Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2018

	Administration	tne	instructions to the Form 55	00.					
Pensio	on Benefit Guaranty Corporation				This	Form is Open to Pu Inspection	oildı		
Part I	Annual Report le	dentification Informatio	n						
For cale	ndar plan year 2018 or fis	cal plan year beginning 01/01/2	2018	and ending 12/31/20)18				
A This	return/report is for:		nis box must attach a list of dance with the form instructions.)						
		X a single-employer plan	a DFE (specify	r)					
B This	return/report is:	the first return/report	the final return	·					
		an amended return/repor		ear return/report (less than 12	,				
C If the	plan is a collectively-barg	ained plan, check here				• 🗌			
D Chec	k box if filing under:	Form 5558	automatic exten	nsion	the	e DFVC program			
		special extension (enter de	escription)						
Part II	Basic Plan Infor	mation—enter all requested i	nformation						
	ne of plan RLINE SOLUTIONS, LLC	1b	Three-digit plan number (PN) ▶	501					
					1c	Effective date of plants 03/12/2012	an		
Mail City	ing address (include room or town, state or province	er, if for a single-employer plan n, apt., suite no. and street, or F e, country, and ZIP or foreign po	P.O. Box)	uctions)	2b	2b Employer Identification Number (EIN) 45-3064505			
CENTER	LINE SOLUTIONS, INC.				2c Plan Sponsor's telephone number 303-993-3293				
	ABLE MOUNTAIN PKWY I, CO 80403-1642		6035 TABLE MOUNTAIN PKV OLDEN, CO 80403-1642	VY	2d Business code (see instructions) 541512		е		
Caution	: A penalty for the late o	r incomplete filing of this retu	urn/report will be assessed u	unless reasonable cause is	s establis	shed.			
	Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.								
SIGN	Filed with authorized/valid	d electronic signature.	07/03/2019	CORINNE KING					
HERE	Signature of plan adm	inistrator	Date	Date Enter name of individual sid			signing as plan administrator		
SIGN HERE									

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

SIGN HERE

> Form 5500 (2018) v. 171027

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form 5500 (2018) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN **3c** Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN Sponsor's name Plan Name Total number of participants at the beginning of the plan year 326 5 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). 326 a(1) Total number of active participants at the beginning of the plan year 6a(1) 213 a(2) Total number of active participants at the end of the plan year 6a(2)9 Retired or separated participants receiving benefits.... 6b 6c Other retired or separated participants entitled to future benefits...... 222 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 222 Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item) Number of participants who terminated employment during the plan year with accrued benefits that were 6h less than 100% vested

	less than 100	7/8 Vested						011	
7	Enter the total	al number of employers obligated to contribute to the plan (only r	multie	mployer p	lans o	comp	lete this item)	7	
8a	If the plan pro	ovides pension benefits, enter the applicable pension feature cod	des fr	om the Lis	st of P	Plan C	Characteristics Codes	s in the	instructions:
b		ovides welfare benefits, enter the applicable welfare feature code O 4E 4F 4H 4L 4Q	es fro	m the List	of Pla	an Cl	naracteristics Codes	in the ii	nstructions:
	4A 4B 4E								
9a	Plan funding	ement (check all that	apply)						
	(1) X	Insurance		(1)	X		rance	11 77	
	(2)	Code section 412(e)(3) insurance contracts		(2)		Cod	e section 412(e)(3) ir	nsuranc	e contracts
	(3)	Trust		(3)		Trus	t		
	(4)	General assets of the sponsor		(4)		Gen	eral assets of the spo	onsor	
10	Check all app	olicable boxes in 10a and 10b to indicate which schedules are at	ttache	d, and, w	here i	ndica	ated, enter the number	er attac	hed. (See instructions)
а	Pension Sch	nedules	b	General	Sche	edule	es		
	(1)	R (Retirement Plan Information)		(1)			H (Financial Inform	ation)	
	(a) \Box	MD (Multiampleyer Defined Denefit Dlan and Cartain Manay		(2)			I (Financial Informa	ation –	Small Plan)
	(2)	MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan		(3)	X	4_	A (Insurance Inform	nation)	
		actuary		(4)	X		C (Service Provider	r Inform	ation)
	(3)	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participatin	g Plan	Information)
	., п	Information) - signed by the plan actuary		(6)			G (Financial Transa	action S	Schedules)

Form 5500 (2018) 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.)	
11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)	
11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt 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 Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code	!

