Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

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), 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

2011

This Form is Open to Public

					Inspection			
Part I	Annual Report Iden	tification Information						
For cale	ndar plan year 2011 or fiscal p	plan year beginning 03/01/2011		and ending 02/29/2	012			
A This	return/report is for:	a multiemployer plan;	a multipl	e-employer plan; or				
	·	a single-employer plan;	a DFE (s	pecify)				
B This	return/report is:	the first return/report;	<u></u>	return/report;				
		an amended return/report;	a short p	lan year return/report (less that	an 12 months).			
C If the	plan is a collectively-bargaine	ed plan, check here	<u></u>		▶ 🗍			
D Chec	k box if filing under:	Form 5558;	automati	c extension;	the DFVC program;			
		special extension (enter des	cription)					
Part	II Basic Plan Inform	nation—enter all requested informa	ation					
	ne of plan PUBLISHING, INC. BENEFIT				1b Three-digit plan number (PN) ▶			
					1c Effective date of plan 11/01/1988			
	n sponsor's name and address PUBLISHING, INC.	s, including room or suite number (Er	mployer, if for single	-employer plan)	2b Employer Identification Number (EIN) 91-1396047			
	,				2c Sponsor's telephone number 360-394-5820			
	TH AVENUE, SUITE 106 BO, WA 98370	SAME POULSBO	SAME POULSBO, WA 98370					
Caution	: A penalty for the late or inc	complete filing of this return/repor	rt 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	Filed with authorized/valid ele	ectronic signature.	07/26/2012	TIMOTHY BULLOCK				
HERE	Signature of plan administrator		Date	Enter name of individual signing as plan administrator				
SIGN				,				
HERE	Signature of employer/pla	n sponsor	Date	Enter name of individual sid	gning as employer or plan sponsor			
SIGN								

Date

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

Form 5500 (2011) v.012611

Enter name of individual signing as DFE

Form 5500 (2011) Page **2**

	Plan administrator's name and address (if same as plan sponsor, enter "Sar BULLOCK	3b Administrator's EIN 91-1396047			
TIN 19:	BULLOCK 851 8TH AVENUE, SUITE 106 ULSBO, WA 98370			3c Administrator's telephone number 360-394-5820	
4 a	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report: Sponsor's name	nis plan, enter the name, EIN	and	4b EIN 4c PN	
5 6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans complet	o only lines 6a 6l	b Co and Cd\	5	379
U	Number of participants as of the end of the plan year (werrare plans complete	e only lines oa, or	0, 60, and 60).		
а	Active participants			6a	425
b	Retired or separated participants receiving benefits			6b	0
_	Other retired or separated participants entitled to future benefits			6c	0
С	· · ·				
d	Subtotal. Add lines 6a, 6b, and 6c			6d	425
е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive 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 complete this item)			6g	
h	Number of participants that terminated employment during the plan year witless than 100% vested	n accrued benefits	s that were	6h	
7	Enter the total number of employers obligated to contribute to the plan (only			7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	odes from the List	of Plan Characteristic Codes	in the in	nstructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E 4H	des from the List o	of Plan Characteristic Codes i	in the ins	structions:
9a	Plan funding arrangement (check all that apply) (1) X Insurance	9b Plan benef	fit arrangement (check all tha	t apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)	Code section 412(e)(3) i		e contracts
	(3) Trust	(3)	Trust		
10	(4) Separal assets of the sponsor	(4)	General assets of the sp		and (Conjunctions)
	Check all applicable boxes in 10a and 10b to indicate which schedules are a	_		ei allaci	ned. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information)	b General S	_		
		(1)	H (Financial Inform	,	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan	(2)	I (Financial Inform A (Insurance Inform		Small Plan)
	actuary	(3) (4)	C (Service Provide		ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)	D (DFE/Participatin		
	Information) - signed by the plan actuary	(6)	G (Financial Trans	action S	chedules)

