Form 5500	•	t of Employee Benefit Plan		OMB Nos. 12	10-0110
Department of the Treasury Internal Revenue Service	and 4065 of the Employee Retireme	employee benefit plans under sections 104 nt Income Security Act of 1974 (ERISA) and the Internal Revenue Code (the Code).		2017	
Department of Labor Employee Benefits Security Administration	 Complete all entries in accordance with the instructions to the Form 5500. 				
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic
	entification Information				
For calendar plan year 2017 or fisca	I plan year beginning 01/01/2017	and ending 12/31/20	017		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking t participating employer information in accor			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 1	2 months))	
C If the plan is a collectively-bargain	ned plan, check here	—		• 🗌	
D Charly have if filling wordsm	Form 5558	automatic extension	□ the	e DFVC program	
D Check box if filing under:	special extension (enter description)			e Di VC piograffi	
	ation—enter all requested information		41		
1a Name of plan GREAT FLOORS L.L.C. WELFARE	BENEFIT PLAN			Three-digit plan number (PN) ►	501
			1c	Effective date of pla 01/01/2005	an
City or town, state or province, o	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code (if foreign, see instructions)	2b	Employer Identifica Number (EIN) 82-0524095	tion
GREAT FLOORS L.L.C.			2c	Plan Sponsor's tele number 208-664-5405	ephone
524 E. SHERMAN AVE. COEUR D ALENE, ID 83814	524 E. SHEF COEUR D A	RMAN AVE. LENE, ID 83814	2d	Business code (see instructions) 442210	Э

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN	Filed with authorized/valid electronic signature.	08/16/2018	JIM MCGEE
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	08/16/2018	JIM MCGEE
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2017) v. 170203

	Form 5500 (2017) Page 2		
3a	Plan administrator's name and address X Same as Plan Sponsor	3b Ad	ministrator's EIN
			ministrator's telephone mber
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	4b EI	N
a c	Sponsor's name Plan Name	4d PN	l
5	Total number of participants at the beginning of the plan year	5	271
6	Number of participants as of the end of the plan year unless otherwise stated (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)	271
a(2) Total number of active participants at the end of the plan year	6a(2)	295
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	295
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f	Total. Add lines 6d and 6e.	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	. 7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H

9a	Plan fundir	ng arrangement (check all that apply)	9b	9b Plan benefit arrangement (check all that apply)			
	(1) X	Insurance		(1)	X	Insurance	
	(2)	Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts	
	(3)	Trust		(3)		Trust	
	(4)	General assets of the sponsor		(4)		General assets of the sponsor	
10	0 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)						

a Pens	ion Scl	hedules	b	General	Schedule	es
(1)		R (Retirement Plan Information)		(1)		H (Financial Information)
(2)		MB (Multiemployer Defined Benefit Plan and Certain Money		(2)		I (Financial Information – Small Plan)
(2)		Purchase Plan Actuarial Information) - signed by the plan		(3)	X <u>5</u>	A (Insurance Information)
		actuary		(4)	×	C (Service Provider Information)
(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		D (DFE/Participating Plan Information)
		Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)

Page 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.) If "Yes" is checked, complete lines 11b and 11c.			
11b Is the	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.)		

Receipt Confirmation Code_____

						1		
SCHEDULE	A	Insuran	ce Informa	tion		OM	IB No. 1210-0110	
(Form 5500)							
Department of the Treas Internal Revenue Serv		This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2017	
Department of Labo Employee Benefits Security Ad		File as an attachment to Form 5500.						
Pension Benefit Guaranty Co	prporation	 Insurance companies pursuant to 	are required to prov ERISA section 103		tion		m is Open to Public Inspection	
For calendar plan year 20	17 or fiscal plar	year beginning 01/01/2017		and er	nding 12/3	31/2017		
A Name of plan GREAT FLOORS L.L.C.				B Thre	e-digit		501	
GREAT FLOORS L.L.C.	WELFARE DEP			plar	n number (P	N)	501	
C Plan sponsor's name a GREAT FLOORS L.L.C.	as shown on line	e 2a of Form 5500			oyer Identific -0524095	cation Number ((EIN)	
		ning Insurance Contrac						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
DELTA DENTAL OF IDAH								
		(d) Contract or	(e) Approximate number of persons covered at end of		· · · · · · · · · · · · · · · · · · ·		ontract year	
(b) EIN	code	identification number	policy or contract year		(f)	From	(g) To	
91-0621480	47791	3831		210	09/01/201	6	08/31/2017	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions pa	aid. List in line 3	the agents,	brokers, and o	ther persons in	
(a) Total a	amount of comr	missions paid		(b) ⊤	otal amount	of fees paid		
		4457					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to repo	ort all persons).				
		nd address of the agent, broker			sions or fees	s were paid		
THE MURRAY GROUP, IN	NC.		AST FRONT ST., S R D ALENE, ID 83					
(b) Amount of sales ar	nd base	Fe	es and other comm	nissions paid			-	
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	
	4457					3		
	(a) Name a	nd address of the agent, broker	, or other person to	whom commiss	sions or fees	s were paid		
(b) Amount of sales ar	nd base	Fe	es and other comm	nissions paid				
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	

