## 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 sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

0046

2016

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

Part I		t identification information						
For calend	ar plan year 2016 or	fiscal plan year beginning 01/01/2	2016		and ending 12	2/31/2016		
A This re	turn/report is for:	a single-employer plan			an (not multiemployer) ( aployer information in ac		_	
		a one-participant plan	_	preign plan	. ,			,
<b>B</b> This ret	urn/report is	the first return/report	the	final return/report				
_		an amended return/report	a sh	ort plan year retur	n/report (less than 12 m	ionths)		
C Check	box if filing under:	Form 5558		omatic extension		DFVC	program	
<b>.</b>		special extension (enter desc						
Part II		ormation—enter all requested in	formatio	n		1		
1a Name		PSC 401(K) PROFIT SHARING PL	ΛNI			1b The	•	
IVICCAVV VE	TERINART CLINIC,	F3C 401(K) FKOFIT SHAKING FL	AIN				n number N) ▶	001
							ective date of	plan /1999
22 Plan s	noncor's name (empl	loyer, if for a single-employer plan)				2h		
Mailing	g address (include ro	om, apt., suite no. and street, or P.0		(if foreign, one inet	ruotiono)	ZD EIII		ication Number 352535
	TERINARY CLINIC, I	nce, country, and ZIP or foreign pos PSC	tai code	ii ioreigii, see iiist	uctions)	<b>2c</b> Sp	onsor's telepl 859-887	none number -1188
						<b>2d</b> Bus	siness code (	see instructions)
	MAIN STREET						5419	
NICHOLASV	/ILLE, KY 40356							
<b>3a</b> Plan a	idministrator's name a	and address 🛚 Same as Plan Spo	nsor.			<b>3b</b> Adr	ministrator's E	EIN
						3c Adr	ministrator's t	elephone 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	١	
	or's name					4c PN		
<b>5a</b> Total	number of participant	ts at the beginning of the plan year.				5a		10
<b>b</b> Total	number of participant	ts at the end of the plan year				5b		10
		n account balances as of the end of				5c		10
<b>d(1)</b> Tot	al number of active p	articipants at the beginning of the p	lan year.			5d(1)		10
<b>d(2)</b> Tot	tal number of active p	participants at the end of the plan ye	ear			5d(2)		10
		at terminated employment during the				5e		(
Caution: A	A penalty for the late	e or incomplete filing of this retur	n/report	will be assessed	unless reasonable ca			
SB or Sche		other penalties set forth in the instru and signed by an enrolled actuary, nplete.						
SIGN		d/valid electronic signature.		06/07/2017	WILL MCCAW, DVM			
HERE	Signature of plan	administrator		Date	Enter name of individ	lual signin	g as plan adn	ninistrator

Date

Signature of employer/plan sponsor

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

SIGN HERE

Enter name of individual signing as employer or plan sponsor

Preparer's telephone number

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	Were all of the plan's assets during the plan year invested in eligib Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility	an indepe	ndent qualified public a	account	ant (IC	PA)				No No
	If you answered "No" to either line 6a or line 6b, the plan cann								□ .∞ □ .	10
С	If the plan is a defined benefit plan, is it covered under the PBGC ir	nsurance p	orogram (see ERISA se	ection 4	021)?		Yes	No	Not determine	∍d
Pa	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning	of Year	,		(	(b) End	of Year	
а	Total plan assets	7a		117908					1256010	
b	Total plan liabilities	7b								
С	Net plan assets (subtract line 7b from line 7a)	7c	1	117908	3				1256010	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amour	nt				(b) T	otal	
а	Contributions received or receivable from:	0=(4)		13535						
-	(1) Employers	8a(1)		49982						
	(2) Participants	8a(2) 8a(3)		.0002						
	Other income (loss)	8b		74585						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							138102	_
	Benefits paid (including direct rollovers and insurance premiums	- 55								
	to provide benefits)	8d								
<u>e</u>	Certain deemed and/or corrective distributions (see instructions).	8e								
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f								
g	Other expenses	8g			_					
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							0	
<u> </u>	Net income (loss) (subtract line 8h from line 8c)	8i							138102	_
j	Transfers to (from) the plan (see instructions)	8j								
	t IV Plan Characteristics									
9a —.	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2T 3D									
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	des from the List of Pla	n Chara	acterist	tic Cod	des in t	he instru	ictions:	
Par	t V   Compliance Questions									
10	During the plan year:			1	Yes	No	N/A		Amount	
а	Was there a failure to transmit to the plan any participant contributed described in 29 CFR 2510.3-102? (See instructions and DOL's Verogram)	oluntary F	Fiduciary Correction	10a		X				
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		X				
С	Was the plan covered by a fidelity bond?			10c	X				120	000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		X				
е	Were any fees or commissions paid to any brokers, agents, or oth carrier, insurance service, or other organization that provides som the plan? (See instructions.)	ne or all of	the benefits under	10e		X				
f	Has the plan failed to provide any benefit when due under the pla	ın?		10f		X				
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		Χ				
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)			10h		X				
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10	he require	d notice or one of the	10i						

