Form 5500	-	t of Employee Benefit Plan		OMB Nos. 12 12	210-0110		
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).		and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and				
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	l plan year beginning 06/01/2017	and ending 05/31/20	018				
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking t participating employer information in accord			ns.)		
	X a single-employer plan	a DFE (specify)					
B This return/report is:	the first return/report	the final return/report					
an amended return/report a short plan year return/report (less than				12 months)			
C If the plan is a collectively-bargai	 ned plan, check here			• 🗆			
	Form 5558	automatic extension	□ the	e DFVC program			
D Check box if filing under:	special extension (enter description)						
Dort II Regio Dian Inform							
Part II Basic Plan Inform 1a Name of plan	ation—enter all requested information	1	1h	Three-digit plan			
QUINCY UNIVERSITY HEALTH AN	ND WELFARE PLAN			number (PN) >	501		
			1c	Effective date of pla 06/01/2014	an		
	; 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) 37-0661231	ition		
QUINCY UNIVERSITY			2c	Plan Sponsor's tele number 217-222-8020			
1800 COLLEGE AVE QUINCY, IL 62301-2670	1800 COLLI QUINCY, IL	EGE AVE 62301-2670	2d	Business code (see instructions) 611000	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 HERE	Filed with authorized/valid electronic signature.	11/27/2018	TANYA MOORE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
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) Page 2		
3a	Plan administrator's name and address 🔀 Same as Plan Sponsor	3b Administ	rator's EIN
		3c Administ number	rator's telephone
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 EIN	
a c	Sponsor's name Plan Name	4d PN	
5	Total number of participants at the beginning of the plan year	5	132
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)	132
a(2) Total number of active participants at the end of the plan year	6a(2)	123
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	123
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<u>6e</u>	
f	Total. Add lines 6d and 6e	<u>6f</u>	123
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	

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 4H 4L

9a	Plan funding arrangement (check all that apply)			Plan bene	efit a	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) X	General assets of the sponsor		(4)	X	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 Pension Schedules b General S						edules	

a Pension Schedules					al Sch	nedule	s
(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	3	A (Insurance Information)
		actuary		(4)	X		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.) Yes No					
lf "Ye	s" 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.)				
Receij	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_____

	-						
SCHEDULE (Form 5500		Insuran	ce Information	n		ON	IB No. 1210-0110
Department of the Treasury Internal Revenue Service 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	Department of Labor						2017
Pension Benefit Guaranty Co					tion	This Fo	m is Onen te Duklis
			es are required to provide the information This I to ERISA section 103(a)(2).			I NIS FO	rm is Open to Public Inspection
For calendar plan year 20)17 or fiscal plan	year beginning 06/01/2017		and er	iding 05/3	31/2018	Г
A Name of plan QUINCY UNIVERSITY H	IEALTH AND W	ELFARE PLAN			e-digit number (Pl	N) ►	501
				D			(= 1) ()
C Plan sponsor's name a QUINCY UNIVERSITY	as shown on line	2a of Form 5500			oyer Identific 0661231	ation Number	(EIN)
		ning Insurance Contract					
1 Coverage Information:							
(a) Name of insurance ca UNITED OF OMAHA LIFE		COMPANY					
(c) NAIC		(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
47-0322111	69868	G000AXWV	123	3	06/01/201	7	05/31/2018
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in
(a) Total	amount of comr	nissions paid		(b) To	otal amount	of fees paid	
		3812					
3 Persons receiving com	nmissions and fe	es. (Complete as many entries	as needed to report all	persons).			
	<i>i</i> /	nd address of the agent, broker,		m commiss	ions or fees	were paid	
JL HUBBARD INSURANC	E & BONDS, IN		8 ROUTE 51 YTH, IL 62535				
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	3812						
	(a) Name a	nd address of the agent, broker,	, or other person to who	n commiss	ions or fees	were paid	
						·	
		E	es and other commission	ns naid			1
(b) Amount of sales a commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice	e, see the Instructions for Form 550	0.

(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			
(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		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end		
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)	I	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Specify nature of costs.

