| Description         Description         Description         2017           Importance of a start of  |   | Form 5500-SF Short Form Annual Return/Report of Small Emp<br>Benefit Plan |  |   |          |                        | oyee   | C             | MB Nos. 1210-0110<br>1210-0089 |  |  |  |  |
|--|---|---|--|---|----------|------------------------|--|---------------|--------------------------------|--|--|--|--|
| Entry bert borth Sourt Administrators         Revenue Code (the Code).         This Point is Open to Public Impection           Part II         Annual Report Identification Information         2 complete all entry fields in accordance with the instructions to the Form S590.SF.         This Point is Open to Public Impection           For calendar plan year Degramming         0.101/2017         and ending         1.201/2017           A This rotum/report is for:         a single-amplyor plan         a foreign plan         a foreign plan           B This netum/report is         a new-participant plan         a foreign plan         a foreign plan           B This netum/report is         a new-participant plan         a foreign plan         a foreign plan           B This netum/report is         a new participant plan         a foreign plan         a foreign plan           B This netum/report is         a new participant plan         a foreign plan         a foreign plan           C Check box if filing under:         prime 558         gene of plan         001/2010           Part II         Basic Plan Information—ment all requested information         1         https://docs.org//docs.or   |   |   |  |   |          | etirement              |  | 2017          |                                |  |  |  |  |
| Part I Annual Report learning the instructions to the Form \$500 SF.     Part I Annual Report learning transmission and ending 12312017     and ending 1231201     and ending 1231201     and ending 123120     and ending |   |   |  |   |          |                        | Internal   |               | •                              |  |  |  |  |
| For calindar plan year 2012 or fiscal plan year beginning       0.01/02/07       and ending       120/12/07         A This return/report is for:       a single-employer plan       ist of participating employer information/report information in accordance with the form instructions.)         B This return/report is       a single-employer plan       ist of participating employer information in accordance with the form instructions.)         B This return/report is       the first return/report       a store participant plan       be first extrum/report         B This return/report is       the first return/report       a store participant plan       be first extrum/report         C Check box if filing under:       Form 5568       unomatic extension       DFVC program         Special extension (enter description)       secial extension (enter description)       DFVC program         C Extension CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       1b Three-digit plan number (CRN)       D01         C Extension Scale and store, or P.0. tox)       CD return/report       2b Employer Indentification Number (ENN)       CD return/report         C Part II       Basic Plan Information - enter all requisited information       1b Three-digit plan number (CRN)       D01         C Reter NEADOWS CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       1b Effect (Medication Number (ENN)       CD return/report (ENN)       CD return/report (ENN)       CD return/report (ENN) <t< td=""><td>Pension Be</td><td>enefit Guaranty Corporation</td><td>Complete all entries in a</td><td>accordance with the</td><td>instru</td><td>ctions to the Form 55</td><td>500-SF.</td><td>Publi</td><td>c inspection</td></t<>   | Pension Be  | enefit Guaranty Corporation   | Complete all entries in a  | accordance with the                             | instru   | ctions to the Form 55  | 500-SF.  | Publi         | c inspection                   |  |  |  |  |
| A       This return/report is for:       a single-employer plan (multicry plan (multicry plan) (multicry plan) (multicry plan) (multicry plan)         B       This return/report is       a one-participant plan       a toreign plan         B       This return/report is       me first return/report       a first return/report       a strong plan         C       Check box if filing under:       Form 5558       g automatic extension       DFVC program         1       This return/report       a strong plan       DFVC program       general extension         1       This return/report       in a mendod return/report       a strong plan       DFVC program         1       This return/report       in first return/report       DFVC program       general extension         1       This return/report       In the first return/report       DFVC program       general extension         1       This return/report       In the first return/report       DFVC program       general extension         1       This return/report       In the first return/report       DFVC program       general extension         1       This return/report       In the return extension       DFVC program       general extension         2       Pans sponsor's name (mplayer, if for a single-emplayer file of noreign, see instructions)       General extension  |   |   |  | 047   |          |                        |  |               |                                |  |  |  |  |