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2018

pursuant to ERISA section 103(a)(2). Inspection											
For calendar plan year:	2018 or fiscal pla	n year beginning 01/01/2018	and er	nding 12/31/2	2018						
A Name of plan CENTERLINE SOLUTION	ONS, LLC. WELI	FARE BENEFIT PLAN		e-digit number (PN)	•	501					
C Plan sponsor's name CENTERLINE SOLUTION		e 2a of Form 5500		oyer Identification 3064505	on Number (EIN)					
		rning Insurance Contract (A. Individual contracts grouped as									
1 Coverage Informatio	n:										
(a) Name of insurance PAUL REVERE LIFE IN		PANY									
4 × = 1 ×	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ntract year					
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) Fr	om	(g) To					
04-1590994	67598	E4553442	1	01/01/2018		12/31/2018					
2 Insurance fee and co descending order of t		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, bro	kers, and ot	her persons in					
(a) Tota	al amount of com		(b) To	otal amount of f	ees paid						
		124				12					
3 Persons receiving co	ommissions and f	ees. (Complete as many entries a	as needed to report all persons).								
		and address of the agent, broker, c		sions or fees we	ere paid						
LOCKTON COMPANIES	S LLC	8110 E U DENVER	JNION AVE #700 R, CO 80337								
(b) Amount of sales	and base	Fees	and other commissions paid								
commissions		(c) Amount	(d) Purpos	e		(e) Organization code					
	47					3					
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees we	ere paid						
PARRISH J PEACHEE	,,	109 N U	NION STREET ELD, IN 46074								
(b) Amount of sales	and base	Fees	and other commissions paid								
commissions		(c) Amount	(d) Purpos	-	(e) Organization code						
	5					3					
For Donomyork Dodge	tion Act Nation	and the Instructions for Form FF	200		Cabaa	lula A (Farm FEOO) 2018					

Schedule A (Form 5500)	2018	Page 2 – 1	
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
MICHAEL BLOCK	16619	O S PINECREEK DRIVE (PORT, IL 60441	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
0			3
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
OPTIO LLC		E ARAPAHOE RD ENWOOD VILLAGE, CO 80112	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
9			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
SARA SORENSEN CONNICK	GREE	E ARAPAHOE NWOOD VILLAGE, CO 80112	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	_ (e) Organization
commissions paid 27	(c) Amount	(u) i dipose	code 3
(a) Nan	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
MELISSA A KOLL	216 C	LIMAX DR DN, CO 80435	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
1			3
(a) Nar	ne and address of the agent, broker	r, or other person to whom commissions or fees were paid	
HOWARD J HOROWITZ	2610	ALCOTT STREET MEL, IN 46032	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 35	(c) Amount	(d) Purpose	code
35	12	BONOS	3

