Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110 1210 - 0089

2017

This Form is Open to Public Inspection

Part								
Fo	r calendar plan year 2017 or fiscal plan year begin	ning $01/01/$	2017 and endin	g 12/31/2017				
A This return/report is for: a multiple-employer plan (Filers checking this box must attach a list participating employer information in accordance with the form instru								
B This return/report is: a single-employer plan the first return/report an amended return/report								
D Ch	Check box if filing under: Form 5558 automatic extension the DFVC program special extension (enter description)							
Part	II Basic Plan Information - enter all r	equested information						
INS	ame of plan JRANCE AND BENEFITS TRUST	-	CE OFFICERS	1b Three-digit plan number (PN) ▶ 501				
	EARCH ASSOCATION OF CALIF			1c Effective date of plan 06/21/1991				
M	an sponsor's name (employer, if for a single-employer p ailing address (include room, apt., suite no. and street, o	r P.O. Box)	2b Employer Identification Number (EIN) 68-6068469					
	ty or town, state or province, country, and ZIP or foreign URANCE AND BENEFITS TRUST							
				2d Business code (see instructions) 525100				
401	O TRUXEL ROAD							
SAC	RAMENTO CA	95834-3725						
Cautio	n: A penalty for the late or incomplete filing of	this return/report will	be assessed unless rea	asonable cause is established.				
Under pe	naitles of perjury and other penaities set forth in the instructions, I actronic version of this return/report, and to the best of my knowled	declare that I have examined t ige and belief, it is true, correc	nis return/report, including accon t, and complete.	npanying schedules, statements and attachments, as well				
SIGN	X Madling	09-11-13	JUSEPH SO	CHIEMMER				
	Signature of plan administrator	Date	Enter name of individua	al signing as plan administrator				
SIGN								
GITTO MEST	Signature of employer/plan sponsor	Date	Enter name of individua	al signing as employer or plan sponsor				
SIGN								
	Signature of DFE Date Enter name of individual signing as DFE							

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

Form 5500 (2017) v. 170203

Form 5500 (2017) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 4b FIN 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: **4d** PN a Sponsor's name C Plan Name 647725 5 Total number of participants at the beginning of the plan year 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). 6a(1) 57928 a (1) Total number of active participants at the beginning of the plan year a (2) Total number of active participants at the end of the plan year 65576 6a(2) **b** Retired or separated participants receiving benefits 6b C Other retired or separated participants entitled to future benefits 6c **d** Subtotal. Add lines **6a(2), 6b,** and **6c** 6d 65576 6e e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e 6f g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 6g h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested _____ 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete 207 7 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4F 4H 4L 9a Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance (2) Code section 412(e)(3) insurance contracts (2)Code section 412(e)(3) insurance contracts (3) Trust (3)General assets of the sponsor (4)General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) **b** General Schedules a Pension Schedules R (Retirement Plan Information) (1) (Financial Information) (1) MB (Multiemployer Defined Benefit Plan and Certain Money (2)ı (Financial Information - Small Plan) 3 Purchase Plan Actuarial Information) - signed by the plan (3)Α (Insurance Information) actuary (4) С (Service Provider Information) SB (Single-Employer Defined Benefit Plan Actuarial D (5) (DFE/Participating Plan Information) Information) - signed by the plan actuary (Financial Transaction Schedules)

Form 5500 (2017) Page **3**

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)									
CFR	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 If "Yes" is checked, complete lines 11b and 11c.									
11b Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)	Yes	No							
enter	Enter the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form 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.)									
Rece	eipt Confirmation Code									

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Insurance Information**

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

► File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

			1 / / 1	/2017			1 2 / 2 1 / 2 0 1	7		
For calendar plan year 20	11/ or fiscal plan	year beginning U	T/UT	/2017	and endin	-	12/31/201	<u>/</u> _		
A Name of plan						B Th	ree-digit			
INSURANCE A	ND BENEI	TITS TRUST	OF T	HE PEACE	OFFICERS	pla	n number (PN)	▶	501	
C Plan sponsor's na	mo oo obouin o	n line 2e of Form 550	10			D En	nployer Identification	n Niu	mbor (EINI)	
INSURANCE A				HE DODAC			68-6068 4		mber (Eliv)	
		erning Insuranc			no Food and (Comm				
		_								
		Schedule A. Individu	al contra	cts grouped as a	unit in Parts II and	illi can	be reported on a si	ngle 8	schedule A.	
1 Coverage Informa	tion:									
(a) Name of incurance	o carrior									
(a) Name of insurance	e carrier									
RELIASTAR L	IFE INSU	JRANCE COMA	PNY							
	(c) NAIC	(d) Contract o	r	(a) Approxim	nate number of per	eone	Policy or	contr	act vear	
(b) EIN	code	identification num		covered at end	of policy or contra	ct year	(f) From	1		
					. ,		(I) FIOIII	+	(g) To	
41-0451140	67105	56226 2				527	10/01/201	دام د	/20/2017	
							•	_		
		formation. Enter the t	otal fees	and total comm	issions paid. List in	line 3 th	ie agents, brokers,	and o	other persons	
in descending ord		•								
(a)	Total amount of	commissions paid			(b) ⁻	Total am	ount of fees paid			
			25	058					57208	
3 Persons receiving	commissions a	nd fees. (Complete a	ıs many e	entries as neede	d to report all perso	ns).				
		d address of the age					fees were paid			
MYERS-STEVE				,						
26101 MARQU										
MISSION VIE			9269	2						
HIDDION VID	50	T CA	7207						1 ,	
(b) Amount of sale	es and base	Fees and other commissions paid							(e)	
commission	s paid								Organization	
	•	(c) Amount			(d) Purp	pose			code	
			ADMINISTRATION FEE							
		50	116						3	
	(a) Name ar	d address of the age	nt. broke	er, or other perso	n to whom commis	sions or	fees were paid			
MYERS-STEVE				, ,						
26101 MARQU										
MISSION VIE			9269	2						
MISSION AIR	00	- CA	9209.	<u> </u>					Τ	
(b) Amount of sale	es and base			Fees and other	er commissions pai	d			(e)	
commission	s paid				•				Organization	
	•	(c) Amount			(d) Purp	ose			code	
			W]	RITING A	GENT					
	25058								3	

