Benefit Plan B	Form 5500-SF		Short Form Annual Return/Report of Small Employe			yee	OMB Nos. 1210-0110 1210-0089		
Dependent of Labs     Performance						e <b>2012</b>			
Part I     Annual Report Martification Information     and ending     12/31/2012       A This returniteport is for:     a single-employer plan     a multiple-employer plan (not multimployer)     a one-participant plan       B This returniteport is for:     a single-employer plan     a multiple-employer plan (not multimployer)     a one-participant plan       B This returniteport is:     the first returniteport     a short plan year returniteport     a one-participant plan       B This returniteport is:     the first returniteport     a subort plan year returniteport     a one-participant plan       B This returniteport is:     the first returniteport     a subort plan year returniteport     a one-participant plan       B This returniteport is:     the first returniteport     a subort plan year returniteport     a one-participant plan       B This returniteport is:     the first returniteport     a subort plan year returniteport     bFVC program       B A This returniteport is:     the first returniteport     a subort plan year returniteport     bVC program       B A This returniteport     DE     DE     DE     DE     DE       B A an administrator's name and address; include room or suite number (employer, if for a single-employer plan)     2b Employer featuretor	Department of Labor Employee Benefits Security Administration Retirement Income Security Act of 1974 (ERISA), and sections the Internal Revenue Code (the Code).		ctions 6057(b) and 6058	ons 6057(b) and 6058(a) of		This Form is Open to Public			
For calendar plan year 2012 or fiscal plan year beginning   0.101/2012   and ending   12/31/2012     A This return/report is tor:   a single-employer plan   a multiple-employer plan (not multimployer)   a one-participant plan     B This return/report is:   the first return/report   a short plan year return/report (less than 12 months)   DFVC program     C Check box if filing under:   spocial extension (netre description)   DFVC program   DFVC program     Part III Basic Plan Information—enter all requested information   1b Three-digit plan number   DFVC program     14 Name of plan   DFVC program   0.01   1C Effective data of plan     RK PHARMA 401(K) PIS PLAN   1b Three-digit plan number   0.01   1C Effective data of plan     RK PHARMA   address, include room or suite number (employer, if for a single-employer plan)   12 D Employed fleatrification Number     RK PHARMA   2012   DS posors's telephone number   23 D Administrator's telephone number     23 Plan administrator's name and address   Same as Plan Sponsor Address   24 Business code (see instruction 448110     34 Plan administrator's name and address   Same as Plan Sponsor Address   25 Ad-2148     55 D   C   Componers telephone number   27 -0197281     36 Administra				nce with the instru	ctions to the Form 5500	0-SF.		poonon	
A This return/report is for:      ⓐ aingle-employer plan     ⓑ the first return/report     ⓑ the first return/report     ⓑ the first return/report     ⓑ an an ended return/report     ⓑ short plan year return/report     ⓑ short plan year return/report     ⓑ short plan year     return/report     ⓑ short plan year     return/report     ⓑ short plan year     return/report     ⓑ short plan year     return/report     ⓑ short plan year     return/report     ⓑ short plan     short plan year     return/report     ⓑ short plan     Short     Short plan     Short					and ending 1	2/31/	2012		
B   This return/report   In the first return/report   In the first return/report   In the first return/report     C   Check box if filing under:   In an anended return/report   In a stormatic extension   ID FVC program     Part II   Basic Plan Information—enter all requested information   ID   Three-digit plan number (my)   001     1   The return report   ID   Three-digit plan number (my)   001     2   PLAREMA 401(K) P/S PLAN   ID   Three-digit plan number (my)   001     2   Enclose data of plan (K) P/S PLAN   ID   Three-digit plan number (my)   001     2   Enclose data of plan (K) P/S PLAN   ID   Three-digit plan number (my)   001     2   Enclose data of plan (K) P/S PLAN   ID   Three-digit plan number (my)   001     2   Enclose data of plan (K) P/S PLAN   ID   Three-digit plan number (my)   001     2   Enclose data of plan (K) P/S PLAN   ID   Three-digit plan number (my)   001     2   Enclose data of plan (K) P/S PLAN   ID   The administrator's telephone number (mo)   2     3   P Han Administrator's telephone number for the plan sponsor has changed since the last return/report file	_			multiple-employer p				pant plan	
C   C Check box if filing under:		· · ·		1 1 7 1	(				
A lift 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 (model) as sorts of the plan sponsor's name and address. <b>1b</b> Three-digit plan number (EIN) <b>1c</b> Effective date of plan         (PN) <b>2b</b> Employer denomination <b>1c</b> Effective date of plan         (EIN) <b>27</b> -0197281 <b>2c</b> Sponsor's tellephone number         (EIN) <b>27</b> -0197281 <b>26</b> Environment of the plan number (EIN) <b>27</b> -0197281 <b>26</b> Environment of the plan number (EIN) <b>27</b> -0197281 <b>30</b> Administrator's name and address         Same as Plan Sponsor Name         Same as Plan Sponsor Address <b>30</b> Administrator's telephone number <b>4</b> -010 <b>27</b> -0197281 <b>3c</b> Administrator's telephone number <b>4</b> -010 <b>27</b> -0197281 <b>3c</b> Administrator's telephone number <b>4</b> -010 <b>27</b> -0197281 <b>3c</b> Administrator's telephone number <b>4</b> -010 <b>3c</b> Administrator's telephone number <b>4</b> -010 <b>5c 5c 5c</b>		· [	an amended return/report	short plan year retur	n/report (less than 12 mo	onths	)		
