#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

Part I		dentification Information				
For cale	ndar plan year 2016 or fis	scal plan year beginning 01/01/2016		and ending 12/31/2016		
<b>A</b> This	return/report is for:	a multiemployer plan	participating e	ployer plan (Filers checking this lemployer information in accordan		
		x a single-employer plan	a DFE (specif			
<b>B</b> This	return/report is:	the first return/report	X the final return	•		
		x an amended return/report	a short plan y	ear return/report (less than 12 mo	onths)	)
C If the	plan is a collectively-barg	gained plan, check here				<b>)</b>
D Chec	ck box if filing under:	☐ Form 5558	automatic exte	nsion	□ the	e DFVC program
D One	in box ii iiiiig under.	special extension (enter description				
Part I	Rasic Plan Infor	mation—enter all requested informati	,			
	ne of plan	mation—enter all requested informati	1011		1b	Three-digit plan
	TO HEALTH AND WELF	ARE WRAP PLAN				number (PN) ▶ 502
					1c	Effective date of plan 01/01/2016
		yer, if for a single-employer plan)			2b	Employer Identification
		n, apt., suite no. and street, or P.O. Box e, country, and ZIP or foreign postal cod		ructions)		Number (EIN) 22-2873640
•	O MANAGEMENT COMP		ie (ii ioroigii, see iiisti	ruotionaj	20	Plan Sponsor's telephone
					20	number
						315-413-3416
	RIGHTON AVE		IGHTON AVE		2d	Business code (see
SYRACI	JSE, NY 13205-2201	SYRACU	SE, NY 13205-2201			instructions) 623000
Caution	: A penalty for the late o	or incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is es	tabli	shed.
		ner penalties set forth in the instructions, well as the electronic version of this return.				
SIGN HERE	Filed with authorized/vali	d electronic signature.	10/03/2018	JAMES BRAYER		
	Signature of plan adm	inistrator	Date	Enter name of individual signi	ng as	plan administrator
SIGN HERE						
	Signature of employer	/plan sponsor	Date	Enter name of individual signi	ng as	employer or plan sponsor
SIGN HERE						
IILKL	Signature of DFE		Date	Enter name of individual signi		
Prepare	r's name (including firm na	ame, if applicable) and address (include	room or suite number	er) Prepa	arer's	telephone number
I						

Form 5500 (2016) Page **2** 

3a	Plan administrator's name and address X Same as Plan Sponsor	3b Administrator's EIN		
		<b>3c</b> Administrator's telephone number		
4	If the name and/or EIN of the plan sponsor has changed since the last return EIN and the plan number from the last return/report:	/report filed for this plan, enter the name,	4b EIN	
а	Sponsor's name		4c PN	
5	Total number of participants at the beginning of the plan year		5 0	
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	d (welfare plans complete only lines 6a(1),		
a(1	) Total number of active participants at the beginning of the plan year		6a(1) 0	
a(2	Total number of active participants at the end of the plan year		6a(2) 0	
b	Retired or separated participants receiving benefits		6b 0	
С	Other retired or separated participants entitled to future benefits		6c <u>0</u>	
d	Subtotal. Add lines 6a(2), 6b, and 6c.		6d 0	
e	Deceased participants whose beneficiaries are receiving or are entitled to rec		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>		6f	
g	Number of participants with account balances as of the end of the plan year complete this item)		6g	
h	Number of participants that 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	multiemployer plans complete this item)	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 4E 4H 4L	les from the List of Plan Characteristics Codes	s in the instructions:	
9a	Plan funding arrangement (check all that apply)  (1) Insurance	9b Plan benefit arrangement (check all that	at apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section 412(e)(3)	insurance contracts	
	(3) Trust	(3) Trust	modranoe dentracte	
	(4) X General assets of the sponsor	(4) X General assets of the sp	oonsor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a			
_		_	, , , , , , , , , , , , , , , , , , ,	
а	Pension Schedules (1) R (Retirement Plan Information)	b General Schedules (1) H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(3) A (Insurance Infor C (Service Provide	er Information)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participati (6) G (Financial Trans	ng Plan Information) saction Schedules)	

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

Form 5500 (2016)

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.

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 20	For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016						
A Name of plan LORETTO HEALTH AND	WELFARE WE	RAP PLAN			e-digit n number (PN)	502	
C Plan sponsor's name	as shown on line	e 2a of Form 5500		<b>D</b> Emplo	oyer Identification Number	(EIN)	
LORETTO MANAGEMEN	NT COMPANY			22-	2873640		
	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 context.							
4w	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	<b>(g)</b> To	
15-0329043	55107	00044255	352		01/01/2016	12/31/2016	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total	amount of comr	nissions paid		<b>(b)</b> To	otal amount of fees paid		
		125715				0	
3 Persons receiving con	nmissions and fe	ees. (Complete as many entries	s as needed to report all p	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commiss	sions or fees were paid		
ENV INSURANCY AGEN	CY		OSWEGO ROAD POOL, NY 13090				
(b) Amount of sales a	and hase	Fe	es and other commission	s paid			
commissions pa		(c) Amount	(d) Purpose		е	(e) Organization code	
	125715					3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
(b) Amount of sales a	and base	Fe	es and other commissior	ns paid			
commissions pa		(c) Amount		(d) Purpos	e	(e) Organization code	
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.  Schedule A (Form 5500) 2016 v. 160205							

