

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 6047(e), and 6058(a) of the Internal Revenue Code (the Code). <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	OMB Nos. 1210-0110 1210-0089 <div style="text-align: center; font-size: 1.2em; font-weight: bold;">2009</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2009 or fiscal plan year beginning <u>12/01/2007</u> and ending <u>11/30/2008</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan; or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.	<input type="checkbox"/>
D Check box if filing under:	<input type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II	Basic Plan Information —enter all requested information				
1a Name of plan <u>KCI SUPPLY COMPANY 401(K) PLAN</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">1b Three-digit plan number (PN) ▶</td> <td style="width: 20%; text-align: center;"><u>001</u></td> </tr> <tr> <td colspan="2">1c Effective date of plan <u>12/01/2006</u></td> </tr> </table>	1b Three-digit plan number (PN) ▶	<u>001</u>	1c Effective date of plan <u>12/01/2006</u>	
1b Three-digit plan number (PN) ▶	<u>001</u>				
1c Effective date of plan <u>12/01/2006</u>					
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) <u>KENTUCKIANA CONTRACTOR & INDUSTRIAL SUPPLY CO. LLC</u> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>3708 MANSLICK ROAD</u> <u>LOUISVILLE, KY 40215</u> </div> <div style="width: 45%;"> <u>3708 MANSLICK ROAD</u> <u>LOUISVILLE, KY 40215</u> </div> </div>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN) <u>54-2138351</u></td> </tr> <tr> <td>2c Sponsor's telephone number <u>502-361-1669</u></td> </tr> <tr> <td>2d Business code (see instructions) <u>423800</u></td> </tr> </table>	2b Employer Identification Number (EIN) <u>54-2138351</u>	2c Sponsor's telephone number <u>502-361-1669</u>	2d Business code (see instructions) <u>423800</u>	
2b Employer Identification Number (EIN) <u>54-2138351</u>					
2c Sponsor's telephone number <u>502-361-1669</u>					
2d Business code (see instructions) <u>423800</u>					

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			
	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

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

Form 5500 (2009)
v.092307.1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same") KENTUCKIANA CONTRACTOR & INDUSTRIAL SUPPLY CO. LLC 3708 MANSLICK ROAD LOUISVILLE, KY 40215		3b Administrator's EIN 54-2138351
3c Administrator's telephone number 502-361-1669		
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
5 Total number of participants at the beginning of the plan year	5	
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	
b Retired or separated participants receiving benefits.....	6b	
c Other retired or separated participants entitled to future benefits.....	6c	
d Subtotal. Add lines 6a , 6b , and 6c	6d	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	
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 that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

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 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 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 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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Form 5500

Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of 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 sections 6047(e),
6057(b), and 6058(a) of the Internal Revenue Code (the Code).▶ Complete all entries in accordance with
the instructions to the Form 5500.Official Use Only
OMB Nos. 1210-0110
1210-0089

2007

This Form is Open to
Public Inspection.

Annual Report Identification Information

For the calendar plan year 2007 or fiscal plan year beginning 12/01/2007, and ending 11/30/2008,

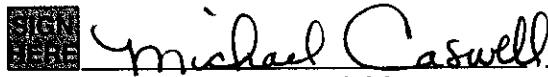
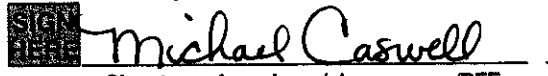
- A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☒ a single-employer plan (other than a (4) ☐ a DFE (specify) _____
multiple-employer plan);
- B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C If the plan is a collectively-bargained plan, check here ☐
- D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ☐

Basic Plan Information -- enter all requested information.