Part II   Basic Plan Information—enter all requested information     1a Name of plan RX PHARMA 401(K) P/S PLAN   1b Three-digit plan number (PN) b   001     1c   Effective date of plan 01/07/2010   01     2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b Employer Identification Number (PN) b   01     2a Plan administrator's name and address; Include room or suite number (employer, if for a single-employer plan)   2b Employer Identification Number (2C) -019/281   2c Sponsor's telephone number 425:346:2148     2d Business code (see instruction 446110   3b Administrator's Integration 446110   3b Administrator's Integration 446110     3a Plan administrator's name and address [Same as Plan Sponsor Name [Same as Plan Sponsor Address Total number of participants at the beginning of the plan year   3c Administrator's Integration integration 425:346:2148     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's name_EDNONDS PHARNACY   4c PN 001     5a   5a   5a     b Total number of participants at the beginning of the plan year   5a     c Are well of the plan's assets during the plan year invested in eligible assets? (See instructions.)   5c     6a   were all of the plan's assets during the plan year invested in eligible assets? (See instructins.)   5c <td< td=""><td>C Check</td><td>box if filing under:</td><td>Form 5558</td><td>utomatic extension</td><td></td><td></td><td>DFVC progra</td><td>ım</td></td<>	C Check	box if filing under:	Form 5558	utomatic extension			DFVC progra	ım	
1a Name of plan   1b Three-digit plan number (PN) ▶   001     1x PHARMA 401(K) P/S PLAN   1c Effective date of plan 01012010   1c Effective date of plan 01012010     2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b Employer Identification Number (EN) ▶     2at Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b Employer Identification Number 425:348-2148     2d Business code (see instructions 446110   3c Sponsor's telephone number 425:348-2148     3a Plan administrator's name and address [Same as Plan Sponsor Name [Same as Plan Sponsor Address 2000 (CP) 446110   3b Administrator's telephone number 425:348-2148     3c Administrator's telephone number feen plan number form the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report.   3b Administrator's telephone number 425:348-2148     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 form the last return/report.   4c PN 001     5a   5b   5c     6a Were all of the plan sponsor has changed since the last return/report filed for this plan, enter the fast of the plan year.   5a     5a   5b   5c     5a   5c   5c     5a   5c   5c			special extension (enter description)	l i i i i i i i i i i i i i i i i i i i					
KK PHARMA 401(K) PIS PLAN   plan number (PN) ▶   001     1c   Effective date of plan 0101/2010   1c   Effective date of plan 0101/2010     2a   Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b   Employer Identification Number (EIN) 27-0197281     3a1 212TH ST SW SUITE D-100 DMONDS, WA 99026   2c   Sponsor's telephone number 446110   3b   Administrator's telephone number 425-346-2143     3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address 27-0197281   3b   Administrator's telephone number 425-346-2143     3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address 27-0197281   3c   Administrator's telephone number 425-346-2143     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   27-0197281     3a   Total number of participants at the end of the plan year.   5a   5b   5c     5a   Sb   Sc   Sc   5c     5a   Sb   Sc   Sc   5c     5a   Sb   Sc   Sc   Sc <td>Part II</td> <td>Basic Plan Inform</td> <td>nation—enter all requested informati</td> <td>on</td> <td></td> <td></td> <td></td> <td></td>	Part II	Basic Plan Inform	nation—enter all requested informati	on					
2a   Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)   2b   Engloyer Identification Number (EIN) 27-0197281     2b   Engloyer Identification Number (EIN) 27-0197281   2c   Sponsor's tabephone number (EIN) 27-0197281     3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address   3b   Administrator's EIN 27-0197281     3c   Administrator's name and address   Same as Plan Sponsor Address   3b   Administrator's EIN 27-0197281     3c   Administrator's ISIN 212TH ST SW SUITE D-100   EDMONDS, WA 39026   3c   Administrator's EIN 27-0197281     3c   Administrator's ISIN 212TH ST SW SUITE D-100   EDMONDS, WA 39026   3c   Administrator's ISIN 27-0197281     3c   Administrator's IsInghone number from the last return/report.   4b   EIN   27-0197281     3c   Administrator's IsInghone number from the last return/report.   4c   PN   001     3a   Total number of participants at the end of the plan year   5a   5c   5c     3c   Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)   Sc   5c   5c     3c   Were all of the plan'		•				1b	plan number	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)     XX PHARMA   27/0197281   2c   Sponsor's telephone number 425:346-2148     Stat 212TH ST SW SUITE D-100   2c   Sponsor's telephone number 446:110     3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address     SP HARMA   7631 212TH ST SW SUITE D-100 EDMONDS, WA 98026   3b   Administrator's EIN 27/0197281     3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address     SP HARMA   7631 212TH ST SW SUITE D-100 EDMONDS, WA 98026   3b   Administrator's EIN 27/0197281     3a   til 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.   4c   PN   001     3a   Total number of participants at the end of the plan year   5a   5b   5c     3a   Were all of the plan's sasets during the plan year invested in eligible assets? (See instructions.)   Str   Yes []     b   Arey ou claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)   Yes [] <td< td=""><td></td><td></td><td></td><td></td><td></td><td>1c</td><td>Effective date o</td><td>•</td></td<>						1c	Effective date o	•	