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

Fees and other commissions paid

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

(e) Organization code

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_	10	II Investment and Annuity Centreet Information			
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	nay be treated as a	unit for purposes of
_	C	this report.	and		
		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	na	5	
ь		tracts With Allocated Funds:			
	а	State the basis of premium rates			
				Cla	
	b	Premiums paid to carrier		_	
	C	Premiums due but unpaid at the end of the year		<b>6c</b>	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		У, Ц У У У			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check horo	7	
7		tracts With Unallocated Funds (Do not include portions of these contracts ma			
•			ate participation guarantee		
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그			
		(3) guaranteed investment (4) dther	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0
	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)		
		<b>)</b>			
				7.(5)	
	,	(5) Total deductions			0
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

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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 carrier may be treated as a unit for purposes of this report.							
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	Dental	С	Vision		<b>d</b> Life insuran	ce
	е	Temporary disability (accident and sickness)	Long-term disability	, a	Supplemental une	mplovment	h X Prescription	drua
	i [	Stop loss (large deductible)	HMO contract	, Si			I  Indemnity co	-
	m [	Other (specify)		• • •				muot
	L	Cuter (specify) /						
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)		5187330	7	
		(2) Increase (decrease) in amount due but unpaid.	F	9a(2)		3107330	$\exists$	
		(3) Increase (decrease) in unearned premium reser		9a(3)			_	
		(4) Earned ((1) + (2) - (3))	<u> </u>			9a(4)		5187330
	_	Benefit charges (1) Claims paid	T T	9b(1)		3573818		0107000
		(2) Increase (decrease) in claim reserves	F	9b(2)		3373010	_	
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )	-	. ,		0b/3)		3573818
						` '		3373010
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on	·	0-(4)(A)	1	474404	_	
		(A) Commissions	<u> </u>	9c(1)(A)		171181		
		(B) Administrative service or other fees	i i	9c(1)(B)		643228	<u> </u>	
		(C) Other specific acquisition costs	T T	9c(1)(C)			_	
		(D) Other expenses	<u> </u>	9c(1)(D)			_	
		(E) Taxes	i i	9c(1)(E)			_	
		(F) Charges for risks or other contingencies	F	9c(1)(F)				
		(G) Other retention charges		9c(1)(G)		814410		
		(H) Total retention	······			9c(1)(H)		1628819
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits afte	er retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9c(2	<b>2)</b> .)			
10		nexperience-rated contracts:		•	.,	- 1		
		Total premiums or subscription charges paid to car	rier			10a		
	_	If the carrier, service, or other organization incurred						
	D	retention of the contract or policy, other than report				10b		
	Spe	cify nature of costs.	.ou	o, roport an				
_	- ut 1	Dravisian of Information						
	art I				г	<del>-</del>		
11	Did	the insurance company fail to provide any informa	ion necessary to comple	ete Schedu	le A?	Yes	× No	
12	lf 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

2016

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2).			Inspection					
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016				and en	ding 12/3	1/2016		
A Name of plan LORETTO HEALTH AND	WELFARE WE	RAP PLAN		B Three-digit plan number (PN) 502		502		
C Plan sponsor's name a LORETTO MANAGEMEN		e 2a of Form 5500		-	oyer Identific 2873640	ation Number (	EIN)	
		rning Insurance Contract . Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca								
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	contract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contrac		(f)	From	<b>(g)</b> To	
11-3051991	93440	LRT12C01C02	1149		01/01/2016	5	12/31/2016	
2 Insurance fee and come descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount	of fees paid		
	5601 0							
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
ENV INSURANCY AGENC	Υ		SWEGO ROAD POOL, NY 13090					
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose		(e) Organization code		
	5601						3	
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	ees and other commissions paid					
commissions pa		(c) Amount		(d) Purpos	9		(e) Organization code	
For Paperwork Reductio	n Act Notice.	see the Instructions for Form 5	5500.			Sched	lule A (Form 5500) 2016	

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

Fees and other commissions paid

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

(e) Organization code

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_	10	II Investment and Annuity Centreet Information							
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	nay be treated as a	unit for purposes of				
this report.  4 Current value of plan's interest under this contract in the general account at year end									
		rent value of plan's interest under this contract in separate accounts at year e	na	5					
ь		tracts With Allocated Funds:							
	а	State the basis of premium rates							
				Cla					
	b	Premiums paid to carrier		_					
	C	Premiums due but unpaid at the end of the year		<b>6c</b>					
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>					
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) other (specify)							
		У, Ц У У У							
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check horo	7					
7		tracts With Unallocated Funds (Do not include portions of these contracts ma							
•			ate participation guarantee						
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그							
		(3) guaranteed investment (4) dther	•						
	b	Balance at the end of the previous year		7b					
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(2) Dividends and credits	7c(2)						
		(3) Interest credited during the year	7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	7c(5)						
		•							
		(6)Total additions		7c(6)	0				
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0				
	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)						
		<b>)</b>							
				7.(5)					
	,	(5) Total deductions			0				
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0				