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

Schedule A (Form 5500) 2017 v. 170203

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Schedule A (Form 5500) 2017

(a) Name and MYERS-STEVENS & TOO 26101 MARQUERITE PK MISSION VIEJO	HEY CO INC	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization
<u> </u>	(c) Amount	(d) Purpose	code
		OVERWRITE FEE	
	7092		3
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	_
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(-)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of supurposes of this report.	ıch individua	al contracts with each	carrier m	ay be treated as a unit for
4 (Current	value of plan's interest under this contract in the general account	at year end		4	
5 (Current	value of plan's interest under this contract in separate accounts a	at year end		5	
6	Contrac	cts With Allocated Funds:				
а	State	the basis of premium rates				
		iums paid to carrier			6b	
		iums due but unpaid at the end of the year			6с	
d		carrier, service, or other organization incurred any specific costs in				
		equisition or retention of the contract or policy, enter amount			6d	
	-	ify nature of costs				
е		of contract: (1) 🔲 individual policies (2) 📙 group defen	red annuity			
	(3)	other (specify)				
					. [
<u>+</u>		tract purchased, in whole or in part, to distribute benefits from a to				
′		racts With Unallocated Funds (Do not include portions of these co		· ·	•	
а	Type	of contract: (1) deposit administration (2)		te participation guaran	tee	
		(3) guaranteed investment (4)	other	•		
L	5 .				76	
		nce at the end of the previous year	7-(4)		7b	
C		ions: (1) Contributions deposited during the year				
		ividends and credits				
		nterest credited during the year				
		ransferred from separate account				
	(5) C	Other (specify below)	7c(5)			
	(C) T				70(6)	0
٨		otal additions			7c(6) 7d	
		of balance and additions (add lines 7b and 7c(6))	Г		/u	
C	Dedu	isbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		dministration charge made by carrier				
		ransferred to separate account	7e(3)			
	(4) O	other (specify below)	7e(4)			
	(5) T	otal doductions			7e(5)	0
f		otal deductions			76(3)	

Pa	irt III	Welfare Benefit Contract Information					
		If more than one contract covers the same group of en					
		employee organization(s), the information may be com-					
		as a unit. Where contracts cover individual employees	s, the entire group	of such individual	contracts wit	h each carr	ier may be
		treated as a unit for purposes of this report.					
8	Renefit a	and contract type (check all applicable boxes)					
•		alth (other than dental or vision) b Dental		c Vision		dГ	Life insurance
		- H		—		⊢	1
	. —	Н Н	erm disability	. —	al unemployn	nent !'-	Prescription drug
		· · · · · · · · · · · · · · · · · · ·	contract	K ∐ PPO contrac	CT	' _	Indemnity contract
		her (specify) ► AD&D					
9	•	ce-rated contracts:	0 (1)				
а		s: (1) Amount received					
		rease (decrease) in amount due but unpaid					
	(3) Incr	rease (decrease) in unearned premium reserve	9a(3)				
	(4) Ear	ned ((1) + (2) - (3))			9a(4)		
b	Benefit o	harges: (1) Claims paid	9b(1)				
	(2) Incr	rease (decrease) in claim reserves	9b(2)				
		urred claims (add (1) and (2))			9b(3)		
		ms charged			9b(4)		
С	Remaind	er of premium: (1) Retention charges (on an accrual basi	s)				
		Commissions	(4)(4)				
	(B)	Administrative service or other fees					
	(C)	Other specific acquisition costs					
	(D)	Other expenses					
	(E)	Taxes	- (1)(-)				
	(E) (F)	Charges for risks or other contingencies					
	(i) (G)						
		Other retention charges			9c(1)(H)		
	(H)	Total retention			9c(2)		
4		dends or retroactive rate refunds. (These amounts were	_	_	9d(1)		
u		f policyholder reserves at end of year: (1) Amount held to	•				
		m reserves			9d(2)		
		er reserves			9d(3)		
		s or retroactive rate refunds due. (Do not include amoun	t entered in line 9	oc(2).)	9e		
10	-	rience-rated contracts:					720766
a		miums or subscription charges paid to carrier			10a		730766
b	If the car	rier, service, or other organization incurred any specific o	costs in connecti	on with			
	the acqu	isition or retention of the contract or policy, other than re	eported in Part I,	line 2			
	above, re	eport amount			10b		
Sp	pecify nat	ure of costs N/A					
Pa	rt IV	Provision of Information					
$\overline{}$				Cabadula AO	П	V	X No
11		nsurance company fail to provide any information necess		Scnedule A?		Yes	X No
12	If the ans	swer to line 11 is "Yes," specify the information not provi	ded. 🕨				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Insurance Information**

