### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## 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

2013

Pensio	on Benefit Guaranty Corporation				Inis	Inspection	ublic	
Part I	Part I Annual Report Identification Information							
For cale	ndar plan year 2013 or fiscal pla	<del>_</del>			/2013			
A This	return/report is for:	a multiemployer plan;		e-employer plan; or				
		x a single-employer plan;	a DFE (	specify)				
			П., с.,					
<b>B</b> This	return/report is:	the first return/report;	브	return/report;				
		an amended return/report;		olan year return/report (less	than 12 m	onths).		
C If the	plan is a collectively-bargained	plan, check here	_		<u></u>	. ▶ ∐		
<b>D</b> Chec	k box if filing under:	Form 5558;	automat	ic extension;	th	e DFVC program;		
		special extension (enter des	cription)					
Part	II Basic Plan Informa	tion—enter all requested informa	ition					
	ne of plan				1b	Three-digit plan	502	
SKAGIT	GARDENS, INC. WELFARE PL	_AN			10	number (PN) ▶ Effective date of pl	an	
					'	02/01/2005	an	
2a Plar	sponsor's name and address; i	nclude room or suite number (emp	oloyer, if for a single	-employer plan)	2b	Employer Identifica	ation	
01/4017	CARRENO INO					Number (EIN) 80-0161154		
SKAGII	GARDENS, INC.				2c	Sponsor's telephor	ne	
						number		
3100 OL	D HIGHWAY 99 SOUTH	3100 OLD	HIGHWAY 99 SOL	ITH		360-424-614		
	VERNON, WA 98273		ERNON, WA 9827		2d	Business code (se instructions)	е	
						111400		
Caution	· A penalty for the late or inco	mplete filing of this return/repor	t will be assessed	unless reasonable cause	is establi	shed		
		alties set forth in the instructions, I					edules.	
		the electronic version of this return						
SIGN HERE	Filed with authorized/valid elec-	tronic signature.	07/31/2014	MISTY BENDER				
HEKE	Signature of plan administra	ator	Date	Enter name of individual	signing as	plan administrator		
SIGN HERE								
TILICE	Signature of employer/plan	sponsor	Date	Enter name of individual	signing as	employer or plan sp	onsor	
SIGN HERE								
	Signature of DFE		Date	Enter name of individual				
Preparer	's name (including firm name, if	applicable) and address; include r	oom or suite numbe		Preparer's optional)	telephone number		
				`	optional			

	Form 5500 (2013)		F	Page <b>2</b>			
3a	Plan administrator's name and address Same as Plan Sponso	r Name	Same as F	Plan Spor	nsor Address	<b>3b</b> Administra 80-0161154	
Sk	AGIT GARDENS, INC.					3c Administrat	
	00 OLD HIGHWAY 99 SOUTH DUNT VERNON, WA 98273					number 360-42	·
4	If the name and/or EIN of the plan sponsor has changed since the EIN and the plan number from the last return/report:	e last retur	rn/report file	d for this	plan, enter the name,	, 4b EIN	
а	Sponsor's name					4c PN	
5	Total number of participants at the beginning of the plan year					5	134
6	Number of participants as of the end of the plan year (welfare pla	ins comple	ete only lines	6a, 6b,	<b>6c,</b> and <b>6d</b> ).		
а	Active participants					6a	150
b	Retired or separated participants receiving benefits					6b	6
С	Other retired or separated participants entitled to future benefits					6c	0
d	Subtotal. Add lines 6a, 6b, and 6c					6d	156
е	Deceased participants whose beneficiaries are receiving or are e	ntitled to re	eceive bene	fits			
f	Total. Add lines <b>6d</b> and <b>6e</b>					6f	156
g	Number of participants with account balances as of the end of the complete this item)					6g	
h	Number of participants that terminated employment during the plates than 100% vested	•				6h	
7	Enter the total number of employers obligated to contribute to the						
8a b	If the plan provides pension benefits, enter the applicable pension lift the plan provides welfare benefits, enter the applicable welfare 4D 4A 4B 4Q						
9a	Plan funding arrangement (check all that apply)  (1)		9b Plar (1) (2) (3) (4)	benefit a	arrangement (check a Insurance Code section 412(e Trust General assets of th	e)(3) insurance contra	octs
10	Check all applicable boxes in 10a and 10b to indicate which sche	dules are	attached, ar	ıd, where	e indicated, enter the r	number attached. (S	ee instructions)
а	Pension Schedules		b Ger	neral Sch	nedules		
	(1) R (Retirement Plan Information)		(1)	П	<b>H</b> (Financial Ir	nformation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certal Purchase Plan Actuarial Information) - signed by the actuary	-	(2) (3) (4)	X	_4 A (Insurance	nformation – Small Pl Information) ovider Information)	an)
	(3) SB (Single-Employer Defined Benefit Plan Actuaria Information) - signed by the plan actuary	al	(5) (6)		<b>D</b> (DFE/Partic	cipating Plan Informat	