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

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

		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
			<u> </u>

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2017

		Schedule A (Form 5500) 2017	Page 3		
		u Investment and Annuity Contract Information			
ł	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier m	nav he treated	as a unit for nurnoses of
		this report.		lay be treated	
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5		rent value of plan's interest under this contract in separate accounts at year e		_	
6	Con	tracts With Allocated Funds:		- 1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co	nnection with 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 deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	acting plan, shack have	1	
7			÷.		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)			
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(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	- (-)		
		(4) Other (specify below)			
		•			
				7c/5)	ſ
	£	(5) Total deductions		7e(5) 7f	C
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		/ 1	

Ρ	Part	III Welfare Benefit Contract Information If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individue the information and the entire group of such individue the information and the entire group of such individue the information and the entire group of such individue the entire group of the entire group of such individue the entire group of the entire group of the entire group of the entire the entire group of the entire group of t	roup of employees of the ng purposes if such contra	acts are exp	erience-rated as a unit	. Where contra	cts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b X Dental	С	Vision	d	Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disability	/ g	Supplemental unemp	ployment h	Prescription drug
	i	Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract	I	Indemnity contract
	m	Other (specify)			_	_	
9	Expe	erience-rated contracts:					
	a	Premiums: (1) Amount received		9a(1)		148580	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	148580
	b	Benefit charges (1) Claims paid		9b(1)		109139	
		(2) Increase (decrease) in claim reserves		9b(2)		145255	
		(3) Incurred claims (add (1) and (2))				9b(3)	254394
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on	· · ·				
		(A) Commissions		9c(1)(A)		4457	
		(B) Administrative service or other fees		9c(1)(B)		19315	
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	_			9c(1)(H)	23772
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not	t include amount entered	in line 9c(2)	.)	9e	
10) No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	rrier			10a	
	b Spe	If the carrier, service, or other organization incurre retention of the contract or policy, other than repor- ecify nature of costs.	, ,			. 10b	

Part 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 a	swer to line 11 is "Yes," specify the information not provided.			

					_					
			Insura	nce Informa	ation		OM	IB No. 1210-0110		
•	orm 5500 ment of the Treas	,	This schedule is requir	red to be filed unde	er section 104 of	the				
Intern	al Revenue Servi	ice	Employee Retirement					2017		
	partment of Labor nefits Security Adr		File as ar	n attachment to Fo	orm 5500.					
Pension Ber	nefit Guaranty Co	rporation	Insurance companies pursuant to	s are required to pr ERISA section 10		ation	This For	m is Open to Public Inspection		
For calendar	plan year 20'	17 or fiscal pla	an year beginning 01/01/2017		and	ending 12/	31/2017	•		
A Name of p GREAT FLO		WELFARE BE	ENEFIT PLAN			ree-digit an number (P	PN) ►	501		
C Plan spon GREAT FLO		s shown on li	ne 2a of Form 5500			oloyer Identifi 2-0524095	cation Number	(EIN)		
Part I			erning Insurance Contra A. Individual contracts grouped							
1 Coverage	Information:									
(a) Name of KAISER PERI		rrier								
(b) [(c) NAIC	(d) Contract or		(e) Approximate number of persons covered at end of policy or contract year		Policy or c	ontract year		
(b) E	_11N	code	identification number	•) From	(g) To		
91-1467158		47055	6685800		374	01/01/201	17	12/31/2017		
		mission inforn amount paid	nation. Enter the total fees and t	otal commissions p	paid. List in line	3 the agents	, brokers, and o	ther persons in		
	(a) Total a	amount of con	nmissions paid		(b)	Total amount	t of fees paid			
			50019					0		
3 Persons re	eceiving com	missions and	fees. (Complete as many entrie	es as needed to rep	port all persons					
			and address of the agent, broke	er, or other person	to whom comm	ssions or fee	s were paid			
THE MURRA	Y GROUP, IN	IC.		3OX 3725 UR D ALENE, ID 8	33816					
(b) Amou	nt of sales an	nd base	F	ees and other com	missions paid					
	nmissions pai		(c) Amount		(d) Purp	ose		(e) Organization code		
		50019						3		
		(a) Name	and address of the agent, broke	er, or other person	to whom comm	ssions or fee	s were paid			
	Ees and other commissions paid									

