Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

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

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

Р	ension Benefit Guaranty Corporation	▶ Complete all entries in accor	dance wit	h the instructions to the Form 550	0-SF.					
		dentification Information								
For	For calendar plan year 2010 or fiscal plan year beginning 01/01/2010 and ending 12/31/2010									
Α.	This return/report is for:	single-employer plan	multiple-e	employer plan (not multiemployer)		one-participant plan				
В	This return/report is for:									
		an amended return/report	short plan	n year return/report (less than 12 mor	nths)					
C	Check box if filing under:	Form 5558	automatio	extension		DFVC program				
_	[special extension (enter description	on)							
Do	rt II Pacia Plan Inform		,							
		mation—enter all requested inform	ation		1h	Throo digit				
	Name of plan	RE COMMUNITY 401(K) PLAN			ID	Three-digit plan number				
IIIL	COURT TARD DEMENTIA CAP	CE COMMONTT 40T(K) FLAN				(PN) • 001				
					1c	Effective date of plan				
						01/01/2001				
		ess (employer, if for single-employer	plan)		2b	Employer Identification Number				
COU	RTYARD COMPENSATION, LI	LC				(EIN) 26-1096159				
275 5	ERICKSEN AVE., SUITE 222				2c	Plan sponsor's telephone number 206-842-0929				
	BRIDGE ISLAND, WA 98110				24	Business code (see instructions)				
					Zu	623000				
3a	Plan administrator's name and	address (if same as Plan sponsor, e	nter "Same	e")	3b	Administrator's EIN				
NOR	THWEST CARE MANAGEMEN	NT, INC. 375 ERICKS BAINBRIDG	EN AVE. N	I.E., SUITE 222		91-1572936				
		BAINBRIDG	L IOLAND,	WA 30110	3с	Administrator's telephone number 206-842-0929				
4 .	(the second and the FINI of the sele		-11 /	and Clark for the and a control to	41.					
		an sponsor has changed since the la er from the last return/report. Sponso		eport filed for this plan, enter the	4b EIN					
	iamo, Em, ana mo piam nambo	4c PN								
5a	Total number of participants at	t the beginning of the plan year			5a	51				
b	Total number of participants at	5b	55							
С	Total number of participants w	30								
				•	5c	4				
6a	6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)									
b	Are you claiming a waiver of the	he annual examination and report of	an indeper	ndent qualified public accountant (IQI	PA)					
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)									
		ner 6a or 6b, the plan cannot use F	orm 5500-	SF and must instead use Form 55	00.					
Pa	rt III Financial Informa	ation		T	_					
7	Plan Assets and Liabilities			(a) Beginning of Year		(b) End of Year				
а	Total plan assets		. 7a	50186)	29577				
b	Total plan liabilities		. 7b							
С	Net plan assets (subtract line 7	7b from line 7a)	7с	50186	5	29577				
8	Income, Expenses, and Transf	fers for this Plan Year		(a) Amount		(b) Total				
а	Contributions received or rece		2 (1)	854						
	, , , ,		. 8a(1)	3419	_					
	•			3418	<u>'</u>					
_	(3) Others (including rollovers		` '	0000	_					
b	Other income (loss)		. 8b	3939)					
С	Total income (add lines 8a(1),	8a(2), 8a(3), and 8b)	. 8c			8212				
d		rollovers and insurance premiums	. 8d	27768	3					
е		tive distributions (see instructions)								
f		rs (salaries, fees, commissions)								
				1053	3					
g h	·					28821				
;		8e, 8f, and 8g)				-20609				
;		e 8h from line 8c)								
J	manarera to (mom) the plan (Se	ee instructions)	. 8i							

Form 5500-SF 2010	Page 2-

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Part IV	Plan	(`hara	cteristics
ı aıtıv ı	ı ıaıı	Onal a	SIGH SHOS

