					
	e Type of contract: (1) individual policies	(2) group deferre	d annuity			
	(3) \ other (specify)	_				
	(a) T again (aboxis)					
	f If contract purchased, in whole or in part, to d	stribute benefits from a termin	nating plan.	check here		
	f If contract purchased, in whole or in part, to d Contracts With Unallocated Funds (Do not include)					
			ata narficina	tion guarantee		
,	a Type of contract: (1) deposit administ	= .		don gaarantoo		
	(3) 🔲 guaranteed inve	stment (4) 🗍 other 🕨				
					71.	
	b Balance at the end of the previous year				7b	
	c Additions: (1) Contributions deposited during					
	(2) Dividends and credits					
	(3) Interest credited during the year					
	(4) Transferred from separate account					
	(5) Other (specify below)	***************************************	10(0)			
	•					
			a Transpirati		7_(6)	
	(6)Total additions				7c(6) 7d	
	d Total of balance and additions (add lines 7b ar	nd 7c(6))			IU	
	e Deductions:		70/1)			
	(1) Disbursed from fund to pay benefits or pur		7e(1)			
	(2) Administration charge made by carrier		7e(2) 7e(3)			
	(3) Transferred to separate account		7e(3)	** *		
	(4) Other (specify below)		((())			
	>		- 5.7.			
	(5) Total deductions				7e(5)	
	f Balance at the end of the current year (subtra				7f	

Schedule A	(Form	5500)	2017
OUR GUILD TO	(1 01111	JUUU,	14011

Page 4

the ii emp	ore than one contract covers the same	group of employees of the				
	ovees, the entire orotto at such individ	ting purposes if such cont lual contracts with each c	racts are exp	erience-rated as a unit	Where cor	tracts cover individual
	ntract type (check all applicable boxes		arrior may be	deated as a drift for po	ii poses oi ii i	is report.
-	other than dental or vision)	b Dental	сΓ	Vision		d X Life insurance
<u> </u>	ary disability (accident and sickness)	f Long-term disabili	-			브
. 📙		□		Supplemental unemp	oloyment	h Prescription drug
<u>—</u>	s (large deductible)	j HMO contract	k [PPO contract		I Indemnity contract
m 🛛 Other (s	pecify) ▶AD&D					
9 Experience-rate	ed contracts:			18 Mile III	-	Afares is can sustrict express site
	(1) Amount received		9a(1)		12740	
(2) Increas	e (decrease) in amount due but unpai	d			-676	
	e (decrease) in unearned premium re				0,0	
	((1) + (2) - (3))				9a(4)	12064
	argeś (1) Claims paid				0	
(2) Increas	e (decrease) in claim reserves	***************************************	9b(2)	1000	521	
(3) Incurre	d claims (add (1) and (2))				9b(3)	521
(4) Claims	charged				9b(4)	521
C Remainde	r of premium: (1) Retention charges (d	on an accrual basis)				
	mmissions				1911	
	ministrative service or other fees				0	
	ner specific acquisition costs				0	
	ner expenses		9c(1)(D)		2108	
	xes		9c(1)(E)		241	
	arges for risks or other contingencies				965	
	ner retention charges			-··· ,,	6319	
	tal retention				9c(1)(H)	11544
	nds or retroactive rate refunds. (These				9c(2)	
	olicyholder reserves at end of year: (*				9d(1)	0
	eserves				9d(2)	2475
(3) Other r	eserves				9d(3)	0
	or retroactive rate refunds due. (Do ne- e-rated contracts:	ot include amount entered	i in line 9c(2)	.)	9e	0
TO NORGADORICING		arrior		ſ	40-	
•		38111er	* >	***************************************	10a	1
a Total prem	iums or subscription charges paid to					
a Total premb If the carrie	nums or subscription charges paid to er, service, or other organization incur f the contract or policy, other than rep	red any specific costs in c	onnection wit	h the acquisition or	10b	

Pa	rt IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
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