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	lule A (Form 5500) 2017		
			v. 170203

(a) Name and address of the agent, broker, 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		
			<u> </u>		

(a) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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		

Schedule A (Form 5500) 2017

		Schedule A (Form 5500) 2017	Page 3		
		u Investment and Annuity Contract Information			
ł	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier m	nav he treated	as a unit for nurnoses of
		this report.		lay be treated	
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5		rent value of plan's interest under this contract in separate accounts at year e		_	
6	Con	tracts With Allocated Funds:		- 1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co	nnection with 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 deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	acting plan, shack have	1	
7			÷.		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)			
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(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	- (-)		
		(4) Other (specify below)			
		•			
				7c(5)	ſ
	£	(5) Total deductions		7e(5) 7f	C
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		/ 1	

Specify nature of costs.

Ρ	art	III Welfare Be	nefit Contract Informa	ation						
		the information	ne contract covers the same a may be combined for report e entire group of such individ	ing purposes if su	uch contracts are	expe	rience-rated as a unit	. Where co	ntracts cover in	
8	Ben	efit and contract type	(check all applicable boxes)			-				
	-	Health (other than	,	b Dental		с□	Vision		d Life insura	ance
	e		ty (accident and sickness)	f Long-term	disability	님	Supplemental unemp	olovment	h X Prescripti	
	. L			~		- =		bioyment		•
	1	Stop loss (large de		j HMO cont	ract	k _	PPO contract		I Indemnity	contract
	m	Other (specify)								
_	_									
9	•	erience-rated contract			0=/4	、			-	
			nt received			<i>.</i>			-	
			se) in amount due but unpaic se) in unearned premium res			<i>'</i>			-	
		., .	- (3))		· · · · ·			9a(4)		
		() () ()	Claims paid			1		Ja(4)		
			se) in claim reserves			/			-	
			add (1) and (2)		i			9b(3)		
		., .	(-) (-)/					9b(4)		
	С	•	um: (1) Retention charges (o							
			S			A)			-	
		(B) Administrativ	e service or other fees			B)				
		(C) Other specifi	ic acquisition costs			C)				
		(D) Other expen	ses			-				
		(E) Taxes				-			_	
		(F) Charges for	risks or other contingencies						_	
		()	ion charges					9c(1)(H)		
		()	(H) Total retention							
			oactive rate refunds. (These		1					
	d		er reserves at end of year: (1	,	•			9d(1)		
		(2) Claim reserves					9d(2)			
		()						9d(3)		
			tive rate refunds due. (Do no	ot include amount	t entered in line 9)c(2).)	. 9e		
10		nexperience-rated co								
	-		ubscription charges paid to c					10a		1776072
	b		e, or other organization incurr					10b		