Ρ	art	11	Welfare Benefit Contract Informa		same emplo	over(s) or members of	the same ei	mployee organizations(s),
			the information may be combined for reporti employees, the entire group of such individu					
8	Ben	efit ar	nd contract type (check all applicable boxes)					
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d X Life insurance
	e	Te	mporary disability (accident and sickness)	f X Long-term disabilit	y g	Supplemental unemp	oloyment	h Prescription drug
	ίĪ	Sto	op loss (large deductible)	j 🗍 HMO contract	k	PPO contract		I Indemnity contract
	m] Ot	her (specify)		L	1		
	L							
9	Expe	rienc	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)			
		` '	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) E	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	penefits after	retirement	9d(1)	
		(2) (Claim reserves				9d(2)	
		(3) (Other reserves				9d(3)	
	е	Divid	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	28436
	b	If the	e carrier, service, or other organization incurre	ed any specific costs in co	onnection wit	h the acquisition or		
			ntion of the contract or policy, other than repo				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		Insuran	ce Informatio	n		O	//B No. 1210-0110
(Form 5500) Department of the Treasury This schedule is required to be filed under section			tion 104 of the				
Internal Revenue Serv Department of Labo	vice	Employee Retirement In	come Security Act of 19	74 (ERISA			2017
Employee Benefits Security Ad	Iministration	File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	 Insurance companies a pursuant to E 	are required to provide t ERISA section 103(a)(2)		ion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	17 or fiscal plan	year beginning 06/01/2017		and er	ding 05/3	31/2018	1
A Name of plan QUINCY UNIVERSITY H	EALTH AND W	ELFARE PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name a QUINCY UNIVERSITY	as shown on line	2a of Form 5500			oyer Identific 0661231	cation Number	(EIN)
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca HARTFORD LIFE AND AC							
(b) EIN	(c) NAIC	(d) Contract or identification number	.,	Approximate number of sons covered at end of		,	contract year
	code		policy or contrac			From	(g) To
06-0838648	70815	ETB006357	123 06/01/		06/01/201	7	05/31/2018
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	other persons in
(a) Total	amount of comm			(b) To	otal amount	of fees paid	
		113					
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	1 <i>i</i>	nd address of the agent, broker,		m commiss	ions or fees	were paid	
WINTERS INSURANCE G	ROUP LLP		5TH STREET SY, IL 62301				
(b) Amount of sales a	nd base	Fee	ees and other commissions paid			_	
commissions paid (c) Amount 113		(c) Amount		(d) Purpos	e		(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
		Fer	es and other commission	ns paid			
(b) Amount of sales and base commissions paid		(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

	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		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end		
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)	I	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

	art I	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 s	cts are expe	erience-rated as a unit.	Where con	tracts cover individual
8	Bene	efit and contract type (check all applicable boxes)	_				_
	а	Health (other than dental or vision)	b Dental	С	Vision	C	d Life insurance
	е	Temporary disability (accident and sickness)	f 🗌 Long-term disability	g	Supplemental unemp	loyment	h Prescription drug
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	X Other (specify) ►BUSINESS TRAVEL ACCIDE	ENT				
9	Expe	erience-rated contracts:					
	a F	Premiums: (1) Amount received		9a(1)			
		(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)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (or	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)			1
		(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 c	ash, or 🛛 d	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide be	enefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entered in	n line 9c(2) .)	9e	
10	No	onexperience-rated contracts:					
	а	Total premiums or subscription charges paid to ca	arrier			10a	750
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repo				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 answer to line 11 is "Yes," specify the information not provided.

Specify nature of costs.

SC	HEDULE	Α	Insurai	nc	e Informatior	า		OM	B No. 1210-0110
•	orm 5500	,	-						
	tment of the Treas nal Revenue Servi		This schedule is require Employee Retirement						2017
	epartment of Labor enefits Security Adr		File as an	n att	achment to Form 55	00.			
Pension Be	enefit Guaranty Co	rporation	 Insurance companies pursuant to 		e required to provide th RISA section 103(a)(2)		tion		m is Open to Public Inspection
-	· · · ·	17 or fiscal pla	n year beginning 06/01/2017			and er	nding 05/3	31/2018	- F
A Name of QUINCY UN		EALTH AND V	VELFARE PLAN				ee-digit n number (P	N) ►	501
C Plan spor		s shown on lin	e 2a of Form 5500			•	oyer Identific -0661231	cation Number ((EIN)
Part I			rning Insurance Contract						
1 Coverage	Information:		Ę.				•	-	
(a) Name of VISION SER	insurance ca VICE PLAN	rrier							
		(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	(g) To
20-0891619		12516	30041644		72		06/01/201	7	05/31/2018
		mission inform amount paid.	ation. Enter the total fees and to	total	commissions paid. Li	st in line 3	the agents,	brokers, and o	ther persons in
		amount of com	missions paid			(b) ⊤	otal amount	of fees paid	
			631						
3 Persons r	receiving com	missions and f	ees. (Complete as many entrie	es as	s needed to report all	persons).			
GROUP BEN		11	and address of the agent, broke	· ·	<u>r other person to whor</u> X 133	n commiss	sions or fees	s were paid	
GROOP BEN		LK3, LLC			ADISON, IA 52627				_
(b) Amou	unt of sales ar	nd base		ees	and other commission				
COR	mmissions pai	631	(c) Amount			(d) Purpos	e		(e) Organization code
		631							
		(a) Name a	and address of the agent, broke	er. o	r other person to whor	n commis	sions or fees	were paid	
				- , -					
(b) Amor	unt of sales ar	nd base	F [,]	ees	and other commissior	ns paid			
• •	mmissions pai		(c) Amount			(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice	e, see the Instructions for Forr	n 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		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end		
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
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	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Specify nature of costs.