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

► File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

					5011011 103(a)(2)			no mopeodon	
For calendar plan year 20	117 or fiscal plan	year beginning 01/0	1/201	7	and e	nding	12/31/2017		
A Name of plan INSURANCE A	ND BENE	FITS TRUST OF	THE P	EACE	OFFICER		ree-digit an number (PN)	501	
		n line 2a of Form 5500 FITS TRUST OF	THE P	ORAC		D En	nployer Identification 68-606846		
		erning Insurance Co Schedule A. Individual cor							
1 Coverage Informa	tion:								
(a) Name of insurance		JRANCE COMAPNY	OF N	EW Y	ORK				
(b) EIN	(c) NAIC	(d) Contract or			nate number of		Policy or co	ontract year	
	code	identification number	covere	covered at end of policy or contract			(f) From	(g) To	
41-0451140	67105	56326-3				9585	10/01/2016	09/30/2017	
2 Insurance fee and in descending ord		formation. Enter the total fortion for the total for the paid.	ees and to	al comm	issions paid. Li	st in line 3 th	ne agents, brokers, a	nd other persons	
(a) -	Total amount of	commissions paid				(b) Total am	ount of fees paid		
			59329					128106	
3 Persons receiving		ind fees. (Complete as mai	•						
MEVERS-STEV		nd address of the agent, br DOHEY CO INC	oker, or ot	ner perso	n to whom con	nmissions or	fees were paid		
26101 MARQU									
MISSION VIE		CA 926	592						
(b) Amount of sale			Fees and other commissions paid						
commission	s paid	(c) Amount	<u> </u>					Organization code	
		(6)7	ADMIN	ISTR	. ,				
		116008	1					3	
		nd address of the agent, br	oker, or otl	her perso	n to whom con	nmissions or	fees were paid		
		OOHEY CO INC							
26101 MARQU MISSION VIE		CA 926	592						
(b) Amount of sale			Fees	and oth	er commissions	paid		(e) Organization	
commission	s paid	(c) Amount			(d) F	Purpose			
			WRITI	NG A	GENT				
	50320		1					1 2	

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

Schedule A (Form 5500) 2017 v. 170203

<u>-</u>

Schedule A (Form 5500) 2017

(a) Name and MEYERS-STEVENS & TO 26101 MARQUERITE PK MISSION VIEJO	OHEY CO INC	oker, or other person to whom commissions or fees were paid 92	
(b) Amount of sales and base commissions paid	(c) Amount	(e) Organization code	
	12098	(d) Purpose OVERWRITE FEE	3
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization
	(c) Amount	(d) Purpose	code
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of supurposes of this report.	ıch individua	al contracts with each	carrier m	ay be treated as a unit for
4 (Current	value of plan's interest under this contract in the general account	at year end		4	
5 (Current	value of plan's interest under this contract in separate accounts a	at year end		5	
6	Contrac	cts With Allocated Funds:				
а	State	the basis of premium rates				
		iums paid to carrier			6b	
		iums due but unpaid at the end of the year			6с	
d		carrier, service, or other organization incurred any specific costs in				
		equisition or retention of the contract or policy, enter amount			6d	
	-	ify nature of costs				
е		of contract: (1) 🔲 individual policies (2) 📙 group defen	red annuity			
	(3)	other (specify)				
					. [
<u>+</u>		tract purchased, in whole or in part, to distribute benefits from a to				
′		racts With Unallocated Funds (Do not include portions of these co		· ·	-	
а	Type	of contract: (1) deposit administration (2)		te participation guaran	tee	
		(3) guaranteed investment (4)	other	•		
L	5 .				76	
		nce at the end of the previous year	7-(4)		7b	
C		ions: (1) Contributions deposited during the year				
		ividends and credits				
		nterest credited during the year				
		ransferred from separate account				
	(5) C	Other (specify below)	7c(5)			
	(C) T				70(6)	0
٨		otal additions			7c(6) 7d	
		of balance and additions (add lines 7b and 7c(6))	Г		/u	
C	Dedu	isbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		dministration charge made by carrier				
		ransferred to separate account	7e(3)			
	(4) O	other (specify below)	7e(4)			
	(5) T	otal doductions			7e(5)	0
f		otal deductions			76(3)	