| A This return/report is for: <ul> <li></li></ul>   | For calend  |   |  |   |          |                        |  | king this has | must attach a                  |  |  |  |  |
| B This return/report is       the first return/report       the first return/report       the first return/report         C Check box if filing under:       Spacial extension (enter description)       DPCC program         Part II       Basic Plan Information—enter all requested information       DPCC program         Information—enter all requested information       Ib       Three-digit         IR Ame of plan       GREEN MEADOWS CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       Ib       Three-digit         IR Ame of plan       Check box if for a single-employer plan)       001       1c       Enclave date of plan         GREEN MEADOWS CARE HOME LLC       401 K PROFIT SHARING PLAN TRUST       Ib       Three-digit       001         II C Enclave date of plan       GREEN MEADOWS CARE HOME LLC       401 K PROFIT SHARING PLAN TRUST       Ib       Control of the plan number         Cliv or town, actic a single-employer plan       Maining address (include room, act, suite no and street, or P.O. Box)       Control of the plan sponsor control of the plan sponsor.       Ib       Business code (see instructions)         GREEN MEADOWS CARE HOME LLC       Same as Plan Sponsor.       Ib       Administrator's talephone number         C Administrator's name and address [] Same as Plan Sponsor.       Ib       Administrator's talephone number         G Nomber of participants at the end of the plan year       Sa  | A This ret  | turn/report is for:   |  | list of participati                             |          |                        |  | -             |                                |  |  |  |  |
| Image: Second Secon                             | <b>B</b> This rate  | un lan ant in   | a one-participant plan   |   |          |                        |  |               |                                |  |  |  |  |
| C Check box if tiling under:       Form 5558       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       1       The meeting in the enter all requested information         14 Name of plan       GREEN MEADOWS CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       1       The Three-digit plan number of 0010/2016         2a Plan sponsor's name (employer, if for a single-employer plan)       1       C. Effective date of plan of 000/2016         2b Employer Identification Number (EN) of the plan sponsor's name, plan with and street, or P.O. Box)       2       C. Sponsor's telephone number 380-0433-2485         2ad Plan administrator's name and address       Same as Plan Sponsor.       3       3       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 the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for the plan sponsor's name, EIN, the plan name and the plan number form the last return/report filed for the plan number of participants at the beginning of the plan year.       5       3       Administrator's telephone number         5       Total number of participants at the beginning of the plan year.       5       5       6       1         6       Number of participants at the beginning o  |   |   | the first return/report  | the first return/report the final return/report |          |                        |  |               |                                |  |  |  |  |
| Part II       Basic Plan Information—enter all reguested information         1a Name of plan       1b Three-digit plan number         GREEN MEADOWS CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       1b Three-digit plan number         2a Plan sponsor's name (employer, if for a single-employer plan)       1c Effective date of plan         Malling address (include room, apt, suite no. and street, or P-O. Box)       2b Employer Identification Number         City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2c Sponsor's talephone number         3GREEN MEADOWS CARE HOME LLC       3do-433-2485         2data Sponsor's name, country, and ZIP or foreign postal code (if foreign, see instructions)       2c Sponsor's talephone number         3GREEN MEADOWS CARE HOME LLC       3do-433-2485         2dd Business code (see instructions)       623000         3a Plan administrator's name and address       Same as Plan Sponsor.       3b Administrator's telephone number         4 If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report filled for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filled for this plan, enter the plan sponsor's name, EIN, the plan name and the plan year       5a       1d         5a Total number of participants at the beginning of the plan year       5b       8       5c       1         6(1) Total number of active   |   |   | an amended return/report a short plan year return/report (less than 12 months) |   |          |                        |  |               |                                |  |  |  |  |