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

OMB No. 1210-0110

			ERISA section 103(a)(2).	momation	'' I his For	m is Open to Public Inspection	
For calendar plan year 20	11 or fiscal pla	n year beginning 03/01/2011		and endi	ng 02/29/2012		
A Name of plan SOUND PUBLISHING, IN	IC. BENEFIT I	PLAN		B Three-o	digit umber (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 SOUND PUBLISHING, INC. D Employer Identification Number (EIN) 91-1396047						(EIN)	
Part I 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 Information:							
(a) Name of insurance ca							
HCC LIFE INSURANCE (COMPANY						
(b) FIN	(c) NAIC	(d) Contract or	(e) Approximate num persons covered at 6		Policy or co	ontract year	
(b) EIN	code	identification number	policy or contract y		(f) From	(g) To	
35-1817054	92711	HCL18366	321		03/01/2011	02/29/2012	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. List	in item 3 th	ne agents, brokers, and o	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all pe	ersons).			
	(a) Name	and address of the agent, broke	er, or other person to whom	commission	ns or fees were paid		
(b) Amount of sales ar	nd base	F	ees and other commissions	paid			
commissions pa	id	(c) Amount	(d) Purpose		(e) Organization code	
	(a) Name	and address of the agent, broke	er, or other person to whom	commissio	ns or fees were paid		
	Т					T	
(b) Amount of sales ar			ees and other commissions	•		(a) Ourse signation and a	
commissions pa	iu	(c) Amount	(α) Purpose		(e) Organization code	

Schedule A (Form 5500)	2011	Page 2 - 1]			
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid			
(4)	and address of the agont, siene	., c. carer percent to innern				
(I) A		Fees and other commission	s paid	(-) ()		
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code		
•	, ,					
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid			
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid			
	T			T		
(b) Amount of sales and base		Fees and other commission		(e) Organization		
commissions paid	(c) Amount		(d) Purpose	code		
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid			
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid			
	I					
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization		
commissions paid	(c) Amount		(d) Fulpose	code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
		, ,	•			
		Fees and other commission	naid	T.,		
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code		
Commissions paid	(o) / anount		(±). 3.5000			
				1		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	d as a unit for purposes of			
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year en			5	
6	Contr	racts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan ch	neck here		
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
				on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(e) [] 3				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		(6)Total additions			7c(6)	
	d ⊺	Total of balance and additions (add b and c(6))	·····		7d	
	e c	Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	((2) Administration charge made by carrier	. 7e(2)			
	((3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		•				
	((5) Total deductions			7e(5)	
	,	Balance at the end of the current year (subtract e(5) from d)				

Schedule A (Form 5500) 2011		Paç	ge 4	
Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the same urposes if such contracts are e	experienc	e-rated as a unit. Where contract	
efit and contract type (check all applicable boxes)	ı			
Health (other than dental or vision)	b Dental	С	Vision	d Life insurance
Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k∏	PPO contract	I Indemnity contract
Other (specify)	- Ц			-
J '' ''				
erience-rated contracts:				
Premiums: (1) Amount received		9a(1)		
(2) Increase (decrease) in amount due but unpaid	d	9a(2)		
(3) Increase (decrease) in unearned premium res	serve	9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	
Benefit charges (1) Claims paid	g	9b(1)		
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
Remainder of premium: (1) Retention charges (c	on an accrual basis)			
(A) Commissions	9c	(1)(A)		
(B) Administrative service or other fees		(1)(B)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

210694

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid.....

(C) Other specific acquisition costs..... (D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(C)

9c(1)(D) 9c(1)(E)

9c(1)(F)

¹² If the answer to line 11 is "Yes," specify the information not provided.