Pa	art II		Welfare Benefit Contract Inform If more than one contract covers the sam employee organization(s), the information as a unit. Where contracts cover individu treated as a unit for purposes of this rep	ne group of emplon n may be combined al employees, the	ed for reporti	ng purposes if such	contracts are ex	perience-rated	
8	Ben a e i m	He Te	nd contract type (check all applicable boxe alth (other than dental or vision) mporary disability (accident and sickness) op loss (large deductible) her (specify)	b Dental	-	c Vision g Supplement k PPO contract	al unemployment t	d X Life insurance h Prescription of I Indemnity cor	lrug
9	Exp	erien	ce-rated contracts:						
а	Prer	nium	s: (1) Amount received		9a(1)				
	(2)	Incr	ease (decrease) in amount due but unpaid		9a(2)				
			ease (decrease) in unearned premium rese		9a(3)				
			ned ((1) + (2) - (3))				9a(4)		
b	Ben	efit c	harges: (1) Claims paid		9b(1)				
			ease (decrease) in claim reserves						
			urred claims (add (1) and (2))				9b(3)		
			ms charged				9b(4)		
С	Rem	aind	er of premium: (1) Retention charges (on ar	n 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)				
			Total retention				9c(1)(H)		
	(2)	Divi	dends or retroactive rate refunds. (These a	mounts were 🔲 ı	oaid in cash,	or credited.)	9c(2)		
d	Stat	us of	f policyholder reserves at end of year: (1) A	mount held to pro	vide benefits	after retirement	9d(1)		
	(2)	Clai	m reserves				9d(2)		
	(3)	Oth	er reserves				9d(3)		
<u>e</u>	Divid	dend	s or retroactive rate refunds due. (Do not in	nclude amount en	tered in line 9	9c(2).)	9e		
10		•	rience-rated contracts:					44065	
a	Tota	l pre	miums or subscription charges paid to carr	rier			10a	11865	36
b			rier, service, or other organization incurred						
			isition or retention of the contract or policy	, other than repor	ted in Part I,	line 2			
			eport amount				10b		
S	pecify	natı	ure of costs						
D.	art I\	,	Provision of Information						
11		_		mation necessary	to complete	Schodule A2	Ye	es X No	
			nsurance company fail to provide any informa swer to line 11 is "Yes," specify the informa			Sofiedule A!	[] fe	50 <u>F4</u> INU	
		- unic	and in the real appears the information	on not provided	. 📂				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Insurance Information**

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

► File as an attachment to Form 5500.

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

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

		Pui	Suarit to	LI IIOA 30	c(a)(2).			no mopeodon
For calendar plan year 20	17 or fiscal plan	year beginning 01/01	1/201	.7	and endin	g	12/31/2017	
A Name of plan						B Th	ree-digit	
INSURANCE A	ND BENE	FITS TRUST OF S	THE P	EACE	OFFICERS	pla	an number (PN)	501
		on line 2a of Form 5500				D En	nployer Identification	
		FITS TRUST OF					68-606846	
		cerning Insurance Cor						
4	· ·	e Schedule A. Individual conti	racts gro	uped as a	unit in Parts II and	III can	be reported on a sing	gle Schedule A.
1 Coverage Informati	tion:							
(a) Name of insurance	e carrier							
		COMDANY						
STANDARD IN	SURANCE	COMPANI						
	(-) NIAIO	(a) O a satura at a su	1 (-)	A i			Delieveres	entroet voor
(b) EIN	(c) NAIC code	(d) Contract or identification number			nate number of pers of policy or contract		•	ontract year
			1			, ,	(f) From	(g) To
93-0242990	69019	649401			20	188	01/01/2017	12/31/2017
2 Insurance fee and	commission in	nformation. Enter the total fee	es and to	tal comm	issions paid. List in	line 3 th	ne agents, brokers, a	nd other persons
in descending ord	er of the amou	ınt paid.						
(a) ⁷	Total amount o	of commissions paid			(b) ⊺	otal am	ount of fees paid	
			0					0
3 Persons receiving	commissions	and fees. (Complete as many	entries a	as needed	d to report all perso	ns).		
	(a) Name a	and address of the agent, bro	ker, or ot	her perso	n to whom commis	sions o	r fees were paid	
NONE								
(b) Amount of sale	es and base		Fees	s and othe	er commissions pai	d		(e)
commission	s paid	(a) Amount		(d) Purpose code				Organization
		(c) Amount			(a) Furp	use		
	(a) Name a	and address of the agent, bro	ker or ot	her nerso	n to whom commis	sions o	r fees were naid	
	(u) Numo e	and address of the agent, bro	101, 01 01	nor perso	THE WHOTH COMMITTE	010110 01	reco were paid	
(b) Amount of sale	o and base		_					(e)
(b) Amount of sale			Fees	s and othe	er commissions pai	d		Organization
commission	s paiu	(c) Amount			(d) Purp	ose		code

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

Schedule A (Form 5500) 2017 v. 170203

Schedule A (Form 5500) 2017		Page 2-		
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(d) Haine and	a doubted of the agent, bro	short, or other person to whom commissions or rece were paid		
(b) Amount of sales and base commissions paid	(2) Amount	Fees and other commissions paid		
	(c) Amount	(d) Purpose	code	
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
	-			
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
			•	
(a) Name an	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		(e) Organization		
	(c) Amount	(d) Purpose	code	
			•	
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
	(c) Amount	(d) Purpose	code	
(a) Name and	d address of the agent, bro	oker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

Pa	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of supurposes of this report.	ıch individua	al contracts with each	carrier m	ay be treated as a unit for
4 (Current	value of plan's interest under this contract in the general account	at year end		4	
5 (Current	value of plan's interest under this contract in separate accounts a	at year end		5	
6	Contrac	cts With Allocated Funds:				
а	State	the basis of premium rates				
		iums paid to carrier			6b	
		iums due but unpaid at the end of the year			6с	
d		carrier, service, or other organization incurred any specific costs in				
		equisition or retention of the contract or policy, enter amount			6d	
	-	ify nature of costs				
е		of contract: (1) 🔲 individual policies (2) 📙 group defen	red annuity			
	(3)	other (specify)				
					. [
<u>+</u>		tract purchased, in whole or in part, to distribute benefits from a to				
′		racts With Unallocated Funds (Do not include portions of these co		· ·	-	
а	Type	of contract: (1) deposit administration (2)		te participation guaran	tee	
		(3) guaranteed investment (4)	other	•		
L	5 .				76	
		nce at the end of the previous year	7-(4)		7b	
C		ions: (1) Contributions deposited during the year				
		ividends and credits				
		nterest credited during the year				
		ransferred from separate account				
	(5) C	Other (specify below)	7c(5)			
	(C) T				70(6)	0
٨		otal additions			7c(6) 7d	
		of balance and additions (add lines 7b and 7c(6))	Г		/u	
C	Dedu	isbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		dministration charge made by carrier				
		ransferred to separate account	7e(3)			
	(4) O	other (specify below)	7e(4)			
	(5) T	otal doductions			7e(5)	0
f		otal deductions			76(3)	