31 212TH ST SW SUITE D-100 MONDS, WA 96026   2c   Sponsor's telephone number 425-346-2148     2d   Business code (see instructions 446110     3a   Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address 7631 212TH ST SW SUITE D-100 EDMONDS, WA 98026   3b   Administrator's EIN 27-0197281     3c   Administrator's telephone number 425-346-2148   3c   Administrator's telephone number 425-346-2148     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   27-0197281     3a   Total number of participants at the beginning of the plan year   5a   5b   5c     5d   C   Nome   5a   5b   5c     3a   Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   5c   5c     3a   Were all of the plan's assets during the plan year invested in independent qualified public accountant (IQPA)   Yes   Yes     4   Are you claiming a waiver of the annual and report of an independent qualified public accountant (IQPA)   Yes   Yes     a Kere all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   Stoc   5c			ess; include room or suite number (em	ployer, if for a single	-employer plan)	2b	Employer Identi	fication Number	
MONDS, WA 98026   2d Business code (see instructions 446110     ia Plan administrator's name and address   Same as Plan Sponsor Name   Same as Plan Sponsor Address     PHARMA   7631 212TH ST SW SUITE D-100   3b Administrator's telephone numt 425-346-2148     ib 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 27-0197281     a Sponsor's name EDMONDS PHARMACY   4c PN 001     a Total number of participants at the beginning of the plan year.   5a     c Number of participants at the beginning of the plan year.   5b     c Number of participants at the end of the plan year invested in eligible assets? (See instructions.)   Stress     ia Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   Stress     ia Verse all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   Yes     if you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)   Yes     under 29 CFR 2520.104-467 (See instructions on waiver eligibility and conditions.)   Yes   If yea answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.     aution: A penalty for the late or incomplete filing of this return/report will be assesse qualess reasonable cause is establ				2c	C Sponsor's telephone number				
PHARMA   7631 212TH ST SW SUITE D-100 EDMONDS, WA 98026   27-0197281     3C   Administrator's telephone numt 425-346-2148     4   b   EIN   27-0197281     3C   Administrator's telephone numt 425-346-2148   4b   EIN   27-0197281     4   b   EIN   27-0197281   4c   PN   001     a   Sponsor's nameEDMONDS PHARMACY   4c   PN   001   5a   5b   5c     a   Total number of participants at the beginning of the plan year   5a   5b   5c   c   comber of participants at the end of the plan year   5c   c   c   Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)   5c   c   c   ves						2d		,	
PHARMA   76312121H ST SW SUITE D-100 EDMONDS, WA 98026   3c   Administrator's telephone numt 425-346-2148     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   27-0197281     a Sponsor's nameEDMONDS PHARMACY   4c   PN   001     a Total number of participants at the beginning of the plan year   5a   5b     c Number of participants at the end of the plan year   5b   c     c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)   5c   c     a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   Yes   c     b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)   Yes   c     if you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.   aution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.     nder penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedul B or Schedule ME completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge an elief, it is	<b>a</b> Plan a	administrator's name and	address Same as Plan Sponsor Na	me Same as Pla	n Sponsor Address	3b			
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 form the last return/report.   4b   EIN   27-0197281     a   Sponsor's nameEDMONDS PHARMACY   4c   PN   001     5a   Total number of participants at the beginning of the plan year   5a   5b   5c     c   Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)   5c   5c     5a   Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   Yes   Yes     b   Are you claiming a waiver of the anual examination and report of an independent qualified public accountant (IQPA)   Yes   Yes     if you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.   Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.     Jnder penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.   Schedul     Signature of plan administrator   Date   Enter name of individual signing as employer or plan sponsor	PHARM	A				3c			
5a   Total number of participants at the beginning of the plan year				t return/report filed f	or this plan, enter the	4b	EIN 27-01	97281	
b   Total number of participants at the end of the plan year	_					4c	PN	001	
C   Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)				5a		1			