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to E	RISA section 103(a)(2).			
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013	and e	nding 12	/31/2013	
A Name of plan SKAGIT GARDENS, INC.	WELFARE PL	_AN		ee-digit n number (Pl	N) •	502
C Plan sponsor's name a SKAGIT GARDENS, INC.		ne 2a of Form 5500	·	oyer Identific 61154	cation Number (	EIN)
		ning Insurance Contract ( Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca	rrier					
AMERITAS LIFE INSURA	ANCE CORP.			•		
/L) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f)	From	<b>(g)</b> To
47-0098400	61301	010-034809	147	01/01/20	)13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. List in line 3	the agents,	brokers, and o	ther persons in
(a) Total	amount of com	missions paid	<b>(b)</b> ⊺	otal amount	of fees paid	
		3060				0
3 Persons receiving com	missions and f	fees. (Complete as many entries	as needed to report all persons).			
		and address of the agent, broker,		sions or fees	were paid	
KIBBLE AND PRENTICE	HOLDING CO		NION ST, STE 1000 TLE, WA 98101			
(b) Amount of sales ar	nd base _	Fee	s and other commissions paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code
	1009	0 0				3
	(a) Name a	and address of the agent, broker,	or other person to whom commis	sions or fees	were paid	
THE PARTNERS GROUI		11740	SW 68TH PKWY, STE 200	0.00	more para	
PORTLAND, OR 97223						
(b) Amount of sales ar			s and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	se		(e) Organization code
	2051	0 0				3

Schedule A (Form 5500)	2013	Page <b>2 -</b> 1			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
(4)	and and address of the agent, stone	.,			
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(o) / tinodit	(a) 1 dipose	0000		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(O) / timodine	(a) 1 diposes	0000		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
	_				
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(o) / unoun	(4)	3345		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
		Fees and other commissions paid	() 0		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(1)	(2)			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca and har-		Fees and other commissions paid	(2) Omanination		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year		4		
		ent value of plan's interest under this contract in separate accounts at year e		5		
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C <sub>.</sub>	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) direct (				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(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 lines <b>7b</b> and <b>7c(6)</b> ).			7d	
		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)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )				

Page <b>4</b>	
employer(s) or members of the same en perience-rated as a unit. Where contra- as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d Life insurance h Prescription dru I Indemnity contr

Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees of the surposes if such contracts a	are experienc	ce-rated as a unit. Wh	ere contracts		
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> X Dental	С	Vision		<b>d</b> Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b>	Supplemental unem	ployment	h Prescription dru	ıg
	i [	Stop loss (large deductible)	j	k □	PPO contract	-	I Indemnity contr	act
	m	Other (specify)	,	L	]		- 🗆	
		_ Cuter (specify)						
9	Expe	erience-rated contracts:						
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	j	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))	·····			9a(4)		(
	b	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)		
	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				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide t	penefits 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	in line 9c(2)	.)	. 9e		
10	) No	nexperience-rated contracts:		· •				
	а	Total premiums or subscription charges paid to c	arrier			. 10a		61209
	b	If the carrier, service, or other organization incurr						
		retention of the contract or policy, other than repo	orted in Part I, line 2 above	e, report amo	ount	10b		