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	e treated as a	a unit for purposes of		
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d	
		retention of the contract or policy, enter amount.			0 4	
		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 termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)	<u>.</u>		
		(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		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Р	art I	III	Welfare Benefit Contract Informa- If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	group	p of o	ses if such	contr	acts are	expe	erience-rated as a unit	. Where	contrac	ts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b	D	ental		(: □	Vision		d	Life insurance	
	е	=	mporary disability (accident and sickness)	f	Lo	ong-term dis	abilit	v (ı∏	Supplemental unemp	olovment	t h	Prescription drug	
	i	=	op loss (large deductible)	_	_	MO contract		-	「 ''	PPO contract	,		Indemnity contract	
	L								`⊔	FFO Contract		'	indenning contract	
	m	X O	ther (specify) SUPPLEMENTAL INSURAN	NCE,	CAN	NCER POLIC	JIES							
<u>a</u>	Evno	rion	ce-rated contracts:											
9	•		iums: (1) Amount received				Г	9a(1)						
			ncrease (decrease) in amount due but unpai				-	9a(2)						
			ncrease (decrease) in unearned premium res				T.							
		` '	Earned ((1) + (2) - (3))				-				9a(4	1)		
	_	. ,	efit charges (1) Claims paid											
			ncrease (decrease) in claim reserves				-		_					
			ncurred claims (add (1) and (2))								9b(3	3)		
		(4) C	Claims charged								9b(4	1)		
	С	Ren	nainder of premium: (1) Retention charges (n an	accı	rual 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								00/1)/	/LI\		
			(H) Total retention			_					9c(1)			
			Dividends or retroactive rate refunds. (These			L-1		L	_		9c(2	•		
	d		us of policyholder reserves at end of year: (1								9d(1	•		
		` '	Claim reserves Other reserves								9d(2 9d(3	•		
	е	` '	dends or retroactive rate refunds due. (Do n								9e			
10			erience-rated contracts:	Ot mio	Jiuuo	amount on	.0.00		<u>- (-) ·</u>	,				
			al premiums or subscription charges paid to	arrie	r						10a	a .		458
	b	If the	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.	red a	ny sį	pecific costs	in co	onnection	with	h the acquisition or	10b			
P	art I	V	Provision of Information											
11	Did	the	insurance company fail to provide any inform	natior	n nec	cessary to co	omple	ete Sched	lule	A?	Yes	X	lo	
12	lf th	he ar	nswer to line 11 is "Yes," specify the informat	ion n	ot pr	rovided.								_

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

2018

			ERISA section 103(a)(2)	This Form is Open to Public Inspection			
For calendar plan year 20°	18 or fiscal pla	an year beginning 01/01/2018		and er	nding 12/31	1/2018	
A Name of plan CENTERLINE SOLUTION	IS, LLC. WEL	FARE BENEFIT PLAN			e-digit n number (PN) •	501
C Plan sponsor's name a CENTERLINE SOLUTION	IS, INC.			45-	oyer Identifica -3064505		
on a separa		rning Insurance Contract A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance car CIGNA	rrier		(2) Annual instance		1	Dalianas	
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate nu persons covered a policy or contract	t end of	(f)	From	(g) To
59-1031071	67369	000620611	219	•	}	12/31/2018	
2 Insurance fee and common descending order of the		nation. Enter the total fees and to	otal commissions paid. Li	st in line 3	the agents, b	orokers, and	other persons in
		nmissions paid		(b) To	otal amount o	of fees paid	
. ,		0		` ` `			57720
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees	were paid	
EXCALIBUR FINANCIAL G	BROUP		KNIGHTS RUN #110 PA, FL 33602				
(b) Amount of sales an	d base	F	ees and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code
	0	57720	SERVICE FEE				3
	(a) Name	and address of the agent, broke	er, or other person to whor	n commiss	sions or fees	were paid	
(b) Amount of sales an	d base	F	ees and other commission	ns paid			
commissions pai		(c) Amount	((d) Purpos		(e) Organization code	

Schedule A (Form 5500	Page 2 – 1						
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid					
		From and other constitutions and	(-)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	T						
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
, ,	<u> </u>						
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
•							
(a) Na	The standard of the stand business						
(a) Na	me 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	(0,1	(a) supers	code				
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid					
	T		1				
(h) Amount of sales and hase		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code				
			Organization				