Pa	art IV	Provision of Information			
11	Did the	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12	If the an	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE A			Insurar	nce Informatio	on		014	B No. 1210-0110
(Form 5500)								B NO. 1210-0110
	tment of the Treas		This schedule is require Employee Retirement I					2017
	epartment of Labor enefits Security Ad		File as an	attachment to Form	5500.			
Pension Be	enefit Guaranty Co	orporation	Insurance companies	are required to provide	e the informa	tion	This For	m is Open to Public
		47 (•	ERISA section 103(a)	()			Inspection
A Name of	· · ·	17 or fiscal pla	n year beginning 01/01/2017		and er	naing <u>12/;</u> e-digit	31/2017	
		WELFARE BE	NEFIT PLAN			n number (P	'N)	501
C Plan spor	nsor's name a	is shown on lir	e 2a of Form 5500		D Empl	oyer Identifi	cation Number ((EIN)
GREAT FLC	OORS L.L.C.				82	-0524095		
Part I			rning Insurance Contract					
1 Coverage	Information:		A. Individual contracts grouped	as a unit in Parts II and	i ili can de le	eponed on a	single Schedul	e A.
I Coverage	miornation.							
.,	insurance ca	rrier F IDAHO, INC						
VILLAIVIETT	E DENTAL OI		-					
(b) EIN (c) NAIC		(d) Contract or	(e) Approximate persons covered				ontract year	
(8)		code	identification number	policy or contra		(f)) From	(g) To
93-1253100		95819	ID351		97	01/01/201	17	12/31/2017
		mission inform amount paid.	ation. Enter the total fees and to	otal commissions paid.	List in line 3	the agents,	, brokers, and of	ther persons in
	(a) Total a	amount of com	missions paid		(b) ⊺	otal amount	of fees paid	
			1224					0
3 Persons	receiving com	missions and f	ees. (Complete as many entrie	s as needed to report a	all persons).			
	Y GROUP. IN	<i>i</i>	and address of the agent, broke			sions or fees	s were paid	
	IT GROUP, IN	vC.		AST FRONT ST., STE JR D ALENE, ID 83814				
(b) Amou	unt of sales ar	nd base	Fe	ees and other commiss	ions paid			-
COI	mmissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
		1224						3
		(a) Name a	and address of the agent, broke	r, or other person to wh	nom commis	sions or fees	s were paid	
			-					
(k) A	int of online -		Fe	ees and other commiss	ions paid			
• •	unt of sales ar mmissions pai		(c) Amount	(d) Purpose			(e) Organization code	

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

(a) Name and address of the agent, broker, 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		
			<u> </u>		

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2017

		Schedule A (Form 5500) 2017	Page 3		
		u Investment and Annuity Contract Information			
ł	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier m	nav he treated	as a unit for nurnoses of
		this report.		lay be treated	
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5		rent value of plan's interest under this contract in separate accounts at year e		_	
6	Con	tracts With Allocated Funds:		- 1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co	nnection with 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 deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	acting plan, shack have	1	
7			÷.		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)			
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(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	- (-)		
		(4) Other (specify below)			
		•			
				7c(5)	ſ
	£	(5) Total deductions		7e(5) 7f	C
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		/ 1	

Ρ	Part	III Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	roup of employees of the ng purposes if such contra	acts are expe	erience-rated as a unit. Where	e contra	acts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b X Dental	С	Vision	d	Life insurance
	e [Temporary disability (accident and sickness)	f Long-term disability	y g	Supplemental unemploymen	t h	Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract	ΙĪ	Indemnity contract
	m	Other (specify)	_			-	_
9	Expe	erience-rated contracts:					
	а	Premiums: (1) Amount received		9a(1)	40	805	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium rese	erve	9a(3)			
		(4) Earned ((1) + (2) - (3))				4)	40805
	b	Benefit charges (1) Claims paid		9b(1)	40	723	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				3)	40723
		(4) Claims charged				4)	
	С	Remainder of premium: (1) Retention charges (or	an accrual basis)				
		(A) Commissions		9c(1)(A)	1	224	
		(B) Administrative service or other fees		9c(1)(B)	4	489	
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses	_	9c(1)(D)			
		(E) Taxes		9c(1)(E)		31	
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)	-		
		(H) Total retention	······	·····		(H)	5744
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.) 9c(2	2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	penefits after	retirement	1)	
		(2) Claim reserves				2)	
		(3) Other reserves				3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2).) 9e	•	
10	Nc	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			a	
	b Spe	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo- cify nature of costs.				5	

Part IV	Provision of Information			
11 Did t	e 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.			

