Designed basis         2011           Designed Lister         This form is required to the four under sections 104 and 4056 of the Engloyee         This Form is Open to Public           Perso a control scatting Scatt		Form 5500-SF		eturn/Report of Small Employee Benefit Plan			OMB Nos. 1210-0110 1210-0089			
Description         Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>		Internel Department of the Treasury						2011		
Part Annual Report Genual Report Clear Ministrator         Part Annual	Department of Labor Inis form is required to be filed				1974 (ERISA), and sections 6057(b) and 6058(a) of			This Form is Open to Public		
For centering plan year 2011 or fited plan year beginning     0107/2011     an ending     1237/2011       A This returniveport is for:     If a single employer plan is the final returniveport     a multiple-employer plan (not multiproped)     a one-participant plan       B This returniveport is     If the first returniveport     a storp part year returniveport (less than 12 months)     DPVC program       C Check bool if filing under:     Perm 5558     a donable extension     DPVC program       Special extension (enter description)     If the final extension (enter description)     001       Part LII     Basic Plan Information—enter all requested information     1     1       COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN     001     (PA)     001       COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN     001     (CE)     (PA)       20 SOUTH MAN     ServiceS     210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES       210 SOUTH MAN     ServiceS     210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES       210 SOUTH MAN     ServiceS     210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES       210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES       210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES     210 SOUTH AGING AND HUMAN SERVICES       210 SOUTH	P	ension Benefit Guaranty Corporation	Complete all entries in accord	dance witl	h the instructions to the Form 5500	)-SF.	IIIS	pection		
A       This return/report is for:       a single-employer plan       a multiple-employer plan (not multiemployer)       a one-participant plan         B       This return/report is:       a maneaded trutun/report       b first neturn/report       a maneaded trutun/report         C       Check box if filing under:       Perm ES68       automatic extension       DFVC program         Part II       Basic Plan Information-enter all requested information       1b       Three-digit plan number         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       1b       Three-digit plan number       001         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       1b       Three-digit plan number       001         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       2b       Enclose trutionation number       001         COUNCIL ON AGING AND HUMAN SERVICES       COUNCIL ON AGING AND HUMAN SERVICES       200 SOUTH MAN       Second										
The instructure interview       Image: State interview <t< th=""><th>-</th><th></th><th></th><th></th><th></th><th>2/31/2</th><th></th><th></th></t<>	-					2/31/2				
C Check box if tilling under:       an amended return/report       a short plan year return/report (less than 12 months)         Part III       Basic Plan Information—enter all requested information       1         13       Name of plan       1         14       Name of plan       001         15       There dipt       001         16       Inter description)       01         28       Plan sponsor's name and address: include room or suite number (employer, if for a single-employer plan)       20         29       Employer identification Number (Employer, if for a single-employer plan)       20         20       SOUTH MAN       2000-300-000         20       SOUTH MAN       2000-000-000         20       Souton to an address (f same as plan sponsor, enter "Same")       2000-000         20       Sout		· .		•			a one-particip	oant plan		
C Check box (If filing under:       Form 5558       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       1a. Name of plan       01       DT-rese-digit plan information—enter all requested information         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       1b. Truee-digit plan information—enter all requested information       1c. Effective date of plan 06/28/20/07         Za Plan sponsor's name and address, include room or suite number (employer, if for a single-employer plan)       2b. Employer identification Number (EN)       2c. Sponsor's telephone number (EN)         COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN       2c. Sponsor's telephone number (EN)       2c. Sponsor's telephone number (EN)         COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN       2c. Administrator's telephone number (EN)       2c. Administrator's telephone number (EN)         COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN       2c. Administrator's telephone number (COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN         COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN       2c. Administrator's telephone number (COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN         COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN       2c. Administrator's telephone number (COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN         COUNCIL ON AGING AND HUMAN SERVICES       210 SOUTH MAN       2c. Administrator	Β -	This return/report is:			1					
Part III       Basic Plan Information — oner all requested information         14       Name of plan         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       11b         Three-digit plan number       001         23       Plan agonsor's name and address; include room or suite number (employer, # for a single-employer plan)       22b         23a       Plan agonsor's name and address; include room or suite number (employer, # for a single-employer plan)       22b         24a       Plan agonsor's name and address; include room or suite number (employer, # for a single-employer plan)       22b         250       Employer Identification Number (EN)       22b         260       Soponor's telephone number       5400         27b       Soponor's name       20b         3a       Plan administrator's name and address (I same as plan soonsor) enter "Same")       20b         27b       CLFAX, WA 99111       32b         3a       Plan administrator's helphone number       54100         3a       Plan administrator's name from he last return/report.       3b         3a       The name and/or EIN of the plan soonsor enter "Same")       3b         3a       The name and/or EIN of the plan soonsor enter "Same")       3c         3a       The name and/or EIN of the plan soonsor       5c       1			an amended return/report	a short pla	an year return/report (less than 12 mc	onths)	-			
Part II       Basic Plan Information—enter all requested information         1a Name of plan       Different all requested information         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       1b Three-digit plan number (mN)         2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b Employer Identification Number (EN)         COUNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         210 SOUTH MAN       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         210 SOUTH MAN       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         20 SOUTH MAN       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         20 SOUTH MAN       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         20 SOUTH MAN       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         20 SOUTH MAN       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         COLNCIL ON AGING AND HUMAN SERVICES       20 SOUTH MAN         Contration under of participants at the end of t	C	Check box if filing under:	Form 5558	automatic	extension		DFVC progra	m		