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	e treated as a	a unit for purposes of		
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d	
		retention of the contract or policy, enter amount.			0 4	
		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 termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) guaranteed investment (4) other				
		_				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	. 7c(1)	<u>.</u>		
		(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		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art I	II	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual.	group	p of e	ses if s	such cor	tracts are	expe	erience-rated as a uni	t. Where c	ontract	s cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)										
	a	Не	ealth (other than dental or vision)	b	De	ental			С	Vision		d	Life insurance
	еĒ	Τe	emporary disability (accident and sickness)	f	= Lc	ong-terr	m disabi	lity	gΠ	Supplemental unem	ployment	h∏	Prescription drug
	ιĖ	-	op loss (large deductible)	ιĖ	_	MO con		-	- ⊔	PPO contract	, ,	- =	Indemnity contract
	<u>_</u>	_		, _L	۱	WIO 0011	itiaot		^	1110 continuot		• 📖	macminity contract
	m] 0	ther (specify)										
a	Evno	rion	ce-rated contracts:										
5	•		niums: (1) Amount received					9a(1					
			ncrease (decrease) in amount due but unpaid						_				
			ncrease (decrease) in unearned premium res						-				
		` '	Earned ((1) + (2) - (3))								. 9a(4)		
		. ,	efit charges (1) Claims paid										
		(2) lı	ncrease (decrease) in claim reserves					. 9b(2)				
		(3) lı	ncurred claims (add (1) and (2))								. 9b(3)		
		(4) (Claims charged								. 9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (c	n an	accr	rual bas	sis)						
			(A) Commissions										
			(B) Administrative service or other fees					0 (4)//				_	
			(C) Other specific acquisition costs					0 (4)/				_	
			(D) Other expenses					0 - /4 \ / /	_			_	
			(E) Taxes										
			(F) Charges for risks or other contingencies. (G) Other retention charges		•••••			9c(1)(3)			_	
			(H) Total retention(H)								9c(1)(H)	
			Dividends or retroactive rate refunds. (These			_			_			_	
	d		tus of policyholder reserves at end of year: (1			<u> </u>							
	•		Claim reserves								9d(2)		
		` '	Other reserves										
	е	` '	dends or retroactive rate refunds due. (Do n										
10	Noi	пехр	perience-rated contracts:										
	а	Tota	al premiums or subscription charges paid to o	carrie	r						. 10a		164847
	_	rete	e carrier, service, or other organization incur ntion of the contract or policy, other than rep nature of costs.								. 10b		
P	Spec	cify r		orted	in P	Part I, lir	ne 2 abo	ve, report	amo	unt	. 10b		
								.1	41	ло П	Voc	V N1.	
			insurance company fail to provide any inform					olete Sche	dule	A?	Yes	× No	0
12	If th	ne ar	nswer to line 11 is "Yes," specify the informat	ion n	ot pro	ovided.	. •						

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

2018

This Form is Open to Public Inspection

v. 171027

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018													
A Name of plan CENTERLINE SOLUTION	NS, LLC. WELF	ARE BENEFIT PLAN			e-digit number (PN)	>	501						
				<u> </u>		•	l						
C Plan sponsor's name a	s shown on line	2a of Form 5500		D Emplo	yer Identification Nu	ımber (EIN)						
CENTERLINE SOLUTION	CENTERLINE SOLUTIONS, INC. 45-3064505												
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.												
1 Coverage Information:													
(a) Name of insurance car COLONIAL LIFE & ACCIDI		CE COMPANY											
(L) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu		Polic	Policy or contract year							
(b) EIN	code	identification number	persons covered at policy or contract		(f) From		(g) To						
57-0144607	62049	E4553442	25		01/01/2018		12/31/2018						
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 commissions paid (b) Total amount of fees paid													
		1642					140						
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).									
	(a) Name a	nd address of the agent, broker	, or other person to whon	n commiss	ions or fees were pa	aid							
HOWARD J HOROWITZ			ALCOTT STREET EL, IN 46032										
		Fo	as and other commission	no noid									
(b) Amount of sales an commissions pai		(c) Amount	es and other commission	is paid (d) Purpos	Δ		(e) Organization code						
commissions par	82		ONUS	(d) i dipos			3						
	(a) Name a	nd address of the agent, broker	, or other person to whom	n commiss	ions or fees were pa	aid							
LOCKTON COMPANIES			E UNION AVE #700 ER, CO 80337										
(b) Amount of sales an	nd base	Fe	es and other commission	ns paid									
commissions pai		(c) Amount		(d) Purpos		(e) Organization code							
	379	22 E	SONUS				3						
For Paperwork Reduction	n Act Notice, s	see the Instructions for Form	5500.			Sched	lule A (Form 5500) 2018						

