Benefit Plan 2016 Benefit Plan 2016 Colspan="2">2016 Previous Bender This form is required to be filed under sections 0057(b) and 0058(a) of the Internal Revenue Code (the Code). 2018 Previous Bender This form is required to be filed under sections 0057(b) and 0058(a) of the Internal Revenue Code (the Code). 2018 Part I Annual Report Identification Information For calendar plan year 2018 or fiscal plan year beginning Complete all entries in accordance with the instructions to the Form 5500-SF. Part I Annual Report Identification Information an one-participant plan and ending 12/3/2018 A mise return/report is for: a none-participant plan a foreign plan B This return/report is be first return/report the first return/report the first return/report In the first return/report (less than 12 months) C Check box if filing under: plan aponsor's name (employer, if for a single-employer plan) mating 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) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see inst
Empire Briefle Secury Administrator's name and address
Part I Complete all entries in accordance with the instructions to the Form 5500-SF. Part I Annual Report Identification Information For calendar plan year 2018 or fiscal plan year beginning a single-employer plan an enultiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) A This return/report is for: a one-participant plan a foreign plan B This return/report is the first return/report the first return/report a short plan year return/report (less than 12 months) C Check box if filing under: Form 5558 automatic extension DFVC program B special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan MAMES B. HUTCHINSON, D.D.S., P.S. 401(K) PLAN 1b Three-digit plan number (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) 2b Employer Identification Number (EIN) 91-1154433 2c Sponsor's telephone number 360-043-8111 2d Business code (see instructions) 3c Administrator's telephone number 360-043-8111 2d Business code (see instructions) Gas and address [N Administrator's telephone number 360-043-8111] 3c Administrator's telepho
For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018 A This return/report is for: a single-employer plan a multiple-employer plan (molton multimemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) B This return/report is a one-participant plan a foreign plan B This return/report is the first return/report the first return/report a short plan year return/report B This return/report is Form 5558 automatic extension DFVC program Part II Basic Plan Information—enter all requested information 1b Three-digit plan number (PN) ▶ 001 1c Effective date of plan 010/1/1989 001 1c Effective date of plan 01/01/1989 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) 2b Employer Identification Number (EIN) 91-1154433 2c Sponsor's telephone number 360-943-6111 2d Business code (see instructions) 621210 3a Plan administrator's name and address is Same as Plan Sponsor. 3b Administrator's telephone number 360-943-6111
A This return/report is for: a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) B This return/report is a one-participant plan a foreign plan C Check box if filing under: Form 5558 automatic extension DFVC program g special extension (enter description) peried extension (enter description) DFVC program 001 Ta Name of plan AMES B. HUTCHINSON, D.D.S., P.S. 401(K) PLAN 1b Three-digit plan number (EIN) 001 C Part II Basic Plan Information—enter all requested information 1c Effective date of plan 01/01/1989 2a Plan sponsor's name (employer, if for a single-employer plan) Maling address (include room, apt., suite no. and street, or P.O. Box) 2b Employer Identification Number (EIN) C Sponsor's telephone number 360-943.6111 2d Business code (see instructions) 2c Sponsor's telephone number 360-943.6111 2d Business code (see instructions) 621210 621210 3c Administrator's telephone number 360-943.6111 3d Plan administrator's name and address [S Same as Plan Sponsor. 3b Administrator's telephone number 360-943.6111 3c Administrator's telephone number 360-943.6111
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B This return/report is
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C C check box if filing under: Form 5558 automatic extension DFVC program Part II Basic Plan Information—enter all requested information Ib Three-digit plan number 1a Name of plan (PN) ▶ 001 Ic Effective date of plan AMES B. HUTCHINSON, D.D.S., P.S. 401(K) PLAN 1b Three-digit plan number 01/01/1989 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) 2b Employer Identification Number (EIN) 91-1154433 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2c Sponsor's telephone number 360-943-6111 2d Business code (see instructions) 621210 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 360-943-6111
Part II Basic Plan Information—enter all requested information 1a Name of plan Ib AMES B. HUTCHINSON, D.D.S., P.S. 401(K) PLAN 01 1c Effective date of plan Mailing address (include room, apt., suite no. and street, or P.O. Box) 01 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2c AMES B. HUTCHINSON, D.D.S., P.S. 360-943-6111 2d Business code (see instructions) AMES B. HUTCHINSON, D.D.S., P.S. 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 3c Administrator's telephone number
Part II Basic Plan Information—enter all requested information 1a Name of plan AMES B. HUTCHINSON, D.D.S., P.S. 401(K) PLAN 1b Three-digit plan number (PN) ▶ 001 1c Effective date of plan of information willing address (include room, apt., suite no. and street, or P.O. Box) (it y or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2b Employer Identification Number (EIN) 91-1154433 2c Sponsor's telephone number 360-943-6111 2d Business code (see instructions) 0 BOX 2619 0 BOX 2619 621210 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 360-943-6111
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AMES B. HUTCHINSON, D.D.S., P.S. 401(K) PLAN plan number (PN) ▶ 001 1c Effective date of plan 01/01/1989 01 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) 91-1154433 2c Sponsor's tlephone number 360-943-6111 2c Sponsor's tlephone number 360-943-6111 2d Business code (see instructions) 621210 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b 3c Administrator's telephone number 3c 3c Administrator's telephone number 3c
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AMES B. HOTCHINSON, D.D.S., P.S. 360-943-6111 2d Business code (see instructions) 0 BOX 2619 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number
O BOX 2619 ILYMPIA, WA 98507 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number
3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number
3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number
3c Administrator's telephone number
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.4b EIN
a Sponsor's name 4d PN
C Plan Name
5a Total number of participants at the beginning of the plan year
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)
d(1) Total number of active participants at the end of the plan year
e Number of participants who terminated employment during the plan year with accrued benefits that were less 5e 0
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.
SIGN Filed with authorized/valid electronic signature. 04/30/2019 JAMES B. HUTCHINSON
HERE Signature of plan administrator Date Enter name of individual signing as plan administrator
SIGN
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor For Parameter Reduction Act Nation are the Instructions for Earny FEOD SE Date Enter name of individual signing as employer or plan sponsor