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Part	VI	Pension Funding Compliance					
11		s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and con 5500) and line 11a below)					es No
11a	Ente	r the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		. 11a			
12		is a defined contribution plan subject to the minimum funding requirements of section 412 of the Co			f		es X No
	(If "	A?				🖰	
а		raiver of the minimum funding standard for a prior year is being amortized in this plan year, see inst ing the waiver		nd enter t Day		of the lette Year _	r ruling
If	you co	ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 1	3.				
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			
	Subt	ract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the letive amount)	eft of a	12d			
е	Will t	he minimum funding amount reported on line 12d be met by the funding deadline?		. 🔲	Yes	No	N/A
Part	VII	Plan Terminations and Transfers of Assets					
13a	Has a	a resolution to terminate the plan been adopted in any plan year?			Yes	s X N	0
	If "Y€	es," enter the amount of any plan assets that reverted to the employer this year		. 13a			
b		e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or broug		e 		Yes X	No
С		rring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identif h assets or liabilities were transferred. (See instructions.)	fy the plan(	s) to			
	13c(1)	Name of plan(s):	13c(2	<b>2)</b> EIN(s)		13c(3	<b>)</b> PN(s)
Part	VIII	Trust Information					
14a	Name	of trust		14b	Trust's E	ΞIN	
14c	Name	of trustee or custodian				s or custodi ne number	an's
Par	t IX	IRS Compliance Questions					
15a	Is the	plan a 401(k) plan? If "No," skip b	Yes			No	
15b		did the plan satisfy the nondiscrimination requirements for employee deferrals under section (3) for the plan year? Check all that apply:		gn-based harbor	d [	"Prior ye test	ar" ADP
			Gur ADP	rent year test	,"	N/A	
16a		testing method was used to satisfy the coverage requirements under section 410(b) for the plan Check all that apply:	Rat perd test	centage		verage enefit test	□ N/A
16b		ne plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) be plan year by combining this plan with any other plan under the permissive aggregation rules?	Yes			No	
	the le		<u>'</u>				
	letter		nter the date	e of the n	nost rec	ent determi	nation
18	Were	ed Benefit Plan or Money Purchase Pension Plan Only: any distributions made during the plan year to an employee who attained age 62 and had not sepa		Ye	s [	No	
19	Was	any plan participant a 5% owner who had attained at least age 70 $\frac{1}{2}$ during the prior plan year?	•••••	. Ye	s	No	