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

Insurance Information

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	ERISA section 103(a)(2)	١.			Inspection	
For calendar plan year 2	017 or fiscal pla	n year beginning 01/01/2017		and en	iding 12/31/20	17		
A Name of plan COMMUNITY YOUTH	SERVICES HEA	LTH & WELFARE PLAN			e-digit number (PN))	501	
Plan sponsor's name	as shown on lir	ne 2a of Form 5500		D Emplo	yer Identification	n Number	(EIN)	
COMMUNITY YOUTH S				91-	0859922			
Part I Information a separation	ation Conce arate Schedule /	rning Insurance Contrac A. Individual contracts grouped a	t Coverage, Fees, is a unit in Parts II and II	and Con Il can be re	nmissions Pr ported on a singl	ovide info le Schedu	rmation for each contract le A.	
Coverage Information	1;							
a) Name of insurance of ATIONAL GUARDIAN I		CE COMPANY/SUPERIOR VISIO	ON PLAN					
		40.0	(e) Approximate n	umber of	F	Policy or o	contract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	it end of	(f) From	m	(g) To	
9-0493780	66583	31425	145	5	01/01/2017		12/31/2017	
Insurance fee and co- descending order of the		nation. Enter the total fees and to	tal commissions paid. L	lst in line 3	the agents, brok	ers, and	other persons in	
	I amount of com	nmissions paid		(b) To	otal amount of fe	es paid		
		0					0	
Persons receiving co	mmissions and	fees. (Complete as many entries	as needed to report all	persons).			.w.=	
		and address of the agent, broker			ions or fees wer	e paid		
				1000				
(b) Amount of sales	and base	Fe	es and other commissio	ns paid			_	
commissions	paid	(c) Amount		(d) Purpos	е		(e) Organization code	
	0						3	
\$1. Company of \$2. On \$1. Other Decomposition of the Company of th	(a) Name	and address of the agent, broker	or other person to who	m commiss	sions or fees wer	e paid	troping on the segment of the second	
	(a) Hamo	<u> </u>	1					
(b) Amount of sales	and hase	Fe	es and other commissio	ns paid				
commissions		(c) Amount		(d) Purpos	e		(e) Organization code	

Schedule A (Form 5500)) 2017	Page 2 – 1	
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
engle-1 Allendare Wall I and The Charles			
(a) Na	me and address of the agent, bro	oker, 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) Na	me and address of the agent, by	oker, or other person to whom commissions or fees were paid	The state of the s
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	ne and address of the agent, bro	oker, or other person to whom commissions or fees were paid	
			. "
(b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organization code
edd De umanes White Astronoc (Same Serv			
		oker, or other person to whom commissions or fees were paid	A STATE OF THE STA
(b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organization code

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_	ac	0	- 1
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Pa	irt II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	ridual contracts with each carrier may	he freated as a unit	for purposes of
	where individual contracts are provided, the entire group of such individual this report.	iddal comilacts with each carrier may		, parposos or
4 C	urrent value of plan's interest under this contract in the general account at year	end	4	
	urrent value of plan's interest under this contract in separate accounts at year e		5	
	ontracts With Allocated Funds:			
2				
•			•	
ł	Premiums paid to carrier		6b	
Ò			6c	
ì		nnection with the acquisition or	6d	
Ì	retention of the contract or policy, enter amount		ou	
	Specify nature of costs			
•	e Type of contract: (1) ☐ individual policies (2) ☐ group deferre	d annuity		
	(3) other (specify)			
	(a) The enter (abacuta)			
		nating plan, shock hara		
	f If contract purchased, in whole or in part, to distribute benefits from a terminal			
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma			
á	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
	_			
ı	Balance at the end of the previous year		7b	
	Additions: (1) Contributions deposited during the year	- (4)		
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account			
	(5) Other (specify below)			
	(0) 0 (10) (0) 0 (10)			
			. 7c(6)	
	(6)Total additions		7d	
	d Total of balance and additions (add lines 7b and 7c(6)).	The work of the street and the salidation	er visa dagan arasasi kada	
	e Deductions:	7-(4)		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	7e(4)		
-	→			
	(5) Total deductions	produced to the second of the	7e(5)	
	(5) Total deductions		7f	