| Part II       Basic Plan Information—enter all requested information         1a Name of plan       GREEN MEADOWS CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       1b       Three-digit plan number (PN) ▶       001         1c       Effective date of plan Oriol/2016       1c       Effective date of plan Oriol/2016       2b       Employer Identification Number (EN) ♦       001       0101/2016         2a       Plan sponsor's name (employer, if for a single-employer plan) (Non, state or province, country, and 2IP or foreign postal code (if foreign, see instructions)       2b       Employer Identification Number (EIN) 46.4566702       2c       Sponsor's talephone number 38.04.45.06702         2ccs02 SE 5TH STREET       CAMAS, WA 98007       3b       Administrator's EIN       623000         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number 38.04.83.48.8         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 form the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan page       5b       8         5a       Total number of participants at the beginning of the plan year       5b       8       11         5b       Total numb  | C Check   | box if filing under:  | X Form 5558  | automatic extens                                | sion     |                        | DFVC program                                       |               |                                |  |  |  |  |
| 1a Name of plan       1b Threa-digit plan number       001         1c Effective date of plan sponsor's name (employer, if for a single-employer plan)       1c Effective date of plan of 01/2016         2a Plan sponsor's name (employer, if for a single-employer plan)       1c Effective date of plan of 01/2016         2b Employer Identification Number (EIN) of the open sponsor's name (employer, and SIPe) of foreign postal code (if foreign, see instructions)       2b Employer Identification Number (EIN) 45-4569702         2cc Sponsor's talephone number 360-6832-2485       2d Business code (see instructions)       623000         3a Plan administrator's name and address Same as Plan Sponsor.       3b Administrator's EIN       3cc Administrator's talephone number 360-833-2486         2d Business code (see instructions)       623000       623000       623000         3a Plan administrator's name and address Same as Plan Sponsor.       3b Administrator's talephone number 4dministrator's talephone number 562       3c Administrator's talephone number 562         5a Total number of participants with account balances as of the plan year.       5a 111       5b 8       8         5a Total number of participants with account balances as of the plan year.       5d(1) 100       100       5d(2) 8       8       6       0         611) Total number of active participants at the beginning of the plan year.       5d(1) 100       100       5d(2) 8       6       0       0       0   |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| GREEN MEADOWS CARE HOME LLC 401 K PROFIT SHARING PLAN TRUST       plan number<br>(PN)       0.1         2a Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt, suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer Identification Number<br>(EIN)       2b Employer Identification Number<br>(EIN)         2a Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt, suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer Identification Number<br>(EIN)       4b Employer Identification Number<br>(EIN)         2cesoz SE STH STREET<br>CAMAS. WA 98007       3b Administrator's name and address       Same as Plan Sponsor.       3b Administrator's telephone number<br>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<br>this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.       4b EIN         5a Total number of participants at the beginning of the plan year.       5b       8<br>c       1         5a Total number of participants with account balances as of the plan year.       5b       8<br>c       1         complete his item,<br>complete his   | Part II   | Basic Plan Infor  | mation—enter all requested inf   | ormation  |          |                        |  |               |                                |  |  |  |  |
| Image: constraint of the plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suile no. and street, or P.O. Box)<br>City or twon, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer Identification Number<br>(EN) 4 5-4569702         2ct Sponsor's telephone number<br>360-832-486       2c Sponsor's telephone number<br>360-832-486         2d Business code (see instructions)       623000         3a Plan administrator's name and address       Same as Plan Sponsor.         3b Administrator's telephone number<br>360-832-486         2d If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.         5a Total number of participants at the beginning of the plan year.         5a Total number of participants at the beginning of the plan year.         5b       6         611       52         622       8         612       8  |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| 2a Pian sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt, suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer (lentification Number<br>(EIN)         2c Sponsor's table phone, country, and ZIP or foreign postal code (if foreign, see instructions)       2c Sponsor's telephone number<br>360-833-2485         2d Business code (see instructions)       2c Sponsor's telephone number<br>360-833-2485         2d Business code (see instructions)       623000         3a Plan administrator's name and address       Same as Plan Sponsor.         3 for Administrator's telephone number<br>as Sponsor's name.       2b Employers         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for<br>this plan, enter the plan sponsor's name. EIN, the plan name and the plan number from the last return/report filed for<br>this plan, enter the plan sponsor's name.       4b EIN         4 If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report filed for<br>this plan, sing and the plan sponsor's name.       5a       11         5 Total number of participants at the beginning of the plan year.       5b       8       1         6 Number of participants at the beginning of the plan year.       5d(1)       10       10         d(2) Total number of active participants at the beginning of the plan year.       5d(2)       8       0         c Number of  | GREEN ME  | ADOWS CARE HOME I   | LC 401 K PROFIT SHARING PL   | AN TRUST  |          |                        | •  |               | 001                            |  |  |  |  |