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

Specify nature of costs >

Schedule A (Form 5500) 2013

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

# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to EF	RISA section 103(a)(2).		mspection
For calendar plan year 20	13 or fiscal plar	n year beginning 01/01/2013	and e	nding 12/31/20	013
A Name of plan SKAGIT GARDENS, INC. WELFARE PLAN				e-digit n number (PN)	502
C Plan sponsor's name a SKAGIT GARDENS, INC.	s shown on line	e 2a of Form 5500		oyer Identification 61154	Number (EIN)
		ning Insurance Contract C Individual contracts grouped as a			
1 Coverage Information:					
(a) Name of insurance ca					
- TREMETOR BEGG GROOM	ı		(e) Approximate number of	D <sub>r</sub>	olicy or contract year
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	<u> </u>
91-0499247	47570	4000204	149	01/01/2013	12/31/2013
2 Insurance fee and comp descending order of the		ation. Enter the total fees and total	I commissions paid. List in line 3	the agents, broke	ers, and other persons in
(a) Total a	amount of comr	missions paid	(b) T	otal amount of fee	s paid
		20618			2033
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).		
		and address of the agent, broker, o		sions or fees were	paid
THE PARTNERS GROUP	. ,	11740	SW 68TH PKWY, STE 200 _AND, OR 97223		F
(b) Amount of sales ar	nd bass	Fees	and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	e	(e) Organization code
	10437	0 0			3
	(=) NI======				
KIBBLE AND PRENTICE	- 1	and address of the agent, broker, o	NION ST, STE 1000	sions or tees were	paid
NIDDLE AND PRENTICE	HOLDING CO		LE, WA 98101		
(b) Amount of sales ar	nd base	Fees	and other commissions paid		
commissions pai		(c) Amount	(d) Purpos	e	(e) Organization code
	10181	2033 PR	EFERRED PRODUCER		3

Schedule A (Form 5500)	2013	Page <b>2 -</b> 1			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
(4)	and and address of the agent, stone	.,			
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(o) / tinodit	(a) 1 dipose	0000		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(O) / timodine	(a) 1 diposes	0000		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
	_				
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(o) / unoun	(4)	3345		
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid		
		Fees and other commissions paid	() 0		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
	(1)	(2)			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca and har-		Fees and other commissions paid	(2) Omanination		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
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Part II		Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4 Current va			value of plan's interest under this contract in the general account at year end			
		ent value of plan's interest under this contract in separate accounts at year e		5		
6	Cont	racts With Allocated Funds:			_	
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C <sub>.</sub>	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) clifer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(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 lines <b>7b</b> and <b>7c(6)</b> ).			7d	
		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)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	(5) Total deductions					

Page 4
uployer(s) or members of the same employee organizations(s), the rience-rated as a unit. Where contracts cover individual employees a unit for purposes of this report.

Pa	rt II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts w	oup of employees of the surposes if such contracts	are experienc	ce-rated as a unit. Whe	ere contracts		;,
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	(	<b>d</b> Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental unemp	loyment	h Prescription drug	
	i [	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	Other (specify)						
9	Ехре	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	l					
		(3) Increase (decrease) in unearned premium res	erve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		0
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	, , , , , , , , , , , , , , , , , , ,					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		-				
		(C) Other specific acquisition costs						
		(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				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits 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	in line <b>9c(2)</b>	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a	6872	260
	b	If the carrier, service, or other organization incurr				10b		
	0	retention of the contract or policy, other than repo	nteu in Part I, line 2 abov	e, report amo	Jurit	IUD	<u> </u>	
	٥þ	Specify 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) 2013