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

OMB No. 1210-0110

			RISA section 103(a)(2).	Inis For	m is Open to Public Inspection			
For calendar plan year 20	11 or fiscal plan	year beginning 03/01/2011	and en	ding 02/29/2012				
A Name of plan SOUND PUBLISHING, IN	IC. BENEFIT P	LAN		e-digit number (PN)	501			
•	C Plan sponsor's name as shown on line 2a of Form 5500 SOUND PUBLISHING, INC. D Employer Identification Number (EIN) 91-1396047							
Part I 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 Information:								
(a) Name of insurance ca		CANADA						
	1	T	(a) Annuacinate number of	Dollovere	ontroot voor			
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	(f) From	ontract year (g) To			
38-1082080	80802	011981	378	03/01/2011	02/29/2012			
2 Insurance fee and com descending order of the		tion. Enter the total fees and tota	commissions paid. List in item 3	the agents, brokers, and o	other persons in			
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
	3800							
3 Persons receiving com	missions and fe	es. (Complete as many entries a	is needed to report all persons).					
			or other person to whom commiss	ions or fees were paid				
BROWN & BROWN OF V	VA DBA DIMAK		OURTH AVENUE SUITE 2400 LE, WA 98101					
(b) Amount of sales ar	nd base	Fees	and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	(e) Organization code				
	1439				3			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
KRISTIN MANWARING II	NSURANCE AS		OX 2107 TOWNSEND, WA 98368					
(b) Amount of sales ar	nd hase	Fees	and other commissions paid					
commissions pa		(c) Amount	(d) Purpose	е	(e) Organization code			
	1439				3			
For Paperwork Reduction	n Act Notice a	nd OMB Control Numbers, see	the instructions for Form 5500	Sche	dule A (Form 5500) 2011			

	2011	Page 2 - 1	
(a) Nar	ne and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid
BROWN & BROWN OF WA	1 T	145 BROADWAY SUITE 700 ACOMA, WA 98402	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 922	(c) Amount	(d) Purpose	code 3
\ <u></u>			
(a) Nar	ne and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base	Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nan	ne and address of the agent, b	oroker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid

Fees and other commissions paid

(d) Purpose

(c) Amount

(e) Organization code

(b) Amount of sales and base commissions paid

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	d as a unit for purposes of			
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year en			5	
6	Contr	racts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan ch	neck here		
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
				on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(e) [] 3				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		(6)Total additions			7c(6)	
	d ⊺	Fotal of balance and additions (add b and c(6))	·····		7d	
	e c	Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	((2) Administration charge made by carrier	. 7e(2)			
	((3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		•				
	((5) Total deductions			7e(5)	
	,	Balance at the end of the current year (subtract e(5) from d)				

Schedule A (Form 5500) 2011	Page 4
	of the same employer(s) or members of the same employee organizations(s), the ntracts are experience-rated as a unit. Where contracts cover individual employed hay be treated as a unit for purposes of this report.
efit and contract type (check all applicable boxes) Health (other than dental or vision) Temporary disability (accident and sickness) Stop loss (large deductible) Other (specify)	
erience-rated contracts:	
Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	9a(4)
Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	9b(3)
(4) Claims charged	9b(4)
Remainder of premium: (1) Retention charges (on an accrual basis	3)
(A) Commissions	
(B) Administrative service or other fees	
(C) Other specific acquisition costs	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a Total premiums or subscription charges paid to carrier 48440 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs Part IV **Provision of Information** 11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

9c(1)(D) 9c(1)(E)

9c(1)(F)

a Health (other than dental or vision)

Experience-rated contracts:

