## 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.

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

ı	Part I	Annual Repor	t identification information							
•	For calendar plan year 2017 or fiscal plan year beginning 01/01/2017 and ending 12/31/2017									
	A This ref	turn/report is for:	X a single-employer plan		olan (not multiemployer) ( mployer information in ac	_				
			a one-participant plan	a foreign plan	1 1/1		,			
	<b>B</b> This retu	urn/report is	the first return/report	the final return/report						
			an amended return/report	a short plan year retu	ırn/report (less than 12 m	onths)				
	C Check	box if filing under:	Form 5558	automatic extension		DFVC progra	am			
1		T =	special extension (enter desc							
I	Part II	Basic Plan Inf	ormation—enter all requested in	formation		T -				
	1a Name AC KREBS	•	OFIT SHARING PLAN & TRUST			1b Three-dig plan num (PN) ▶				
						1c Effective	date of plan 01/01/2015			
•			loyer, if for a single-employer plan)			<b>2b</b> Employer	Identification Number			
			om, apt., suite no. and street, or P.C nce, country, and ZIP or foreign posi		etructions)	(EIN)	61-0413811			
,	A C KREBS		ice, country, and zir or loreign posi	tai code (ii foreign, see ins	aructions)		s telephone number 02-367-6431			
						2d Business	code (see instructions)			
	4000 CRITTI LOUISVILLE	ENDEN DRIVE					327300			
		,, 111 10200								
3a Plan administrator's name and address X Same as Plan Sponsor.							ator's EIN			
						3c Administra	ator's telephone number			
						7 Administr	ator o telepriorie namber			
			he plan sponsor or the plan name he consor's name, EIN, the plan name a			4b EIN				
		or's name	onoor o namo, Env, mo plan namo e	and the plan number nem	ano laot rotam/roporti	4d PN				
	C Plan N	lame								
	_					<b>F</b> -	11			
	_		ts at the beginning of the plan year.			5a				
			ts at the end of the plan year			5b	12			
			h account balances as of the end of			5c 5d(1)	8			
d(1) Total number of active participants at the beginning of the plan year							11			
d(2) Total number of active participants at the end of the plan year							11			
Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested										
	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									
I		Filed with authorize		07/24/2018	WILLIAM GLASSCOO	rk				
HERE							lon administrator			
	OLON:	Signature of plan	auministrator	Date	Enter name of individ	uai signing as pl	an auministrator			
	SIGN HERE	Signature of own	lover/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor					
		L SIGNATURE OF EMP			- Emericante orionivio	uai sidiiilid as Ar	TOPOVEL OF DIAD SOCIETY			

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6a	6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)							X Yes No
b	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)							
	If you answered "No" to either line 6a or line 6b, the plan cann							X Yes   No
С	If the plan is a defined benefit plan, is it covered under the PBGC in	nsurance p	orogram (see ERISA se	ection 4	021)?		Yes No	Not determined
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC p	remium filing for this pl	lan yea	r			(See instructions.)
Pa	rt III Financial Information							
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End	l of Year
а	Total plan assets	7a	1	17147				29653
b	Total plan liabilities	7b						
С	Net plan assets (subtract line 7b from line 7a)	7c	1	17147				29653
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b)	Total
<u>а</u>	Contributions received or receivable from: (1) Employers	. 8a(1)						
	(2) Participants	8a(2)		9733				
	(3) Others (including rollovers)	8a(3)						
b	Other income (loss)	8b		2773				
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						12506
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d						
е	Certain deemed and/or corrective distributions (see instructions)	. 8e						
f	Administrative service providers (salaries, fees, commissions)	8f						
g	Other expenses	8g						
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						12506
<u>j</u>	Transfers to (from) the plan (see instructions)	8j						
Par	t IV Plan Characteristics							
9a	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2T 3D	feature co	odes from the List of Pla	an Cha	racteri	stic Co	des in the ins	structions:
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Plan	n Chara	cterist	tic Cod	les in the inst	ructions:
Par	t V Compliance Questions							
10	During the plan year:				Yes	No		Amount
а	Was there a failure to transmit to the plan any participant contribudescribed in 29 CFR 2510.3-102? (See instructions and DOL's V							
	Program)			10a		X		
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		X		
С				10c	X			100000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	fidelity bo	nd, that was caused	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 plan	n?		10f		X		
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		X		
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			10i				
			•					