HERE

SIGN HERE Signature of plan administrator

Signature of employer/plan sponsor

If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 3D 2G 2J 2K 2T

b	If th	e plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Char	acteris	tic Co	des in	the instru	ıctions		
art	V	Compliance Questions							
0	Du	ring the plan year:		Yes	No		Am	ount	
а		is there a failure to transmit to the plan any participant contributions within the time period described in CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X				
b		ere there any nonexempt transactions with any party-in-interest? (Do not include transactions reported line 10a.)	10b		X				
С	Wa	as the plan covered by a fidelity bond?	10c	X					100000
d		I the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud dishonesty?	10d		X				
е	ins	ere any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, urance service or other organization that provides some or all of the benefits under the plan? (See tructions.)	10e		X				
f	Ha	s the plan failed to provide any benefit when due under the plan?	10f		X				
g	Did	I the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X				
h		nis is an individual account plan, was there a blackout period? (See instructions and 29 CFR 20.101-3.)	10h		X				
i		Oh was answered "Yes," check the box if you either provided the required notice or one of the ceptions to providing the notice applied under 29 CFR 2520.101-3	10i						
art	VI	Pension Funding Compliance	1						
11	ls ti	his a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and cor					F	Yes	No
2		this a defined contribution plan subject to the minimum funding requirements of section 412 of the Cod						Yes	X No
_	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)								
а	lf a	waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructing the waiver.							
lf y	-	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13		_					
b	Ent	er the minimum required contribution for this plan year			12b				
С	Ent	er the amount contributed by the employer to the plan for this plan year			12c				
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)								
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?								
art	VII	Plan Terminations and Transfers of Assets							
3a	Has	s a resolution to terminate the plan been adopted during the plan year or any prior year?		<u>.</u>				Yes	X No
	lf "۱	Yes," enter the amount of any plan assets that reverted to the employer this year			13a				
b		re all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought he PBGC?	under	the co	ontrol			Yes	X No
С		uring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify ich assets or liabilities were transferred. (See instructions.)	the pla	n(s) to	1				
1	3c(1) Name of plan(s):		13	c(2) El	N(s)		13c(3)	PN(s)
laut	ion:	A penalty for the late or incomplete filing of this return/report will be assessed unless reasonal	le cai	ISA İS	establ	ished			
Jnde	er pe	nalties of perjury and other penalties set forth in the instructions, I declare that I have examined this re- nedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return	turn/rep	port, ir	cludin	g, if appli			
	f, it is	s true, correct, and complete.	•	., and		,55t OI III	y 1010V	ouge	u i u
SIG	N	Filed with authorized/valid electronic signature. 05/18/2011 KIMBERLY SCH	IOLL						

