Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

HERE

SIGN **HERE**

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal

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

Revenue Code (the Code).

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection**

Annual Report Identification Information For calendar plan year 2014 or fiscal plan year beginning and ending 12/31/2014 X a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list A This return/report is for: of participating employer information in accordance with the form instructions) a one-participant plan a foreign plan the first return/report the final return/report **B** This return/report is an amended return/report a short plan year return/report (less than 12 months) Form 5558 DFVC program automatic extension C Check box if filing under: special extension (enter description) Basic Plan Information—enter all requested information Part II 1a Name of plan **1b** Three-digit FOOD LIFELINE 403(B) PLAN plan number (PN) ▶ 001 1c Effective date of plan 07/01/1995 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number **FOOD LIFELINE** (EIN) 91-1090450 Sponsor's telephone number 206-545-6600 1702 NE 150TH STREET SHORELINE, WA 98155-7226 Business code (see instructions) 813000 **3a** Plan administrator's name and address XSame as Plan Sponsor. Administrator's EIN **3c** Administrator's telephone number 4b EIN 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. a Sponsor's name 4c PN Total number of participants at the beginning of the plan year 5a 120 **b** Total number of participants at the end of the plan year..... 5b 115 Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c complete this item) d(1) Total number of active participants at the beginning of the plan year..... 5d(1) 70 d(2) Total number of active participants at the end of the plan year..... 5d(2) 65 e Number of participants that terminated employment during the plan year with accrued benefits that were 4 5e less than 100% vested. 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 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 Filed with authorized/valid electronic signature **SIGN**

Date

Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)

Signature of plan administrator

Signature of employer/plan sponsor

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

Preparer's telephone number (optional)

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b	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of a cunder 29 CFR 2520.104-46? (See instructions on waiver eligibility a figure answered "No" to either line 6a or line 6b, the plan cannot will be a first the contraction of the plan cannot will be a first the contraction of the plan cannot will be a first to be a first to the plan cannot will be a first to be a first to the plan cannot will be a first to be a first to the plan cannot will be a first to be a first to the plan cannot will be a first to be a first to the plan cannot will be a first to be a first to the plan cannot will be a first to be a first to the plan cannot will be a first to the plan cannot will be a first to be a first to the plan cannot will be a first	an indepe and condit ot use Fo	ndent qualified public accounta iions.) irm 5500-SF and must instead	nt (IQ	PA) Form	5500.	X Yes [No No
	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	orogram (see ERISA section 40	121)?		Yes	No Not determi	ned
Par					1			
7	Plan Assets and Liabilities		(a) Beginning of Yea				(b) End of Year	
	Fotal plan assets	7a	12969				1371657	
	Fotal plan liabilities	7b	12060	0			1371657	
	Net plan assets (subtract line 7b from line 7a)	7c	12969	131				
	ncome, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total	
	Contributions received or receivable from: 1) Employers	8a(1)	324	804				
	2) Participants	8a(2)	683	808				
	3) Others (including rollovers)	8a(3)		0				
	Other income (loss)	8b	888	328				
С	Fotal income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					189544	1
	Benefits paid (including direct rollovers and insurance premiums							
1	o provide benefits)	8d	1148					
_ е	Certain deemed and/or corrective distributions (see instructions)	8e		0				
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f		0				
g	Other expenses	8g		0				
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					114818	}
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i					74726	3
<u>j</u> .	Transfers to (from) the plan (see instructions)	8j		0				
Part	IV Plan Characteristics							
b	If the plan provides welfare benefits, enter the applicable welfare fe V Compliance Questions	eature cod	les from the List of Plan Charac	cterist	ic Cod	les in t	he instructions:	
10	During the plan year:				Yes	No	Amount	
а b	Was there a failure to transmit to the plan any participant contribut 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu Were there any nonexempt transactions with any party-in-interest'	ıciary Cor	rection Program)	10a		X		
	on line 10a.)	`	•	10b		X		
С	Was the plan covered by a fidelity bond?			10c	X		10	00000
d	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			10d		X		
е	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.)			10e		X		
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		Χ		
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of vear	end.)	10g		X		
	f this is an individual account plan, was there a blackout period? (See instructions and 29 CFR		10g		X			
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3			10i				
Part					•			
11	Is this a defined benefit plan subject to minimum funding requirements 5500) and line 11a below)							X No
11a	Enter the unpaid minimum required contribution for current year from					11a		
12	12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?							
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,							
а	If a waiver of the minimum funding standard for a prior year is being ranting the waiver.	ng amortiz	ed in this plan year, see instruc		, and e	enter th Day		ıg