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P	art II							
		If more than one contract covers the same guesting information may be combined for reporting employees, the entire group of such individuals.	g purposes if such con	tracts are expe	erience-rated as a uni	t. Where cor	ntract	ts cover individual
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	c X	Vision		d	Life insurance
	е 🗆	Temporary disability (accident and sickness)	f  Long-term disabil	=	Supplemental unem	ployment	h∏	Prescription drug
	iΪ	Stop loss (large deductible)	j ∏ HMO contract	_ =	PPO contract	,	ᆜ	Indemnity contract
	m	Other (specify)		□	TT O contract		• Ш	madminy contract
	m _	Other (specify)						
9	Exner	rience-rated contracts:						
_	•	remiums: (1) Amount received		9a(1)		56010	7	
		(2) Increase (decrease) in amount due but unpaid				00010	1	
	,	(3) Increase (decrease) in unearned premium rese					1	
	,	(4) Earned ((1) + (2) - (3))				. 9a(4)		56010
	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)		0
	(-	(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (on	an accrual basis)				_	
		(A) Commissions		9c(1)(A)			4	
		(B) Administrative service or other fees		9c(1)(B)			4	
		(C) Other specific acquisition costs		9c(1)(C)			4	
		(D) Other expenses		9c(1)(D)			4	
		(E) Taxes		9c(1)(E) 9c(1)(F)			4	
		(F) Charges for risks or other contingencies		0 (4)(0)			4	
		(G) Other retention charges(H) Total retention				9c(1)(H)	-	0
	,	(2) Dividends or retroactive rate refunds. (These a	_				+	
		Status of policyholder reserves at end of year: (1)	—			9c(2) 9d(1)	+	
		(2) Claim reserves	·			9d(1)	+	
		(3) Other reserves				9d(3)	+	
		Dividends or retroactive rate refunds due. (Do not				9e	1	
10		nexperience-rated contracts:	molado ambant ontolo	<u> </u>	,			
		Total premiums or subscription charges paid to ca	rrier			10a		
	b i	If the carrier, service, or other organization incurre	d any specific costs in o	connection with	n the acquisition or		1	
		retention of the contract or policy, other than repor	, ,		•	10b		
	Spec	ify nature of costs.						
Pa	art I\	V Provision of Information						
11	Did	the insurance company fail to provide any informa	tion necessary to comp	lete Schedule	A?	Yes	X N	0
		e answer to line 11 is "Yes," specify the informatio			<del>  </del>			
-		-, -, -, - ,						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 20	For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016							
A Name of plan LORETTO HEALTH AND	RAP PLAN			ee-digit n number (PN)	502			
•	C Plan sponsor's name as shown on line 2a of Form 5500 LORETTO MANAGEMENT COMPANY					(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		MPANY						
/I-> FINI	(c) NAIC	(d) Contract or	(e) Approximate no		Policy or c	ontract year		
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To		
13-5581829	65978	0151137	0	)	01/01/2015	12/31/2015		
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents, brokers, and c	other persons in		
(a) Total a	amount of com	missions paid		<b>(b)</b> To	otal amount of fees paid			
		5014				0		
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).				
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	sions or fees were paid			
ENV INSURANCY AGENC	Υ		DSWEGO ROAD POOL, NY 13090					
						1		
(b) Amount of sales ar				s and other commissions paid				
commissions pa		(c) Amount		(d) Purpos	ee	(e) Organization code		
	5014					3		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
(In) Amazonat of sol		Fe	es and other commission	ns paid				
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpose		(e) Organization code		
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.  Schedule A (Form 5500) 2016								

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

Fees and other commissions paid

(d) Purpose

(c) Amount

**(b)** Amount of sales and base commissions paid

(e) Organization code

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_	10	II Investment and Annuity Centreet Information							
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	nay be treated as a	unit for purposes of				
this report.  4 Current value of plan's interest under this contract in the general account at year end									
		rent value of plan's interest under this contract in separate accounts at year e	na	5					
ь		tracts With Allocated Funds:							
	а	State the basis of premium rates							
				Cla					
	b	Premiums paid to carrier		_					
	C	Premiums due but unpaid at the end of the year		<b>6c</b>					
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>					
		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	nating plan, check horo	7					
7		tracts With Unallocated Funds (Do not include portions of these contracts ma							
•			ate participation guarantee						
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그							
		(3) guaranteed investment (4) dther	•						
	b	Balance at the end of the previous year		7b					
	С	Additions: (1) Contributions deposited during the year	7c(1)						
		(2) Dividends and credits	7c(2)						
		(3) Interest credited during the year	7c(3)						
		(4) Transferred from separate account	7c(4)						
		(5) Other (specify below)	7c(5)						
		•							
		(6)Total additions		7c(6)	0				
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0				
	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)						
		<b>)</b>							
				7.(5)					
	,	(5) Total deductions			0				
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0				

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Pa	art I	II	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group of employees of th	tracts are expe	erience-rated as a un	it. Where co	ontracts cover in	
8	Bene	efit an	nd contract type (check all applicable boxes)						
	а	Hea	alth (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insura	ance
	e 🗆	Ter	mporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unem	plovment	h Prescripti	on drua
	ιĖ	J 7	pp loss (large deductible)	j  HMO contract	· - <u>-</u>	PPO contract	, ,	I ☐ Indemnity	-
	m >	_	ner (specify) AD&D	, rime somiaet	·· _	] T T O OOTMOOR			Communication
<b>9</b> E	Ехре	rienc	e-rated contracts:						
	a F	remi	ums: (1) Amount received		9a(1)				
		(2) In	crease (decrease) in amount due but unpai	d	9a(2)				
		(3) In	crease (decrease) in unearned premium res	serve	9a(3)				
		(4) E	arned ((1) + (2) - (3))		· <u>·····</u>		9a(4)		0
	b	Bene	efit charges (1) Claims paid		9b(1)				
		(2) In	crease (decrease) in claim reserves		9b(2)				
		(3) In	curred claims (add (1) and (2))				9b(3)		0
		(4) C	laims charged				9b(4)		
	С	Rem	ainder of premium: (1) Retention charges (	on an accrual basis)					
		(.	A) Commissions		9c(1)(A)				
		(	B) Administrative service or other fees		9c(1)(B)				
		(	C) Other specific acquisition costs		9c(1)(C)				
		(	D) Other expenses		9c(1)(D)				
		(	E) Taxes		9c(1)(E)				
		(	F) Charges for risks or other contingencies		9c(1)(F)				
		(	G) Other retention charges		9c(1)(G)				
		(	H) Total retention				9c(1)(H)	)	0
		(2) D	ividends or retroactive rate refunds. (These	e amounts were 🗌 paid i	n cash, or 🔲 d	credited.)	9c(2)		
	d	Statu	us of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) C	claim reserves				9d(2)		
		(3) C	Other reserves				9d(3)		
	е	Divid	lends or retroactive rate refunds due. (Do n	ot include amount entere	d in line <b>9c(2)</b>	.)	9e		
10	Nor	nexpe	erience-rated contracts:						
	а	Total	I premiums or subscription charges paid to	carrier			10a		
	b	If the	carrier, service, or other organization incur	red any specific costs in o	connection wit	h the acquisition or			
			ntion of the contract or policy, other than rep				10b		
,	Spe	cify na	ature of costs.						
Pa	rt l'	V	Provision of Information						
						40	Va-	NI-	
			nsurance company fail to provide any inforn		iete Schedule	A?	Yes	X No	
12	If th	e 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.