1a Name of plan       1b Three-dgit plan       001         COUNCIL ON AGING AND HUMAN SERVICES 401K PLAN       1b Three-dgit plan       001         2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b Employer (dentification Number (PN) *         210 SOUTH MAIN COLFAX, WA 99111       2c Sponsor's telephone number (source)       2c Sponsor's telephone number (source)         3a Plan administrator's name and address (if same as plan sponsor, enter "Same")       3b Administrator's EIN (Source)       2c Sponsor's telephone number (source)         4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the asponsor and the test return/report.       3b Administrator's telephone number (Source)         3a Otation runber of participants with account balances as of the end of the plan year.       5a 1 1       1c PN         5a Total number of participants with account balances as of the end of the plan year (defined benefit plans do not social and available as etc.)       5a 1 1       1c PN         5a Were all of the plan's assets during the plan year invested in aligble assets? (See instructions.)       2c PN       5a 1 1         5b 1       1       1       1c Control termstor       5d 1       1         6a Were all of the plan's assets during the plan year invested in aligble assets? (See instructions.)       2d PN 23       2d PN 23       2d PN 23         7 Plan Assets and Liabili				-						
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CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR     (PN) >     001       Ic     Effective data of plant     062/2007       Za     Plan sponsor's name and address: include room or suite number (employer, if for a single-employer plant)     2b     Employer identification Number       COLMARL ON AGING AND HUMAN SERVICES     20     Sponsor's telephone number     2c     Sponsor's telephone number       210 SOUTH MANN     COLFAX, WA 99111     2d     Business code (see instructions)       3a     Plan administrator's name and address if same as plan sponsor, enter "Same"     3b     Administrator's telephone number       20 SOUTH MANN     COLFAX, WA 99111     3c     Administrator's telephone number       3a     Plan administrator's telephone number     Same"     3c       2d     Business code (see instructions)     3c     Administrator's telephone number       3a     Cols and     Same"     Same"     3c     Administrator's telephone number       3a     Cols and     Same"		•				10				
Ic       Effective date of plan         06/29/2007         Za       Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COLFAX, WA 99111         3a       Plan administrator's name and address; (if same as plan sponsor, enter "Same")         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN         COUNCL: ON AGING AND HUMAN SERVICES         210 SOUTH MAN	000	ICIL ON AGING AND HOMAN	SERVICES 40TR FLAIN				•	001		
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b Employer Identification Number (EIN)         210 SOUTH MAN       20 SOUTH MAN       2c Sponsor's telephone number (Sonsor's Leiphone number (Sonsor's Leiphone number (Sonsor's Leiphone number Sonsor's name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name end/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name end/or participants at the beginning of the plan year       3b Administrator's EIN (CPA)         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 the or of participants at the end of the plan year       5a       1         5a Total number of participants at the end of the plan year (defined benefit plans do not complete this item).       Sc       1         6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.).       St       1         7a       2035052       224623       24623         7a       233552       24623         7a       233552						1c	( )	fplan		
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624100       3a Plan administrator's name and address (if same as plan sponsor, enter "Same") COUNCIL ON AGING AND HUMAN SERVICES     210 SOUTH MAIN COLFAX, WA 99111     3b Administrator's ENN 91.0964790       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.     4b EIN       a Sponsor's name     4c PN       5a Total number of participants at the beginning of the plan year.     5a     1       complete this item)     5a     1       complete this item)     5c     1       6a Were all of the plan's assets during the plan year instead in eligible assets? (See instructions.)     If yee answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.       Part III     Financester in the Tom line 7a)     7a     23592       7a     23592     294623       b Total number color thin independent qualified public accountant (IQPA)     IV yee       under 29 CFR 2520.104-467 (See instructions on waiver eligibility and conditions.)     IV yee     No       7a     23592     294623       b Total number color thin independent qualified public accountant (IQPA)     IV yee     No       Yee answerd "No" to either 6a or 66, the plan cannot use Form 5500-SF and must instead use Form 5500-     Part IIII     Finances (I) Part IIII       7a     233592     294623	210 5	SOUTH MAIN				2c				
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b       Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)       Image: Control of the annual examination and report of an independent qualified public accountant (IQPA)         Part III       Financial Information       Total plan assets and Liabilities       (a) Beginning of Year       (b) End of Year       294623         Total plan assets       Total plan assets (subtract line 7b from line 7a)       7c       233592       294623       294623         8       Income, Expenses, and Transfers for this Plan Year       (a) Amount       (b) Total       (b) Total       2         2       Part IIII	6a							X Yes No		
If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.         Part III       Financial Information         7       Plan Assets and Liabilities       (a) Beginning of Year       (b) End of Year         a Total plan assets       7a       233592       294623         b Total plan liabilities.       7b       0       0         c Net plan assets (subtract line 7b from line 7a).       7c       233592       294623         8       Income, Expenses, and Transfers for this Plan Year       (a) Amount       (b) Total         a Contributions received or receivable from:       8a(1)       12730         (2) Participants       8a(2)       57594         (3) Others (including rollovers).       8a(3)       536         c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)       8c       70860         9       Benefits paid (including direct rollovers and insurance premiums to provide benefits).       8e       50         f Administrative service providers (salaries, fees, commissions)       8f       50       50         g Other expenses       8g       50       50       50         g Other expenses       8g       50       50       50         g Intorme (loss) (subtract line 8h from line 8c)       8h       982	-									
Part IIIFinancial Information7Plan Assets and Liabilities(a) Beginning of Year(b) End of YearaTotal plan assets7a233592294623bTotal plan liabilities7b00cNet plan assets (subtract line 7b from line 7a)7c2335922946238Income, Expenses, and Transfers for this Plan Year(a) Amount(b) TotalaContributions received or receivable from:8a(1)12730(1)Employers8a(2)57594(3)Others (including rollovers)8a(3)bOther income (loss)8b536CTotal income (add lines 8a(1), 8a(2), 8a(3), and 8b)8c70860dBenefits paid (including direct rollovers and insurance premiums to provide benefits)8d9779eCertain deemed and/or corrective distributions (see instructions)8e50gOther expenses8g1hTotal expenses (add lines 8d, 8e, 8f, and 8g)8h9829iNet income (loss) (subtract line 8h from line 8c)8i61031		•	0,		,			X Yes No		
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h         Total expenses (add lines 8d, 8e, 8f, and 8g)         8h         9829           i         Net income (loss) (subtract line 8h from line 8c)         8i         61031	g	Other expenses	· · · · · · · · · · · · · · · · · · ·	8g						
	h	Total expenses (add lines 8d, 8	Be, 8f, and 8g)					9829		
	i	Net income (loss) (subtract line	e 8h from line 8c)	8i				61031		
j Transfers to (from) the plan (see instructions)	j	Transfers to (from) the plan (se	ee instructions)	8j						