Schedule A (Form 5500)	2018	Page 2 - 1				
(a) Nan	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
COLIN JAMES MCDOUGALL	2739	DURANT TRAILS BLVD FR, FL 33527				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
32			3			
	ne and address of the agent, broker	, or other person to whom commissions or fees were paid				
PARRISH J PEACHEE		I UNION STREET IFIELD, IN 46074				
42.4		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
13			3			
(a) Nan	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
TRILOGY BENEFITS CONSULTING		HAMMOCK WOODS DR SSA, FL 33556				
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization			
commissions paid 9	• • • • • • • • • • • • • • • • • • • •	BONUS	code 3			
(a) Nan	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
DPITIO LLC	8547 E	E ARAPAHOE RD NWOOD VILLAGE, CO 80112				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			
109			3			
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid				
ABIGAIL LEIGH CONNICK	10408 PARK	RUTLEDGE ST ER, CO 80134				
		Fees and other commissions paid	(e)			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code			

9 BONUS

(b) Amount of sales and base commissions paid

131

Page 2 - 2	
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(e) Organization code

Schedule A (Folin 5500)	2010	rage z – [z	
(a) Nar	ne and address of the agent, broker,	or other person to whom commissions or fees were paid	
JANET S DOHERTY	138 SI	KY RIDGE DR CO, FL 33594	
	I	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
57	25	BONUS	3
(a) Nar	ne and address of the agent, broker,	or other person to whom commissions or fees were paid	-
SHARLA LEARY	18284	TENNYSON LANE ER, CO 80134	
(h) Amount of color and book		ees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
23	5	BONUS	3
(a) Nar	me and address of the agent, broker,	or other person to whom commissions or fees were paid	
SARA SORENSEN-CONNICK	GREE	E ARAPAHOE ENWOOD VILLAGE, CO 80112	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 231	(c) Amount	(d) Purpose	code 3
231	2	BONOS	3
(a) Nar	ne and address of the agent, broker,	or other person to whom commissions or fees were paid	
DANIELS SOLUTIONS LLC		POMPANO DR PORT RICHEY, FL 34652	
(h) Associated solve and become	Ţ	Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
31	32		3
(a) Nar	ne and address of the agent, broker,	or other person to whom commissions or fees were paid	
MELISSA A KOLL		LIMAX DR N, CO 80435	

Fees and other commissions paid

8 BONUS

(d) Purpose

(c) Amount

Page	2	-	3
------	---	---	---

EXCALIBUR FINANCIAL GROUP	302 K TAMF	NIGHTS RUN #110 PA, FL 33602	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
312			3
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
ROBERT BRIAN FABRIZIO JR	814 N VALR	I VALRICO RD RICO, FL 33594	
(b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organization code
165			3
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
CORCORAN & HOYT LLC	12505 TAMF	5 BRONCO DR PA, LA 33624	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
2	1	BONUS	3
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	_		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, 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) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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					
		this report.					
		ent value of plan's interest under this contract in the general account at year			4		
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5		
6		racts With Allocated Funds:					
	а	State the basis of premium rates					
	b	Premiums paid to carrier			6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d		
		retention of the contract or policy, enter amount.			0 4		
		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 termination	ating plan, chec	ck here			
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)			
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee			
		(3) guaranteed investment (4) other					
		_					
	b	Balance at the end of the previous year			7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)	<u>.</u>			
		(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		<u> </u>	7c(6)		
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d		
	е	Deductions:					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
		(2) Administration charge made by carrier	. 7e(2)				
		(3) Transferred to separate account	. 7e(3)				
		(4) Other (specify below)	. 7e(4)				
		•					
	_	(5) Total deductions			7e(5)		
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f		