OMB No. 1210-0110

,			e required to provide the informal RISA section 103(a)(2).	This For	rm is Open to Public Inspection
For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016	and er	nding 12/31/2016	-
A Name of plan LORETTO HEALTH AND	WELFARE WR	RAP PLAN		e-digit number (PN)	502
C Plan sponsor's name a LORETTO MANAGEMEN		e 2a of Form 5500	-	oyer Identification Number 2873640	(EIN)
		ning Insurance Contract ( . Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca		NY			
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To
13-1898173	64297	E3090784	5	01/01/2016	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and c	other persons in
(a) Total	amount of comr		<b>(b)</b> To	otal amount of fees paid	
		512			0
3 Persons receiving com		ees. (Complete as many entries a			
DAVAMONID CINIDONIE	(a) Name a	nd address of the agent, broker, o	· · · · · · · · · · · · · · · · · · ·	sions or fees were paid	
RAYMOND SINDONE			ESIDE LANE JS, NY 13031		
(b) Amount of sales a	nd base	Fees	and other commissions paid		
commissions pa			(d) Purpos	(e) Organization code	
	113				
	(a) Name a	nd address of the agent, broker, c	or other person to whom commiss	sions or fees were paid	
MCIHAEL A DIGIROLOMO	)		DEWATERS PARKWAY , NY 13214		
(b) Amount of sales a	nd hase	Fees	and other commissions paid		
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code
	113				3
For Paperwork Reduction	on Act Notice. s	see the Instructions for Form 55	500.	Sche	dule A (Form 5500) 2016

Page <b>2</b> –	1	
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<b>(a)</b> Nar	ne and address of the agent, brol	ker, or other person to whom commissions or fees were paid	
MICHAEL KASCH	761	16 WILD TURKEY	
	LIV	(ERPOOL, NY 13090	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
113			3
110			· ·
		ker, or other person to whom commissions or fees were paid	
MARK FRANCIS		88 WIDEWATERS PARKWAY WITT, NY 13214	
	DE	WITT, NT 13214	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
113			3
		ker, or other person to whom commissions or fees were paid	
PAUL L WILSON	C/C MA	O WILSON FINANCIAL CONCEPTS NLIUS, NY 13104	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
60			3
(a) Nar	ne and address of the agent, brok	ker, or other person to whom commissions or fees were paid	
(2)			
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(o) / tillodite	(a) i dipose	code
<b>(a)</b> Nar	ne and address of the agent, brol	ker, or other person to whom commissions or fees were paid	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization code
commissions paid	7-7	(-)	code
		<u> </u>	l

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_	10	II Investment and Annuity Centreet Information					
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	nay be treated as a	unit for purposes of		
this report.  4 Current value of plan's interest under this contract in the general account at year end							
		rent value of plan's interest under this contract in separate accounts at year e	na	5			
ь		tracts With Allocated Funds:					
	а	State the basis of premium rates					
				Cla			
	b	Premiums paid to carrier		_			
	C	Premiums due but unpaid at the end of the year		<b>6c</b>			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>			
		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	nating plan, check horo	7			
7		tracts With Unallocated Funds (Do not include portions of these contracts ma					
•			ate participation guarantee				
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그					
		(3) guaranteed investment (4) dther	•				
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions		7c(6)	0		
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0		
	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)				
		<b>)</b>					
				7.(5)			
	,	(5) Total deductions			0		
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0		

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Pa	art	III Welfare Benefit Contract Informat	ion					
		If more than one contract covers the same guthe information may be combined for reportir employees, the entire group of such individual.	g purposes if such contr	acts are expe	erience-rated as a unit	t. Where co	ontracts cover individual	
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance	
	e Ī	Temporary disability (accident and sickness)	f X Long-term disability	v <b>a</b> ∏	Supplemental unem	plovment	h Prescription drug	l
	· [	Stop loss (large deductible)	i HMO contract		PPO contract	,	I  Indemnity contract	
	m∫		, I mile community	🗆	110001111101			,
	L							
<b>9</b> E	Ехре	perience-rated contracts:						
	a	Premiums: (1) Amount received		9a(1)		2828	3	
		(2) Increase (decrease) in amount due but unpaid		9a(2)				
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)				
		(4) Earned ((1) + (2) - (3))	<u>-</u>			9a(4)		2828
	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)		0
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses	<u>L</u>	9c(1)(D)				
		(E) Taxes	<u>L</u>	9c(1)(E)			_	
		(F) Charges for risks or other contingencies					_	
		(G) Other retention charges		9c(1)(G)		T		
		(H) Total retention	_	_		9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide b	penefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	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	If the carrier, service, or other organization incurre				10b		
	Sne	retention of the contract or policy, other than reporecify nature of costs.	ted in Part I, line 2 above	e, report amo	unt	100		
	Орс	cony flature of costs.						
Ps	art	IV Provision of Information						
		id the insurance company fail to provide any informa	tion necessary to comple	ata Schadula	Δ2 Π	Yes	X No	
		the answer to line 11 is "Yes." specify the information		Jie Gorieudie	Λ:	700	<u>r</u>	
14	ır t	the answer to line 11 is "Yes." specify the informatio	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