## 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

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

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning	A This return/report is for:    a multiple-employer plan   a multiple-employer plan   that from the checking this box must last of participant plan   a foreign plan   a short plan year return/report (less than 12 months)	attach a
B This return/report is.	B This return/report is	CONTROL DESCRIPTION OF THE PROPERTY OF THE PRO
B This return/report is the first return/report the final return/report the final return/report (less than 12 months)  C Check box if filing under. Form 5558 automatic extension DFVC program special extension (enter description)  Part II Basic Plan Information—enter all requested information  1 b Three-digit plan number (PN) \$ 001  1 c Effective date of plan (PN) \$ 001  2 a Plan sponsor's name (employer, if for a single-employer plan) (PN) \$ 001  2 a Plan sponsor's name (employer, if for a single-employer plan) (PN) \$ 001  2 a Plan sponsor's name (employer, if for a single-employer plan) (PN) \$ 001  2 a Plan sponsor's name (employer, if for a single-employer plan) (PN) \$ 001  2 a Plan sponsor's name (employer, if for a single-employer plan) (PN) \$ 001  2 a Plan sponsor's name (employer, if for a single-employer plan) (PN) \$ 001  2 b Employer Identification Number (EN) 61135535  2 c Sponsor's telephone number (EN) 61135535  2 c Sponsor's telephone number (S 59) 887-1188  2 d Business code (see instructions 541940  3 plan administrator's name and address Same as Plan Sponsor.  3 b Administrator's EIN  3 plan administrator's name and address Same as Plan Sponsor.  4 if the name and/or EIN of the plan sponsor has changed since the last return/report fliad for this plan, enter the name, EIN, and the plan number from the last return/report.  3 ponsor's name  5 a Total number of participants at the beginning of the plan year.  5 a Total number of participants at the off the plan year.  5 a Total number of participants at the beginning of the plan year.  5 a Total number of participants at the beginning of the plan year.  5 a Total number of participants at the beginning of the plan year.  5 a Total number of participants at the end of the plan year.  5 a Coll of participants that terminated employment during the plan year.  5 a Coll of participants at the order participants at the end of the plan year.  5 a Coll of participants at the coll of the plan year.  5 a Coll of participants at the coll of the plan year.  5 a	B This return/report is	
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a short plan year return/report (less than 12 months)  C Check box if filing under:  Form \$558  under plan    Sepecial extension (enter description)  Part II Sasic Plan Information—enter all requested information  1a. Name of plan  CCAN VETERINARY CLINIC, PSC  OF 1/1 SHARINS FLAN  2a Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room, ept., suite no. and street or P.O. Box)  CRY or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  CCAN VETERINARY CLINIC, PSC  CRY or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  CCAN VETERINARY CLINIC, PSC  101 NORTH MAIN STREET  ICHOLASVILLE  XY 40356  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN  3c Administrator's telephone number (459) 887-1188  4f If the name and/or EIN of the plan sponsor has changed since the last return/report flied for this plan, enter the name, EIN, and the plan number from the last return/report.  2 Sponsor's name  4 If the name and/or EIN of the plan sponsor has changed since the last return/report flied for this plan, enter the name, EIN, and the plan number from the last return/report.  5 Total number of participants at the beginning of the plan year.  5 Number of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the beginning of the plan year.  5 Continued of participants at the end of the plan year.  5 Continued of participants at the end of the plan year.  5 Continued of participants at the end of	en emended return/report   a short plan year return/report (less than 12 months)   C Check box if filing under   Form 5558   automatic extension   DFVC program	
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Part II Basic Plan Information—enter all requested information  1a Name of plan  (CCAW VETERINARY CLINIC, PSC  (PN) > 501  1c Effective date of plan number (PN) / 501  1c Effective date of plan 09/01/1999  2a Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room, apt., suite no. and street, or P.O. Box)  CCAW VETERINARY CLINIC, PSC  (EIN) 61-1352535  2c Sponsor's telephone number (EIN) 9 of 1-1352535  2c Sponsor's telephone number (253) 837-1188  2d Business code (see instructions 541940  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's telephone num for 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.  3 Sponsor's name  5 Total number of participants at the beginning of the plan year.  5 Total number of participants at the end of the plan year.  5 Total number of participants at the beginning of the plan year.  5 Total number of participants at the beginning of the plan year.  5 C Number of participants at the beginning of the plan year.  5 C Number of participants at the beginning of the plan year.  5 C Number of participants at the beginning of the plan year.  5 C Number of participants at the beginning of the plan year.  5 D Total number of active participants at the beginning of the plan year.  5 D Total number of active participants at the beginning of the plan year.  5 D Total number of active participants at the beginning of the plan year.  5 D Total number of active participants at the end of the plan year.  5 D Total number of active participants at the beginning of the plan year with accrued benefits that were less to the plan year with accrued benefits that were less to the plan year with accrued benefits that were less to perform and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Scheck Bor Schedule MB completed and signed by an enrolled actuar	Part II Basic Plan Information—enter all requested information  1a Name of plan  1a Name of plan  1a Name of plan  1b Three-digit plan number (PN) > 1c Effective date of plan number (PN) > 1c Effective date of plan number (PN) > 1c Effective date of plan 09/01/1993  2a Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room, apt. suite no. and street, or P.O. Box)  City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  CCAN VETERINARY CLINIC, PSC  10 NORTH MAIN STREET  ICHOLASVILLE  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN  3c Administrator's EIN  3c Administrator's telepit aname. EIN, and the plan number from the last return/report.  