_					
Pa	art III Welfare Benefit Contract Information				
	If more than one contract covers the same group of emple employee organization(s), the information may be combin-				
	as a unit. Where contracts cover individual employees, th	•	•		
	treated as a unit for purposes of this report.	o ontho group	o or odorr marvidudi oo	iniaoto with ca	on carnor may be
8					
0	Benefit and contract type (check all applicable boxes)		o □ vistan		d 🗆
	a Health (other than dental or vision) b Dental e Temporary disability (accident and sickness) f X Long-term	P 1 224	Vision		d Life insurance
	· H	-	Supplemental u	unemployment	. H
	Third control	ract	k ∐ PPO contract		Indemnity contract
9	Other (Specify)				
	Experience-rated contracts:	0-(4)	226	2267	
а		9a(1)		5760	
	(2) Increase (decrease) in amount due but unpaid		12	767	
	(3) Increase (decrease) in unearned premium reserve		1	-	2987260
ı.	(4) Earned ((1) + (2) - (3))			9a(4) 8975	2907200
D	Benefit charges: (1) Claims paid			5046	
	(2) Increase (decrease) in claim reserves				6614021
	(3) Incurred claims (add (1) and (2))			9b(3)	0014021
_	(4) Claims charged			9b(4)	
C	Remainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions	9c(1)(A)			
	(B) Administrative service or other fees	9c(1)(B)		2000	
	(C) Other specific acquisition costs	9c(1)(C)		1426	
	(D) Other expenses	9c(1)(D)		0200	
	(E) Taxes	9c(1)(E)		8471	
	(F) Charges for risks or other contingencies	9c(1)(F)	33	04/1	
	(G) Other retention charges		16)o/4\/U\	952097
	(H) Total retention			9c(1)(H) 9c(2)	332031
٨	(2) Dividends or retroactive rate refunds. (These amounts were			9d(1)	
u	Status of policyholder reserves at end of year: (1) Amount held to pro		 	9d(1) 9d(2)	15120344
	(2) Claim reserves			9d(2) 9d(3)	13120344
_	(3) Other reserves			9e	
<u>е</u> 10		iterea in line s	(2).)	<i>3</i> e	
	Nonexperience-rated contracts:		Г	10a	
a h				100	
D	If the carrier, service, or other organization incurred any specific cost				
	the acquisition or retention of the contract or policy, other than report	10b			
c	above, report amount			100	
3	pecify nature of costs				

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

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

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

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

► File as an attachment to Form 5500.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection.

Pension Benefit Guaranty Corporation	efit Guaranty Corporation File as an attachment to Form 5500.			
or calendar plan year 2017 or fiscal p	olan year beginning 01/01/2017	and ending	12/31/2017	
A Name of plan INSURANCE AND BENEF	ITS TRUST OF THE PEACE		hree-digit 501 blan number (PN)	
C Plan sponsor's name as shown on INSURANCE AND BENEF			Employer Identification Number (EIN) 68-6068469	
Part I Service Provider Info	ormation (see instructions)			
indirectly, \$5,000 or more in total co the person's position with the plan- required disclosures, you are required	cordance with the instructions, to report the interpretation (i.e., money or anything else of new during the plan year. If a person received only red to answer line 1 but are not required to income.	nonetary value) in connection w y eligible indirect compensation clude that person when comple	vith services rendered to the plan or for which the plan received the	
Information on Persons Re	eceiving Only Eligible Indirect Com	pensation		
	nether you are excluding a person from the rer hich the plan received the required disclosure			
-	r the name and EIN or address of each persor compensation. Complete as many entries as n	· · · · · · · · · · · · · · · · · · ·	ures for the service providers	
(b) Enter name ar	nd EIN or address of person who provided you	u disclosures on eligible indirec	t compensation	
(h) Enter name ar	nd EIN or address of person who provided you	u dicaloguras an aligible indires	t componenties	
(b) Enter name an	id Lift of address of person who provided you	a disclosures on engine indirec	t compensation	
(b) Enter name ar	nd EIN or address of person who provided you	u disclosures on eligible indirec	t compensation	
(2) 2	<u> = </u>			
(h) Entar nama ar	and FIN or address of person who provided you	u disclosures on aligible indires	t compensation	
(b) Enter name ar	nd EIN or address of person who provided you	a disclosures on eligible indirec	т сотпрепъацон	

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

Schedule C (Form 5500) 2017

v. 170203

Schedule C (Form 5500) 2017	Page 2 -	
(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	
(h) Enter name and EIN or address of payson who	p provided you disclosures on eligible indirect compensation	
(b) Enter hame and Env or address or person who	provided you disclosures on engible malifect compensation	
(b) Enter name and EIN or address of person who	provided you disclosures on eligible indirect compensation	
(b) Enter name and EIN or address of person who	provided you disclosures on eligible indirect compensation	
(b) Enter name and EIN or address of person who	provided you disclosures on eligible indirect compensation	
(-)		_
(b) Enter name and EIN or address of person who	provided you disclosures on eligible indirect compensation	
No. Colonia and Clair		
(b) Enter name and EIN or address of person who	provided you disclosures on eligible indirect compensation	

	Schedule C (Form 5	,	vidoro Dossivina F	Nivoot ov Indivoot C	Page 3 -	
you in to	answered "Yes" to line	1a on page 1, co	omplete as many entries	as needed to list each p	ompensation. Except for the erson receiving, directly or indicated to the plan or their position.	rectly, \$5,000 or more
			(a) Enter name and EIN	l or address (see instruc	tions)	
PORA				23-7077256		
(b) Service Code(s		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?