**<sup>12</sup>** If the answer to line 11 is "Yes," specify the information not provided.

# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to Ef	RISA section 103(a)(2).		mapeonon			
For calendar plan year 20	13 or fiscal plar	year beginning 01/01/2013	and e	ending 12/31/2013				
A Name of plan SKAGIT GARDENS, INC.	WELFARE PL	AN		ee-digit n number (PN)	502			
C Plan sponsor's name a SKAGIT GARDENS, INC.	s shown on line	e 2a of Form 5500		loyer Identification Num 161154	ber (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	rrier							
UNUM LIFE INSURANCI	E COMPANY C	F AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy	or contract year			
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	<b>(g)</b> To			
01-0278678	62235	029911	144	01/01/2013	12/31/2013			
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total	amount of comr	i	(b) <sup>-</sup>	Total amount of fees pa	id			
		591			99			
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all persons).					
	(a) Name a	nd address of the agent, broker, o	or other person to whom commis	ssions or fees were paid	<u> </u>			
KIBBLE AND PRENTICE	HOLDING CO		NION ST, STE 1000 FLE, WA 98101					
(b) Amount of sales ar	nd base	Fees	and other commissions paid					
commissions pa		(c) Amount		se	(e) Organization code			
231 46 /			DITIONAL COMPENSATION		3			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
THE PARTNERS GROUP  11740 SW 68TH PKWY, STE 200 PORTLAND, OR 97223								
(b) Amount of sales and base			and other commissions paid					
commissions pa		(c) Amount	(d) Purpo	se	(e) Organization code			
	360	53 AD	DITIONAL COMPENSATION		3			
	A 1 N 1	101100 ( 111 )						

Schedule A (Form 5500)	2013	Page <b>2 -</b> 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
(4)	and and address of the agent, stone	.,				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / tinodit	(a) 1 dipose	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(O) / timodine	(a) 1 diposes	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
	_					
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / unoun	(4)	3345			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
		Fees and other commissions paid	() 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(1)	(2)				
<b>(a)</b> Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca and har-		Fees and other commissions paid	(2) Omanination			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	, ,	, , ,				

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Part II		Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4 Current va			value of plan's interest under this contract in the general account at year end			
		ent value of plan's interest under this contract in separate accounts at year e		5		
6	Cont	racts With Allocated Funds:			_	
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C <sub>.</sub>	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		· ·		
		(3) guaranteed investment (4) clifer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
		(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(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 lines <b>7b</b> and <b>7c(6)</b> ).			7d	
		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)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	(5) Total deductions					

schedule A (Form 5500) 2013	Page <b>4</b>	
	, and the second	
Welfare Benefit Contract Information  If more than one contract covers the same group of employ information may be combined for reporting purposes if suc the entire group of such individual contracts with each carr	n contracts are experience-rated as a unit. Where cor	ntracts cover individual employees,
and contract type (check all applicable boxes)		
ealth (other than dental or vision) <b>b</b> Dental	<b>c</b> Vision	<b>d</b> X Life insurance
emporary disability (accident and sickness) $f f$ $\prod$ Long-t	erm disability $\mathbf{g}  \overline{}$ Supplemental unemployme	ent <b>h</b> Prescription drug
top loss (large deductible) j 🗍 HMO o	contract <b>k</b> PPO contract	I Indemnity contract
ther (specify) ACCIDENTAL DEATH AND DISMEMBER	MENT	_
(-1, 7)		
ce-rated contracts:		
niums: (1) Amount received	9a(1)	
ncrease (decrease) in amount due but unpaid	9a(2)	
ncrease (decrease) in unearned premium reserve	9a(3)	
Earned ((1) + (2) - (3))	9a	n(4)
nefit charges (1) Claims paid	9b(1)	
ncrease (decrease) in claim reserves	9b(2)	
ncurred claims (add (1) and (2))	9b	p(3)
Claims charged	9b	0(4)
mainder of premium: (1) Retention charges (on an accrual t	pasis)	
(A) Commissions	9c(1)(A)	
(D) Administrative convice or other foce		

information may be combined for reporting purposes if such contracts a the entire group of such individual contracts with each carrier may be tr 8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disabilit Stop loss (large deductible) j HMO contract m X Other (specify) ▶ACCIDENTAL DEATH AND DISMEMBERMENT Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid..... (3) Increase (decrease) in unearned premium reserve ..... (4) Earned ((1) + (2) - (3))..... Benefit charges (1) Claims paid ..... (2) Increase (decrease) in claim reserves...... (3) Incurred claims (add (1) and (2))...... (4) Claims charged ..... Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions ..... (B) Administrative service or other fees..... 9c(1)(C) (C) Other specific acquisition costs ..... (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies..... (H) Total retention..... 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)..... 9c(2)d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement ...... 9d(1) (2) Claim reserves ..... 9d(2) 9d(3) (3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier ...... 5912 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, line 2 above, report amount..... Specify nature of costs