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.  4 EN PN  5 Total number of participants at the beginning of the plan year.  5 D Total number of participants with account balances as of the end of the plan year.  5 D Total number of participants with account balances as of the end of the plan year.  5 D Total number of participants that terminated employment during the plan year with accound benefits that were less than 100% vested.  6 Number of participants that terminated employment during the plan year with accound benefits that were less than 100% vested.  6 Number of participants that terminated employment during the plan year with accound benefits that were less than 100% vested.  6 Number of participants that terminated employment during the plan year with accound benefits that were less than 100% vested.  6 Number of participants that terminated employment during the plan year with accound benefits that were less than 100% vested.  6 Number of participants with account balances as of the plan year.  6 Number of participants that terminated employment during the plan year with account benefits that were less to the n	
18 Name of plan  CCAW VETERINARY CLINIC, PSC  O1 (K) PROFIT SHARING PLAN  10 C Effective date of plan  O9 O1/1999  28 Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room, apt. suite no, and street, or P.O. Box)  City or fown, state or protince, country, and ZIP or foreign postal code (if foreign, see instructions)  ICCAW VETERINARY CLINIC, PSC  CLORN VETERINARY CLINIC, PSC  O1 NORTH MAIN STREET  ICHOLASVILLE  39 Plan administrator's name and address Same as Plan Sponsor.  30 Administrator's telephone number  (859) 887-1188  2d Business code (see instructions 541940  31 Plan administrator's name and address Same as Plan Sponsor.  30 Administrator's telephone num  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.  2 Sponsor's name  3 Total number of participants at the beginning of the plan year.  5 Total number of participants at the end of the plan year.  5 Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete file is term).  4 If the name and/or EIN of the plan propose is the end of the plan year.  5 Total number of participants at the end of the plan year.  5 Total number of participants that terminated employment during the plan year with accrued benefits that were less then 100% vested.  5 Total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.  5 Total number of participants that terminated employment during the plan year with accrued benefits the were less than 100% vested.  5 Total number of participants that terminated employment during the plan year with accrued benefits the were less than 100% vested.  5 Total number of participants that terminated employment during the plan year with accrued benefits the were less to generally and the plan year including, if applicable, a Schet Bor Schedule M	18 Name of plan CCAW VETERINARY CLINIC, PSC OIT (X) PROFIT SHARING PLAN 10 (Effective date of plan O9/01/1399 28 Plan sponsor's name (employer, if for a single-employer plan) Maling address (include room, apt., suite ob., and street, or P.O. Box) City of town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) CCAW VETERINARY CLINIC, PSC CCAW VETERINARY CLINIC, PSC CCAW VETERINARY CLINIC, PSC TICHOLASVILLE 39 Plan administrator's name and address SS Same as Plan Sponsor.  KY 40356 30 Administrator's name and address SS Same as Plan Sponsor.  30 Administrator's telepit The name, EIN and the plan number from the last return/report. 31 Administrator's telepit 32 Total number of participants at the beginning of the plan year.  53 Total number of participants at the beginning of the plan year (only defined contribution plans complete this ltem) 54 Complete this ltem) 55 Complete this ltem) 56 Complete this ltem) 57 Cotal number of active participants at the beginning of the plan year 58 Complete this ltem) 59 Complete this ltem) 50 Complete this ltem) 5	
## PROFIT SHARING PLAN    PROFIT SHARING PLAN   PROFIT SHARING PLAN   1	Pict   ROCAW VETERINARY CLINIC, PSC   Pict   ROFIT SHARING PLAN   To Effective date of plan 09/01/1399	
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) CICAW VETERINARY CLINIC, PSC  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign, see instructions)  CICAW VETERINARY CLINIC, and ZIP of foreign pseudone instructions of filed for this plan under clinic pseudone instructions of filed for this plan under clinic pseudone instructions of filed for this plan under clinic pseudone instructions of filed for this plan under clinic pseudone instructions of filed for this plan under cli	2a Plan sponsor's name (employer, if for a single-employer plan)  Mailing address (include room apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  ICCAW VETERINARY CLINIC, PSC  CCAW VETERINARY  CCAW VETERI	
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B 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 a elief, it is true, correct, and complete.  WILL MCCAW, DVM  Signature of plan administrator  Date  Enter name of individual signing as plan administrator	B 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 knielief, it is true, correct, and complete.  WILL MCCAW, DVM  Signature of plan administrator  Date  Enter name of individual signing as employer or individual signing as	
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	repairs a name (modeling in many, it apparease) and address (include room or suite number)	e, a Schedul iowledge and istrator
JUN 1	Signature of employer/plan sponsor Date Enter name of individual signing as employer or	
	Treparer a telephone nu	e, a Schedul lowledge and istrator