Page	4

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such comployees, the entire group of such individual contracts with each	ontracts are experient	ce-rated as a unit. Where co	ntracts cover individual
8 Benefit and contract type (check all applicable boxes)			
a Health (other than dental or vision) b Dental	c X Visi	ion	d Life insurance
e Temporary disability (accident and sickness) f Long-term disab	=		. 🗄
	- <u>-</u> <u>-</u> -	• • • • • • • • • • • • • • • • • • • •	h ☐ Prescription drug
	K 🗆 bbi	O contract	I Indemnity contract
m			
9 Experience-rated contracts:		····	TRANSPORT
•	0-(4)		
Premiums: (1) Amount received			
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))		00/4)	
b Benefit charges (1) Claims paid			TANASSE A DESCRIPTION AND AND AND AND AND AND AND AND AND AN
(2) Increase (decrease) in claim reserves		<u>. </u>	
(3) Incurred claims (add (1) and (2))		9b(3)	FACTOR AND THE PROPERTY AND
(4) Claims charged			7111
C Remainder of premium: (1) Retention charges (on an accrual basis)		JD(4)	
(A) Commissions	9c(1)(A)	···········	
(B) Administrative service or other fees			
(C) Other specific acquisition costs		· · · · · · · · · · · · · · · · · · ·	
(D) Other expenses			
(E) Taxes			
(F) Charges for risks or other contingencies	*****		
(G) Other retention charges			
(H) Total retention		9c(1)(H)	The state of the s
(2) Dividends or retroactive rate refunds. (These amounts were paid			
d Status of policyholder reserves at end of year: (1) Amount held to provid		\-/-	
(2) Claim reserves			
(3) Other reserves			
e Dividends or retroactive rate refunds due. (Do not include amount enter			
10 Nonexperience-rated contracts:		·	
a Total premiums or subscription charges paid to carrier		10a	9877
b If the carrier, service, or other organization incurred any specific costs in retention of the contract or policy, other than reported in Part I, line 2 abo Specify nature of costs.	n connection with the ove, report amount	acquisition or 10b	
Part IV Provision of Information			
		П. г	
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A?	Yes	X No
12 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor Benefits Security Administration

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

2017

Pension Benefit Guaranty Co.	rporation		ERISA section 103(a)(2).			orm is Open to Public Inspection	
For calendar plan year 201	17 or fiscal plai	n year beginning 01/01/2017		and en	ding 12/31	1/2017	
A Name of plan COMMUNITY YOUTH SERVICES HEALTH & WELFARE PLAN				e-digit number (PN) •	501	
C Plan sponsor's name a		e 2a of Form 5500		-	oyer Identifica 0859922	ation Number	MERIKATA PARENTAN PA Parentan Parentan Pa
Part I Informat	t ion Conce r ate Schedule A	rning Insurance Contract . Individual contracts grouped a	t Coverage, Fees, a s a unit in Parts II and III	and Con can be re	nmissions ported on a s	Provide infe ingle Sched	ormation for each contrac ule A.
1 Coverage Information:							
(a) Name of insurance ca STANDARD INSURANCE			(a) Approximate nu	ımber of		Policy or	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	(e) Approximate number of persons covered at end of policy or contract year		From	(g) To
93-0242990	69019	753610	123		01/01/2017	·	12/31/2017
2 Insurance fee and com- descending order of the		ation. Enter the total fees and tot	al commissions paid. Li				other persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount o	of fees paid	
	•	3684					0
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
		and address of the agent, broker			ions or fees	were paid	
GHB INC		PO BC	OX 1608 PIA, WA 98507				
		Fe	es and other commission	ns paid			
(b) Amount of sales at commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
commissions pa	3684		I/A ·				3
	(a) Name	and address of the agent, broker	, or other person to who	n commiss		were paid	
	Tay Hairio		• • • • • • • • • • • • • • • • • • • •	. **	- 140-		
					,		
		Fe	es and other commission	ns paid	~~	· ··	
(b) Amount of sales at commissions pa		(c) Amount		(d) Purpos	8		(e) Organization cod

Schedule A (Form 5500) 20	17	Page 2 – 1	
(a) Name	and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
		·	
(b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organizatio code

(a) Name	and address of the agent, br	roker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organizatio
commissions paid	(c) Amount	(d) Purpose	code
	•		
(a) Name	and address of the agent hi	oker, or other person to whom commissions or fees were pai	
(a) (value o	and address of the agent, bi	oker, or other person to whom commissions or fees were par	ld
	•		
		Fees and other commissions paid	(a)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organizatio
	(c) Amount		(e) Organizatio code
commissions paid		(d) Purpose	Organizatio code
commissions paid			Organizatio code
commissions paid		(d) Purpose	Organizatio code
commissions paid		(d) Purpose	Organizatio code
commissions paid (a) Name a	and address of the agent, br	(d) Purpose oker, or other person to whom commissions or fees were pai	Organizatio code
commissions paid		(d) Purpose Oker, or other person to whom commissions or fees were pai	Organizatio code
commissions paid (a) Name a	and address of the agent, br	(d) Purpose oker, or other person to whom commissions or fees were pai	d (e) Organizatio