Pa	art	Ш	Welfare Benefit Contract Inform	atio	n									
			If more than one contract covers the same the information may be combined for repor employees, the entire group of such individ	ting p	urpos	ses if such	contrac	ts are exp	peri	ience-rated as a uni	t. Where c	ontract	ts cover individ	
8	Ben	efit a	nd contract type (check all applicable boxes)											
	а	Не	ealth (other than dental or vision)	b	De	ental		С	١,	Vision		d	Life insurance	9
	еĪ	=	emporary disability (accident and sickness)	f	בו ב	ng-term dis	ability	g		Supplemental unem	nlovment	h⊟	Prescription of	
	. [=	op loss (large deductible)			ло contract	-			PPO contract	pioyillolik		Indemnity cor	-
	' [[□ ſ				ĸ.		FFO Contract		•⊔	indenning cor	iliaci
	m	X O	ther (specify) VOLUNTARY ACCIDENT A	ND C	RIII	CA ILLNES	S							
Ω.		o ri o ro	as rated contracts.											
			ce-rated contracts: niums: (1) Amount received					00/1)	T					
	а		ncrease (decrease) in amount due but unpai					9a(1) 9a(2)						
			ncrease (decrease) in unearned premium res					9a(3)						
			Earned ((1) + (2) - (3))								. 9a(4)			
	b	. ,	efit charges (1) Claims paid					9b(1)	Ī		1 55(1)			
			ncrease (decrease) in claim reserves					9b(2)						
		(3) li	ncurred claims (add (1) and (2))								. 9b(3)			
		(4) (Claims charged								. 9b(4)			
	С	Ren	nainder of premium: (1) Retention charges (n an	accrı	ual basis)								
			(A) Commissions				9	c(1)(A)						
			(B) Administrative service or other fees					c(1)(B)						
			(C) Other specific acquisition costs					c(1)(C)						
			(D) Other expenses					c(1)(D)						
			(E) Taxes				9	C(1)(E)						
			(F) Charges for risks or other contingencies.				<u>9</u>	c(1)(F)						
			(G) Other retention charges								9c(1)(H	ı\		
			(H) Total retention Dividends or retroactive rate refunds. (These									'		
	a													
	d		tus of policyholder reserves at end of year: (1								. 9d(1) . 9d(2)			
		` '	Other reserves								9d(3)			
	е	` '	dends or retroactive rate refunds due. (Do n											
10	_		perience-rated contracts:						,,		1			
	а		al premiums or subscription charges paid to	carrie	r						. 10a			8656
	b		e carrier, service, or other organization incur ntion of the contract or policy, other than rep							•	. 10b			
	Spe	cify r	nature of costs.											
Pa	art	IV	Provision of Information											
<u>1</u> 1	Die	d the	insurance company fail to provide any inform	nation	nec	essary to co	omplete	Schedule	<u>е</u> А	١?	Yes	X N	0	
12	If t	he ar	nswer to line 11 is "Yes," specify the informat	ion no	ot pro	ovided.								

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

2018

		pursuant to EF	RISA section 103(a)(2).	"	Inspection	
For calendar plan year 20	018 or fiscal pla	n year beginning 01/01/2018	and en	ding 12/31/2018		
A Name of plan CENTERLINE SOLUTIO	NS, LLC. WELF	FARE BENEFIT PLAN		e-digit number (PN)	501	
C Plan sponsor's name CENTERLINE SOLUTIO		e 2a of Form 5500		oyer Identification No 3064505	umber (EIN)	
		rning Insurance Contract (Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca		ΙΥ				
(1.) FIN	(c) NAIC	(d) Contract or	(e) Approximate number of	Poli	cy or contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
42-0127290	61271	1086151	370	01/01/2018	12/31/2018	
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 other persons in	
(a) Total	amount of com		(b) To	otal amount of fees	paid	
		36180				
3 Persons receiving con	nmissions and f	ees. (Complete as many entries a	s needed to report all persons).			
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were pa	aid	
ROBERT FABRIZIO			GHTS RUN#110 FL 33602			
(b) Amount of sales a	nd base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpose	(d) Purpose		
	18090				3	
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were pa	aid	
WILLIAM J MANNIX	. ,	812 N V	ALRICO RD O, FL 33594	·		
(b) Amount of sales a	and base	Fees	and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code	
	18090				3	
For Borrows de Bordond's	on Act Nation	and the Instructions for Form FF	200		Schodule A (Form FEOO) 2019	