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

Part III

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

# SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

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

OMB No. 1210-0110

2013

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2).		•			
For calendar plan year 20	13 or fiscal pla	an year beginning 01/01/2013	and	l ending 12/31/2013				
A Name of plan SKAGIT GARDENS, INC. WELFARE PLAN				hree-digit lan number (PN)	502			
C Plan sponsor's name a SKAGIT GARDENS, INC.	is shown on li	ne 2a of Form 5500		pployer Identification Numbe 0161154	r (EIN)			
		ning Insurance Contract . Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca		OF AMERICA						
	I		(e) Approximate number o	f Policy or	contract year			
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year		<b>(g)</b> To			
01-0278678	62235	029912	13	01/01/2013	12/31/2013			
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	tal commissions paid. List in line	e 3 the agents, brokers, and	other persons in			
(a) Total a	amount of con	nmissions paid	(b)	Total amount of fees paid				
		723			81			
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all persons	i).				
		and address of the agent, broker		nissions or fees were paid				
THE PARTNERS GROUI	<b>D</b>		0 SW 68TH PKWY, STE 200 TLAND, OR 97223					
(b) Amount of sales ar	nd base	Fe	es and other commissions paid					
commissions pa	id	(c) Amount	<b>(d)</b> Purp	oose	(e) Organization code			
422 41		41 A	DDITIONAL COMPENSATION		3			
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
KIBBLE AND PRENTICE HOLDING COMPANY  601 UNION ST, STE 1000								
SEATTLE, WA 98101								
(b) Amount of sales and base			es and other commissions paid	(-) (				
commissions pa		(c) Amount	(d) Purp	oose	(e) Organization code			
	301	40 A	DDITIONAL COMPENSATION		3			

Schedule A (Form 5500)	2013	Page <b>2 -</b> 1				
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
(4)	and and address of the agent, stone	.,				
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / tinodit	(a) 1 dipose	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	ere paid			
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(O) / timodine	(a) 1 diposes	0000			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
	_					
		Fees and other commissions paid				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(o) / unoun	(4)	3345			
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees w	vere paid			
		Fees and other commissions paid	() 0			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	(1)	()				
<b>(a)</b> Na	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					
(h) Amount of calca and har-		Fees and other commissions paid	(2) Omanination			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
	, ,	, , ,				

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Pa	art II					
		Where individual contracts are provided, the entire group of such individual this report.	idual contra	cts with each carrier ma	ly be treated as a	a unit for purposes of
4	Curr	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 e			5	
6	Cont	racts With Allocated Funds:				_
	а	State the basis of premium rates •				
	_					
	b	Premiums paid to carrier			6b	
	C.	Premiums due but unpaid at the end of the year			6с	
	d	If the carrier, service, or other organization incurred any specific costs in coretention 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	nating plan, o	check here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а			tion guarantee		
		(3) guaranteed investment (4) other		ŭ		
		(3) guaranteed investment (4) clifer y				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	1		75	
	•	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	- (a)			
		(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 lines <b>7b</b> and <b>7c(6)</b> ).			7d	
		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)			
		<b>&gt;</b>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> )				

Schedule A (Form 5500) 2013		Page <b>4</b>		
Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting p the entire group of such individual contracts of	roup of employees of the same urposes if such contracts are	experience-rated as	a unit. Where contract	
efit and contract type (check all applicable boxes)				
Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> X Life insurance
Temporary disability (accident and sickness)	f Long-term disability	<b>g</b> Suppleme	ental unemployment	h Prescription drug
Stop loss (large deductible)	j HMO contract	k  PPO con	tract	I Indemnity contract
X Other (specify) ▶ACCIDENTAL DEATH AND	DISMEMBERMENT	<u> </u>		
J ( ) //				
erience-rated contracts:				
Premiums: (1) Amount received	<u></u>	9a(1)		
(2) Increase (decrease) in amount due but unpaid	?t	9a(2)		
(3) Increase (decrease) in unearned premium res		9a(3)		
(4) Earned ((1) + (2) - (3))			9a(4)	(
Benefit charges (1) Claims paid	ç	9b(1)		
(2) Increase (decrease) in claim reserves	ç	9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged				
Remainder of premium: (1) Retention charges (c	on an accrual basis)			
(A) Commissions		:(1)(A)		
(B) Administrative service or other fees		c(1)(B)		