OMB No. 1210-0110

			RISA section 103(a)(2).	Inis For	m is Open to Public Inspection
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016	and en	iding 12/31/2016	
A Name of plan LORETTO HEALTH AND WELFARE WRAP PLAN				e-digit number (PN)	502
C Plan sponsor's name a LORETTO MANAGEMEN		e 2a of Form 5500	-	oyer Identification Number 2873640	(EIN)
		ning Insurance Contract ( Individual contracts grouped as			
1 Coverage Information:					
(a) Name of insurance ca		NY			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	Policy or c	ontract year
(b) EIN	code	identification number	policy or contract year	(f) From	<b>(g)</b> To
13-1898173	64297	E4375523	3	01/01/2016	12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	other persons in
(a) Total a	amount of comr		<b>(b)</b> To	otal amount of fees paid	
		106			0
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	s needed to report all persons).		
	(a) Name a	nd address of the agent, broker, o		ions or fees were paid	
STUART GROSSMAN			RBECK DRIVE S, NY 13104		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pa	id	(c) Amount	(d) Purpose	e	(e) Organization code
70					3
	(a) Name a	nd address of the agent, broker, c	or other person to whom commiss	ions or fees were paid	
CHARLES P HOPE			TARINE AVE DOL, NY 13090		
(b) Amount of color and	nd book	Fees	and other commissions paid		
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose	e	(e) Organization code
·	18				3
For Panerwork Reduction	n Act Notice	see the Instructions for Form 55	500	Sche	dule A (Form 5500) 2016

	<b>-</b>		
Schedule A	(Form	5500)	2016

Page <b>2</b> –	1	
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(a) Name and address of the agent, broker,	or other person to whom commissions or fees were paid			
CASE DODTODELLO WAY				

RICHARD P HOPE

8105 PORTOBELLO WAY LIVERPOOL, NY 13090

		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
18			3
(a) Nar	ne 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
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(I) Assessed of soles and bear		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nav			
( <b>a</b> ) Nar	ne 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
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

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_	10	II Investment and Annuity Centreet Information					
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	nay be treated as a	unit for purposes of		
this report.  4 Current value of plan's interest under this contract in the general account at year end							
		rent value of plan's interest under this contract in separate accounts at year e	na	5			
ь		tracts With Allocated Funds:					
	а	State the basis of premium rates					
				Cla			
	b	Premiums paid to carrier		_			
	C	Premiums due but unpaid at the end of the year		<b>6c</b>			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>			
		Specify nature of costs					
	е	Type of contract: (1) individual policies (2) group deferred	d annuity				
		(3) other (specify)					
		У, Ц У У У					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check horo	7			
7		tracts With Unallocated Funds (Do not include portions of these contracts ma					
•			ate participation guarantee				
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그					
		(3) guaranteed investment (4) dther	•				
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions		7c(6)	0		
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0		
	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)				
		<b>)</b>					
				7.(5)			
	,	(5) Total deductions			0		
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0		

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F	Part	III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individe	group of employees of th	tracts are	exp	erience-rated as a un	it. Where co	ontracts	s cover individual
8	Ben	efit a	nd contract type (check all applicable boxes)							
	а	Не	ealth (other than dental or vision)	<b>b</b> Dental		С	Vision		d	Life insurance
	е	= Te	emporary disability (accident and sickness)	f X Long-term disabil	itv	g	Supplemental unem	nplovment	h∏	Prescription drug
	i	=	op loss (large deductible)	j HMO contract	-		PPO contract	. ,	- =	Indemnity contract
	m		her (specify)	, rame contract		∟	] 11 0 001111401		- Ш	maoning contract
	[	٦ °.	inel (epecity)							
9	Ехр	eriend	ce-rated contracts:				-			
	а	Prem	iums: (1) Amount received		9a(1)	)		147	1	
		(2) Ir	ncrease (decrease) in amount due but unpai	d	9a(2)	)				
		1l (E)	ncrease (decrease) in unearned premium re	serve	9a(3)	)	<u> </u>	1		
		` '	Earned ((1) + (2) - (3))					9a(4)		1471
	b		efit charges (1) Claims paid				<u> </u>		_	
		` '	ncrease (decrease) in claim reserves				L	21 (2)		
			ncurred claims (add (1) and (2))					9b(3)		(
	_	` '	Claims charged					9b(4)		
	С		nainder of premium: (1) Retention charges (		0=/4\/	A \			_	
			(A) Commissions		9c(1)(				-	
			(B) Administrative service or other fees		9c(1)(				_	
			(C) Other specific acquisition costs(D) Other expenses		9c(1)(				-	
			(E) Taxes		9c(1)(l	-			-	
			(F) Charges for risks or other contingencies		9c(1)(					
			(G) Other retention charges		0 - /4\//					
			(H) Total retention			-		9c(1)(H	)	(
			Oividends or retroactive rate refunds. (These	_		_		9c(2)	,	
	d		us of policyholder reserves at end of year: (	_		_		9d(1)		
	-		Claim reserves	•				9d(2)		
		` '	Other reserves					9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do r	ot include amount entere	d in line 9	c(2)	).)	9e		
10	) No		erience-rated contracts:					•		
	а	Tota	al premiums or subscription charges paid to	carrier				10a		
	b	If the	e carrier, service, or other organization incur	red any specific costs in	connectio	n wit	th the acquisition or			
		rete	ntion of the contract or policy, other than rep					10b		
	Эре	City i	nature of costs.							
P	art	IV	Provision of Information							
				nation page and to accomp	Note Cake	ماريام		Yes	X No	<u> </u>
			insurance company fail to provide any inform		nete Sche	aule	A f	162	^ INO	-
12	∠ If t	he ar	nswer to line 11 is "Yes," specify the information	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.