| 2a Plan sponsor's name (employer, if for a single-employer plan)       2b Employer Identification Number         (EIN)       4b-d689702         City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2c Sponsor's telephone number         3GREEN MEADOWS CARE HOME LLC       2c Sponsor's telephone number         33a Plan administrator's name and address       3sme as Plan Sponsor.       3b Administrator's EIN         3a Plan administrator's name and address       same as Plan Sponsor.       3b 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         4       If the name of participants at the beginning of the plan year       5a       11         4       Data number of participants at the beginning of the plan year       5a       11         b Total number of participants at the end of the plan year       5b       8       1         c Number of participants at the beginning of the plan year       5d(1)       10       10         d(2) Total number of active participants at the beginning of the plan year       5d(2)       8       0         c Number of participants with account balances as of the end of the plan year       5d(2)       8       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>· · · · ·</td><td colspan="4"></td></t<>   |   |   |  |   |          |                        | · · · · ·  |               |                                |  |  |  |  |
| Mailing address (include room, apt, suite no. and street, or P.O. Box)       IEIN       IEIN       4-5459702         CREEN MEADOWS CARE HOME LLC       2C       Sponsor's telephone number       30-83.24265         226       Sponsor's telephone number       623000         3a Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's EIN         3c       Administrator's name and address       Same as Plan Sponsor.       3c       Administrator's telephone number         3c       Administrator's name, and address       Same as Plan Sponsor.       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.       4d       PN         5a       Total number of participants at the end of the plan year       5a       11         b       Total number of participants at the end of the plan year.       5b       8         C       Number of participants with account balances as of the end year with accrued benefits that were less       5c       1         d(1)       Total number of active participants at the end of the plan year.       5d(1)       10         d(2)       Total number of participants with account balances as of the end of the plan year.   |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| City of town, static or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2         CREEN MEADOWS CARE HOME LLC       2         Soc.033-2485       2d         Business code (see instructions)       62:3000         3a Plan administrator's name and address       Same as Plan Sponsor.       3b         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         4       If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.       4b       EIN         4       If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report.       4b       EIN         4       If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report.       5a       1d         4d       PN       5a       11       5b       8         5a       Total number of participants at the beginning of the plan year.       5b       8       8         c       Number of participants with account balances as of the end of the plan year.       5d(1)       10         d(1) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 10x/k vested   |   |   |  | . Box)  |          |                        |  |               |                                |  |  |  |  |
| 26502 SE 5TH STREET       2d Business code (see instructions)         3a Plan administrator's name and address S Same as Plan Sponsor.       3b Administrator's EIN         3c Administrator's 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 has changed since the last return/report filed for.       4b EIN         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for.       4d P N         5a Sponsor's name       5a 11         5a Total number of participants at the beginning of the plan year.       5a 11         5b 8       8         5c Number of participants at the end of the plan year.       5b 8         5c 10 a number of participants at the beginning of the plan year.       5d(1) 10         d(1) Total number of active participants at the end of the plan year.       5d(2) 8         6 Number of participants with account balances as of the end of the plan year with accrued benefits that were less then 10% vested.       5d(2) 8         7 Unda number of active participants at the end of the plan year.       5d(2) 8       8         7 Number of participants who terminated employment during the plan year with accrued benefits that were less then 10% vested.       5d(2) 8         9 Number of participants who terminated employment during the plan year with accrued benefits that were less the electronic version of this returur/report, including, if applicable, a Sche  | City or   | town, state or province   | , country, and ZIP or foreign posta  |   | e instru | uctions)               | 2c Sponsor's telephone number                      |               |                                |  |  |  |  |
