

<div>Form 5500</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Annual Return/Report of Employee Benefit Plan</div> <div>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 6047(e), and 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div>	<div>OMB Nos. 1210-0110 1210-0089</div> <div>2009</div> <div>This Form is Open to Public Inspection</div>
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Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning 09/01/2004 and ending 08/31/2005	
A	This return/report is for: <div><div><input type="checkbox"/> a multiemployer plan;</div><div><input checked="" type="checkbox"/> a single-employer plan;</div><div><input type="checkbox"/> a multiple-employer plan; or</div><div><input type="checkbox"/> a DFE (specify) ____</div></div>
B	This return/report is: <div><div><input type="checkbox"/> the first return/report;</div><div><input checked="" type="checkbox"/> an amended return/report;</div><div><input type="checkbox"/> the final return/report;</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months).</div></div>
C	If the plan is a collectively-bargained plan, check here. ▶ <input type="checkbox"/>
D	Check box if filing under: <div><div><input checked="" type="checkbox"/> Form 5558;</div><div><input type="checkbox"/> automatic extension;</div><div><input type="checkbox"/> the DFVC program;</div><div><input type="checkbox"/> special extension (enter description)</div></div>

Part II	Basic Plan Information—enter all requested information	
1a	Name of plan ALFRED'S FABRIC CENTERS, INC. PROFIT SHARING PLAN	1b Three-digit plan number (PN) ▶ 003
		1c Effective date of plan 09/01/1988
2a	Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) ALFREDS FABRIC CENTERS, INC. 1814 CENTRAL AVENUE ALBANY, NY 12205	2b Employer Identification Number (EIN) 14-1586312 2c Sponsor's telephone number 518-489-6700 2d Business code (see instructions) 451130

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	03/17/2010	LAWRENCE ALFRED
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") ALFREDS FABRIC CENTERS, INC. 1814 CENTRAL AVENUE ALBANY, NY 12205	3b Administrator's EIN 14-1586312 3c Administrator's telephone number 518-489-6700
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	12
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6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a , 6b , 6c , and 6d).		
a Active participants.....	6a	7
b Retired or separated participants receiving benefits.....	6b	0
c Other retired or separated participants entitled to future benefits.....	6c	0
d Subtotal. Add lines 6a , 6b , and 6c	6d	7
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	0
f Total. Add lines 6d and 6e	6f	7
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	5
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	0

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
 2E 3D

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

9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input checked="" type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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SCHEDULE I (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information—Small Plan 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 2009 This Form is Open to Public Inspection
For calendar plan year 2009 or fiscal plan year beginning 09/01/2004 and ending 08/31/2005		
A Name of plan ALFRED'S FABRIC CENTERS, INC. PROFIT SHARING PLAN		B Three-digit plan number (PN) ► 003
C Plan sponsor's name as shown on line 2a of Form 5500 ALFREDS FABRIC CENTERS, INC.		D Employer Identification Number (EIN) 14-1586312

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I	Small Plan Financial Information
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Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. 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.**

		(a) Beginning of Year	(b) End of Year
1 Plan Assets and Liabilities:			
a Total plan assets	1a	360754	375341
b Total plan liabilities	1b	0	0
c Net plan assets (subtract line 1b from line 1a).....	1c	360754	375341
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable:			
(1) Employers	2a(1)	0	
(2) Participants.....	2a(2)	0	
(3) Others (including rollovers)	2a(3)	0	
b Noncash contributions.....	2b	0	
c Other income.....	2c	44492	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c).....	2d		44492
e Benefits paid (including direct rollovers)	2e	9349	
f Corrective distributions (see instructions)	2f	0	
g Certain deemed distributions of participant loans (see instructions)	2g	13027	
h Administrative service providers (salaries, fees, and commissions).....	2h	7529	
i Other expenses.....	2i	0	
j Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		29905
k Net income (loss) (subtract line 2j from line 2d).....	2k		14587
l Transfers to (from) the plan (see instructions)	2l		0