50 PARTY IN INTEREST 14 682136.

Yes No X

No

Yes No

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

MYERS-STEVENS TOOHEY & CO INC

95-2637676

(b)	(c)	(d)	(e)	(f)	(g)	(h)
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	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 answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	472032.	Yes No 🗓	Yes No		Yes No

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

REICH ADELL & CVITAN

94-1205338

(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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	138393.	Yes No 🗓	Yes No		Yes No

Page 3 -	

you answered "Yes" to line 1a on page 1, 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) THE SEGAL COMPANY 94-1050399 **(f)** Did indirect (b) (d) (e) (h) (c) (g) Enter total indirect Relationship to Enter direct Did service provider Did the service Service compensation include compensation received by employer, employee receive indirect provider give you Code(s) compensation eliaible indirect service provider excludina organization, or paid by the compensation? a formula instead eligible indirect compensation, for person known to be plan. If none. (sources other of an amount or which the plan compensation for which you a party-in-interest enter -0-. than plan or estimated amount? received the answered "Yes" to element plan sponsor) required disclosures? (f). If none, enter -0-. 16 NONE 50 88117. Yes No X Yes No Yes | No | (a) Enter name and EIN or address (see instructions) 30-0702322 **HEMMING MORSE** (d) (h) (b) (c) (e) (g) Did indirect Enter total indirect Service Relationship to Enter direct Did service provider Did the service compensation include compensation received by Code(s) provider give you employer, employee compensation receive indirect service provider excluding eligible indirect organization, or compensation? a formula instead paid by the eligible indirect compensation, for plan. If none, person known to be (sources other of an amount or which the plan compensation for which you a party-in-interest enter -0-. than plan or estimated amount? received the answered "Yes" to element plan sponsor) required disclosures? (f). If none, enter -0-. 10 NONE 50 23500. Yes No X Yes | No | Yes No (a) Enter name and EIN or address (see instructions) ROBERT FEINGLASS 80-0231345 (d) (b) (c) (e) (f) (g) (h) Did indirect Enter total indirect Relationship to Enter direct Did service provider Did the service Service compensation received by compensation include Code(s) employer, employee compensation receive indirect provider give you organization, or eliaible indirect service provider excluding paid by the compensation? a formula instead compensation, for eligible indirect person known to be plan. If none, (sources other of an amount or which the plan compensation for which you a party-in-interest enter -0-. than plan or estimated amount? answered "Yes" to element received the plan sponsor) (f). If none, enter -0-. required disclosures? 29 NONE 50 17262. Yes No X Yes No Yes No

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom

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you answered "Yes" to line 1a on page 1, 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) **UBS** 2029 CENTURY PARK EAST, ST 3000 LOS ANGELES 90067 CA (b) (d) (e) (f) (h) (c) (g) Did indirect Enter total indirect Relationship to Enter direct Did service provider Did the service Service compensation include compensation received by employer, employee receive indirect provider give you Code(s) compensation eliaible indirect service provider excludina organization, or paid by the compensation? a formula instead eligible indirect compensation, for person known to be plan. If none. (sources other of an amount or which the plan compensation for which you a party-in-interest enter -0-. than plan or estimated amount? received the answered "Yes" to element plan sponsor) (f). If none, enter -0-. required disclosures? 27 NONE 51 16128. Yes No X Yes No No Yes No (a) Enter name and EIN or address (see instructions) SHANE TALBOT 68-6068469 (d) (h) (b) (c) (e) (g) Did indirect Enter total indirect Service Relationship to Enter direct Did service provider Did the service compensation include compensation received by Code(s) provider give you employer, employee compensation receive indirect service provider excluding eligible indirect organization, or compensation? a formula instead paid by the compensation, for eligible indirect plan. If none, person known to be (sources other of an amount or which the plan compensation for which you a party-in-interest enter -0-. than plan or estimated amount? received the answered "Yes" to element plan sponsor) required disclosures? (f). If none, enter -0-. 20 TRUSTEE 50 5948. Yes No X Yes No Yes No (a) Enter name and EIN or address (see instructions) DAMON KURTZ 68-6068469 (d) (b) (c) (e) (f) (g) (h) Did indirect Enter total indirect Relationship to Enter direct Did service provider Did the service Service compensation received by compensation include Code(s) employer, employee compensation receive indirect provider give you eliaible indirect service provider excluding organization, or paid by the compensation? a formula instead compensation, for eligible indirect person known to be plan. If none, (sources other of an amount or which the plan compensation for which you than plan or estimated amount? a party-in-interest enter -0-. answered "Yes" to element received the plan sponsor) (f). If none, enter -0-. required disclosures? 20 TRUSTEE 50 Yes No X 5660. Yes No Yes | No |