OMB No. 1210-0110

,			RISA section 103(a)(2).	This Fo	rm is Open to Public Inspection	
For calendar plan year 20	16 or fiscal plan	year beginning 01/01/2016	and er	nding 12/31/2016		
A Name of plan LORETTO HEALTH AND	WELFARE WR	RAP PLAN		ee-digit n number (PN)	502	
C Plan sponsor's name a LORETTO MANAGEMEN		e 2a of Form 5500		oyer Identification Number 2873640	(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		NY				
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or o	ontract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To	
13-1898173	64297	E7436355	55	01/01/2016	12/31/2016	
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers, and o	other persons in	
(a) Total	amount of comr		<b>(b)</b> To	otal amount of fees paid		
		5237			0	
3 Persons receiving com		ees. (Complete as many entries a				
MICHAEL KACCH	(a) Name a	nd address of the agent, broker, o	<u>'</u>	sions or fees were paid		
MICHAEL KASCH			LD TURKEY DOL, NY 13090			
(b) Amount of sales a	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	(e) Organization code		
	1039			3		
	(a) Name a	nd address of the agent, broker, c	or other person to whom commiss	sions or fees were paid		
RAYMOND SINDONE		140 FIRE CAMILLU	ESIDE LANE JS, NY 13031			
(b) Amount of sales a	nd hase	Fees	and other commissions paid	nd other commissions paid		
commissions pa		(c) Amount	(d) Purpos	(e) Organization code		
	867				3	
For Paperwork Reduction	on Act Notice. s	see the Instructions for Form 55	500.	Sche	dule A (Form 5500) 2016	

Page <b>2</b> -	1		
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<b>(a)</b> Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
MICHAEL A DIGIROLOMO		WIDEWATERS PARKWAY	
	DEWI	TT, NY 13214	
			1
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(c) Amount	(u) r dipose	code
862			3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
MARK FRANCIS		WIDEWATERS PARKWAY	
		TT, NY 13214	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
788			3
(a) Nor	me and address of the agent broken	r, or other person to whom commissions or fees were paid	
		· · · · · · · · · · · · · · · · · · ·	
STUART GROSSMAN		VERBECK DRIVE LIUS, NY 13104	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
732			3
		r, or other person to whom commissions or fees were paid	
NATHANIEL GOLDMAN		YORK LIFE TT, NY 13214	
	DEWI	11, NT 13214	
			T
45.5		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
627	(1)	(*)	3
021			3
<b>(a)</b> Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
RICHARD P HOPE	8105	PORTOBELLO WAY	
	LIVEF	RPOOL, NY 13090	
		Fees and other commissions paid	(e)
(b) Amount of sales and base			Organization
commissions paid	(c) Amount	(d) Purpose	code
159			3

Page <b>2</b> –	2	
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<b>(a)</b> Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
ENV INSURANCY AGENCY		OSWEGO ROAD RPOOL, NY 13090	
	LIVER	XFOOL, NT 13090	
		Fees and other commissions paid	(e)
<b>(b)</b> Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
130			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
CHARLES P HOPE		ECTARINE AVE	
		RPOOL, NY 13090	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
30			3
		r, or other person to whom commissions or fees were paid	
JASON P MOODY	138 S BALD	OFTWIND CIRCLE WINSVILLE, NY 13027	
	525	, , , , , , , , , , , , , , , , , , , ,	
		(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
3			3
<b>(a)</b> Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(C) Amount	(u) Fulpose	code
(a) Nor	no and address of the agent, broken	r, or other person to whom commissions or fees were paid	
(a) Ivai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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_	10	II Investment and Annuity Centreet Information					
ŀ	Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of						
_	C	this report.	and				
		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	na	5			
ь		tracts With Allocated Funds:					
	а	State the basis of premium rates					
				Cla			
	b	Premiums paid to carrier		_			
	C	Premiums due but unpaid at the end of the year		<b>6c</b>			
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>			
		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	nating plan, check horo	7			
7		tracts With Unallocated Funds (Do not include portions of these contracts ma					
•			ate participation guarantee				
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그					
		(3) guaranteed investment (4) dther	•				
	b	Balance at the end of the previous year		7b			
	С	Additions: (1) Contributions deposited during the year	7c(1)				
		(2) Dividends and credits	7c(2)				
		(3) Interest credited during the year	7c(3)				
		(4) Transferred from separate account	7c(4)				
		(5) Other (specify below)	7c(5)				
		•					
		(6)Total additions		7c(6)	0		
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0		
	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)				
		<b>)</b>					
				7.(5)			
	,	(5) Total deductions			0		
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0		