Fees and other commissions paid

(d) Purpose

(c) Amount

(b) Amount of sales and base commissions paid

(e) Organization code

⊇age	3

	art	Investment and Annuity Contract Information				
	aıı	Where individual contracts are provided, the entire group of such indivi	dual contra	acts with each carrier m	ay be treated	d as a unit for purposes of
	14:32	this report.			4	
4	Curre	ent value of plan's interest under this contract in the general account at year	ena		5	
		ent value of plan's interest under this contract in separate accounts at year er	IG	***************************************		
6		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	•••••		6с	
	d	If the carrier, service, or other organization incurred any specific costs in cor	nection w	th the acquisition or	6d	
		retention of the contract or policy, enter amount				
		Specify_nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	annuity			
		(3) other (specify)				
		· ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan,	check here		
7		racts With Unallocated Funds (Do not include portions of these contracts ma				
•	а	Type of contract: (1) deposit administration (2) immedia	te participa	ation guarantee		
	•	(3) guaranteed investment (4) other				
		(3) Guaranteed investment (3) Guaranteed investment				
	L	Balance at the end of the previous year			7b	
	<u>b</u>	Additions: (1) Contributions deposited during the year	7c(1)			
	С	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	7c(5)			
)				
		•				
		(6)Total additions	<u> </u>		7c(6)	
	А	Total of balance and additions (add lines 7b and 7c(6)).		******	7d	
		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)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		***************************************	7f	

Schedule A	(Earm	EEOO\	2017
Scriedule A	ı rorm	נטטככ	2017

Page 4

Part III Welfare Benefit Contract Information				
If more than one contract covers the same group of the information may be combined for reporting pure employees, the entire group of such individual con	poses if such contr	acts are expe	erience-rated as a unit. Where co	ntracts cover individual
Benefit and contract type (check all applicable boxes)		- Inor may bo	area as a unit for purposes of a	по торогс.
	Dental	٦٦	\	ما □
		c∐	Vision	d Life insurance
e 🔲 Temporary disability (accident and sickness) 🏻 f 📋	Long-term disability	y a∏	Supplemental unemployment	h Prescription drug
i Stop loss (large deductible)	HMO contract	k []	PPO contract	I Indemnity contract
m Other (specify) ▶				_
9 Experience-rated contracts:				
a Premiums: (1) Amount received	[9a(1)	73688	
(2) Increase (decrease) in amount due but unpaid		9a(2)		
(3) Increase (decrease) in unearned premium reserve		9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	73688
b Benefit charges (1) Claims paid		9b(1)	55183	
(2) Increase (decrease) in claim reserves		9b(2)	41	
(3) Incurred claims (add (1) and (2))			9b(3)	55224
(4) Claims charged	***************************************		9b(4)	55224
C Remainder of premium: (1) Retention charges (on an ac	, _			新 斯斯斯斯 电影 化二二二甲
(A) Commissions		9c(1)(A)	3684	
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs	-	9c(1)(C)		□활 화활 화 한 및 분명보기에 됐
(D) Other expenses		9c(1)(D)	14149	그라 얼마했다. 취라로운 보이다
(E) Taxes		9c(1)(E)	1474	
(F) Charges for risks or other contingencies			1842	
(G) Other retention charges	_		0	
(H) Total retention	F			21149
(2) Dividends or retroactive rate refunds. (These amoun	nts were 📗 paid in	cash, or 📗 c	redited.) 9c(2)	
d Status of policyholder reserves at end of year: (1) Amou	int held to provide b	enefits after	retirement 9d(1)	
(2) Claim reserves			1	3222
(3) Other reserves				
e Dividends or retroactive rate refunds due. (Do not include	de amount entered	in line 9c(2).)9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier		•••••	10a	
b If the carrier, service, or other organization incurred any retention of the contract or policy, other than reported in Specify nature of costs.	specific costs in co Part I, line 2 above	onnection with a, report amo	n the acquisition or unt10b	
Part IV Provision of Information				
11 Did the insurance company fail to provide any information ne		te Schedule	A? Yes	X No
12 If the answer to line 11 is "Yes," specify the information not p	provided. 🕨			···-