10 Nonexperience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid.....

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

12 If the answer to line 11 is "Yes," specify the information not provided.

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

OMB No. 1210-0110

		pursuant to E	RISA section 103(a)(2).			Inspection
For calendar plan year 20	11 or fiscal plan	year beginning 03/01/2011	and er	nding 02/29)/2012	•
A Name of plan SOUND PUBLISHING, INC. BENEFIT PLAN				e-digit number (PN)	•	501
C Plan sponsor's name as shown on line 2a of Form 5500 SOUND PUBLISHING, INC. D Employer Identification Number (EIN) 91-1396047					EIN)	
			Coverage, Fees, and Com a unit in Parts II and III can be rep			
1 Coverage Information:						
(a) Name of insurance ca		CANADA				
	1		(e) Approximate number of		Policy or co	ntract vear
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) F	•	(g) To
38-1082080	80802	011981	378	03/01/2011		02/29/2012
2 Insurance fee and com descending order of the		tion. Enter the total fees and total	ll commissions paid. List in item 3	3 the agents, b	rokers, and o	ther persons in
(a) Total a	amount of comn	•	(b) To	otal amount of	fees paid	
		3931				0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persons).			
			or other person to whom commiss	sions or fees w	ere paid	
BROWN & BROWN OF V	VASHINGTON,		FOURTH AVENUE SUITE 2400 FLE, WA 98101			
(b) Amount of sales ar	nd base	Fee	s and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	(d) Purpose		(e) Organization code
1702						3
	(a) Name a	nd address of the agent, broker,	or other person to whom commiss	sions or fees w	ere paid	
KRISTIN MANWARING II	NSURANCE AS		OX 2107 TOWNSEND, WA 98368		·	
(b) Amount of sales ar	nd base	Fee	s and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	e		(e) Organization code
	1702					3
For Donomuork Boductio	n Act Notice o	nd OMB Control Numbers and	the instructions for Form FEOO		Cabaa	lula A (Form FEOO) 2011

Schedule A (Form 5500) 2	011	Page 2 - 1	
(a) Nam	e and address of the agent, bu	roker, or other person to whom commissions or fees were pa	iid
BROWN & BROWN OF WA		145 BROADWAY SUITE 700 ACOMA, WA 98402	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid 527	(c) Amount	(d) Purpose	code 3
(a) Nam	e and address of the agent, bu	roker, or other person to whom commissions or fees were pa	nid
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Nam	e and address of the agent, but	roker, or other person to whom commissions or fees were pa	iid
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Nom	a and address of the agent by	roker, or other person to whom commissions or fees were pa	.:A
(a) ream	e and address of the agent, of	Toker, or other person to whom commissions or fees were pa	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nam	e and address of the agent, but	roker, or other person to whom commissions or fees were pa	id

Fees and other commissions paid

(d) Purpose

(c) Amount

(e) Organization code

(b) Amount of sales and base commissions paid

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Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts report.				cts with each carrier ma	ay be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year en			5	
6	Contr	racts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan ch	neck here		
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
				on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(e) [] 3				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		(6)Total additions			7c(6)	
	d ⊺	Fotal of balance and additions (add b and c(6))	·····		7d	
	e c	Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	((2) Administration charge made by carrier	. 7e(2)			
	((3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		•				
	((5) Total deductions			7e(5)	
	,	Balance at the end of the current year (subtract e(5) from d)				

Schedule A (Form 5500) 2011	Page 4	
information may be combined for reporting purp	pp of employees of the same employer(s) or members of coses if such contracts are experience-rated as a unit. When the each carrier may be treated as a unit for purposes of the contracts are experience-rated.	Where contracts cover individual employees
<u>'</u>	Dental C Vision Long-term disability B HMO contract C Vision G Supplemental une k PPO contract	d Life insurance h Prescription drug I Indemnity contract
erience-rated contracts:		
Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reser	ve 9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)
Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		9b(3)
(4) Claims charged		9b(4)
Remainder of premium: (1) Retention charges (on a		
(A) Commissions	`````	
(B) Administrative service or other fees		
(C) Other specific acquisition costs	9c(1)(C)	

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

28084

retention of the contract or policy, other than reported in Part I, item 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

a Health (other than dental or vision)

Experience-rated contracts:

Benefit and contract type (check all applicable boxes)

Part III

a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid.....

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

9c(1)(D) 9c(1)(E)

9c(1)(F)

¹² If the answer to line 11 is "Yes," specify the information not provided.