			_					Γ	
SCHEDULE A			Insurar	nce	e Information	ו		OM	IB No. 1210-0110
•	orm 5500		This school do is sourced		he Cherley de service	- 404 - (1)			
	rtment of the Treas rnal Revenue Serv		This schedule is require Employee Retirement I						2017
	epartment of Labo enefits Security Ad		File as an	n atta	achment to Form 55	00.			
Pension Be	enefit Guaranty Co	prporation	 Insurance companies pursuant to 		required to provide the SA section 103(a)(2)		tion	This For	m is Open to Public Inspection
For calendar	r plan year 20	17 or fiscal pla	n year beginning 01/01/2017			and er	nding 12/3	31/2017	
A Name of GREAT FLC		WELFARE BEI	NEFIT PLAN				e-digit number (P	N) 🕨	501
•	nsor's name a DORS L.L.C.	as shown on lin	e 2a of Form 5500				oyer Identific 0524095	cation Number ((EIN)
Part I			rning Insurance Contract						
1 Coverage	Information:		<u> </u>						
0		***:0 *							
.,	f insurance ca RITAGE LIFE								
(b)		(c) NAIC	(d) Contract or	(e) Approximate			Policy or co		ontract year
(d)	EIN	code	identification number		persons covered at e policy or contract y		(f)	From	(g) To
82-0123320		63983	GL-3119		144	144 01/01/2017 12/31/2017			12/31/2017
		mission information information information in the mission information in the mission in the mis	ation. Enter the total fees and to	otal c	commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
	(a) Total a	amount of com	missions paid			(b) To	otal amount	of fees paid	
			5496						0
3 Persons	receiving com	missions and f	ees. (Complete as many entries	es as	needed to report all	persons).			
			and address of the agent, broke			n commiss	ions or fees	s were paid	
	AY GROUP, IN	NC.	P.O. E COEL		3725) ALENE, ID 83816-2	529			
(b) Amou	unt of sales ar	nd base	Fe	Fees and other commissions paid				-	
COI	mmissions pa		(c) Amount			(d) Purpos	е		(e) Organization code
		5496							3
		(a) Name a	and address of the agent, broke	ar or	other person to whor	n commiss	ions or fees	s were paid	
				, or					
(b) Amo	unt of sales ar	nd base	Fe	ees a	and other commissior	ns paid			
	mmissions pa		(c) Amount		(d) Purpose				(e) Organization code

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

(a) Name and address of the agent, broker, 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		
			<u> </u>		

(a) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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) Name and address of the agent, broker, 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	

Schedule A (Form 5500) 2017

		Schedule A (Form 5500) 2017	Page 3		
		u Investment and Annuity Contract Information			
ł	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier m	nav he treated	as a unit for nurnoses of
		this report.		lay be treated	
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5		rent value of plan's interest under this contract in separate accounts at year e		_	
6	Con	tracts With Allocated Funds:		- 1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co	nnection with 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 deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	acting plan, shack have	1	
7			÷.		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)			
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(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	- (-)		
		(4) Other (specify below)			
		•			
				7c(5)	ſ
	£	(5) Total deductions		7e(5) 7f	C
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		/ 1	

Ρ	art		Welfare Benefit Contract Informa	tion					
			If more than one contract covers the same g the information may be combined for reporti						,
			employees, the entire group of such individu						
8	Ben	efit a	nd contract type (check all applicable boxes)						
	a	He	ealth (other than dental or vision)	b Dental	c	Vision		d X Life insurance	
	e	K Te	emporary disability (accident and sickness)	f X Long-term disabilit	v a	Supplemental unemp	olovment	h Prescription drug	
	т Г	_	op loss (large deductible)	j HMO contract		PPO contract	, and the second s	I Indemnity contract	
	' L	_	,		n_				
	m	Ot	ther (specify)						
0	- Luna		an rotad contractor						
3			ce-rated contracts: iums: (1) Amount received		9a(1)			-	
			ncrease (decrease) in amount due but unpaid		• • •			-	
		. ,	ncrease (decrease) in amount due but unpaid					-	
		• •	Earned ((1) + (2) - (3))				9a(4)		
	-	``	efit charges (1) Claims paid				00(1)		
			ncrease (decrease) in claim reserves		• •			-	
			ncurred claims (add (1) and (2))				9b(3)		
			Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (or	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies		9c(1)(F)				
			(G) Other retention charges				1		
			(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)		
		• •	Other reserves				9d(3)		
	е		dends or retroactive rate refunds due. (Do no	t include amount entered	l in line 9c(2)	.)	9e		
10		•	erience-rated contracts:				45		
	а	Tota	al premiums or subscription charges paid to ca	arrier			10a	;	36641
	b		e carrier, service, or other organization incurre				405		
		rete	ntion of the contract or policy, other than repo	rted in Part I, line 2 abov	e, report amo	ount	10b		

Pa	art IV Provision of Information			
11	Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40				