a		

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Form	220	U-01	ZUI	b

	all of the plan's assets during the plan year invested in eligible	e assets? (	See instructions.)		********				MI	es No
b Are yo	ou claiming a waiver of the annual examination and report of a	an independ	lent qualified public ac	counta	nt (IQF	PA)			X Y	es No
under	29 CFR 2520.104-46? (See instructions on waiver eligibility a answered "No" to either line 6a or line 6b, the plan cann	and conditio	ns.)	inetası	d nea l	-orm	5500		Ы'	es 🖺 140
- If you	plan is a defined benefit plan, is it covered under the PBGC in	ot use ron	aram (see ERISA ser	tion 40	2112	П	Yes [	No [	Not d	letermined
		surance pro	ogram (see ENGA see	70017 40		'''' U	100	J,,,, T	J /100.0	
Part III	Financial Information									
7 Plan	Assets and Liabilities		(a) Beginning o				(b	) End o	~~~	
a Total	plan assets	7a	<u>.</u> ,.	17,9	80				1,	256,010
	plan liabilities	7b								
c Net p	lan assets (subtract line 7b from line 7a)	7c	1,	17,9	808				1,	256,010
	ne, Expenses, and Transfers for this Plan Year		(a) Amount	egen Mar		1.11		(b) To	ital	
	ibutions received or receivable from:	8a(1)		13,5	,35					
	mployers	8a(2)		49,9						
	Participants			101						
	Others (including rollovers)	8a(3)		741	0.5					
	income (loss)	8b		74,!	000					
	income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c								138,102
	fits paid (including direct rollovers and insurance premiums ovide benefits)	8d								
No. of the Control of	in deemed and/or corrective distributions (see instructions)	8e		5210721						
ano sa Sasantin Israelia ili.	nistrative service providers (salaries, fees, commissions)	8f								
	r expenses	8g	grade de la companya							
9 011.01										
h Total	evnences (add lines 8d 8e 8f and 8g)									
	expenses (add lines 8d, 8e, 8f, and 8g)	8h								120 10
i Net ir	ncome (loss) (subtract line 8h from line 8c)	81								138,10
i Net ir j Trans	ncome (loss) (subtract line 8h from line 8c)									138,10
i Net in j Trans	ncome (loss) (subtract line 8h from line 8c)sfers to (from) the plan (see instructions)	8i 8j								
i Net ir j Trans Part IV 9a If the	Plan Characteristics e plan provides pension benefits, enter the applicable pension	8i 8j	des from the List of Pla	an Cha	racteri	stic Co	odes in	the inst	ructions	
i Net ir j Trans Part IV 9a If the	ncome (loss) (subtract line 8h from line 8c) sfers to (from) the plan (see instructions)	8i 8j feature coo								
i Net ir j Trans Part IV 9a If the	Plan Characteristics e plan provides pension benefits, enter the applicable pension	8i 8j feature coo								
i Net ir j Trans Part IV 9a If the	recome (loss) (subtract line 8h from line 8c)  Sifers to (from) the plan (see instructions)	8i 8j feature coo								
i Net ir j Trans Part IV 9a If the b If the	Plan Characteristics e plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2T 3D e plan provides welfare benefits, enter the applicable welfare to	8i 8j feature coo			acteris				uctions:	
i Net ir j Trans Part IV 9a If the b If the Part V 10 Dur	procome (loss) (subtract line 8h from line 8c)  Sers to (from) the plan (see instructions)	8i 8j feature code	es from the List of Pla			tic Coo	les in t			
i Net ir j Trans Part IV 9a If the b If the Part V 10 Dur a Wa de	plan Characteristics e plan provides pension benefits, enter the applicable pension e plan provides welfare benefits, enter the applicable welfare to compliance Questions  Compliance Questions ing the plan year: s there a failure to transmit to the plan any participant contribusoribed in 29 CFR 2510.3-102? (See instructions and DOL's Neglects to (from the plan to (from	8i 8j feature code teature code utions withir	es from the List of Pla the time period iduciary Correction		acteris	No.	les in t		uctions:	