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2017

This Form is Open to Public

		pursuant to E	RISA section 103(a)(2)		111131	Inspection
or calendar plan year	2017 or fiscal pla	an year beginning 01/01/2017		and en	ding 12/31/2017	
Name of plan COMMUNITY YOUTH	I SERVICES HEA	ALTH & WELFARE PLAN		B Three	e-digit number (PN)	501
_			•			
Plan sponsor's nam COMMUNITY YOUTH		ne 2a of Form 5500			yer Identification Numbe 0859922	er (EIN)
on a se	parate Schedule	rning Insurance Contract A. Individual contracts grouped as	Coverage, Fees, s a unit in Parts II and II	and Con I can be re	nmissions Provide in ported on a single Sched	formation for each contract dule A.
Coverage Information	on:					
a) Name of insurance AISER FOUNDATION		OF WASHINGTON OPTIONS, IN	С			,
	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		(g) To
1-1467158	47055	6584700	116	,	01/01/2017	12/31/2017
2 Insurance fee and of descending order of		nation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents, brokers, and	other persons in
	tal amount of con	nmissions paid		(b) To	otal amount of fees paid	0
		23771				
Persons receiving of	commissions and	fees. (Complete as many entries	as needed to report all	persons).	lana aufana wann noid	
SHB INC	(a) Name	and address of the agent, broker,		n commiss	ions or lees were paid	
31 IP3 (F4C)		OLYMP	PÍA, WA 98507			
		Fee	es and other commission	ns paid		
(b) Amount of sale commissions		(c) Amount		(d) Purpos	θ	(e) Organization code
	23771	0 N/	'A			3
			·			
The Assert Congress of the State of Congress	Angra, Shirt Walter	and address of the agent, broker,	or other person to who	m commiss	ions or fees were paid	<u> 18-198 (1851) - 18-18-18-18 (1861)</u>
	(a) Name	and address of the agent, broker,	of other percent to inves			
		Fee	es and other commission	ns paid		
(b) Amount of sale commissions		(c) Amount		(d) Purpos	e	(e) Organization code

Schedule A	(Form	5500\	204	7
ochedule A	i Form	DOUG	201	1

Page **2** – 1

(a) Name a	and address of the agent, brok	er, or other person to whom commissions or fees were paid	
	****	444	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(2) Norman			
(a) Name 8	ind address of the agent, brok	er, 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 of	and address of the areat hash	er, or other person to whom commissions or fees were paid	
· (a) Name a	ind address of the agent, brok	er, or other person to whom commissions or lees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			Code
Control of the contro			9. 36 E. 36 L. VR. 92 . 3. L. C
(a) Name a	ind address of the agent, broke	er, 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	(e) Organization code
			COUR
x 236, 625, 52, 53, 53, 53, 53, 53, 53, 53, 53, 53, 53	te Congress de Primero de Contra de	Service Condition of the Condition of th	programme to the control of the cont
(a) Name a	nd address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	. (0)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization
commissions paid	/-/ ,	(a) Lui puse	code
		, i	
		<u>†</u>	l

ac	ıe	3

F	art	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier may	be treated	d 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	
<u>-</u> -	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
		tracts With Allocated Funds:				
	а	State the basis of premium rates				
				I		
	b	Premiums paid to carrier	••••••		6b	
	C	Premiums due but unpaid at the end of the year			<u>6c</u>	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection wi	th the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan,	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participa	ition guarantee		•
		(3) guaranteed investment (4) other	•			
		(o) [] gadaantood invocations (*)				
					7b	
	b	Balance at the end of the previous year			7.0	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7-(0)			
		(3) Interest credited during the year				
		(4) Transferred from separate account			-	
		(5) Other (specify below)				
					7~(G)	
		(6)Total additions			7c(6) 7d	
		Total of balance and additions (add lines 7b and 7c(6))		Township on a direct by the Army	ı ru	
	е	Deductions:	70/43			
		(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(3)	- 44.		
		(4) Other (specify below)				
		•				
		(5) Total deductions		.,,	7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A	(Form	55001	2017
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Page 4