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| 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         4       Market Tele Plan Sponsor's name, EIN, the plan name and the plan number from the last return/report.       4d       PN         5a       Total number of participants at the beginning of the plan year       5a       11         b       Total number of participants at the end of the plan year       5b       8         c       Number of participants at the end of the plan year       5c       1         complete this item)       5c       1       5d(1)       10         d(1)       Total number of active participants at the end of the plan year       5d(2)       8       0         d(1)       Total number of active participants at the end of the plan year       5d(2)       8       0         d(1)       Total number of active participants at the end of the plan year       5d(2)       8       0         d(1)       Total number of active 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 filling of this return/report will be assessed unless reasonable ca  | CAMAS, WA   | 98607   |  |   |          |                        |  | 02300         | 00                             |  |  |  |  |
| 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       11         5a       Total number of participants at the beginning of the plan year       5b       8         c       Number of participants at the end of the plan year       5b       8         c       Number of participants at the end of the plan year       5c       1         d(1)       Total number of active participants at the beginning of the plan year       5c       1         d(1)       Total number of active participants at the end of the plan year       5d(1)       10         d(2)       Total number of active participants at the end of the plan year       5d(2)       8         c       Number of active participants at the end of the plan year       5d(2)       8         d(1)       Total number of active participants at the end of the plan year       5d(2)       8       0         d(2)       Total number of active participants who terminated employment during the plan year with accrued benefits that were less<br>than 100% vested.       5e       0   | <b>3a</b> Plan a  | dministrator's name and   | d address 🗴 Same as Plan Spor  | isor.   |          |                        | <b>3b</b> Administrator's EIN                      |               |                                |  |  |  |  |
| 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       11         b Total number of participants at the beginning of the plan year       5a       11         b Total number of participants at the end of the plan year       5b       8         c Number of participants with account balances as of the end of the plan year.       5d(1)       10         d(1) Total number of active participants at the beginning of the plan year.       5d(2)       8         e Number of participants with account balances as of the end of the plan year.       5d(2)       8         d(1) Total number of active participants at the end of the plan year.       5d(2)       8         e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.       5e       0         Caution: A penalty for the late or incomplete filling of this return/report, including, if applicable, a Schedule BS or Schedule BMS completed and signed by an enrolled actury, as well as the electronic version of this return/report, including, if applicable, a Schedule BS or Schedule BMS completed.       0/7/31/2019       JOSEPH STEPHENS         If the dwith authorized/valid electronic signature.       0/7/31/2019 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>   |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.       4d PN         a Sponsor's name       4d PN         c Plan Name       5a       11         b Total number of participants at the beginning of the plan year  |   |   |  |   |          |                        | <b>3c</b> Administrator's telephone number         |               |                                |  |  |  |  |
| this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.       4d PN         a Sponsor's name       4d PN         c Plan Name       5a       11         b Total number of participants at the beginning of the plan year  |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.       4d PN         a Sponsor's name       4d PN         c Plan Name       5a       11         b Total number of participants at the beginning of the plan year  |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| a Sponsor's name       4d PN         c Plan Name       5a         5a Total number of participants at the beginning of the plan year       5a       11         b Total number of participants at the end of the plan year       5b       8         c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)       5c       1         d(1) Total number of active participants at the beginning of the plan year       5d(1)       10         d(2) Total number of active participants at the end of the plan year       5d(2)       8         e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested       5e       0         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.       07/31/2019       JOSEPH STEPHENS         SIGN       Filed with authorized/valid electronic signature.       07/31/2019       JOSEPH STEPHENS       Intername of individual signing as plan administrator  |   |   |  |   |          |                        | 4b EIN   |               |                                |  |  |  |  |