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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 complete Sch (Form 5500) and line 11a below)	nedule S	B	Y	′es X No				
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	. 11a							
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, as applicable.)									
а	<b>a</b> If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver								
lf y	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							
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 (enter a minus sign to the left of a negative amount)	12d							
е	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?		Ye	s X N	0				
	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 under the control of the PBGC?			Yes X	No				
С	<b>c</b> If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)								
<b>13c(1)</b> Name of plan(s): <b>13c(2)</b> I				13c(3	<b>)</b> PN(s)				

## 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.

OMB Nos. 1210-0110 1210-0089

2017

This Form is Open to Public Inspection

For calendar plan year 2017 or fiscal plan year beginning 0101/2017  A This return/report is for:  a one-participant plan a namended return/report a short plan year return/report (less than 12 months)  C Check box if filing under:   Form 5558	Part I	Annual Report	Identification Information	1		and anding 1019	1/2017	1	
A This return/report is for:    a one-participant plan   a foreign	For calendar	plan year 2017 or f	iscal plan year beginning 01/01/20	17		and ending 12/3	1/201/	hooking this ha	v must attach a
B This return/report is	A This retur	n/report is for:		_ list o	of participating emplo	(not multiemployer) (i oyer information in ac	cordar	nce with the form	instructions.)
C Check box if filing under: Form 5558   automatic extension   DFVC program    Part II   Basic Plan Information—enter all requested information   1a Name of plan   AC Krebs Co., Inc. 401(k) Profit Sharing Plan & Trust    2a Plan sponsor's name (employer, if for a single-employer plan)   City or town, state or province, country, and 2IP or foreign postal code (if foreign, see instructions)   4 C Krebs Co., Inc. 401(k) Profit Sharing Plan & Trust    2a Plan sponsor's name (employer, if for a single-employer plan)   City or town, state or province, country, and 2IP or foreign postal code (if foreign, see instructions)   4 C Krebs Co., Inc.   4 C Krebs Co., Inc.   4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan page in the plan year in the plan y	D This was to	lean art in	<u> </u>						
C Check box if filing under:	<b>b</b> This return	report is	Ц						
Special extension (enter description)   Part II   Basic Plan Information — enter all requested information   1a Name of plan   AC Krebs Co., Inc. 401(k) Profit Sharing Plan & Trust   1c Effective date of plan   C Plan Name of plan   C Plan Sponsor's name (employer, if for a single-employer plan)   Mailing address (include room, apt., suite no. and street, or P.O. Box)   Cily or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)   2c Employer Identification Number (S02) 367-6431   2d Business code (see instructions)   327300   367-6431   2d Business code (see instructions)   327300   367-6431   2d Business code (see instructions)   327300   3d Administrator's telephone number   S02) 367-6431   3			an amended return/report	a sho	ort plan year return/n	eport (less than 12 m	ontns)		
Part II   Basic Plan Information—enter all requested information   1a Name of plan   AC Krebs Co., Inc. 401(k) Profit Sharing Plan & Trust   1c Effective date of plan or (PN)   001     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)   2b Employer Identification Number (EIN) 61-0413811     2c Sponsor's telephone number (So2) 367-8431     2d Business code (see instructions)   327300     3a Plan administrator's name and address   Same as Plan Sponsor.   3b Administrator's telephone number (so2) 367-367     4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report a Sponsor's name   Plan Name   5a Total number of participants at the beginning of the plan year   5b 12     5a Total number of participants at the end of the plan year   5c 8   12     5b Total number of participants with account balances as of the end of the plan year   5d(1) 11     6c Number of participants with account balances as of the plan year   5d(2) 11     6c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested   15d(2) 11     6c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested   15d(2) 11     6c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested   15d(2) 11     6c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested   15d(2) 11     6c Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested   15d(2) 11     6c Number of participants who ter	C Check bo	x if filing under:			matic extension		DF	VC program	