Part						
	If more than one contract covers the same of the information may be combined for reporting	group of employees of th	e same emplo tracts are expe	yer(s) or members of t erience-rated as a unit.	he same e Where co	mployee organizations(s), intracts cover individual
h G 18	employees, the entire group of such individu	ual contracts with each c	arrier may be	treated as a unit for pu	rposes of t	his report.
8 Ben	efit and contract type (check all applicable boxes)					
a Þ	Health (other than dental or vision)	b Dental	с∏	Vision		d Life insurance
еĪ	Temporary disability (accident and sickness)	f Long-term disabili	느		lovment	h Prescription drug
, [Stop loss (large deductible)	j HMO contract			ioyinani,	
' L] [] Filvio contract	K 🔼	PPO contract		I Indemnity contract
m	Other (specify)					
		* 474				1
	erience-rated contracts;					
	Premiums: (1) Amount received					
	(2) Increase (decrease) in amount due but unpaid		\vdash			
	(3) Increase (decrease) in unearned premium reso				0-(4)	
	(4) Earned ((1) + (2) - (3))				9a(4)	e de les de décidentes en comparte en
	Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves				01- (0)	
	(4) Claims charged				9b(3)	
	Remainder of premium: (1) Retention charges (or		******************	••••••••	9b(4)	#50 x 12
·	(A) Commissions	,	9c(1)(A)			
	(B) Administrative service or other fees				·····	
	(C) Other specific acquisition costs					→[2] 12. 하는 말로 받는 시간일 위
	(D) Other expenses					
	(E) Taxes					
	(F) Charges for risks or other contingencies					
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention				9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These				9c(2)	
d	Status of policyholder reserves at end of year: (1)	_		La company of the com	9d(1)	
	(2) Claim reserves	·		ŀ	9d(2)	
	(3) Other reserves				9d(3)	
е	Dividends or retroactive rate refunds due. (Do no				9e	
	nexperience-rated contracts;			,		
а	Total premiums or subscription charges paid to ca	arrier	•••••		10a	582328
b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repocify nature of costs.	ed any specific costs in c	connection with	n the acquisition or	10b	
Part I	V Provision of Information					
11 Did	the insurance company fail to provide any informa	ation necessary to compl	ete Schedule	A?	Yes	X No
	ne answer to line 11 is "Yes," specify the Information		- DE COMBUNIO			

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

		pursuant to F	ERISA section 103(a)(2)		i		Inspection	
For calendar plan year 2017 o	r fiscal pla	an year beginning 01/01/2017		and en	ding 12/31/20	17		
A Name of plan COMMUNITY YOUTH SERV				B Thre	e-digit number (PN)	>	501	
	_							
C Plan sponsor's name as sl COMMUNITY YOUTH SERV		ne 2a of Form 5500			yer Identification 0859922	Number	(EIN)	
COMMUNITY YOUTH SERV	ICES							
Part I Information on a separate	n Conce Schedule	rning Insurance Contract A. Individual contracts grouped a	t Coverage, Fees, is a unit in Parts II and II	and Con I can be re	nmissions Proported on a singl	ovide info le Schedi	ormation for each contract ule A.	
1 Coverage Information:								
(a) Name of insurance carried		SSISTANCE PROGRAM						
-IRST CHOICE HEALTH EWI	-LOIEL M		(e) Approximate nu	ımher of	l F	Policy or	contract year	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f) Froi		(g) To	
91-1272766			166	3	01/01/2017		12/31/2017	
Insurance fee and commis descending order of the am		nation. Enter the total fees and to	tal commissions paid. 1.	ist in line 3	the agents, brok	ers, and	other persons in	
		nmissions paid		(b) To	otal amount of fe	es paid_		
		4288					0	
		fees. (Complete as many entries						
GHB INC	(a) Name	and address of the agent, broker	, or other person to who OX 1608	m commiss	sions or rees were	a paid		
GI ID II TO		OLYM	PIA, WA 98507					
•								
(b) Amount of sales and b	222	Fe	es and other commission	ns paid				
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code	
	4288	0					3	
		of the manhabara of a control o	of the state of th	alu va u njugerigad	en er vila vila er			
	(a) Name	and address of the agent, broker	, or other person to who	m commiss	sions or fees were	e paid		
(h) Amount of calca and h	2000		es and other commissio	ns paid				
(b) Amount of sales and b commissions paid	Jase	(c) Amount		(d) Purpose			(e) Organization code	