Schedule A (Form 5500) 2018 Page 2 – 1					
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
		From and other constitutions and	(-)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
, ,	<u> </u>				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
•					
(a) Na	The standard of the stand business				
(a) Na	me 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	(0,1	(a) supers	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T		1		
(h) Amount of sales and hase		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code		
			Organization		

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					
		this report.					
		ent value of plan's interest under this contract in the general account at year			4		
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5		
6		racts With Allocated Funds:					
	а	State the basis of premium rates					
	b	Premiums paid to carrier			6b		
	C	Premiums due but unpaid at the end of the year			6c		
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d		
		retention of the contract or policy, enter amount.			0 4		
		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 termination	ating plan, chec	ck here			
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)			
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee			
		(3) guaranteed investment (4) other					
		_					
	b	Balance at the end of the previous year			7b		
	С	Additions: (1) Contributions deposited during the year	. 7c(1)	<u>.</u>			
		(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		<u> </u>	7c(6)		
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d		
	е	Deductions:					
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)				
		(2) Administration charge made by carrier	. 7e(2)				
		(3) Transferred to separate account	. 7e(3)				
		(4) Other (specify below)	. 7e(4)				
		•					
	_	(5) Total deductions			7e(5)		
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f		

P	Part I		Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individual contract covers the same the information may be combined for report employees, the entire group of such individual contract covers the co	group of employees of the	racts are exp	erience-rated as a un	it. Where co	ontracts cover	
8	Ben	efit a	nd contract type (check all applicable boxes)						
	а	He	alth (other than dental or vision)	b X Dental	c	Vision		d X Life ins	urance
	e D	_ K Te	mporary disability (accident and sickness)	f X Long-term disability	ty g [Supplemental unem	plovment	h Prescri	otion drua
	i [=	pp loss (large deductible)	j HMO contract		PPO contract	, ,	I X Indemn	-
	· L	_		J Timo contract	· [1 1 0 contract		I M III GCIIII	ny comitact
	m	Ot	her (specify)						
<u>a</u>	Evno	rione	e-rated contracts:						
9	•		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res						
			arned ((1) + (2) - (3))			ı	9a(4)		
	b	. ,	efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves						
			ncurred claims (add (1) and (2))				9b(3)		
		(4) C	laims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (c	n an accrual basis)					
		((A) Commissions		9c(1)(A)				
		((B) Administrative service or other fees		_ ,,,,				
		((C) Other specific acquisition costs						
			(D) Other expenses		0. (4)(5)			_	
			(E) Taxes						
			(F) Charges for risks or other contingencies		0-(4)(0)			_	
			(G) Other retention charges				9c(1)(H	١	
			H) Total retention	_	_			/	
	a		Dividends or retroactive rate refunds. (These	—			_ ` /		
	d		us of policyholder reserves at end of year: (1	•			•		
		` '	Other reserves						
	e	` '	dends or retroactive rate refunds due. (Do n						
10			erience-rated contracts:	st morado amoditi oficoro	2 III III IO 00(2)	, , ,			
	а		Il premiums or subscription charges paid to o	arrier			10a		284306
	b		e carrier, service, or other organization incur						
	-		ntion of the contract or policy, other than rep				10b		
	Spe	cify n	ature of costs.						
D	art I	V	Provision of Information						
							l va-	V N-	
			insurance company fail to provide any inform		ete Schedule	e A?	Yes	X No	
12	2 If th	he ar	swer to line 11 is "Yes," specify the informat	on not provided.					