18	112 11 14 CA - 14						- 11		
Plan number of plan	Part II	Basic Plan Inf	ormation—enter all requested in	nformation			1h	Three-digit	
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apl., sulle no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) A C Krebs Co., Inc.  4000 Crittenden Drive Louisville, KY 40209 3a Plan administrator's name and address \(\times\) Same as Plan Sponsor.  4b If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year.  b Total number of participants with account balances as of the end of the plan year (only defined contribution plans complete this liem).  d(1) Total number of active participants at the beginning of the plan year.  d(2) Total number of participants at the beginning of the plan year.  e Number of participants with account balances as of the end of the plan year.  b Unumber of participants at the beginning of the plan year.  d(2) Total number of active participants at the beginning of the plan year.  e Number of participants with account balances as of the end of the plan year.  b Unumber of participants at the beginning of the plan year.  c Number of participants with account balances as of the end of the plan year.  d(2) Total number of active participants at the beginning of the plan year.  e Number of participants with account balances as of the end of the plan year.  5c Section (SD) Administrator's telephone number (SD) 367-0431  2d Business code (see instructions) 327300  4d PN  4d PN  5a Total number of participants at the beginning of the plan year.  5b 12  6c Sponsor's name (SD) Administrator's telephone number (SD) Administrator's telephone number (SD) 367-0431  2d Business code (see instructions) 327300  4d PN  4d PN			or . Die 6 Teach						001
2a Plan sponsor's name (employer, if for a single-employer plan) Mailling 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) A C Krebs Co., Inc.  2b Employer Identification Number (EIN) 61-0413811 2c Sponsor's telephone number (502) 367-6431 2d Business code (see instructions) 327300  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN 3c Administrator's telephone number (502) 367-6431 3c Administrator's telephone number (502) 367-6431 3d Plan administrator's name and address Same as Plan Sponsor.  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year	AC Krebs Co.	, Inc. 401(k) Profit 8	Sharing Plan & Trust						VI ITOMAN
Alling 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)  A C Krebs Co., Inc.  4000 Crittenden Drive  Louisville, KY 40209  3a Plan administrator's name and address Same as Plan Sponsor.  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  Sponsor's name Plan Name  5a Total number of participants at the beginning of the plan year. C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  d(1) Total number of active participants at the beginning of the plan year.  d(2) Total number of active participants at the head of the plan year.  e Number of participants with account balances as of the end of the plan year.  d(2) Total number of active participants at the head of the plan year.  e Number of participants with account balances as of the end of the plan year.  d(2) Total number of active participants at the head of the plan year.  e Number of participants with account balances as of the end of the plan year.  d(2) Total number of active participants at the head of the plan year.  5b Sd(2) 11  5c Sd(2) 11  5c Sd(2) 11  5c Sd(2) 11							1c		f plan
City or town, state or province, country, and ZIP or foreign postal code (it foreign, see instructions)  A C Krebs Co., Inc.  2c Sponsor's telephone number (502) 367-8431  2d Business code (see instructions) 327300  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN  3c Administrator's telephone number this plan, enter the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  a Sponsor's name  c Plan Name  5a Total number of participants at the beginning of the plan year	1 4 - Illian er	address (include re	om ant suite no and street or P.	O. Boxi			2b		