1a Name of plan KCI SUPPLY COMPANY 401(K) PLAN	1b Three-digit plan number (PN) ▶ 001
	1c Effective date of plan (mo., day, yr.) 12/01/2006
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) KENTUCKIANA CONTRACTOR & INDUSTRIAL SUPPLY CO. LLC 3708 MANSCLICK ROAD LOUISVILLE KY 40215	2b Employer Identification Number (EIN) 54-2138351
	2c Sponsor's telephone number 502-361-1669
	2d Business code (see instructions) 423800

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

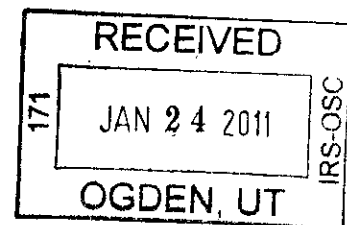
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of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

 Signature of plan administrator	Date	BRENDA CASWELL Michael Caswell Type or print name of individual signing as plan administrator
 Signature of employer/plan sponsor/DFE	Date	BRENDA CASWELL Michael Caswell Type or print name of individual signing as employer, plan sponsor or DFE

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

v10.1

Form 5500 (2007)



3a Plan administrator's name and address (If same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

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 below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address
SENTRY LIFE INSURANCE COMPANY

1800 NORTH POINT DRIVE

b EIN

39-6040276

c Telephone number

715-346-6000

STEVENS POINT

WI

54481

6 Total number of participants at the beginning of the plan year	6	7
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	6
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	2
d Subtotal. Add lines 7a, 7b, and 7c	7d	8
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	8
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	7
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	1

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

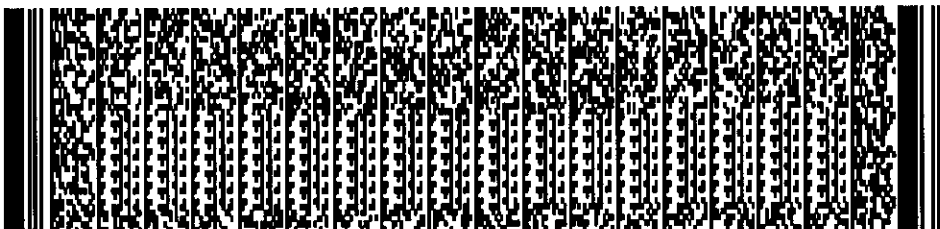
- a** ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2E 2F 2G 2J 3B 3E
- b** ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
(2) ☐ Code section 412(i) insurance contracts
(3) ☒ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
(2) ☐ Code section 412(i) insurance contracts
(3) ☒ Trust
(4) ☐ General assets of the sponsor



10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)**a Pension Benefit Schedules**

- | | | | |
|-----|-------------------------------------|-----|--|
| (1) | <input type="checkbox"/> | R | (Retirement Plan information) |
| (2) | <input type="checkbox"/> | B | (Actuarial Information) |
| (3) | <input type="checkbox"/> | E | (ESOP Annual information) |
| (4) | <input checked="" type="checkbox"/> | SSA | (Separated Vested Participant Information) |

b Financial Schedules

- | | | | |
|-----|-------------------------------------|------------|---------------------------------------|
| (1) | <input type="checkbox"/> | H | (Financial information) |
| (2) | <input checked="" type="checkbox"/> | I | (Financial information -- Small Plan) |
| (3) | <input checked="" type="checkbox"/> | <u>1</u> 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) |



**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.

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

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

Official Use Only

OMB No. 1210-0110

2007

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

For calendar plan year 2007 or fiscal plan year beginning 12/01/2007 and ending 11/30/2008

A Name of plan KCI SUPPLY COMPANY 401(K) PLAN	B Three-digit plan number ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 KENTUCKIANA CONTRACTOR & INDUSTRIAL SUPPLY CO. LLC	D Employer Identification Number 54-2138351

Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

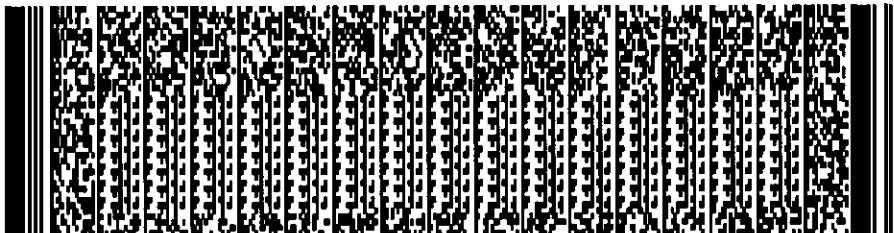
SENTRY LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
39-6040276	68810	87-62836-71	8	12/01/2007	11/30/2008

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	
Total amount of commissions paid	Total fees paid / amount
60	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500. v10.1 Schedule A (Form 5500) 2007



(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

MATTHEW MILLOWAY
8904 ELKS BLUFF DRIVE
LOUISVILLE

KY

40220

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
32			3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

TONYA KELLER
4402 BAY RUN COURT
LOUISVILLE

KY

40245

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	
28			3

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	



Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	
5	Contracts With Allocated Funds	
a	State the basis of premium rates ▶	
b	Premiums paid to carrier	
c	Premiums due but unpaid at the end of the year	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	
	Specify nature of costs ▶	
e	Type of contract (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	<input type="checkbox"/>
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below) ▶	
b	Balance at the end of the previous year	
c	Additions: (1) Contributions deposited during the year	
	(2) Dividends and credits	
	(3) Interest credited during the year	
	(4) Transferred from separate account	
	(5) Other (specify below)	
	▶	
	(6) Total additions	
d	Total of balance and additions (add b and c(6))	
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	
	(4) Other (specify below)	
	▶	
	(5) Total deductions	
f	Balance at the end of the current year (subtract e(5) from d)	



Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

- | | | | |
|--|--|---|--|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life Insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

8 Experience-rated contracts

- | | | |
|--|--|--|
| a Premiums: (1) Amount received | | |
| (2) Increase (decrease) in amount due but unpaid | | |
| (3) Increase (decrease) in unearned premium reserve | | |
| (4) Earned ((1) + (2) - (3)) | | |
| b Benefit charges: (1) Claims paid | | |
| (2) Increase (decrease) in claim reserves | | |
| (3) Incurred claims (add (1) and (2)) | | |
| (4) Claims charged | | |
| c Remainder of premium: (1) Retention charges (on an accrual basis) -- | | |
| (A) Commissions | | |
| (B) Administrative service or other fees | | |
| (C) Other specific acquisition costs | | |
| (D) Other expenses | | |
| (E) Taxes | | |
| (F) Charges for risks or other contingencies | | |
| (G) Other retention charges | | |
| (H) Total retention | | |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | |
| d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | |
| (2) Claim reserves | | |
| (3) Other reserves | | |
| e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) | | |

9 Nonexperience-rated contracts:

- | | |
|---|--|
| a Total premiums or subscription charges paid to carrier | |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount | |
| Specify nature of costs ▶ | |



**SCHEDULE I
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

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.**

Official Use Only

OMB No. 1210-0110

2007**This Form is Open to
Public Inspection.**

For calendar year 2007 or fiscal plan year beginning 12/01/2007 , and ending 11/30/2008 ,	
A Name of plan KCI SUPPLY COMPANY 401(K) PLAN	B Three-digit plan number ► 001
C Plan sponsor's name as shown on line 2a of Form 5500 KENTUCKIANA CONTRACTOR & INDUSTRIAL SUPPLY CO. LLC	D Employer Identification Number 54-2138351

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.

Small Plan Financial Information

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.**

1 Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
a Total plan assets	1a	26557	42069
b Total plan liabilities	1b	0	0
c Net plan assets (subtract line 1b from line 1a)	1c	26557	42069
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable			
(1) Employers	2a(1)	8049	
(2) Participants	2a(2)	23289	
(3) Others (including rollovers)	2a(3)	0	
b Noncash contributions	2b	0	
c Other income	2c	-15826	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		15512
e Benefits paid (including direct rollovers)	2e	0	
f Corrective distributions (see instructions)	2f	0	
g Certain deemed distributions of participant loans (see instructions)	2g	0	
h Other expenses	2h	0	
i Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		0
j Net income (loss) (subtract line 2i from line 2d)	2j		15512
k Transfers to (from) the plan (see instructions)	2k		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	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500.

v10.1

Schedule I (Form 5500) 2007



	Yes	No	Amount
3c Real estate (other than employer real property)		X	
d Employer securities		X	
e Participant loans		X	
f Loans (other than to participants)		X	
g Tangible personal property		X	

Transactions During Plan Year

	Yes	No	Amount
4 During the plan year:			
a Did the employer fail 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.)		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 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		10000
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		

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)