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Pa	art I	II Welfare Benefit Contract Informa	tion				
		If more than one contract covers the same of the information may be combined for reportion employees, the entire group of such individual.	ng purposes if such cont	racts are expe	erience-rated as a u	nit. Where co	ontracts cover individual
8	Bene	efit and contract type (check all applicable boxes)		-			·
	аГ	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		<b>d</b> Life insurance
	e [	Temporary disability (accident and sickness)	f X Long-term disability	<u></u>	Supplemental uner	mnlovment	<b>h</b> ☐ Prescription drug
	. L			·		прюутнети	
	' <u> </u>	Stop loss (large deductible)	j HMO contract	K _	PPO contract		I Indemnity contract
	m	Other (specify)					
^							
		erience-rated contracts:		0-(4)		00440	
		Premiums: (1) Amount received		9a(1) 9a(2)		26119	<del>)</del>
		<ul><li>(2) Increase (decrease) in amount due but unpaid</li><li>(3) Increase (decrease) in unearned premium res</li></ul>		9a(2)			
		(4) Earned ((1) + (2) - (3))				9a(4)	26119
	_	Benefit charges (1) Claims paid		9b(1)		Ju(+)	20110
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				. 9b(3)	0
		(4) Claims charged					
	С	Remainder 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) 9c(1)(G)			_
		(G) Other retention charges				9c(1)(H)	) 0
		(H) Total retention					0
	٦	(2) Dividends or retroactive rate refunds. (These	_				
	d	Status of policyholder reserves at end of year: (1) (2) Claim reserves(1)	•			•	
		(3) Other reserves					
	е	Dividends or retroactive rate refunds due. (Do no					
10		nexperience-rated contracts:	a morado amount omorod	· · · · · · · · · · · · · · · · · · ·	.,	.   00	
		Total premiums or subscription charges paid to ca	arrier			. 10a	
	_	If the carrier, service, or other organization incurre					
		retention of the contract or policy, other than repo				. 10b	
	Spe	cify nature of costs.					
Pa	art l	V Provision of Information					
		the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	A?	Yes	X No
		ne answer to line 11 is "Yes," specify the information		2.0 00/104410			<u> </u>
	11 (1	is anomer to line it is ites, specify the initialitial	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.

OMB No. 1210-0110

T ension benefit duaranty oc	прогашот	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				m is Open to Public Inspection
For calendar plan year 20	16 or fiscal plar	year beginning 01/01/2016	and e	ending 12/31/20	016	
A Name of plan LORETTO HEALTH AND	WELFARE WR	RAP PLAN		ree-digit an number (PN)	<b>)</b>	502
C Plan sponsor's name a LORETTO MANAGEMEN		e 2a of Form 5500		oloyer Identificatio 2-2873640	on Number (	EIN)
		ning Insurance Contract ( . Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		NY				
	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) Fro	om	<b>(g)</b> To
13-1898173	64297	E7784051	133	01/01/2016		12/31/2016
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line	3 the agents, bro	kers, and ot	her persons in
(a) Total a	amount of comr	nissions paid	(b)	Total amount of f	ees paid	
		10444				0
3 Persons receiving com		ees. (Complete as many entries a				
DAVAGNID I GINDONE	(a) Name a	nd address of the agent, broker, o	•	ssions or fees we	re paid	
RAYMOND J SINDONE			ESIDE LANE JS, NY 13031			
(b) Amount of sales ar	nd hase	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	1819					3
	(a) Name a	nd address of the agent, broker, c	or other person to whom commis	ssions or fees we	re paid	
MICHAEL A DIGIROLOMO			DEWATERS PARKWAY , NY 13214			
(la) Amazini - ( 1		Fees	Fees and other commissions paid  (d) Purpose			
(b) Amount of sales ar commissions pa		(c) Amount				(e) Organization code
	1819					3
For Paperwork Reduction	n Act Notice, s	see the Instructions for Form 55	500.		Sched	lule A (Form 5500) 2016

Schedule A (Form 5500) 2016		Page <b>2 -</b> 1	
(a) Name a	nd address of the agent, broke	er, or other person to whom commissions or fees were paid	
MICHAEL KASCH		S WILD TURKEY RPOOL, NY 13090	
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code
1786			3
(a) Name a	nd address of the agent, broke	er, or other person to whom commissions or fees were paid	
MARK FRANCIS		3 WIDEWATERS PARKWAY VITT, NY 13214	
	52.	,	
			(-)
(b) Amount of sales and base	(a) A == at	Fees and other commissions paid	<b>(e)</b> Organization
commissions paid	(c) Amount	(d) Purpose	code 3
1093			3
		er, or other person to whom commissions or fees were paid	
STUART GROSSMAN		3 VERBECK DRIVE ILIUS, NY 13104	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1503		, , ,	3
(a) Nama a	nd address of the agent, broke	er, or other person to whom commissions or fees were paid	
NATHANIEL GOLDMAN	NEW	/ YORK LIFE	
	DEW	/ITT, NY 13214	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
909			3
(a) Name a	nd address of the agent, broke	er, or other person to whom commissions or fees were paid	

7789 OSWEGO ROAD LIVERPOOL, NY 13090

(c) Amount

Fees and other commissions paid

(d) Purpose

(e) Organization code

**ENV INSURANCY AGENCY** 

**(b)** Amount of sales and base commissions paid

(a) Nam	e and address of the agent, brok	ter, or other person to whom commissions or fees were paid	1
RICHARD P HOPE	810 LIVI	5 PORTOBELLO WAY ERPOOL, NY 13090	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
236			3
(a) Nam	e and address of the agent, brok	ker, or other person to whom commissions or fees were paid	<u> </u>
CHARLES P HOPE	14 N	NECTARINE AVE ERPOOL, NY 13090	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
158			3
(a) Nam	e and address of the agent, brok	ker, or other person to whom commissions or fees were paid	<u>'</u>
EMPLOYEE FAMILY PROTECTION IN	IC PO	BOX 1237 ASTONBURY, CT 06033	
(b) Amount of color and book		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
30			3
(a) Nam	e and address of the agent, brok	ker, or other person to whom commissions or fees were paid	
JASON P MOODY	138	SOFTWIND CIRCLE DWINSVILLE, NY 13027	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
20			
(a) Nam	e and address of the agent, brok	ker, 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