2d Business code (see instructions) 327300	City or t	own, state or provir	nce, country, and ZIP or foreign pos	stal code (i	if foreign, see instruc	ctions)	2c		
Louisville, KY 40209   3b Administrator's name and address   Same as Plan Sponsor.   3b Administrator's EIN   3c Administrator's telephone number   3c Administrator's telephone number   3d Administrator's telephone numbe							2d		(see instructions)
3a Plan administrator's name and address Same as Plan Sponsor.  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year	4000 Crittend	en Drive							
3a Plan administrator's name and address ☑ Same as Plan Sponsor.  3b Administrator's telephone number of participants at the end of the plan year complete this item)  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year	Louisville, KY	40209							
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  a Sponsor's name c Plan Name  5a Total number of participants at the beginning of the plan year	3a Plan ad	ministrator's name	and address X Same as Plan Spo	onsor.			3b	Administrator's	EIN
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return report.  a Sponsor's name c Plan Name  5a 11  b Total number of participants at the beginning of the plan year								Administrator	tologilene names
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return report.  a Sponsor's name c Plan Name  5a 11  b Total number of participants at the beginning of the plan year	4 If the n	ame and/or EIN of	the plan sponsor or the plan name	has chang	ged since the last ret	urn/report filed for	4b	EIN	
a Sponsor's name c Plan Name  5a 11  b Total number of participants at the beginning of the plan year	this pla	an, enter the plan s	ponsor's name, EIN, the plan name	e and the p	olan number from the	last return/report.	4d	PN	
Total number of participants at the beginning of the plan year									
b Total number of participants at the end of the plan year								ia	11
b Total number of participants at the end of the plan year.  c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)									12
d(1) Total number of active participants at the beginning of the plan year	c Numbe	er of participants wi	th account balances as of the end	of the plan	year (only defined of	contribution plans			. 8
d(1) Total number of active participants at the beginning of the plan year  d(2) Total number of active participants at the end of the plan year	compl	ete this item)		nlan year			50	1(1)	11
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	d(1) Total number of active participants at the beginning of the plan year						-		11
than 100% vested	Number of participants who terminated employment during the plan year with accrued benefits that were less							5e	0
Caution: A penalty for the late of incomplete ming of this retarmine of the second of	than '	100% vested			will be accessed i	inless reasonable c	ause i	s established.	
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, it appreciately a set of the penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, it appreciately a set of the penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, it appreciately a set of the penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, and to the best of my knowledge and set of the penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, and to the best of my knowledge and set of the penalties of penalties of penalties of penalties set forth in the instructions, I declare that I have examined this return/report, and to the best of my knowledge and set of the penalties of penalt	Under pena SB or Sche	alties of perjury and	l other penalties set forth in the inst d and signed by an enrolled actuary						licable, a Schedule ny knowledge and
belief, it is true, correct, and complete.  SIGN 1/2 Plan Affassor 7-74-18 WILLIAM GLASSCOCK		0 1-110	om Allessor		7-24-18	WILLIAM GLASSCO	CK		
HERE Signature of plan administrator Date Enter name of individual signing as plan administrator	CONT CONT.	Ch C				Enter name of indiv	idual s	igning as plan a	dministrator
SIGN	SIGN								
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan spons  For Paperwork Reduction Act Notice, see the Instructions for Form 5500-SF.  Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor v.170	HERE	Signature of em	ployer/plan sponsor		Date	Enter name of indiv	idual s	signing as emplo	yer or plan sponsor Form 5500-SF (2017