(A) Commissions ..... (B) Administrative service or other fees..... 9c(1)(C) (C) Other specific acquisition costs ..... (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies..... (H) Total retention..... 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)..... 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement ...... 9d(1) (2) Claim reserves ..... 9d(2) 9d(3) (3) Other reserves..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e **10** Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier ...... 4814 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, line 2 above, report amount.....

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

8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision)

Experience-rated contracts:

Specify nature of costs

m X Other (specify) ▶ACCIDENTAL DEATH AND DISMEMBERMENT

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

Part III

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

## Form M-1 Compliance Information

## FOR Skagit Gardens, Inc. Welfare Plan

This is a Form M-1 compliance statement for Skagit Gardens, Inc.'s Skagit Gardens, Inc. Welfare Plan, EIN 80-0161154, Plan No. 502, for period January 1, 2013 through December 31, 2013.

1. If the plan provides welfare benefits, is the plan a multiple employer welfare arrangement (MEWA) that is subject to the Form M-1 filing requirements? (If "Yes" is checked, complete lines 2 & 3)					
			Yes	☑ No	
2.	Is the plan currently in compliance with the Form M-1	•	g requ Yes	iirements? □ No	,
	Enter the Receipt Confirmation Code for the most recled in accordance with the Form M-1 filing requiremen Receipt Confirmation Code will result in rejection of the plete.)	ts. (F	ailure		<b>a</b>

3604248404

Form 5500	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		
Department of the Treasury Internal Revenue Service			2013  This Form is Open to Public Inspection		
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation					
Part I Annual Report Ider	ntification Information				
For calendar plan year 2013 or fiscal	plan year beginning 01/01/2013		and ending 12/31/	2013	
A This return/report is for:	☐ a multiemployer plan;  ☒ a single-employer plan;	<u>-</u>	employer plan; or ecify)		
<b>B</b> This return/report is:	the first return/report; an amended return/report;		eturn/report; an year return/report (less t	han 12 months).	
C If the plan is a collectively-bargain	ed plan, check here				
<b>D</b> Check box if filing under:	Form 5558; special extension (enter des		extension;	the DFVC program;	
Part II Basic Plan Inform	mation—enter all requested informa	ution			
1a Name of plan SKAGIT GARDENS, INC. WELFARE				<b>1b</b> Three-digit plan number (PN) ▶ 502	
Chief & Carlot I Charlet and an a Lond College College College College				1c Effective date of plan 02/01/2005	
2a Plan sponsor's name and addres	2b Employer Identification Number (EIN) 80-0161154				
SKAGIT GARDENS, INC.				2C Sponsor's telephone number 360-424-6144	
3100 OLD HIGHWAY 99 SOUTH 3100 OLD HIGHWAY 99 SOUTH MOUNT VERNON, WA 98273 MOUNT VERNON, WA 98273			2d Business code (see instructions)		
Courtiers A penalty for the late or is	ncomplete filing of this return/repor	rt will he seeseed I	inless reasonable cause	is established.	
Under penalties of periury and other	penalties set forth in the instructions, as the electronic version of this return	I declare that I have	examined this return/report	, including accompanying schedules,	
SIGN Magnit	Pail	7/31/14	Margaret +	Partida '	
HERE Signature of plan admini	strator	Date		signing as plan administrator	
SIGN Tolast	Pult	7/31/14	Margaret		
HERE Signature of employer/pl	an sponsor	Date	Enter name of individual	signing as employer or plan sponsor	
SIGN HERE					
Signature of DFE	e, if applicable) and address; include	Date	Enter name of individual	signing as DFE Preparer's telephone number	
Preparer's name (Including IIIm nam	e, ir applicable) and address, include	room of suite numbe		optional)	
			-		