complete this item)   5c     5a   Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   X     b   Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)   X     b   Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)   X     inder 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)   X   Yes     if you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.   X     Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.   J     Jnder penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedul   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.     Signature of plan administrator   Date   Enter name of individual signing as plan administrator     Signature of employer/plan sponsor   Date   Enter name of individual signing as employer or plan sponsor				5b		1			
6a   Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)   Yes     b   Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)   Yes     under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)   Yes   Yes     If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.   Yes     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, if applicable, a Schedul     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 spelief, it is true, correct, and complete.     SIGN   Filed with authorized/valid electronic signature.   06/28/2013   SAIKRISHNA ARUMILLI     SIGN   Filed with authorized/valid electronic signature.   Date   Enter name of individual signing as plan administrator     SIGN   Signature of employer/plan sponsor   Date   Enter name of individual signing as employer or plan spons				• •	-	5c		1	
under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)								X Yes No	
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.     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, if applicable, a Schedul 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 HERE     Filed with authorized/valid electronic signature.   06/28/2013   SAIKRISHNA ARUMILLI     Signature of plan administrator   Date   Enter name of individual signing as plan administrator     Signature of employer/plan sponsor   Date   Enter name of individual signing as employer or plan sponsor								X Yes No	
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 Schedul 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.     06/28/2013     SAIKRISHNA ARUMILLI       Signature of plan administrator     Date     Enter name of individual signing as plan administrator       SIGN     Signature of employer/plan sponsor     Date     Enter name of individual signing as employer or plan sponsor		,		,					
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 HERE   Filed with authorized/valid electronic signature.   06/28/2013   SAIKRISHNA ARUMILLI     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	Caution:	A penalty for the late or	incomplete filing of this return/repo	rt will be assessed	unless reasonable cau	se is	established.		
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	SB or Sch	edule MB completed and	signed by an enrolled actuary, as well						
Signature of plan administrator Date Enter name of individual signing as plan administrator   Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan spons		Filed with authorized/va	lid electronic signature.	06/28/2013	SAIKRISHNA ARUMIL	LLI			
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan spons	HEKE	Signature of plan adr	ninistrator	Date	Enter name of individu	ual sig	gning as plan adr	ninistrator	
Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan spons									
Preparer's name (including infit name, it applicable) and address; include room or suite number (optional)									
	Preparer's	name (including firm nar	ne, if applicable) and address; include	room or suite numbe	er (optional)	Prep	barer's telephone	number (optional)	
For Panerwork Paduction Act Notice and OMB Control Numbers, see the instructions for Form 5500-SE								Form 5500-SE (2012)	

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

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8i       8j       on feature cod					7936 instructions: istructions:
m feature cod					instructions: structions:
on feature cod					structions:
					structions:
					structions:
			Yes	No	
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)				x	
	nclude transactions report	ed <b>10b</b>		x	
		10c		Х	
Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?				x	
Il of the benef	by an insurance carrier, its under the plan? (See			х	
		10e			
olan?		10f		Х	
t as of year er	nd.)	10g	Х		4325
If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				x	
·····	notice or one of the	10i			
the required					
the required				ule SB (Fo	rm TYes TN
the required 101-3	es," see instructions and	complete	Sched	<u></u>	
d the required 101-3	es," see instructions and			11a	
d the required 101-3				11a	
d the required 101-3	nts of section 412 of the C			11a	
d the required 101-3 ements? (If "Y ng requirement w, as applica eing amortize	nts of section 412 of the C	Code or se	ction 3	11a 302 of ERIS	SA? Yes X N
 ec	irements? (If "Y	irements? (If "Yes," see instructions and	irements? (If "Yes," see instructions and complete		

С	Enter	the amount contributed by the employer to the plan for this plan year	12c			
d						
е		he minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No N/A	
Part	Part VII Plan Terminations and Transfers of Assets					
13a	Has a	a resolution to terminate the plan been adopted in any plan year?	, ,	Yes X No		
	lf "Ye	es," enter the amount of any plan assets that reverted to the employer this year	13a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the of the PBGC?				Yes X No	
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): 1			IN(s)	<b>13c(3)</b> PN(s)	
Part	VIII	Trust Information (optional)				

14a Name of trust	14b Trust's EIN