Ρ	art		Welfare Benefit Contract Informa	tion				
			If more than one contract covers the same					
			the information may be combined for report employees, the entire group of such individu					
8	Ben	efit a	nd contract type (check all applicable boxes)					
Ŭ	a	_	ealth (other than dental or vision)	b Dental	c	Vision		d Life insurance
			,					
	е	_	1	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription drug
	i	St	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Ot	ther (specify)					
	-							
9	Expe	eriend	ce-rated contracts:					
	a	Prem	iums: (1) Amount received		9a(1)			
		(2) lı	ncrease (decrease) in amount due but unpaid					_
		(3) lı	ncrease (decrease) in unearned premium res	erve	9a(3)		1	
	-	• •	Earned ((1) + (2) - (3))				9a(4)	
			efit charges (1) Claims paid		• •			_
			ncrease (decrease) in claim reserves					
		(3) lı	ncurred claims (add (1) and (2))				9b(3)	
			Claims charged				9b(4)	
	С		nainder of premium: (1) Retention charges (or					_
			(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				0.(4)(1)	
			(H) Total retention	_			9c(1)(H)	
			Dividends or retroactive rate refunds. (These					
	d		us of policyholder reserves at end of year: (1)	•			9d(1)	
		(2) (Claim reserves				9d(2)	
		• •	Other reserves				9d(3)	
4.5			dends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e	
10		•	erience-rated contracts:					
	а	Tota	al premiums or subscription charges paid to c	arrier			10a	6307
	b		e carrier, service, or other organization incurr					
		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 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 Provide	er Information	C	OMB No. 1210-0110
(Form 5500)				2017
Department of the Treasury Internal Revenue Service	This schedule is required to be filed u Retirement Income Securit			2017
Department of Labor Employee Benefits Security Administration	► File as an attachm	ent to Form 5500.	This Fe	orm is Open to Public Inspection.
Pension Benefit Guaranty Corporation For calendar plan year 2017 or fiscal	Dlan year beginning 06/01/2017	and ending 05/3	1/2018	
A Name of plan			1/2010	
QUINCY UNIVERSITY HEALTH AN	D WELFARE PLAN	B Three-digit plan number (PN)	•	501
Plan sponsor's name as shown on QUINCY UNIVERSITY	line 2a of Form 5500	D Employer Identification 37-0661231	on Number (EIN)
Part I Service Provider In	nformation (see instructions)			
answer line 1 but are not required t	o include that person when completing the re	emainder of this Part.		
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," entreceived only eligible indirect comp 		mainder of this Part because they receinstructions for definitions and conditions son providing the required disclosures fielded (see instructions).	ns)	Yes No
 a Check "Yes" or "No" to indicate whe indirect compensation for which the off of the second se	ether you are excluding a person from the re plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee mame and EIN or address of person who pro-	mainder of this Part because they receinstructions for definitions and conditions son providing the required disclosures fielded (see instructions).	ns)	Yes No
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," entreceived only eligible indirect comp (b) Enter r BLUE CROSS AND BLUE SHIELD 36-1236610 	ether you are excluding a person from the re o plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee name and EIN or address of person who pro- OF IL 300 EAST RANE	mainder of this Part because they recei instructions for definitions and condition son providing the required disclosures f ded (see instructions). vided you disclosures on eligible indirect OOLPH STREET 601	ns)	Yes No
 a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," entreceived only eligible indirect comp (b) Enter r BLUE CROSS AND BLUE SHIELD 36-1236610 	ether you are excluding a person from the re e plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee name and EIN or address of person who prov OF IL 300 EAST RANE CHICAGO, IL 60	mainder of this Part because they recein instructions for definitions and condition son providing the required disclosures f ded (see instructions). vided you disclosures on eligible indirect DOLPH STREET 601	ns)	Yes No
 a Check "Yes" or "No" to indicate whe indirect compensation for which the only only only eligible indirect compensation for which the received only eligible indirect compensation (b) Enter restrict the BLUE CROSS AND BLUE SHIELD 36-1236610 (b) Enter restrict the blue shield blue	ether you are excluding a person from the re e plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee name and EIN or address of person who prov OF IL 300 EAST RANE CHICAGO, IL 60 name and EIN or address of person who prov C PO BOX 133	mainder of this Part because they recein instructions for definitions and condition son providing the required disclosures f ded (see instructions). vided you disclosures on eligible indirect DOLPH STREET 601	ns)	Yes No
A Check "Yes" or "No" to indicate whe indirect compensation for which the If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r BLUE CROSS AND BLUE SHIELD 36-1236610 (b) Enter r GROUP BENEFIT PARTNERS, LLC 27-4689597	ether you are excluding a person from the re e plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee name and EIN or address of person who prov OF IL 300 EAST RANE CHICAGO, IL 60 name and EIN or address of person who prov C PO BOX 133	mainder of this Part because they recei instructions for definitions and condition son providing the required disclosures f ded (see instructions). vided you disclosures on eligible indirect OOLPH STREET 601 vided you disclosures on eligible indirect N, IA 52627	ns)	tion
A Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r BLUE CROSS AND BLUE SHIELD 36-1236610 (b) Enter r GROUP BENEFIT PARTNERS, LLC 27-4689597	ether you are excluding a person from the re e plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee name and EIN or address of person who prov OF IL 300 EAST RANE CHICAGO, IL 60 name and EIN or address of person who prov PO BOX 133 FORT MADISON	mainder of this Part because they recei instructions for definitions and condition son providing the required disclosures f ded (see instructions). vided you disclosures on eligible indirect OOLPH STREET 601 vided you disclosures on eligible indirect N, IA 52627	ns)	tion
a Check "Yes" or "No" to indicate whe indirect compensation for which the b If you answered line 1a "Yes," ent received only eligible indirect comp (b) Enter r BLUE CROSS AND BLUE SHIELD 36-1236610 (b) Enter r GROUP BENEFIT PARTNERS, LLC 27-4689597 (b) Enter r	ether you are excluding a person from the re e plan received the required disclosures (see er the name and EIN or address of each per ensation. Complete as many entries as nee name and EIN or address of person who prov OF IL 300 EAST RANE CHICAGO, IL 60 name and EIN or address of person who prov PO BOX 133 FORT MADISON	mainder of this Part because they recei instructions for definitions and condition son providing the required disclosures f ded (see instructions). vided you disclosures on eligible indirect OOLPH STREET 601 vided you disclosures on eligible indirect I, IA 52627	ns) for the servic et compensat	tion