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

OMB No. 1210-0110

		pursuant to E	RISA section 103(a)(2).			Inspection
For calendar plan year 20	11 or fiscal plan	year beginning 03/01/2011	and er	nding 02	/29/2012	
A Name of plan SOUND PUBLISHING, INC. BENEFIT PLAN				ee-digit n number (PI	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 SOUND PUBLISHING, INC. D Employer Identification Number (EIN) 91-1396047					EIN)	
			Coverage, Fees, and Com a unit in Parts II and III can be rep			
1 Coverage Information:						
(a) Name of insurance ca	rrier					
	(a) NIAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f)	From	(g) To
91-6056925	47317	12077894	325	03/01/20)11	02/29/2012
2 Insurance fee and composite descending order of the		tion. Enter the total fees and total	l commissions paid. List in item 3	3 the agents	, brokers, and c	other persons in
(a) Total a	amount of comm	·	(b) T	otal amount	of fees paid	
		1424				0
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all persons).			
	(a) Name a	y .	or other person to whom commiss	sions or fees	were paid	
KRISTIN MANWARING II	NSURANCE		OX 2107 TOWNSEND, WA 98368			
(b) Amount of sales ar	nd base	Fee	s and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	(d) Purpose		(e) Organization code
712						3
	(a) Name a	nd address of the agent, broker,	or other person to whom commiss	sions or fees	were paid	
BROWN & BROWN OF V	VA DBA DIMAR		FOURTH AVENUE SUITE 2400 FLE, WA 98101			
(b) Amount of sales ar	nd hase	Fee	s and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	se		(e) Organization code
	712					3
For Denominant Deduction	n Act Notice c	nd OMB Control Numbers and	the instructions for Form FEOO		Cabas	Iula A (Farm FEOO) 2011

Schedule A (Form 5500)	2011	Page 2 - 1]	
	ame and address of the agent, broke	r. or other person to whom o	commissions or fees were paid	
(4)	and address of the agont, siene	., c. carer percent to innern		
(I) A		Fees and other commission	s paid	(-) ()
(b) Amount of sales and base commissions paid	(c) Amount		(d) Purpose	(e) Organization code
•	, ,			
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	s paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	ame and address of the agent, broke	r, or other person to whom o	commissions or fees were paid	
	T			T
(b) Amount of sales and base				(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	ame and address of the agent, broke	r or other person to whom o	commissions or fees were paid	
(a) (ve	and address of the agent, broke	r, or other person to whom t	commissions of fees were paid	
	I			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	s paid (d) Purpose	(e) Organization
commissions paid	(c) Amount		(d) Fulpose	code
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
		, ,	•	
		Fees and other commission	naid	T.,
(b) Amount of sales and base commissions paid	(c) Amount	1 003 and other commission	(d) Purpose	(e) Organization code
Commissions paid	(o) / anount		(±). 3.5000	
				1

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Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts report.				cts with each carrier ma	ay be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
_		ent value of plan's interest under this contract in separate accounts at year en			5	
6	Contr	racts With Allocated Funds:				
	а	State the basis of premium rates				
		Premiums paid to carrier			6b	
		Premiums due but unpaid at the end of the year			6c	
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan ch	neck here		
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
				on guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		(e) [] 3				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		(6)Total additions			7c(6)	
	d ⊺	Fotal of balance and additions (add b and c(6))	·····		7d	
	e c	Deductions:				
	((1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	((2) Administration charge made by carrier	. 7e(2)			
	((3) Transferred to separate account	. 7e(3)			
	((4) Other (specify below)	. 7e(4)			
		•				
	((5) Total deductions			7e(5)	
	,	Balance at the end of the current year (subtract e(5) from d)				

Page 4	
employer(s) or members of the same emperience-rated as a unit. Where contract as a unit for purposes of this report.	
c x Vision g ☐ Supplemental unemployment k ☐ PPO contract	d Life insurance h Prescription I Indemnity co