12 If the answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

								I	
SC	HEDULE	Α	Insurai	nc	e Information	n		OM	B No. 1210-0110
•	orm 5500		This set a data is a solit		te ha filadaa dagaa dagaa da				
	tment of the Treas nal Revenue Serv		This schedule is requir Employee Retirement						2017
	epartment of Labor nefits Security Ad		File as an	n at	tachment to Form 55	00.			
Pension Be	enefit Guaranty Co	rporation	Insurance companies pursuant to		re required to provide to RISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar	plan year 20 [°]	17 or fiscal pla	n year beginning 01/01/2017			and er	nding 12/3	31/2017	
A Name of	•	VELFARE BE					e-digit		501
OREATTEC	JOINO E.E.O. 1					plar	n number (P	N) 🕨	501
						_			
C Plan spor		s shown on lir	e 2a of Form 5500				oyer Identific -0524095	cation Number ((EIN)
UNEATTEC	ONO L.L.O.					02	0024000		
Part I			rning Insurance Contra						
1 Cavaraga		ate Schedule A	A. Individual contracts grouped	as	a unit in Parts II and II	I can be re	ported on a	single Schedul	e A.
1 Coverage	Information:								
.,	insurance ca								
UNITED HER	RITAGE LIFE	INS CO							
		(c) NAIC	(d) Contract or		(e) Approximate number of			Policy or co	ontract year
(b)	EIN	code	identification number		persons covered a policy or contrac		(f)	From	(g) To
82-0123320		63983	GV-3119		214 01/01/2017		7	12/31/2017	
	fee and com		ation. Enter the total fees and to	otal	l commissions paid. Li	ist in line 3	the agents,	brokers, and of	ther persons in
	(a) Total a	amount of com	missions paid			(b) T	otal amount	of fees paid	
			1586						0
3 Persons r	eceiving com	missions and f	ees. (Complete as many entrie	es a	as needed to report all	persons).			
			and address of the agent, broke			m commiss	sions or fees	s were paid	
THE MURRA	Y GROUP, IN	IC.			X 3725 D ALENE, ID 83816-2	2529			
(b) Amou	unt of sales ar	nd base	F	ees	and other commission	ns paid			-
cor	mmissions pai		(c) Amount			(d) Purpos	e		(e) Organization code
1586								3	
		(a) Name :	and address of the agent, broke	ar c	or other person to who	m commiss	sions or fees	s were naid	
			and address of the agent, bloke	,, c					
(b) Amor	unt of sales ar	nd base	F	ees	and other commission	ns paid			
• •	nmissions pai		(c) Amount			(d) Purpos	e		(e) Organization code

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

(a) Name and address of the agent, broker, 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	
			<u> </u>	

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

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

Schedule A (Form 5500) 2017

		Schedule A (Form 5500) 2017	Page 3		
		u Investment and Annuity Contract Information			
ł	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier m	nav he treated	as a unit for nurnoses of
		this report.		lay be treated	
4	Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5		rent value of plan's interest under this contract in separate accounts at year e		_	
6	Con	tracts With Allocated Funds:		- 1 - 1	
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in co	nnection with 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 deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	acting plan, shack have	1	
7			÷.		
1		tracts With Unallocated Funds (Do not include portions of these contracts ma			
	а		ate participation guarantee		
		(3) guaranteed investment (4) other	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits			
		(3) Interest credited during the year			
		(4) Transferred from separate account			
		(5) Other (specify below)			
		(6)Total additions		7c(6)	(
	d	Total of balance and additions (add lines 7b and 7c(6)).			
		Deductions:			
		(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	- (-)		
		(4) Other (specify below)			
		•			
				7c(5)	ſ
	£	(5) Total deductions		7e(5) 7f	C
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		/ 1	

Specify nature of costs.

Ρ	art		Welfare Benefit Contract Information one contract covers the same of the information may be combined for reporting employees, the entire group of such individual sectors of the information of the entire group of the individual sectors of the individual sectors of the information of the entire group of the individual sectors of the individual sectors of the information of the information sectors o	roup of employees of the ng purposes if such contr	acts are exp	erience-rated as a unit	. Where co	ntracts cover individua	
8	Bene	efit a	nd contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	b Dental	C	Vision		d Life insurance	
	e	Те	mporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	oloyment	h Prescription dru	g
	iΓ	Sto	op loss (large deductible)	j 🗍 HMO contract	k	PPO contract		I Indemnity contra	act
	m	Ot	her (specify)		L	-			
9	Expe	eriend	ce-rated contracts:	_					
	a	Prem	iums: (1) Amount received		9a(1)				
		(2) Ir	ncrease (decrease) in amount due but unpaid		9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium res	erve	9a(3)				
		(4) E	arned ((1) + (2) - (3))				9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		
		(4) C	Claims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (or	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies		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	Stat	us of policyholder reserves at end of year: (1)	Amount held to provide I	benefits after	r retirement	9d(1)		
		(2) (Claim reserves				9d(2)		
		(3) (Other reserves				9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do no	t include amount entered	in line 9c(2)	.)	9e		
10) No	nexp	erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to ca	arrier			10a		31719
	b		e carrier, service, or other organization incurrent				10b		