i Net ir j Trans Part IV 9a If the b If the Part V 10 Dur a Wa de Pre	plan Characteristics e plan provides pension benefits, enter the applicable pension e plan provides welfare benefits, enter the applicable welfare to compliance Questions  Compliance Questions In the plan year: In the plan year: In the plan any participant contribution of the plan and policy of th	8i 8j feature code	es from the List of Pla n the time period iduciary Correction		acteris	tic Coo	les in t		uctions:	
i Net ir j Trans Part IV 9a If the b If the Part V 10 Dur a Wa de Pro b We	plan Characteristics e plan provides pension benefits, enter the applicable pension a plan provides welfare benefits, enter the applicable welfare to compliance Questions  Compliance Questions Ting the plan year. Is there a failure to transmit to the plan any participant contribution of the plan 29 CFR 2510.3-102? (See instructions and DOL's voogram)	feature code  determined the second s	es from the List of Pla	n Chara	acteris	No X	les in t		uctions:	
i Net ir j Trans Part IV 9a If the b If the Part V 10 Dur a Wa de Pro b We rep	come (loss) (subtract line 8h from line 8c)  Sers to (from) the plan (see instructions)	feature code stions within Voluntary First (Do not in the code)	es from the List of Pla in the time period iduciary Correction include transactions	10a	Yes	No.	les in t		uctions:	unt
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Part VI Pension Funding Compliance				
11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and comp (Form 5500) and line 11a below)				Yes No
11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		1a		
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code ERISA?		302 of		Yes No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)  a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions granting the waiver		nter th	e date of	the letter ruling Year
If you 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		12b		
C 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 (enter a minus sign to the left negative amount)	ofa	12d		
e Will the minimum funding amount reported on line 12d be met by the funding 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?			Yes	X No
If "Yes," 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 control of the PBGC?	t under the			Yes X No
c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)		to		
13c(1) Name of plan(s):	13c(2)	EIN(s)		13c(3) PN(s)
				9-1
Part VIII Trust Information				
14a Name of trust		14b	Trust's E	IN
14c Name of trustee or custodian				s or custodian's ne number
Part IX IRS Compliance Questions				
<b>15a</b> Is the plan a 401(k) plan? If "No," skip b	Yes			No
15b How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:			L	"Prior year" ADP test
	ADP 1		r' [	N/A
16a What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:	Ratio	entage		verage enefit test N/A
<b>6b</b> Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?	Yes	÷		No
17a If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS of the letter and the serial number.	pinion lette	or adv	risory let	ter, enter the date of
17b If the plan is an individually-designed plan that received a favorable determination letter from the IRS, ent letter	ter the date	of the	most rec	ent determination
Defined Benefit Plan or Money Purchase Pension Plan Only:  Were any distributions made during the plan year to an employee who attained age 62 and had not separ service?		Δ	ÐS	No
19 Was any plan participant a 5% owner who had attained at least age 70 ½ during the prior plan year?		Y	es	No