| C       Plan Name         5a       Total number of participants at the beginning of the plan year  | •   |   | sor's name, EIN, the plan name a   | nd the plan number f                            | rom the  | e last return/report.  | <b>4d</b> PN                                       |               |                                |  |  |  |  |
| b       Total number of participants at the end 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)   | 5a Total number of participants at the beginning of the plan year   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| complete this item)       JC       1         d(1) Total number of active participants at the beginning of the plan year       5d(1)       10         d(2) Total number of active participants at the end of the plan year       5d(2)       8         e       Number of participants who terminated employment during the plan year with accrued benefits that were less       5e       0         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.       07/31/2019       JOSEPH STEPHENS         Signature of plan administrator       Date       Enter name of individual signing as plan administrator   |   |   |  |   |          | 5b                     |  | 8             |                                |  |  |  |  |
| d(2) Total number of active participants at the end of the plan year       5d(2)       8         e       Number of participants who terminated employment during the plan year with accrued benefits that were less       5e       0         caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.       0         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.       07/31/2019       JOSEPH STEPHENS         HERE       Signature of plan administrator       Date       Enter name of individual signing as plan administrator   | comp  | lete this item)   |  |   |          |                        |  |               | 1                              |  |  |  |  |
| e       Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested       5e       0         Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.       0         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.       07/31/2019       JOSEPH STEPHENS         Signature of plan administrator       Date       Enter name of individual signing as plan administrator  | d(1) Total number of active participants at the beginning of the plan year  |   |  |   |          |                        | . ,  |               | 10                             |  |  |  |  |
| than 100% vested       Se       Se         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 HERE       Filed with authorized/valid electronic signature.       07/31/2019       JOSEPH STEPHENS         Signature of plan administrator       Date       Enter name of individual signing as plan administrator   |   |   |  |   |          |                        | 5d(2)  |               | 8                              |  |  |  |  |
| 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 HERE       Filed with authorized/valid electronic signature.       07/31/2019       JOSEPH STEPHENS         Signature of plan administrator       Date       Enter name of individual signing as plan administrator  |   |   |  |   |          |                        |  |               | 0                              |  |  |  |  |
| 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 HERE       Filed with authorized/valid electronic signature.       07/31/2019       JOSEPH STEPHENS         Signature of plan administrator       Date       Enter name of individual signing as plan administrator  |   |   |  |   |          |                        |  |               |                                |  |  |  |  |
| SIGN<br>HERE         Filed with authorized/valid electronic signature.         07/31/2019         JOSEPH STEPHENS           Signature of plan administrator         Date         Enter name of individual signing as plan administrator           SIGN<br>HERE         V         V         V   | 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 |   |  |   |          |                        |  |               |                                |  |  |  |  |
| HERE     Signature of plan administrator     Date     Enter name of individual signing as plan administrator       SIGN     HERE     Image: Signature of plan administrator     Image: Signature of plan administrator   |   |   |  | 07/31/2019                                      |          | JOSEPH STEPHENS        |  |               |                                |  |  |  |  |
| SIGN<br>HERE   |   |   |  | Date  |          | Enter name of individu | ual signing  | as plan adm   | ninistrator                    |  |  |  |  |
|  | SIGN  |   |  |   |          |                        | · · ·  |               |                                |  |  |  |  |
|  |   | Signature of employ   | /er/plan sponsor   | Date  |          | Enter name of individu | e of individual signing as employer or plan sponse |               |                                |  |  |  |  |