Schedule A (Form 5500) 2017	Page 2 — 1	
(a) Na	ime and address of the agent in	proker, or other person to whom commissions or fees were paid	
	ine and address of the agent, i	noker, or other person to whom commissions or lees were paid	
		Fees and other commissions paid	(2)
(b) Amount of sales and base	(c) Amount	-	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
		S. CARINARIA	
	me and address of the agent, b	proker, or other person to whom commissions or fees were paid	THE REPORT OF THE PARTY OF THE
	T		
(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, b	proker, or other person to whom commissions or fees were paid	normal of the second of the se
(b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organization code
			1 48 - 48
(a) Na	me and address of the agent, b	proker, 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
S. SONE OF SUMMERS OF SONE STREET, STREET	36.786.787		
the state of the s	takidi di marining ang ing ing ing ing ing ing ing ing ing i	roker, or other person to whom commissions or fees were paid	of a great Paris to the first and a second of the second
(b) Amount of sales and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
-			and the fight for

aa	е	3

	this report.				4		
C	rrent value of plan's interest under this contract in the general account at year	end		*****	<u>4</u> 5		
	rrent value of plan's interest under this contract in separate accounts at year e	nd			<u> </u>		
C	ontracts With Allocated Funds:						
a	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 w	ith the acquis	sition or	6d		
	Specify nature of costs						
е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity					
1				•	<u></u>		
7 C	ontracts With Unallocated Funds (Do not include portions of these contracts ma	intained in	separate ac	counts)			
а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ation guaran	lee			
						,	
b	Balance at the end of the previous year				7b		
b		7c(1)			7b		
		7c(1) 7c(2)			7b		
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3)			7b		
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)			7b		
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)		an abardena Sheka	7b		
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)			7b		
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)			7b		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)					
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6) Total additions Total of balance and additions (add lines 7b and 7c(6)).	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(1)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(1)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(1) 7e(2) 7e(3)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(1) 7e(2) 7e(3)			, 7c(6)		
C	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7c(1) 7c(2) 7e(1) 7e(2) 7e(3) 7e(4)			, 7c(6)		

Schedule A	(Form	5500	201	7
CONGGGG A			, 4v i	7

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contemployees, the entire group of such individual contracts with each care.	tracts are experience-rated as a uni	Mhere cor	ntracte cover individual
Benefit and contract type (check all applicable boxes)		117.	
a Health (other than dental or vision) b Dental	c □ Vision		d Life insurance
e Temporary disability (accident and sickness) f Long-term disabili	님		h Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k PPO contract	pioyment	
m X Other (specify) MENTAL HEALTH COUNSELING - MORE THAN RE	F-t		I Indemnity contract
MORE I AN RE	FERRALS		
9 Experience-rated contracts:		7	
a Premiums: (1) Amount received	9a(1)	***	
(2) Increase (decrease) in amount due but unpaid		***	
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))		9a(4)	The control of the second state and and
b Benefit charges (1) Claims paid	9b(1)	(-/	Differences and the conference
(2) Increase (decrease) in claim reserves			
(3) Incurred claims (add (1) and (2))		9b(3)	<u> </u>
(4) Claims charged	•••••	9b(4)	
 Remainder of premium: (1) Retention charges (on an accrual basis) 			
(A) Commissions	<u> </u>		
(B) Administrative service or other fees			
(C) Other specific acquisition costs			
(D) Other expenses			
(E) Taxes			
(F) Charges for risks or other contingencies			
(G) Other retention charges			
(H) Total retention	,	9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were paid in		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
Dividends or retroactive rate refunds due. (Do not include amount entered	l in line 9c(2).)	9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier		10a	
b If the carrier, service, or other organization incurred any specific costs in or retention of the contract or policy, other than reported in Part I, line 2 above Specify nature of costs.	onnection with the acquisition or e, report amount	10b	
Part IV Provision of Information			7
11 Did the insurance company fail to provide any information necessary to comple	ete Schedule A?X	Yes	No
12 If the answer to line 11 is "Yes," specify the information not provided. O INFORMATION PROVIDED			