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

Page 2- 1

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

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

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

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)

GROUP BENEFIT PARTNERS, LLC

PO BOX 133 FORT MADISON, IA 52627

27-4689597

(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	
12	CONSULTANT	28800	Yes 🗌 No 🗙	Yes 🗌 No 🔀	0	Yes 🗌 No 🛛

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

BLUE CROSS AND BLUE SHIELD OF IL

300 EAST RANDOLPH STREET CHICAGO, IL 60601

(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	
22	CLAIMS ADMINISTRATOR	64048	Yes 🗌 No 🗙	Yes 🗌 No 🛛	0	Yes 🗌 No 🗙
(a) Enter name and EIN or address (see instructions)						

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	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	Did the service provider give you a formula instead of an amount or estimated amount?
					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 No Yes Yes No Yes Yes<					Yes 🗌 No 🗍
	(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	formula used to determine	compensation, including any the service provider's eligibility 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.

Page **5 -** 1

Pa	rt II Service Providers Who Fail or Refuse to I	Provide Infori	mation
4	Provide, to the extent possible, the following information for eact this Schedule.	ch service provide	r who failed or refused to provide the information necessary to complete
	(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

Page 6 - 1

e Telephone:

Part III Termination Information on Accountants and Enrolled Actuaries (s (complete as many entries as needed)	mination Information on Accountants and Enrolled Actuaries (see instructions) plete 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: