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 sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

1210-0089

OMB Nos. 1210-0110

2011

This Form is Open to Public Inspection

	Complete all entries in accord	dance with	h the instructions to the Form 55	00-SF.	
	art I Annual Report Identification Information				
For	calendar plan year 2011 or fiscal plan year beginning 01/01/2011	1	and ending	12/31/2	2011
A ·	This return/report is for:	a multiple	-employer plan (not multiemployer)		a one-participant plan
В	This return/report is: the first return/report	the final r	eturn/report		
	an amended return/report	a short pla	an year return/report (less than 12 r	nonths)	
C	Check box if filing under: Form 5558	automatic	extension		DFVC program
	special extension (enter descriptio				
Do	rt II Basic Plan Information—enter all requested informa	,			
		ation		1h	Three-digit
	Name of plan COURTYARD DEMENTIA CARE COMMUNITY 401(K) PLAN				plan number
	SOURT TAKE BEIMENTIN OF THE COMMONT TO THE TOTAL				(PN) ▶ 001
				1c	Effective date of plan
					01/01/2001
	Plan sponsor's name and address; include room or suite number (er RTYARD COMPENSATION, LLC	mployer, if	for a single-employer plan)		Employer Identification Number
COU	RTTARD COMPENSATION, LLC				(EIN) 26-1096159
				2c	Sponsor's telephone number 206-842-0929
	RICKSEN AVE., SUITE 222			24	
DAIIN	BRIDGE ISLAND, WA 98110			Zu	Business code (see instructions) 623000
32	Plan administrator's name and address (if same as plan sponsor, er	nter "Same	,")	3h	Administrator's EIN
	THWEST CARE MANAGEMENT, INC. 375 ERICKSE	EN AVE. N	l.É., SUITE 222	35	91-1572936
	BAINBRIDGE	ISLAND,	WA 98110	3c	Administrator's telephone number
				1	206-842-0929
4	If the name and/or EIN of the plan sponsor has changed since the kaname, EIN, and the plan number from the last return/report.	ast return/	report filed for this plan, enter the	4b	EIN
а	Sponsor's name			4c	PN
	Total number of participants at the beginning of the plan year				5:
b	Total number of participants at the end of the plan year			- Ou	
				go	
С	Number of participants with account balances as of the end of the p complete this item)	• ,	·	. 5c	
6a	Were all of the plan's assets during the plan year invested in eligible				X Yes No
b	Are you claiming a waiver of the annual examination and report of a		,		
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a		•		X Yes No
D-	If you answered "No" to either 6a or 6b, the plan cannot use Fo	orm 5500-	SF and must instead use Form 5	500.	
Pa	rt III Financial Information		T		
1	Plan Assets and Liabilities		(a) Beginning of Year	+	(b) End of Year
а	Total plan assets		29577		11279
b	Total plan liabilities	7b	20577	+	11279
_ <u>c</u>	Net plan assets (subtract line 7b from line 7a)	7c	29577		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total
а	Contributions received or receivable from: (1) Employers	8a(1)	931		
	(2) Participants	8a(2)	3724		
	(3) Others (including rollovers)	8a(3)			
b	Other income (loss)	8b	-878		
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		5.0		3777
c d	Benefits paid (including direct rollovers and insurance premiums	8c			
u	to provide benefits)	8d	22075		
е	Certain deemed and/or corrective distributions (see instructions)	8e			
f	Administrative service providers (salaries, fees, commissions)	. 8f			
g	Other expenses	8g			
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h			22075
i	Net income (loss) (subtract line 8h from line 8c)	8i			-18298
i	Transfers to (from) the plan (see instructions)				
,	(- , (8j			

Form	5500.	SF.	201

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Part IV	Plan Characteristics

- **9a** 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
 - If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

art	٧	Compliance Questions						
0	Durir	ng the plan year:		Yes	No	Δ	mount	
а		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		Х			
b		e there any nonexempt transactions with any party-in-interest? (Do not include transactions reported ne 10a.)	10b		X			
С	Was	the plan covered by a fidelity bond?	10c	Χ				100000
d		he plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud shonesty?	10d		Х			
е	insur	any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, ance service or other organization that provides some or all of the benefits under the plan? (See actions.)	10e		X			
f	Has	the plan failed to provide any benefit when due under the plan?	10f		X			
g	Did t	he plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		X			
h		s is an individual account plan, was there a blackout period? (See instructions and 29 CFR .101-3.)	10h		Х			
i		n was answered "Yes," check the box if you either provided the required notice or one of the ptions to providing the notice applied under 29 CFR 2520.101-3	10i					
art	VI	Pension Funding Compliance				•		
11	Is thi	s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com					П у	п
							Yes	No
12		is a defined contribution plan subject to the minimum funding requirements of section 412 of the Code	or se	ction	302 of	ERISA?	Yes	X No
2	•	es," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.) raiver of the minimum funding standard for a prior year is being amortized in this plan year, see instru	otiono	and a	ontor th	o data of the	lottor ruli	ina
а		ing the waiverMon						
lf y	you co	ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				1		
b	Ente	the minimum required contribution for this plan year			12b			
С		the amount contributed by the employer to the plan for this plan year			12c			
d		ract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left tive amount)		[12d			
е	Will t	he minimum funding amount reported on line 12d be met by the funding deadline?				Yes	No	N/A
art	VII	Plan Terminations and Transfers of Assets						
13a	Has a	a resolution to terminate the plan been adopted in any plan year?			X	/es No		
	If "Ye	es," enter the amount of any plan assets that reverted to the employer this year	1	3a				C
b		e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought a PBGC?	under	the co	ontrol		Yes	X No
С		ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the assets or liabilities were transferred. (See instructions.)	ne pla	n(s) to)		_	_
1	3c(1)	Name of plan(s):		13	c(2) El	N(s)	13c(3)	PN(s)
	: •					i a la a d		
		penalty for the late or incomplete filing of this return/report will be assessed unless reasonab alties of perjury and other penalties set forth in the instructions. I declare that I have examined this retu					lo a Sabr	odule.
JIIUE	i Della	nues oi penury and other penalues sectorul in the INSTRUCTIONS. I deciale that I have examined this fell	4111/TE	JUIL II	ICIUUIII	u. II avvilcab	ie. a ouite	-uui c

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	Filed with authorized/valid electronic signature.	03/09/2012	DARAH COONEY
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

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

OMB Nos. 1210-0110 1210-0089

2011

This Form is Open to Public Inspection

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Α	This return/report is for:	a multiple	e-employer plan (not multiemployer)		a one-participant plan			
В	This return/report is:	the final r	eturn/report					
	an amended return/report a short plan year return/report (less than 12 months)							
C	Check box if filing under; Form 5558		DFVC program					
	special extension (enter description							
Pa	rt II Basic Plan Information—enter all requested information	alion		-	TOTAL STREET,			
1a	Name of plan			1b	Three-digit			
THE	COURTYARD DEMENTIA CARE COMMUNITY 401(K) PLAN			11355601	plan number			
					(PN) 001			
				1c	Effective date of plan 01/01/2001			
2a	Plan sponsor's name and address; include room or suite number (erRTYARD COMPENSATION, LLC	mplover if	for a single-employer plan)	2h				
COU	RTYARD COMPENSATION, LLC		ici a single ciripisyci piarij	20	Employer Identification Number (EIN) 26-1096159			
				2c	Sponsor's telephone number			
375	ERICKSEN AVE SUITE 222				206-842-0929			
BAIN	BRIDGE ISLAND WA 98110			2d	Business code (see instructions)			
			**		623000			
	Plan administrator's name and address (if same as plan sponsor, er THWEST CARE MANAGEMENT, INC. 375 FRICKSI		!") I.E., SUITE 222	3b	Administrator's EIN			
11011	BAINBRIDGE			30	91-1572936 Administrator's telephone number			
		38	TO STATE OF THE ST	00	206-842-0929			
4	If the name and/or EIN of the plan sponsor has changed since the la	ast return/	report filed for this plan, enter the	4b	EIN			
а	name, EIN, and the plan number from the last return/report. Sponsor's name							
	Total number of participants at the beginning of the plan year			4c				
b	Total number of participants at the end of the plan year			5a	55			
c	Number of participants with account balances as of the end of the p			5b	3			
	complete this item)	Jefined benefit plans do not	5c	3				
6a	Were all of the plan's assets during the plan year invested in eligible			_	X Yes No			
b	Are you claiming a waiver of the annual examination and report of a	an indeper	ident qualified public accountant (IOI	PAI				
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a	and conditi	ons.)	*******	X Yes No			
Pa	If you answered "No" to either 6a or 6b, the plan cannot use Fort III Financial Information	orm 5500-	SF and must instead use Form 55	30.				
7	Plan Assets and Liabilities		(a) Parissis = of V	1				
а	Total plan assets	7a	(a) Beginning of Year 29577	-	(b) End of Year 11279			
b	Total plan liabilities	7b	2007	+	11279			
С	Net plan assets (subtract line 7b from line 7a)	7c	29577		11279			
8	Income, Expenses, and Transfers for this Plan Year			-				
а	Contributions received or receivable from:	4035-1	(a) Amount		(b) Total			
	(1) Employers	8a(1)	931	J				
	(2) Participants	8a(2)	3724					
	(3) Others (including rollovers)	8a(3)						
b	Other income (loss)	8b	-878					
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			3777			
d	Benefits paid (including direct rollovers and insurance premiums	<u>.</u> .	20075					
۵	to provide benefits)	8d	22075					
	Certain deemed and/or corrective distributions (see instructions)	8e						
t	Administrative service providers (salaries, fees, commissions)	8f		_				
g	Other expenses	8g						
h ;	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		_	22075			
ì	Net income (loss) (subtract line 8h from line 8c)	8i		-	-18298			
	Transfers to (from) the plan (see instructions)	8j						

Form 5500-SF 2011

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Part IV	Plan Characteristics
FOIL IV	Figure Characteristics

9a 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 the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

	and the second s		ar of Fig. Official	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	000	CO III I	ine manaction	13.	
Part	V Compliance Questions		1900-180-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1				:#####################################		
10	During the plan year:	600 000 000 000 000 000 000 000 000 000	27.2711.7711		Yes	No	А	mount	
а	Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiducions)	10a		Х					
b	Were there any nonexempt transactions with any party-in-interest? on line 10a.)	actions reported	10b		Х				
C	Was the plan covered by a fidelity bond?),	10c	Х			100000		
d	d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?								
е	Were any fees or commissions paid to any brokers, agents, or other insurance service or other organization that provides some or all of instructions.)	ance carrier,	10e		x				
f	Has the plan failed to provide any benefit when due under the plan?			10f	-111M	Х	*****		
g	Did the plan have any participant loans? (If "Yes," enter amount as	of year end.)		10g	10 C C 11 C 1	Х			
h	If this is an individual account plan, was there a blackout period? (S 2520.101-3.)	ee instructions and 29	9 CFR	10h		х		1000000	
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101-3	required notice or on	e of the	10i					
Part								OWNER STREET, THE PARTY OF THE	
11	Is this a defined benefit plan subject to minimum funding requiremer 5500))	nts? (If "Yes," see inst	ructions and com	plete :	Sched	ule SI	3 (Form	☐ Yes ☐ No	
12	Is this a defined contribution plan subject to the minimum funding re	equirements of section	1 412 of the Code	or se	tion 3	02 of	ERISA?	Yes X No	
	(If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicat	ole.)							
а	If a waiver of the minimum funding standard for a prior year is being granting the waiver.	amortized in this plar	n year, see instruc Mont	lions, h	and e	nter ti	ne date of the	letter ruling	
If y	ou completed line 12a, complete lines 3, 9, and 10 of Schedule I	MB (Form 5500), and	skip to line 13.	J 1	- "	Day		cai	
	Enter the minimum required contribution for this plan year			•••••	[12b			
C	Enter the amount contributed by the employer to the plan for this pla	ın year	********		Г	12c		34-H31-1)	
d	Subtract the amount in line 12c from the amount in line 12b. Enter the negative amount)	ne result (enter a minu	us sian to the left o	of a		12d			
е	Will the minimum funding amount reported on line 12d be met by the	e funding deadline?	**********************				Yes 🗆	No N/A	
Part	VII Plan Terminations and Transfers of Assets	VIII.		-				<u> </u>	
13a	Has a resolution to terminate the plan been adopted in any plan year?		*************************	,		X	Yes No		
	If "Yes," enter the amount of any plan assets that reverted to the em			1000				0	
	Were all the plan assets distributed to participants or beneficiaries, to fithe PBGC?	*******						∏ Yes ☒ No	
С	If during this plan year, any assets or liabilities were transferred from which assets or liabilities were transferred. (See instructions.)	n this plan to another	plan(s), identify th	e plar	ı(s) lo	zmaz.			
1	3c(1) Name of plan(s):		AND THE RESERVE THE PROPERTY OF THE PROPERTY O		130	(2) E	IN(s)	13c(3) PN(s)	
100(0) 11(3)									
	on: A penalty for the late or incomplete filing of this return/repo								
SB or	penalties of perjury and other penalties set forth in the instructions, Schedule MB completed and signed by an enrolled actuary, as well it is true, correct, and complete.	I declare that I have e as the electronic vers	examined this retusion of this return/r	rn/rep eport	ort, in and t	cludin o the	g, if applicabl best of my kn	e, a Schedule owledge and	
SIGN	× Souch	13/8/12	DARAH COONE	ΞΥ		300 70			
HER		Date	Enter name of in	dividu	al sigr	ning a	s plan admini	strator	
SIGN									
HER	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan spons				plan sponsor		