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.				
		Yes	No	Amount
a Partnership/joint venture interests.....	3a		X	
b Employer real property.....	3b		X	
c Real estate (other than employer real property)	3c		X	
d Employer securities.....	3d		X	
e Participant loans.....	3e	X		10501

	Yes	No	Amount
3f Loans (other than to participants)		X	
g Tangible personal property		X	

Part II	Compliance Questions
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4	During the plan year:	Yes	No	Amount
a	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)		X	
e	Was the plan covered by a fidelity bond?	X		40000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		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?		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	X		
l	Has the plan failed to provide any benefit when due under the plan?		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?
 If "Yes," enter the amount of any plan assets that reverted to the employer this year..... ☐ Yes ☒ No Amount:

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

**SCHEDULE P
(FORM 5500)**

Department of the Treasury
Internal Revenue Service

**Annual Return of Fiduciary
of Employee Benefit Trust**

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

► File as an attachment to Form 5500 or 5500-EZ.

Official Use Only

OMB No. 1210-0110

2004

This Form is Open to
Public Inspection.

For trust calendar year 2004 or fiscal year beginning 09/01/2004 and ending 08/31/2005

1a Name of trustee or custodian

LAWRENCE M. ALFRED

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

1814 CENTRAL AVENUE

c City or town, state, and ZIP code

ALBANY NY 12205-0000

2a Name of trust

ALFRED'S FABRIC CENTERS, INC. PROFIT SHARING TRUST

b Trust's employer identification number 14-1779206

3 Name of plan if different from name of trust

ALFRED'S FABRIC CENTERS, INC. PROFIT SHARING PLAN

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? ☒ Yes ☐ No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ 14-1586312

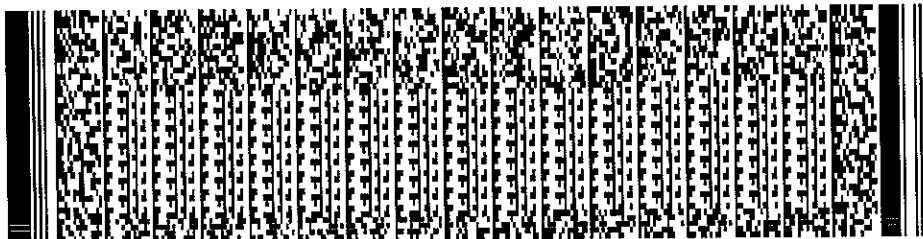
Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

SIGN HERE Signature of fiduciary Date

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.

v7.2

Schedule P (Form 5500) 2004



**SCHEDULE R
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the
Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the
Internal Revenue Code (the Code).

► **File as an Attachment to Form 5500.**

Official Use Only

OMB No. 1210-0110

2004

**This Form is Open to
Public Inspection.**

For calendar year 2004 or fiscal plan year beginning 09/01/2004 and ending 08/31/2005

A Name of plan
ALFRED'S FABRIC CENTERS, INC. PROFIT SHARING PLAN

B Three-digit
plan number 003

C Plan sponsor's name as shown on line 2a of Form 5500
ALFRED'S FABRIC CENTERS, INC.

D Employer Identification Number
14-1586312

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

- 1** Total value of distributions paid in property other than in cash or the forms of property specified in the instructions 0
- 2** Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 14-1779206

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

- 3** Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

- 4** Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? ☐ Yes ☐ No ☐ N/A
If the plan is a defined benefit plan, go to line 7.

- 5** If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver. Month Day Year
If you completed line 5, complete lines 3, 9, and 10 of Schedule B and do not complete the remainder of this schedule.

- 6a** Enter the minimum required contribution for this plan year \$
- b** Enter the amount contributed by the employer to the plan for this plan year \$
- c** Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) \$