For Paperwork Reduction Act Notice, see the Instructions for Form 5500-SF.

Form 5500-SF (2018) v.171027

6a b	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 cannot use Form 5500-SF and must instead use Form 5500.								
С	C If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined								
	If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)								
Pa	Part III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year					
а	Total plan assets	7a	1447953	1406360					
b			860	0					
С	Net plan assets (subtract line 7b from line 7a)	7c	1447093	1406360					
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total					
а			10000						
	(1) Employers	8a(1)	10038						
	(2) Participants	8a(2)	22842						

(Z) Participants	oa(2)	22042	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	-71850	
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		-38970
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1455	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	308	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		1763
i Net income (loss) (subtract line 8h from line 8c)	8i		-40733
j Transfers to (from) the plan (see instructions)	8j		
Part IV Plan Characteristics			

9a	If the	plan	provid	es pe	nsion	benef	its,	enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:	
								2K	

Part	V Compliance Questions				
10	During the plan year:		Yes	No	Amount
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		Х	
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		Х	
С	Was the plan covered by a fidelity bond?	10c	X		150000
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	
e	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?	10f		Х	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	Х		8037
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		Х	
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			

Page **3-** 1

Part	VI	Pension Funding Compliance						
11		nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and rm 5500) and line 11a below)			B		Yes	No
11a	Ent	er the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		11a				
12	ERI	his a defined contribution plan subject to the minimum funding requirements of section 412 of the C SA? "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)		n 302 o	f 	[Yes	X No
а		waiver of the minimum funding standard for a prior year is being amortized in this plan year, see institution the waiver.		l enter _ Da		e of the le		ing
lf	you d	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line	13.		-			
b	Ente	r the minimum required contribution for this plan year		12b				
С	Ente	r the amount contributed by the employer to the plan for this plan year		12c				
d		tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the ative 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	No	
	lf "Y	es," enter the amount of any plan assets that reverted to the employer this year		13a				
b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under control of the PBGC?						Yes	× N	0
С		luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident ch assets or liabilities were transferred. (See instructions.)	tify the plan(s)	to				
1	3c(1) Name of plan(s):	13c(2)	EIN(s)		130	:(3) PN	l(s)