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom

SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fis	scal plan year beginning $01/0$	1/2017 and end	ing 12/31/2017
A Name of plan			B Three-digit plan number (PN) ▶ 501
INSURANCE AND BENEF	FITS TRUST OF THE	PEACE OFFICERS R	
C Plan sponsor's name as shown on	line 2a of Form 5500		D Employer Identification Number (EIN)
INSURANCE AND BENEF	FITS TRUST OF THE	PORAC	68-6068469
Part I Asset and Liability	Statement		

Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

a Total noninterest-bearing cash b Receivables (less allowance for doubtful accounts): (1) Employer contributions (2) Participant contributions (3) Other SEE STATEMENT 1 C General investments: (1) Interest-bearing cash (incl. money market accounts & certificates of deposit) 1a 30656 1b(1) 751000 1b(2) 751000 1458884	380407 1322812
b Receivables (less allowance for doubtful accounts): (1) Employer contributions (2) Participant contributions (3) Other SEE STATEMENT 1 C General investments: (1) Interest-bearing cash (incl. money market accounts & certificates of deposit) 1b(1) 751000 1b(2) 751000 1b(3) 1458884	380407
(1) Employer contributions (2) Participant contributions (3) Other SEE STATEMENT 1 (4) Interest-bearing cash (incl. money market accounts & certificates of deposit) (5) Ib(1) 151000 (6) T51000 (7) T51000 (8) T51000 (9) T51000 (10) T51000 (11) T51000 (12) T51000 (13) T51000 (14) T51000 (15) T51000 (16) T51000 (17) T51000 (18) T51	
(2) Participant contributions (3) Other SEE STATEMENT 1 (4) Interest-bearing cash (incl. money market accounts & certificates of deposit) (5) Participant contributions (751000 1b(2) 1458884 1b(3) 1458884	
(3) Other SEE STATEMENT 1 C General investments: (1) Interest-bearing cash (incl. money market accounts & certificates of deposit) 1c(1) 1313934	
C General investments: (1) Interest-bearing cash (incl. money market accounts & certificates of deposit) 1313934	
(1) Interest-bearing cash (incl. money market accounts & certificates of deposit) 1c(1) 1313934	
	599
(2) U.S. Government securities 1c(2) 99509	
(3) Corporate debt instruments (other than employer securities):	
(A) Preferred1c(3)(A)	
(B) All other 1c(3)(B) 745961	
(4) Corporate stocks (other than employer securities):	
(A) Preferred	
(B) Common 1c(4)(B) 462	
(5) Partnership/joint venture interests 1c(5)	
(6) Real estate (other than employer real property) 1c(6)	
(7) Loans (other than to participants) 1c(7)	
(8) Participant loans 1c(8)	
(9) Value of interest in common/collective trusts 1c(9)	
(10) Value of interest in pooled separate accounts 1c(10)	
(11) Value of interest in master trust investment accounts	
(12) Value of interest in 103-12 investment entities 1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds) 1124106	3679865
(14) Value of funds held in insurance co. general account (unallocated contracts) 1c(14)	
(15) Other SEE STATEMENT 2 1c(15) 437875	751090

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

Schedule H (Form 5500) 2017

v. 170203

1 d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property			
е	Buildings and other property used in plan operation		4188	24669
f	Total assets (add all amounts in lines 1a through 1e)		5966575	6776758
	Liabilities		•	
g	Benefit claims payable	. 1g	1520000	999000
h	Operating payables		178879	221691
i	Acquisition indebtedness	1i		
j	Other liabilities SEE STATEMENT 3	1j	1189439	1024601
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	2888318	2245292
	Net Assets		•	
- 1	Net assets (subtract line 1k from line 1f)	11	3078257	4531466

Part II Income and Expense Statement

Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)		
	(B) Participants	2a(1)(B)	5678954	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		5678954
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market			
	accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)	27591	
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)	5531	
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		33122
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	94794	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		94794
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate \dots	2b(5)(A)		
	(B) Other	2b(5)(B)	181694	
	(C) Total unrealized appreciation of assets.			
	Add lines 2b(5)(A) and (B)	2b(5)(C)		181694