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Pa	30	ıe	~

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COLL	SOUU	-31	201	1

_	the state of the s	e assets?	See instructions.)					X Yes No	
b A	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)  Under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)  If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.								
- 1	f you answered "No" to either line 6a or line 6b, the plan canno	ot use Forr	n 5500-SF and must i	iss 40'	24/2		as $\square$ No	Not determined	
C I	the plan is a defined benefit plan, is it covered under the PBGC in	surance pro	ogram (see ERISA sect	ion 40	21)?	□ ''	es 🗆 Ino	. (See instructions.)	
1	f "Yes" is checked, enter the My PAA confirmation number from the	PBGC pre	emium filing for this plan	n year_	-			. (See Instructions.)	
Par	III Financial Information								
	Plan Assets and Liabilities	11 10 5 10	(a) Beginning of	Year			(b) End	of Year	
	Fotal plan assets	7a		17147				29653	
	Fotal plan liabilities	7b							
	Net plan assets (subtract line 7b from line 7a)	7c		17147	7			29653	
	ncome, Expenses, and Transfers for this Plan Year		(a) Amount				(b) <sup>-</sup>	Total	
8 a	Contributions received or receivable from:								
а	(1) Employers	8a(1)		070	_	- (c)	A 1 1 1 1 1	Name of the state	
	(2) Participants	8a(2)		973	3	196 29			
	(3) Others (including rollovers)	8a(3)			_		A TOTAL		
	Other income (loss)	8b		277	3			12506	
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	The Exposure of		+	10-7-5	E 11. NO.	12506	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d							
	Certain deemed and/or corrective distributions (see instructions)	8e				- 11/14	The state of		
	Administrative service providers (salaries, fees, commissions)	8f					Statement.		
	Other expenses	8g				111	163 201 4	an Et an John 1	
	Total expenses (add lines 8d, 8e, 8f, and 8g)			1					
	Net income (loss) (subtract line 8h from line 8c)			. T	72			12506	
<del>-                                    </del>	Transfers to (from) the plan (see instructions)					1-1	190	an balan a apply	
_ J		0							
Pai	t IV Plan Characteristics  If the plan provides pension benefits, enter the applicable pension	feature co	ides from the List of Pla	an Cha	racteri	stic Cod	es in the in	structions:	
9a	1 2E 2E 2G 21 2T 3D								
b	If the plan provides welfare benefits, enter the applicable welfare	feature cod	les from the List of Plar	Chara	acterist	ic Code	s in the inst	ructions:	
Par	t V Compliance Questions					г. т			
10	During the plan year:				Yes	No		Amount	
а	Was there a failure to transmit to the plan any participant contributes described in 29 CFR 2510.3-102? (See instructions and DOL's Program)	voluntary r	-iductary Correction	10a		×			
	Program)  Were there any nonexempt transactions with any party-in-interest	st? (Do not	include transactions			Х			
I.	reported on line 10a.)			10b	_				
	Was the plan covered by a fidelity bond?			10c	Х			10000	
-	Did the plan have a loss, whether or not reimbursed by the plan' by fraud or dishonesty?		***************************************	10d		Х			
-	Were any fees or commissions paid to any brokers, agents, or o carrier, insurance service, or other organization that provides so the plan? (See instructions.)	ther person me or all of	ns by an insurance f the benefits under	10e		х			
	Has the plan failed to provide any benefit when due under the plant failed to provide any benefit when due under the plant is a second to the plant to provide any benefit when due under the plant to pl	lan?		10f		Х			
	Did the plan have any participant loans? (If "Yes," enter amount	as of year-	-end.)	10g		Х			
	If this is an individual account plan, was there a blackout period 2520,101-3.)	? (See instr	ructions and 29 CFR	10h		Х	144		
-	If 10h was answered "Yes," check the box if you either provided exceptions to providing the notice applied under 29 CFR 2520.1	the require	ed notice or one of the	10i					

age	3-	1
age	3-	- 1

Part VI Pension Funding Compliance		
11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete S (Form 5500) and line 11a below)		
11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a	
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or sect ERISA?  (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	ion 302 c	of Yes X No
If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, a granting the waiver.  Month	nd enter Da	
If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.		1000
<b>b</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 of a negative amount)	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 under the control of the PBGC?		Yes No
c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan which assets or liabilities were transferred. (See instructions.)	(s) to	
13c(1) Name of plan(s): 13c	(2) EIN(s)	13c(3) PN(s)