Date

Date

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee **Benefit Plan**

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

> Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110 1210-0089

2010

This Form is Open to Public Inspection

-	art I Annual Report Identification Information calendar plan year 2010 or fiscal plan year beginning		and anding			2000-000-000-000		
	abla	Π	and ending oyer plan (not multiemployer)		ore at	3 3		
			one-participan	t plan				
В	his return/report is for:							
	an amended return/report	short plan yea	ar return/report (less than 12 mor	iths)	<u></u>			
C Check box if filing under: Form 5558 automatic extension					DFVC program	n		
	special extension (enter descri	ption)						
Pa	rt II Basic Plan Information—enter all requested info	rmation						
	Name of plan			1b	Three-digit			
THE	COURTYARD DEMENTIA CARE COMMUNITY 401(K) PLAN				plan number (PN) ▶	001		
				10	Effective date of			
					01/01/20			
	Plan sponsor's name and address (employer, if for single-employ	yer plan)		2b	Employer Identific			
COU	RTYARD COMPENSATION. LLC				(EIN) 26-1096			
375 F	ERICKSEN AVE., SUITE 222			2c Plan sponsor's telephone number 206-842-0929				
	BRIDGE ISLAND WA 98110			2d	Business code (s	- Management		
	was a second of the second of				623000			
	Plan administrator's name and address (if same as Plan sponsor THWEST CARE MANAGEMENT, INC. 375 ERIC	r, enter "Same") "KSEN AVE. N.E.	CLUTE 222	3b	Administrator's E 91-1572			
NON		DGE ISLAND WA		30	Administrator's te	7/		
				0	206-842	-0929		
4 1	the name and/or EIN of the plan sponsor has changed since the	last return/repor	l filed for this plan, enter the	4b	EIN			
ľ	name, EIN, and the plan number from the last return/report. Spot	nsor's name		4c	DN			
5a	Total number of participants at the beginning of the plan year			5a	1	51		
b Total number of participants at the end of the plan year				5b		55		
C Total number of participants with account balances as of the end of the plan year (defined benefit plans do not								
	complete this item)	······································	Comica perioni piana ao not	5c		4		
6a	Were all of the plan's assets during the plan year invested in eli				********	X Yes No		
b	Are you claiming a waiver of the annual examination and report	of an independer	nt qualified public accountant (IQI	PA)				
	under 29 CFR 2520.104-46? (See instructions on waiver eligibil If you answered "No" to either 6a or 6b, the plan cannot us	ity and conditions	and must instead use Form SE		***************************************	Yes No		
Pa	rt III Financial Information	E 1 01111 0000-01	and must misteau use Form 55			78		
7	Plan Assets and Liabilities	148831	(a) Beginning of Year		(b) End o	of Voor		
а	Total plan assets	7a	50186		(b) Liid (29577		
b	Total plan liabilities		With detailed to the last of t		19954111111			
37.500	Net plan assets (subtract line 7b from line 7a)	-	50186	i		29577		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	1	(b) To	768 3		
	Contributions received or receivable from:							
	(1) Employers	8a(1)	854					
	(2) Participants	8a(2)	3419					
	(3) Others (including rollovers)	8a(3)						
b	Other income (loss)		3939	fig.				
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)			V/	***************************************	8212		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)		27768					
е	Certain deemed and/or corrective distributions (see instructions) 8e						
f	Administrative service providers (salaries, fees, commissions)	8f						
g	Other expenses	8g	1053					
h	Total expenses (add lines 8d, 8e, 8f, and 8g)					28821		
	Mat in a man (loop) (subtract line Ob from the Da)	24.00		-	*	20000		
i	Net income (loss) (subtract line 8h from line 8c)	8i	PARTIES THE WAY GOVERNMENT OF THE PARTIES TO A PER			-20609		

	Form 5500-SF 2010 Page 2- 1							
100.75			=_					
	IV Plan Characteristics							
9a	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Char 3D 2G 2J 2K 2T	acteris	tic Co	des in	the instruction	ins:		
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Chara	cleris	lic Co	des in t	he instructio	ns:		
Part	V Compliance Questions							
10	During the plan year:		Yes	No	А	mount		
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		x				
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		x				
С	Was the plan covered by a fidelity bond?	10c	Х	33.11.81.		100000		
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		х		N 110-12-		
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		x				
f	Has the plan failed to provide any benefit when due under the plan?	10f		Х	2757			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)			X				
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10g		X				
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	101		1150				
Part	No. 4907	1						
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and cor 5500))	nplete	Sched	lule SE	3 (Form	☐ Yes ☐ No		
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Cod					Yes X No		
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)							
а	a 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 letter ruling granting the waiver							
lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13		-					
b	Enter the minimum required contribution for this plan year			12b	61 60	V		
C	Enter the amount contributed by the employer to the plan for this plan year			12c				
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left negative amount)	of a		12d				
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?	********		*****	Yes	No N/A		
Part	VII Plan Terminations and Transfers of Assets							
13a	Has a resolution to terminate the plan been adopted during the plan year or any prior year?					Yes X No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this year			13a		·		
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought of the PBGC?	under	the co	ontrol		☐ Yes 🏿 No		
С	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)					— Ш		
	3c(1) Name of plan(s):		13	c(2) E	IN(s)	13c(3) PN(s)		
				•	Transaction of			
Cau	ion: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonal	ole ca	use is	estab	lished.	Western Course		
	or negatives of periors and other penalties set forth in the instructions. I declare that I have examined this re-					de a Cabadula		

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, 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,	Kember Shall	15/17/2011	KIMBERLY SCHOLL
HERE	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