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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

2018

This Form is Open to Public Inspection.

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018	and ending 12/31/2018	
A Name of plan	B Three-digit	_
CENTERLINE SOLUTIONS, LLC. WELFARE BENEFIT PLAN	plan number (PN)	501
	. ,	
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (E	EIN)
CENTERLINE SOLUTIONS, INC.	45-3064505	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in connect		
plan during the plan year. If a person received only eligible indirect compensation for wh		
answer line 1 but are not required to include that person when completing the remainder	of this Part.	,
	_	
1 Information on Persons Receiving Only Eligible Indirect Compens		
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of		
indirect compensation for which the plan received the required disclosures (see instruction	ons for definitions and conditions)	Yes X No
b If you answered line 1a "Yes," enter the name and EIN or address of each person proving received only eligible indirect compensation. Complete as many entries as needed (see	•	e providers who
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation	on
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation	on
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation	on
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation	on

Schedule C (Form 5500) 2018	Page 2- 1
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person w	ho provided you disclosures on eligible indirect compensation

answered	d "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)		
EXCALIBU	JR FINANCIAL GROU	Р		IGHTS RUN#110 A, FL 33602		
59-350103	32					
(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?	(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?
22	BROKER	0	Yes X No	Yes 🛛 No 🗌	10000	Yes X No
		(a) Enter name and EIN or	address (see instructions)		
CIGNA 59-103107	71			OTTAGE GROVE RD MFIELD, CT 06002		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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?
14	ADMINISTRATOR	61052	Yes No X	Yes No X	0	Yes No X
(a) Enter name and EIN or address (see instructions)						
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be	(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	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required	Enter total indirect compensation received by service provider excluding eligible indirect	(h) Did the service provider give you a formula instead of an amount or

disclosures?

Yes No

sponsor)

Yes No

compensation for which you answered "Yes" to element

Yes No

(f). If none, enter -0-.

Page **3 -** 1

Schedule C (Form 5500) 2018

a party-in-interest

Page	3	-	2
Page	3	-	2

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
(1.6., 111011	ey or arrything else or	·		r address (see instructions)	plan during the plan year. (Si	ee manuchons).
(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)		
(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?	(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	Yes No		Yes No

Page 4 -

Part I Service Provider Information (continued)

or provides contract administrator, consulting, custodial, investment advisory, investment madvestions for (a) each source from whom the service provider received \$1,000 or more in incorprovider gave you a formula used to determine the indirect compensation instead of an amomany entries as needed to report the required information for each source.	direct compensation and (b) each s	ource for whom the service	
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect	
	(see instructions)	compensation	
(d) Enter name and EIN (address) of source of indirect compensation	(a) Describe the indirect	compensation including any	
(a) Effect famile and Effy (address) of source of malifect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.		
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect	
	(see instructions)	compensation	
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility 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	
	(2) 2		
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.	

D	art II Service Providers Who Fail or Refuse to	Drovido Inform	mation
4			
4	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.		
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide
	(a) Enter name and EIN or address of service provider (see 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
	(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 -	l
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Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)					
	No	(complete as many entries as needed)	b EIN:			
a c	Name: Position		D EIN:			
d	Addres		e Telephone:			
u	Addres	SS.	e releptione.			
Ex	planation	γ:				
а	Name:		b EIN:			
С	Positio					
d	Addres		e Telephone:			
			·			
Ex	planation	n:				
а	Name:		b EIN:			
С	Positio					
d	Addres	SS:	e Telephone:			
ΕX	planation):				
	Mana		b EIN:			
a C	Name: Position		D EIN:			
d	Addres		e Telephone:			
u	Addres		С тетернопе.			
Ex	planation	1:				
а	Name:		b EIN:			
С	Positio	n:				
d	Addres		e Telephone:			
-						
Ex	Explanation:					