Pa	art IV	Provision of Information				
11	Did the i	surance company fail to provide any information necessary to complete Schedule A?	Ye	s 🔰	K No	
12	If the an	wer to line 11 is "Yes," specify the information not provided.				

SCHEDULE C	Service Provider II	nformation		OMB No. 1210-0110
(Form 5500)	.			2017
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under Retirement Income Security Act			2011
Department of Labor Employee Benefits Security Administration	File as an attachment t	o Form 5500.	This Form is Open to Public Inspection.	
Pension Benefit Guaranty Corporation For calendar plan year 2017 or fiscal pla	n year beginning 01/01/2017	and ending 12/3	1/2017	mopeotion
A Name of plan				
		plan number (PN)	•	501
C Plan sponsor's name as shown on lin GREAT FLOORS L.L.C.	D Employer Identification 82-0524095	,,,,,,,		
Part I Service Provider Info	ormation (see instructions)			
 plan during the plan year. If a person answer line 1 but are not required to i 1 Information on Persons Rec a Check "Yes" or "No" to indicate wheth indirect compensation for which the plan 	oney or anything else of monetary value) in con received only eligible indirect compensation for include that person when completing the remain ceiving Only Eligible Indirect Comp er you are excluding a person from the remain an received the required disclosures (see instr	or which the plan received the requinder of this Part. ensation der of this Part because they receiven uctions for definitions and condition	ved only el	igible
	the name and EIN or address of each person patient. Complete as many entries as needed (or the serv	ice providers who
(b) Enter nar	ne and EIN or address of person who provided	you disclosures on eligible indirec	t compens	ation
(b) Enter nar	ne and EIN or address of person who provided	you disclosures on eligible indirec	t compens	ation
(b) Enter nar	ne and EIN or address of person who provided	you disclosures on eligible indirec	t compens	ation

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

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

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

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

DELTA DENTAL OF IDAHO

P.O. BOX 2870 BOISE, ID 83701

82-0299431

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0		
	ADM. SVC. PROVIDER	19315	Yes 🗌 No 🗙	Yes 🗌 No 🗌		Yes 🗌 No 🗌	
		(a) Enter name and EIN or address (see instructions)					

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍
	(a) Enter name and EIN or address (see instructions)					

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	person known to be	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan	Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0		
			Yes No	Yes No		Yes No	
	(a) Enter name and EIN or address (see instructions)						

(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0		
	Yes No Yes Yes <th< td=""></th<>						
	(a) Enter name and EIN or address (see instructions)						

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service
Code(s)	employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗍

Part I	Service Provider Information (continued)			
or provid questions provider	ported on line 2 receipt of indirect compensation, other than eligible indirect compensati es contract administrator, consulting, custodial, investment advisory, investment manag s for (a) each source from whom the service provider received \$1,000 or more in indirect gave you a formula used to determine the indirect compensation instead of an amount of ries as needed to report the required information for each source.	ement, broker, or recordkeeping t compensation and (b) each so	g services, answer the following purce for whom the service	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation	
	(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.		
	(a) Enter service provider name as it appears on line 2	(b) Service Codes	(C) Enter amount of indirect	
	(d) Enter service provider name as it appears on line 2	(see instructions)	compensation	
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation	
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.	

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Pa	rt II Service Providers Who Fail or Refuse to I	Provide Infori	mation			
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.						
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
	a) Enter name and EIN or address of service provider (see	(b) Nature of	(C) Describe the information that the service provider failed or refused to			
	instructions)	Service Code(s)	provide			
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
((a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			

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e Telephone:

Part III Termination Information on Accountants and Enrolled Actuaries (s (complete as many entries as needed)	Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
a Name:	b EIN:			
C Position:				
d Address:	e Telephone:			
Explanation:				
a Name:	b EIN:			
C Position:				

Explanation:

Name:	b EIN:
Position:	
Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

	Form 5500	Annual Return/Report of Employee Benefit Plan				OMB Nos. 1210 - 011		
Department of the Treasury Internal Revenue Service 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). Department of Labor Employee Benefits Security Administration Complete all entries in accordance with						2017		
								-
Par		rt Identification Informa						
		or fiscal plan year beginning	01/01/		and ending		/2017	
AT	his return/report is for:	a multiemployer plan			loyer plan (Filers			
	his return/report is:	a single-employer plan the first return/report an amended return/report	t al	DFE (specify) e final return,				form instr.)
		rgained plan, check here						
DC	heck box if filing under:	X Form 5558	s and the second	tomatic exte	nsion	the DFVC pro	gram	
Par	t II Basic Plan In	special extension (enter of formation - enter all request	description)					
L	Name of plan	ronnation - enter all request	ted information		T			
	••••••••	.C. WELFARE BENI	מדת הדאי	NT	16			501
GRE	AI LUOUVO T.T	.C. WELFARE DENI	SFIT PLA	IN		plan numbe		501
					10	Effective da		
		r, if for a single-employer plan) apt., suite no. and street, or P.O. B	ox)		2b		lentification N	Number (EIN)
	City or town, state or province,	country, and ZIP or foreign postal (code (if foreign, se	ee instructions		Plan Spons 8 - 6 6 4 - 5	or's telephon	e number
					2d	Business co		ructions)
524	E. SHERMAN A	VE.						
COE	UR D' ALENE	ID 8381	L4					
Cauti	on: A penalty for the late of	or incomplete filing of this ret	urn/report will	be assessed	d unless reason	able cause is	established	
Under p	enalties of perjury and other penaltie	es set forth in the instructions, I declare th t, and to the best of my knowledge and b	hat I have examined t	his return/report.				
SIGN		2 8	-16-18	JIM MC	CGEE			
	Signature of plan admir	nistrator Date		Enter name	of individual sign	ning as plan ad	dministrator	
SIGN			7478	JIM MC	CGEE			
	Signature of employer/	blan sponsor Date			of individual sign	ning as employ	ver or plan sp	oonsor
SIGN								

HERE Signature of DFE Date Enter name of individual signing as DFE

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3a	Plan administrator's name and address 🛛 Same as Plan Sponsor 3b	Administrator'	ator's EIN		
	30	Administrator'	s telephone number		
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report fil	ed for this plan,	4b EIN		
	enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:				
	Sponsor's name		4d PN		
С	Plan Name				
5	Total number of participants at the beginning of the plan year	5	271		
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete o	nly lines			
	6a(1), 6a(2), 6b, 6c, and 6d).				
а	(1) Total number of active participants at the beginning of the plan year	6a(1) 271		
	(2) Total number of active participants at the end of the plan year		2) 295		
b	Retired or separated participants receiving benefits	6b			
C	Other retired or separated participants entitled to future benefits	60	;		
d	Subtotal. Add lines 6a(2), 6b, and 6c	60	295		
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e			
f	Total. Add lines 6d and 6e				
g	Number of participants with account balances as of the end of the plan year (only defined contribution				
	complete this item)	69			
h	Number of participants who terminated employment during the plan year with accrued benefits that we	re			
	less than 100% vested	6h	1		
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete	ete			
	this item)	7			

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4H

9a	Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)				
	(1) X Insurance	(1) X Insurance			
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) insurance contracts			
	(3) Trust	(3) Trust			
	(4) General assets of the sponsor	(4) General assets of the sponsor			
10	Check all applicable boxes in 10a and 10b to indicate which schedules (See instructions)	are attached, and, where indicated, enter the number attached.			
a	Pension Schedules	b General Schedules			
	(1) R (Retirement Plan Information)	(1) H (Financial Information)			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Information - Small Plan)			
	Purchase Plan Actuarial Information) - signed by the plan	(3) X 5 A (Insurance Information)			
	actuary	(4) X C (Service Provider Information)			
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participating Plan Information)			
	Information) - signed by the plan actuary	(6) G (Financial Transaction Schedules)			

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Part	t 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.) Yes X No							
		s" is checked, complete lines 11b and 11c. plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)	Yes	No				
11c	Enter enter	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing re ter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)	n M-1 annual re	eport,				

Receipt Confirmation Code _

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