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lf :	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For	m 5500), and skip to line 13.			
b	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		12c		
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result negative amount)	-	1 124		
е	Will the minimum funding amount reported on line 12d be met by the funding	g deadline?		Yes	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?		🔲 Y	′es X No	
	If "Yes," enter the amount of any plan assets that reverted to the employer the	his year	13a		
b	Were all the plan assets distributed to participants or beneficiaries, transferred the PBGC?		inder the control		Yes X No
С	If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.)	an to another plan(s), identify th	e plan(s) to		
1	3c(1) Name of plan(s):		13c(2) EI	N(s)	13c(3) PN(s)

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500-SE

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Personal Bernard Guardiay Corporation	► Complete all entries in a		tions to the Form 5600	-SF.	<u> </u>				
	t Identification Information								
For calendar plan year 2014 or		01/01/2014	and ending	12/31/2	014				
A This return/report is for: B This return/report is:	x a single-employer plan a one-participant plan the first return/report	a multiple-employer plan (not multlemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions) a foreign plan the final return/report							
D This reconsiseport is:	=		wirenest Hear than 40 ma						
	an amended return/report	a snon plan year retur	n/report (less than 12 mo	ININS)					
C Check box if filing under:	Form 5558 special extension (enter desc	automatic extension		DFVC	program				
WILLIAGOSTIVE.	<u> </u>								
_	ormation enter all requested	Information	<u></u>	dia =					
1a Name of plan Food Lifeline 403		16 Three-di plan nur (PN) ➤							
		1c Effective date of plan 07/01/1995							
2a Plan sponsor's name and Food Lifeline	address; include room or suite num	ber (employer, if for a single	-employer plan)	2b Employer Identification Number (EIN) 91-1090450					
1702 WE 150th Street				2c Sponsor's telephone number (206) 545-6600					
US Shoreling WA 98155-	7226			2d Busines 81300	s code (see instructions) D				
	and address X Same as Plan Sp	oonsor Name		3b Adminis	Irator's EIN				
3¢ Administrator's telephone number									
	he plan sponsor has changed since umber from the last return/report.	the last return/report filed f	or this plan, enter the	4b EIN					
a Sponsor's name	•			4c PN					
+ 	ts at the beginning of the plan year	*********************	·/ hapt-qhar	5a	120				
5a Total number of participants at the beginning of the plan year					115				
Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this liem)					86				
d(1) Total number of active p	articipants at the beginning of the p	lan year)) 	5d(1)	70				
d(2) Total number of active p	articipants at the end of the plan ve	15 15		5d(2)	65				
d(2) Total number of active participants at the end of the plan year Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested					4				
Coullent A possibuter the la	te or incomplete filling of this retu	rnireport will be assessed	i unless reasonable cau	ise is establi	shod.				
Linder consisting of coduct and	other penalties set forth in the inst d and signed by an enrolled actuary	ructions. I declare that I have , as well as the electronic ve	e examined this return/re ersion of this return/repor	port, including t, and to the b	, if applicable, a Schedule				
SIGN JAMES	Trol	10/7/2015	Jane Fro	1	. <u>.</u>				
HERE Signature of plan a	iministrator	Date	Enter name of individua		an administrator				
sign Mann	Van nou	10/12/2015	_						
	Carleian enonear	Date			mployer or plan sponsor				
HERE Signature of employ Preparer's name (including fin	n name, if applicable) and address:				tephone number (optional)				
			-						