		If more than one contract covers the same gr information may be combined for reporting po the entire group of such individual contracts of	urposes if such contracts ar	e experienc	e-rated as a unit. Whe	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	CX	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	loyment	h Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	i
	m	Other (specify)						
9	Expe	erience-rated contracts:						
•	•	Premiums: (1) Amount received		9a(1)			_	
		(2) Increase (decrease) in amount due but unpaid	<u> </u>	` '				
		(3) Increase (decrease) in unearned premium res		` '			1	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	_	Benefit charges (1) Claims paid	_			• • • • • • • • • • • • • • • • • • • •		
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an 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)				
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in o	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide be	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered i	n c(2) .)		9e		
10	No	nexperience-rated contracts:			,			
	а	Total premiums or subscription charges paid to o	arrier			10a		30833
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than repo				10b		
	Sp	ecify nature of costs						

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Schedule A (Form 5500) 2011

Part III

Welfare Benefit Contract Information

¹² If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

Service Provider Information

File as an attachment to Form 5500.

OMB No. 1210-0110

2011

This Form is Open to Public Inspection.

-or calendar plan year 2011 or fiscal plan year beginning 03/01/2011	and ending 02/29/201	
A Name of plan	B Three-digit	504
SOUND PUBLISHING, INC. BENEFIT PLAN	plan number (PN)	501
Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification N	lumber (EIN)
SOUND PUBLISHING, INC.	91-1396047	
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in conner plan during the plan year. If a person received only eligible indirect compensation for wanswer line 1 but are not required to include that person when completing the remainded	ction with services rendered to the which the plan received the required	plan or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compen	sation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder		only eligible
indirect compensation for which the plan received the required disclosures (see instructi	-	
b If you answered line 1a "Yes," enter the name and EIN or address of each person provereceived only eligible indirect compensation. Complete as many entries as needed (see	•	ne service providers who
(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or address of person who provided yo	ou disclosure on eligible indirect con	npensation
(b) Enter name and EIN or address of person who provided yo	u disclosures on eligible indirect co	mpensation
(4)	<u> </u>	1.5.5555
(b) F-1-1	alleada a company de	
(b) Enter name and EIN or address of person who provided yo	u aisclosures on eligible indirect col	mpensation

Page 3 -	1		
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answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in the person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
FIRST CHO	OICE HEALTH ADMIN	`	a) Entor hame and Ent of	address (see mondeners)		
91-127276	6					
(b) Service Code(s)	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?	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?
12	NONE	115802	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
91-127276((b) Service Code(s)	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?	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?
13	NONE	14510	Yes No X	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
KRISTIN M 20-465076	IANWARING INSURA	NCE ASSOC.				
(b) Service Code(s)	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?	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?
22	NONE	17224	Yes No X	Yes No		Yes No

Page :	3 -	2
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answered	d "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
		((a) Enter name and EIN or	address (see instructions)		
			· ·	· · · · · · · · · · · · · · · · · · ·		
(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	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?	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?
			Yes No	Yes No		Yes No

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

many entities as needed to report the required information for each source.		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	22	17224
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.
BROWN & BROWN OF WA DBA DIMARTINO		
91-0978940		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information					
4 Provide, to the extent possible, the following information for earthis Schedule.					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			

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Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)					
а	Name		b ein:			
С	Positio	n:				
d	Addres	es:	e Telephone:			
Ex	olanatio	1:				
а	Name:		b EIN:			
C	Positio					
d	Addres		e Telephone:			
Explanation:						
а	Name:		b EIN:			
С	Positio					
d	Addres		e Telephone:			
Ex	olanatio	n:				
а	Name:		b EIN:			
C	Positio					
d	Addres		e Telephone:			
Ex	Explanation:					
а	Name:		b EIN:			
C	Positio	n:				
d	Addres		e Telephone:			
Ex	Explanation:					