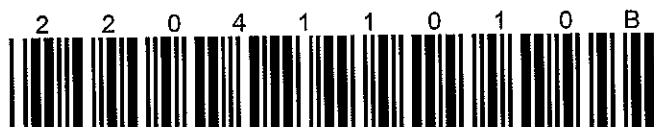
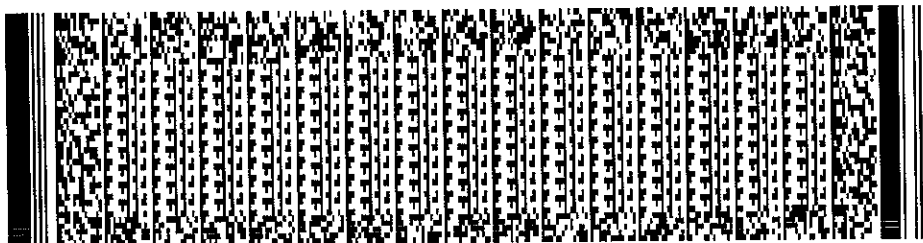
If you completed line 6c, do not complete the remainder of this schedule.

- 7** If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ☐ Yes ☐ No ☐ N/A

Part III Amendments

- 8** If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) ☐ Yes ☐ No

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v7.2 Schedule R (Form 5500) 2004



**SCHEDULE T
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the
Internal Revenue Code (the Code).

► **File as an attachment to Form 5500.**

Official Use Only

OMB No. 1210-0110

2004

**This Form is Open to
Public Inspection.**

For calendar year 2004 or fiscal plan year beginning <u>09/01/2004</u> and ending <u>08/31/2005</u>	
A Name of plan ALFRED'S FABRIC CENTERS, INC. PROFIT SHARING PLAN	B Three-digit plan number ► <u>003</u>
C Plan sponsor's name as shown on line 2a of Form 5500 ALFRED'S FABRIC CENTERS, INC.	D Employer Identification Number <u>14-1586312</u>

Note: If the plan is maintained by:

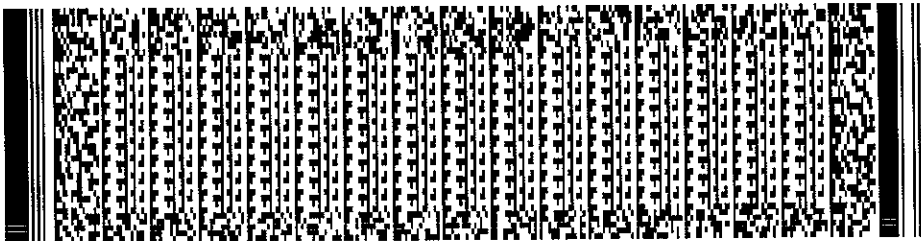
- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
 - An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).
- 1** If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer	1b Employer identification number
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- 2** If the employer maintaining the plan operates QSLOBs, enter the following information:
- a** The number of QSLOBs that the employer operates is _____.
 - b** The number of such QSLOBs that have employees benefiting under this plan is _____.
 - c** Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? . . . ☐ Yes ☐ No
 - d** If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.
►

- 3** Exceptions -- Check the box before each statement that describes the plan or the employer. Also see instructions.
If you check any box, do not complete the rest of this Schedule.
- a** ☐ The employer employs only highly compensated employees (HCEs).
 - b** ☒ No HCEs benefited under the plan at anytime during the plan year.
 - c** ☐ The plan benefits only collectively-bargained employees.
 - d** ☐ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.
 - e** ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v7.2 Schedule T (Form 5500) 2004



- 4** Enter the date the plan year began for which coverage data is being submitted. Month ____ Day ____ Year ____
- a** Did any leased employees perform services for the employer at any time during the plan year? ☐ Yes ☐ No
- b** In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? ☐ Yes ☐ No
- c** Complete the following:
- | | | |
|--|-------------|---------|
| (1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals. | c(1) | _____ |
| (2) Number of excludable employees as defined in IRS regulations (see instructions) | c(2) | _____ |
| (3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1)) | c(3) | _____ |
| (4) Number of nonexcludable employees (line 4c(3)) who are HCEs | c(4) | _____ |
| (5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan | c(5) | _____ |
| (6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs. | c(6) | _____ |
| d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) ► _____ | d | _____ % |
- e** Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

Disaggregated part:

Ratio Percentage:

Exception:

(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____

f This plan satisfies the coverage requirements on the basis of (check one): **(1)** ☐ the ratio percentage test **(2)** ☐ average benefit test