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	6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)							
	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)							M.162 [].10
	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 canno	ot use Fo	rm 5500-SF and must Instead					
Ę.	If the plan is a defined benefit plan, is it covered under the PBGC in	sniauce t	program (see ERISA section 40)	21)?		Yes	i ∐ No	Not determined
P	art III. Financial Information							
7_	Plan Assets and Liabilities		(a) Beginning of Yea	<u> </u>	_		(b) End o	f Year
<u>a</u>	Total plan assets	7a	1,296,9		+			1,371,657
<u>þ</u>	Total plan liabilities	7b		0	+			0
2 .	Net plan assets (subtract line 7b from line 7a) Income, Expenses, and Transfers for this Plan Year	7c	1,296,9 (a) Amount	31	+		(b) To	1,371,657
ă	Contributions received or receivable from:	 	.) (a) Anounc		+		The second second	and to the burder of the
	(1) Employers ************************************	8a[1)	32,4					46.070.00.00.00.00.00
	(2) Participants	8a(2)	68,3					
_	(3) Others (including rollovers)	8a(3)		0				
<u>b</u>	Other income (loss) Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8b 8c	88,8			100,40	<u> ANDESE </u>	
ਰ	Benefits paid (including direct rollovers and insurance premiums	00	A STATE OF THE STA		157,5	5-55	a in Spirite	189,544
_	to provide benefits)	8d	114,8	18			21777	
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	8e		0			8.00	
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f		0	4.			ANGELLE GERREIT TO COMPANIE
<u>a</u>	Olher expenses	8g	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	1	. A	The State of	NEW YORK
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h			+			114,818
÷	Net income (loss) (subtract line 8h from line 8c)	81		0	971.			74,726
رم ا	Transfers to (from) the plan (see instructions)	<u>8j</u>	<u> </u>	<u> </u>	253	11.54.0	el des traditions	MERCHARY ESSENTION
_			for from the Lifet of Class Character	4 - 4 - 6		!- !		
Ja	If the plan provides pension benefits, enter the applicable pension for 2M	eature cot	ies from the List of Plan Charac	aensi	IC C00	es in t	ie msuucii	ons:
	•••							
ь	If the plan provides welfare benefits, enter the applicable welfare fea	ature code	ss from the List of Plan Characte	enstic	Code	s in the	e instructio	ns:
D.	irtV: Compliance Questions							
10	Ouring the plan year:				Yes	No		Amount
	Was there a failure to transmit to the plan any participant contribu-			П	100		•	
	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduc			10a		х		
ŧ	Were there any nonexempt transactions with any party-in-interest on line 10a.)			10b		l x		
				10c	х			100,000
					Ë	\vdash		2,7,7,7,7
	or dishonesty?		**************************************	10d		X		
е	Were any fees or commissions paid to any brokers, agents, or oth	er person	s by an insurance carrier,					
	insurance service, or other organization that provides some or all (instructions.)			10e		x		
f				10f		x		
			· · ·	10g		x		
	If this is an individual account plan, was there a blackout period? (1.49		-		
	2520,101-3.)			10h		x J	100	
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101			101			Paris 1	
Pa	rt:VI Pension Funding Compliance			•				
11								
11:	11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39							
12						02 of F	RISA?	Yes X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below.					T		
а	If a waiver of the minimum funding standard for a prior year is being	g amortiz	ed in this plan year, see instruc					
	granting the waiver	*********		WI _		_ Day		. Year

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lfy	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				
b	Enter the minimum required contribution for this plan year		1	2b	_	
<u>C</u>	Enter the amount contributed by the employer to the plan for this plan year	M199419999999199999999999	1	2c		
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter negative amount)			2d		
e	Will the minimum funding amount reported on line 12d be met by the funding dead	ine?		☐ Yes	□ 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?			Yes 🗵	No.	
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	F		3a		
b	Were all the plan assets distributed to participants or beneficiaries, transferred to a of the PBGC?				☐ Yes 🕱 No	
c	If during this plan year, any assets or liabilities were transferred from this plan to ar which assets or liabilities were transferred. (See instructions.)					
	3c(1) Name of plan(s):		13c(2)	EIN(s)	13c(3) PN(s)	
		[
Part	Mill Trust Information (optional)	1				
440.0	Name of trust		14b Trust's EIN			
144 (varie of trust		14	ID Trust's	EIN	

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