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

Form 5500-SF (2011) v.012611

Page 2 - 1

## 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:

2E 2F 2G 2J 2K 3D 2T

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

Part	V	Compliance Questions					
10	Duri	ng the plan year:		Yes	No	A	mount
а		Vas there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)		Х			8423
b		Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)			X		
С	Was	s the plan covered by a fidelity bond?	10c		Х		
d		the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud shonesty?	10d		Х		
е	insu	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service or other organization that provides some or all of the benefits under the plan? (See instructions.)		х			883
f	Has	Has the plan failed to provide any benefit when due under the plan?		Х			2775
g	Did t	the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		Х		
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		10h		Х		
i		h was answered "Yes," check the box if you either provided the required notice or one of the eptions to providing the notice applied under 29 CFR 2520.101-3	10i				
Part	VI	Pension Funding Compliance					
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500))						
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?						
		es," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.)					
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver						
-		ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.		Г			
b	D Enter the minimum required contribution for this plan year				12b		
С	Enter the amount contributed by the employer to the plan for this plan year						
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)						
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?					No N/A	
Part VII Plan Terminations and Transfers of Assets							
13a	Has	a resolution to terminate the plan been adopted in any plan year?			١	′es X No	
	lf "Ye	es," enter the amount of any plan assets that reverted to the employer this year	1	3a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?						
С	C 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.)						
1	13c(1) Name of plan(s):				<b>13c(2)</b> EIN(s) <b>13c(3)</b> PN(s)		
Caut	ion: A	A penalty for the late or incomplete filing of this return/report will be assessed unless reasonab	le cau	ise is	establ	ished.	

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.	10/16/2012	CINDY ZARING				
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				