For	m 5500-SF	Short Form Annual Re		of Small Emplo	yee	OMB Nos. 1210-0110 1210-0089
	rtment of the Treasury nal Revenue Service	D This form is required to be filed under	enefit Plan sections 104 and 40	65 of the Employee Re	tirement	2018
Employee Be	epartment of Labor enefits Security Administration enefit Guaranty Corporation	Income Security Act of 1974 (ERISA Reven), and sections 6057 ue Code (the Code).	(b) and 6058(a) of the I	nternal	This Form is Open to Public Inspection
		Complete all entries in accorda	ince with the instru	ctions to the Form 55	00-SF.	
Part		lentification Information	1 /0010	second second to be	10/2	1/2010
For calenda	ar plan year 2018 or fisc		1/2018	and ending		31/2018
A This ret	turn/report is for:					king this box must attach a ith the form instructions.)
B This retu	urn/report is r					
			final return/report hort plan year return/	report (less than 12 mc	onths)	
C Check	box if filing under:		tomatic extension		 □ DFVC p	rogram
	Γ.	special extension (enter description)		L		
Part II	Basic Plan Infor	nation—enter all requested informatio	n			
1a Name					1b Thre	e-digit
		N, D.D.S., P.S. 401(K) H	PLAN		plan (PN)	number
					1c Effect	ctive date of plan /01/1989
		er, if for a single-employer plan)				loyer Identification Number
City or	town, state or province,	, apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	ictions)) 91-1154433 nsor's telephone number
JAME	ES B. HUTCHINSO	N, D.D.S., P.S.				943-6111
PO E	30X 2619				2d Busin	ness code (see instructions)
OLYM	1PIA	WA 98507			621	210
3a Plan a	idministrator's name and	address X Same as Plan Sponsor.			3b Adm	inistrator's EIN
					3c Adm	inistrator's telephone number
4 If the this p	name and/or EIN of the lan, enter the plan spons	plan sponsor or the plan name has chan sor's name, EIN, the plan name and the	ged since the last re plan number from th	turn/report filed for e last return/report.	4b EIN	
a Spons c Plan N	sor's name				4d PN	
		t the beginning of the plan year			5a	6
b Total	number of participants a	t the end of the plan year			5b	6
C Numb comp	per of participants with a plete this item)	ccount balances as of the end of the plan	n year (only defined	contribution plans	5c	E
· · /		icipants at the beginning of the plan year			5d(1)	4
		icipants at the end of the plan year erminated employment during the plan y			5d(2)	
than	100% vested				5e	(
Under pen SB or Sch	alties of periury and othe	r incomplete filing of this return/reporter penalties set forth in the instructions, d signed by an enrolled actuary, as well ate	I declare that I have	examined this return/re	port, includ	ling, if applicable, a Schedule
SIGN	Omis R 14	Achon	4/2/19	JAMES B. HUTCH	HINSON	
HERE	Ignature of plan ad	ministrator	Date	Enter name of individ	ual signing	as plan administrator
SIGN						
HERE	Signature of employ	er/plan sponsor	Date	Enter name of individ	ual signing	as employer or plan sponsor

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Form 5500-SF (2018) v,171027 Form 5500-SF (2018)

	Are you claiming a waiver of the annual examination and report of a under 29 CFR 2520.104-46? (See instructions on waiver eligibility a If you answered "No" to either line 6a or line 6b, the plan canno If the plan is a defined benefit plan, is it covered under the PBGC ins If "Yes" is checked, enter the My PAA confirmation number from the	n independ nd conditio ot use Forr surance pro	dent qualified public accountant (IQ ons.) n 5500-SF and must instead use ogram (see ERISA section 4021)?	PA) X Yes [] No Form 5500.] Yes [] No [] Not determined				
Pa	Part III Financial Information							
7	Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year				
_	Total plan assets	7a	1,447,953	1,406,360				
a	Total plan ussets	i u		1,400,500				
	Total plan liabilities	7b	860	1,400,500				

С	Net plan assets (subtract line 7b from line 7a)	7c	1,447,093		1,406,360				
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount		(b) Total				
а	Contributions received or receivable from: (1) Employers	8a(1)	10,038	2.24					
	(2) Participants	8a(2)	22,842						
	(3) Others (including rollovers)	8a(3)	C	0.0.50					
b	Other income (loss)	8b	-71,850						
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			-38,970				
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1,455						
е	Certain deemed and/or corrective distributions (see instructions)	8e	0	<u>1</u> 1.7	and says the lates				
f	Administrative service providers (salaries, fees, commissions)	8f	308						
g	Other expenses	8g	C						
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	shiyi gale Nanjiri ji		1,763				
i	Net income (loss) (subtract line 8h from line 8c)	81			-40,733				
j	Transfers to (from) the plan (see instructions)	8j							
Pa	rt IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 2G 3D 2T 2F 2K	feature code	s from the List of Plan Characte	eristic Co	odes in the instructions:				
b	b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:								
Pa	rt V Compliance Questions								
10	During the plan year:		Ye	s No	Amount				

10	During the plan year:		Yes	No	Amount
а	Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		х	
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		х	
с	Was the plan covered by a fidelity bond?	10c	Х		150,000
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		Х	
e	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		х	
f	Has the plan failed to provide any benefit when due under the plan?	10f		Х	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	X		8,037
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		х	
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			

Form 5500-SF (2018)

Page 3-

Part	VI Pension Funding Compliance						
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and (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		11a				
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the CERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)				Yes [>	No	
a	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see in granting the waiver.		d enter i Day		of the lette Year	ər rulin	g
lfy	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 negative amount)	12d					
e Will the minimum funding amount reported on line 12d be met by the funding deadline?					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	NX	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 broucontrol of the PBGC?	÷					
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ider which assets or liabilities were transferred.	ntify the plan(s) to				
1	3c(1) Name of plan(s):	13c(2) EIN(s)			13c(3) PN(:	5)
_						_	