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_	10	II Investment and Annuity Centreet Information			
ŀ	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	nay be treated as a	unit for purposes of
_	C	this report.	and		
		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	na	5	
ь		tracts With Allocated Funds:			
	а	State the basis of premium rates			
				Cla	
	b	Premiums paid to carrier		_	
	C	Premiums due but unpaid at the end of the year		<b>6c</b>	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		<b>6d</b>	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		У, Ц У У У			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check horo	7	
7		tracts With Unallocated Funds (Do not include portions of these contracts ma			
•			ate participation guarantee		
	а	그 하는 그 그 그 그 가게 되는 것이 되는 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그			
		(3) guaranteed investment (4) dther	•		
	b	Balance at the end of the previous year		7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
	d	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> )		7d	0
	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)		
		<b>)</b>			
				7.(5)	
	,	(5) Total deductions			0
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		<b>7f</b>	0

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Pa	rt II	Welfare Benefit Contract Information if more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of th	tracts are expe	erience-rated as a uni	t. Where co	ntracts cover individual
8	3ene	fit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f X Long-term disabil	ity <b>g</b>	Supplemental unem	ployment	h Prescription drug
	ι F	Stop loss (large deductible)	j HMO contract	· <u> </u>	PPO contract		I  Indemnity contract
	m	Other (specify)	, []		1		
9 F	xper	rience-rated contracts:					
	•	remiums: (1) Amount received		9a(1)		53776	
		Increase (decrease) in amount due but unpaid		<del>- ` ' -  </del>		00110	
		3) Increase (decrease) in unearned premium res		<del>- 11</del>			
		4) Earned ( <b>(1) + (2) - (3)</b> )				. 9a(4)	53776
	,	Benefit charges (1) Claims paid					
		2) Increase (decrease) in claim reserves					
	(	3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	0
		4) Claims charged				9b(4)	
	C	Remainder of premium: (1) Retention charges (c	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 .					
		(G) Other retention charges		9c(1)(G)		T	
		(H) Total retention				9c(1)(H)	0
	(	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or 📗 d	credited.)	9c(2)	
	d :	Status 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)	
		Dividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line <b>9c(2)</b> .	.)	9e	
10	Non	experience-rated contracts:					
	a '	Total premiums or subscription charges paid to o	arrier			10a	
		If the carrier, service, or other organization incur				10b	
	_	retention of the contract or policy, other than rep- ify nature of costs.	orted in Part I, line 2 abov	ve, report amo	ount	100	
Pa	rt I\	/ Provision of Information					
		the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	А?	Yes	X No
		e answer to line 11 is "Yes," specify the informat					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration **Service Provider Information** 

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2016

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation	
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016	and ending 12/31/2016
A Name of plan LORETTO HEALTH AND WELFARE WRAP PLAN	B Three-digit plan number (PN) 502
C Plan sponsor's name as shown on line 2a of Form 5500 LORETTO MANAGEMENT COMPANY	D Employer Identification Number (EIN) 22-2873640
Port I Comice President Information (see instructions)	
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information re or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received <b>only</b> eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of t	with services rendered to the plan or the person's position with the the plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Compensati	on
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the	is Part because they received only eligible
indirect compensation for which the plan received the required disclosures (see instructions to	for definitions and conditions)
<b>b</b> If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see inst	•
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disc	closures on eligible indirect compensation

Schedule C (Form	5500) 2016	Page <b>2-</b> 1
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on clinible indirect compensation
(6)	Enter hame and Env or address of person who provided you	disclosures on eligible indirect compensation
(b)	Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2016		Page <b>3 -</b> 1		
answered	"Yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
LIFETIME	BENEFIT SOLUTION	S		NTINUUM DR. POOL, NY 13088		
16-117176	5					
(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15	THIRD PARTY ADMIN	14178	Yes No 🛚	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		

(f)
Did indirect compensation

include eligible indirect

compensation, for which the plan received the required

disclosures?

Yes No

(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-.

(h)

Did the service

provider give you a

formula instead of

an amount or

estimated amount?

Yes No

(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)

Yes No

Page <b>3</b> -	2
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answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	r address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No No		Yes No

Page <b>4 -</b>
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Schedule C (Form 5500) 2016

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

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

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

Page <b>6 -</b>	l
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Schedule C (Form 5500) 2016

Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
а	Name:		<b>b</b> EIN:	
С	Positio	n:		
d	Addres		e Telephone:	
ŭ	/ tauloc	0.	Totophone.	
	planatior			
LX	piariatioi	•		
a	Name:		<b>b</b> EIN:	
С	Positio	n:		
d	Addres	S:	<b>e</b> Telephone:	
Ex	planatior	1		
	•			
	Niero		h rivi	
a	Name:		<b>b</b> EIN:	
C	Positio			
d	Addres	S:	<b>e</b> Telephone:	
Ex	planatior	:		
а	Name:		<b>b</b> EIN:	
С	Positio	n·		
d	Addres		e Telephone:	
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Fv	planatior	:		
	piariatioi	•		
a	Name:		<b>b</b> EIN:	
С	Positio			
d	Addres	S:	<b>e</b> Telephone:	
Explanation:				