			(a) A	Amount	(b)⊤	otal
	(6) Net investment gain (loss) from common/collective trusts	2b(6)				
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)				
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)				
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)				
	(10) Net investment gain (loss) from registered investment companies					
	(e.g., mutual funds)	2b(10)				48393
С	(e.g., mutual funds) Other income SEE STATEMENT 4	2c				900561
d	Total income. Add all income amounts in column (b) and enter total	2d			./	937518
	Expenses					
е	Benefit payment and payments to provide benefits:			1016004		
	(1) Directly to participants or beneficiaries, including direct rollovers			1816804		
	(2) To insurance carriers for the provision of benefits			3074936		
	(3) Other					001740
	(4) Total benefit payments. Add lines 2e(1) through (3)			-	4	891740
Ť	Corrective distributions (see instructions)			-		
g	Certain deemed distributions of participant loans (see instructions)			-		
h :	Interest expense			267272		
'	Administrative expenses: (1) Professional fees			1154168		
	(2) Contract administrator fees			16128		
	(3) Investment advisory and management fees	2i(3)		155001		
	(4) Other SEE STATEMENT 5			133001	1	592569
i	(5) Total administrative expenses. Add lines 2i(1) through (4) Total expenses. Add all expense amounts in column (b) and enter total			-		484309
J	Net Income and Reconciliation					7404303
k	Net income (loss). Subtract line 2j from line 2d	2k			1	453209
ì	Transfers of assets:	ZK		-		. 133203
•	(1) To this plan	21(1)				
	(2) From this plan	21(2)				
Pa	rt III Accountant's Opinion					
3	Complete lines 3a through 3c if the opinion of an independent qualified public acc	countant is	attached to	this Form 5500		
	Complete line 3d if an opinion is not attached.					
а	The attached opinion of an independent qualified public accountant for this plan	is (see instr	uctions):			
	(1) N Unqualified (2) Qualified (3) Disclaimer (4)	Adverse				
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8	and/or 103	3-12(d)?		Yes	X No
С	Title the hame and the end december (or december) below					
	(1) Name: VAVRINEK, TRINE, DAY & CO., LLP		(2)	EIN: 95-26	48289	
d	The opinion of an independent qualified public accountant is not attached becau	ıse:				
-		ned to the n	ext Form 55	00 pursuant to	29 CFR 2520	0.104-50.
	rt IV Compliance Questions					
4	CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not con		s 4a, 4e, 4f, 4	4g, 4h, 4k, 4m, 4	4n, or 5.	
	103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4	41.	_			
	During the plan year:		Ye	s No	Amoun	t
а	Was there a failure to transmit to the plan any participant contributions within the					
	period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior y	/ear				
	failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary			🗸		
1.	Correction Program.)		. 4a	X		
b	Were any loans by the plan or fixed income obligations due the plan in default as	of the				
	close of the plan year or classified during the year as uncollectible? Disregard	F				
	participant loans secured by participant's account balance. (Attach Schedule G (I		,	x		
	5500) Part I if "Yes" is checked.)		4b	^_		

Page	4	-
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Schedule H (Form 5500) 2017

			Yes	No		Amount	
С	Were any leases to which the plan was a party in default or classified during the year						
	uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X			
d	Were there any nonexempt transactions with any party-in-interest? (Do not include						
	transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is						
	checked.)	4d		X			
е	Was this plan covered by a fidelity bond?	4e	X			100	00000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that						
	was caused by fraud or dishonesty?	4f		X			
g	Did the plan hold any assets whose current value was neither readily determinable or						
	an established market nor set by an independent third party appraiser?	4g		X			
h	Did the plan receive any noncash contributions whose value was neither readily						
	determinable on an established market nor set by an independent third party						
	appraiser?	4h		Х			
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" i						
	checked, and see instructions for format requirements.)	4i	Х				
j	Were any plan transactions or series of transactions in excess of 5% of the current						
	value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see						
	instructions for format requirements.)	4j		Х			
k	Were all the plan assets either distributed to participants or beneficiaries, transferred						
	to another plan, or brought under the control of the PBGC?	4k		Х			
ı	Has the plan failed to provide any benefit when due under the plan?			Х			
m	If this is an individual account plan, was there a blackout period? (See instructions						
	and 29 CFR 2520.101-3.)	4m		Х			
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required n						
	one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		Х			
5 a	Has a resolution to terminate the plan been adopted during the plan year or any prior	r plan year?		Yes	XΝ	lo	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year						
5b	If, during this plan year, any assets or liabilities were transferred from this plan to and	other plan(s), ic	entify t	he plan	(s) to which	ch assets o	r liabilities
	were transferred. (See instructions.)						
	5b(1) Name of plan(s)	5b(2) EIN(s)		5b(3) PN(s)
5 c	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA s	section 4021.)?	L	Yes	∐ No	∐ Not de	etermined
	If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium to	filing for this pl	an year			. (See i	instr.)

SCHEDULE H OTHER RECI	EIVABLES	STATEMENT	1
DESCRIPTION	BEGINNING	ENDING	
OTHER RECEIVABLES	1458884.	132281	2.
TOTAL TO SCHEDULE H, LINE 1B(3)	1458884.	132281	2.
SCHEDULE H OTHER GENERAL	INVESTMENTS	STATEMENT	2
DESCRIPTION	BEGINNING	ENDING	
OTHER GENERAL INVESTMENTS	437875.	75109	0.
MOMAL MO COURDINE II I TAKE 10/15)	437875.	75109	0
TOTAL TO SCHEDULE H, LINE 1C(15)	=======================================		
SCHEDULE H OTHER PLAN L		STATEMENT	3
			_
SCHEDULE H OTHER PLAN L	IABILITIES	STATEMENT	3
SCHEDULE H OTHER PLAN LED	IABILITIES BEGINNING	STATEMENT ENDING	3
SCHEDULE H OTHER PLAN LED DESCRIPTION OTHER LIABILITIES	BEGINNING 1189439. 1189439.	STATEMENT ENDING 102460	3
SCHEDULE H OTHER PLAN LED DESCRIPTION OTHER LIABILITIES TOTAL TO SCHEDULE H, LINE 1J	BEGINNING 1189439. 1189439.	STATEMENT ENDING 102460 102460	3
SCHEDULE H OTHER PLAN LED DESCRIPTION OTHER LIABILITIES TOTAL TO SCHEDULE H, LINE 1J SCHEDULE H OTHER IN	BEGINNING 1189439. 1189439.	STATEMENT ENDING 102460 102460 STATEMENT	3 1. 1.

SCHEDULE H	OTHER ADMINISTRATIVE EXPENSES	STATEMENT	5
DESCRIPTION		AMOUNT	
OTHER ADMINISTRATIVE EXP	ENSES	1550	01.
TOTAL TO SCHEDULE H, LIN	E 2I(4)	1550	01.