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

Form 5500-SF (2017) v.170203

g Other expenses.....

Part IV Plan Characteristics

3D 2G 2J 3H 2F 2E

j

9a

b

2T

h Total expenses (add lines 8d, 8e, 8f, and 8g).....

i Net income (loss) (subtract line 8h from line 8c).....

Transfers to (from) the plan (see instructions) .....

0

0

2 389

| 6a | Were all of the plan's assets during the plan year invested in eligib  |                         | . ,                               |                     |  |  |
|----|--|-------------------------|-----------------------------------|---------------------|--|--|
| b  | Are you claiming a waiver of the annual examination and report of a<br>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 cannot use Form 5500-SF and must instead use Form 5500.                        |                         |                                   |                     |  |  |
| С  | If the plan is a defined benefit plan, is it covered under the PBGC in   | ? Yes No Not determined |                                   |                     |  |  |
|    | If "Yes" is checked, enter the My PAA confirmation number from th  | e PBGC p                | premium filing for this plan year | (See instructions.) |  |  |
| Pa | rt III Financial Information   |                         |                                   |                     |  |  |
| 7  | Plan Assets and Liabilities  |                         | (a) Beginning of Year             | (b) End of Year     |  |  |
| а  | Total plan assets  | 7a                      | 187                               | 576                 |  |  |
| b  | Total plan liabilities   | 7b                      | 0                                 | 0                   |  |  |
| C  | Net plan assets (subtract line 7b from line 7a)  | 7c                      | 187                               | 576                 |  |  |
| 8  | Income, Expenses, and Transfers for this Plan Year   |                         | (a) Amount                        | (b) Total           |  |  |
| а  | Contributions received or receivable from:<br>(1) Employers  | 8a(1)                   | 0                                 |                     |  |  |
|    | (2) Participants   | 8a(2)                   | 333                               |                     |  |  |
|    | (3) Others (including rollovers)   | 8a(3)                   | 0                                 |                     |  |  |
| b  | Other income (loss)  | 8b                      | 58                                |                     |  |  |
| C  | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)   | 8c                      |                                   | 391                 |  |  |
| d  | Benefits paid (including direct rollovers and insurance premiums to provide benefits)  | 8d                      | 0                                 |                     |  |  |
| е  | Certain deemed and/or corrective distributions (see instructions)  | 8e                      | 0                                 |                     |  |  |
| f  | Administrative service providers (salaries, fees, commissions)   | 8f                      | 2                                 |                     |  |  |

8g

8h

8i

8j

If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

| 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 |    | x      |  |  |
| C    | Was the plan covered by a fidelity bond?  | 10c |    | Х      |  |  |
| 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 |    | X      |  |  |
| g    | Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)   | 10g |    | Х      |  |  |
| h    | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)   | 10h |    | 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  |     |    |        |  |  |

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Page 3- 1

| Part   | VI  | Pension Funding Compliance   |         |            |                    |               |        |
|--|---|--|---------|------------|--------------------|---------------|--------|
| 11   |   | nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sch<br>rm 5500) and line 11a below)   | nedule  | SB         |                    | Yes           | s 🗙 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 Code or sectic<br>SA?<br>"Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) | on 302  | of         |                    | Yes           | s 🗙 No |
| a  |   | waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, an<br>nting the waiver   |         | r the date | e of the le<br>Yea |               | uling  |
| lf y   | 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     |            |                    |               |        |
| <b>d</b> 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) |   |  |         |            |                    |               |        |
| 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         | es 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 the control of the PBGC? |  |         | Yes 🗙 No   |                    |               |        |
| С  |   | luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s<br>ch assets or liabilities were transferred. (See instructions.)                 | ) to    |            |                    |               |        |
| 1  | 3c(1  | ) Name of plan(s): 13c(2   | ) EIN(s | 5)         | 130                | <b>:(3)</b> P | 'N(s)  |
|  |   |  |         |            |                    |               |        |