## 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

2018

This Form is Open to Public Inspection

Part I	Annual Report	Identification Information	1								
For calend	ar plan year 2018 or fis	scal plan year beginning 01/01/2	2018		and ending 12	2/31/2018					
A This ret	turn/report is for:	a single-employer plan			n (not multiemployer) ( ployer information in ac	_					
		a one-participant plan	a fore	ign plan							
<b>B</b> This retu	urn/report is	the first return/report	the fina	al return/report							
		an amended return/report	a shor	t plan year return	/report (less than 12 m	onths)					
C Check	box if filing under:	X Form 5558	autom	natic extension		DFVC progra	m				
		special extension (enter descr	ription)								
Part II	Basic Plan Info	ermation—enter all requested inf	formation								
1a Name	•					<b>1b</b> Three-digi					
TRI-COUNT	Y ECONOMIC DEVEL	LOPMENT CORPORATION RETIR	REMENT P	LAN		plan numb (PN) ▶	er	002			
							data of				
			1c Effective of	01/01/							
Mailing	g address (include rooi	oyer, if for a single-employer plan) m, apt., suite no. and street, or P.C				<b>2b</b> Employer (EIN)	Identific				
-		ee, country, and ZIP or foreign posta COPMENT CORPORATION	tal code (if f	oreign, see instru	uctions)		2c Sponsor's telephone number 859-344-0040				
						2d Business code (see instructions)					
300 BUTTERMILK PIKE SUITE 332					813000						
LAKESIDE F	LAKESIDE PARK, KY 41017										
3a Plan a	dministrator's name ar	nd address 🛛 Same as Plan Spor	nsor.			<b>3b</b> Administra	ator's E	N			
						2					
						<b>3C</b> Administra	ator's te	lephone number			
A 16 (b		and an arrange of the order of the second		Labara dha laad aa	to me force and Classification	Ala en					
		e plan sponsor or the plan name hansor's name, EIN, the plan name a				<b>4b</b> EIN					
•	or's name					4d PN					
C Plan N	lame										
<b>5a</b> Total i	number of participants	at the beginning of the plan year				5a		16			
<b>b</b> Total i	number of participants	at the end of the plan year				5b		14			
		account balances as of the end of		` ,	•	5c		13			
<b>d(1)</b> Tota	al number of active pa	rticipants at the beginning of the plant	lan year			5d(1)		8			
d(2) Total number of active participants at the end of the plan year				5d(2)	3						
		terminated employment during the				5e		0			
Caution: A	penalty for the late	or incomplete filing of this return	n/report wi	ill be assessed ι	ınless reasonable caı						
SB or Sche	edule MB completed a	her penalties set forth in the instruction and signed by an enrolled actuary, and the									
SIGN	true, correct, and comp	/valid electronic signature.	08/	/15/2019	LEE CRUME						
HERE	Signature of plan a		_	Date Enter name of individual signing as plan administrator							
SIGN Filed with authorized/valid electronic signature. 08/15/2019 LEE CRUME											

Date

**HERE** 

Enter name of individual signing as employer or plan sponsor

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	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)							. X Ye	s No
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.)								s No
	If you answered "No" to either line 6a or line 6b, the plan cann								ш
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 det	ermined
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC p	remium filing for this p	lan yea	r			(See instr	uctions.)
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) En	d of Year	
а	Total plan assets	7a	204	44283				808359	
b	Total plan liabilities	7b							
c	Net plan assets (subtract line 7b from line 7a)	7c	204	44283				808359	
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt			(b)	Total	
а	Contributions received or receivable from: (1) Employers	8a(1)		34368					
		8a(2)	1	67770					
	(2) Participants	8a(3)	`	57770					
	Other income (loss)	8b	_	88430					
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						13708	
d	Benefits paid (including direct rollovers and insurance premiums	- 00							
	to provide benefits)	8d	124	49407	$\dashv$				
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	8e		205	-				
<u> </u>	Administrative service providers (salaries, fees, commissions)	8f		225					
<u>g</u>	Other expenses	8g						4040000	
<u>n</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						1249632	
<del>+</del>	Net income (loss) (subtract line 8h from line 8c)	8i						-1235924	
Day		8j							
9a	rt IV Plan Characteristics  If the plan provides pension benefits, enter the applicable pension	feature co	odes from the List of DI	an Cha	ractori	etic Co	ndes in the in	etructione:	
	2E 2F 2G 2J 2K 2T 3D	Toature oc	des from the List of the	an Ona	racton	3110 01		structions.	
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	les from the List of Pla	n Chara	acteris	tic Co	des in the ins	tructions:	
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 contribu	tions withi	n the time period						
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)			10a		X			
b				IVa		^			
	reported on line 10a.)	`		10b		X			
				10c	X			250	000
d	Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?	-		10d		X			
е	Were any fees or commissions paid to any brokers, agents, or oth								
	carrier, insurance service, or other organization that provides som the plan? (See instructions.)			10e		X			
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		X			
9	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g	X			49	283
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	ne require	d notice or one of the						
	exceptions to providing the notice applied under 29 CFR 2520.10	1-3		10i	<u> </u>	<u> </u>			

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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 (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 Code or se ERISA?		of	Yes X No				
	(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	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.							
b	Enter the minimum required contribution for this plan year	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 🔀 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 control of the PBGC?	the		Yes X No				
С	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.)	n(s) to						
1	<b>3c(1)</b> Name of plan(s):	(2) EIN(s)	)	<b>13c(3)</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.

2018

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

b Total number of participants at the end of the plan year	Part Annual Report	ldentification Information	1	actions to the Form 5500	P-GF.			
A This return/report is for:    a one-participant plan   a foreign plan	For calendar plan year 2018 or f	iscal plan year beginning	01/01/2018	and ending	12/31/201	8		
B This return/report is	A This return/report is for:	X a single-employer plan	a multiple-employer pla list of participating em	an (not multiemployer) (File ployer information in acco	ers checking this bo	x must attach a		
the first return/report   the final return/report (less than 12 months)		a one-participant plan						
C Check box if filing under:    an amended return/report   a short plan year return/report (less than 12 months)	B This return/report is	the first return/report	the final satura/report					
C Check box if filing under:    Special extension (enter description)   DFVC program		H '			K - 3			
Basic Plan Information—enter all requested Information	C 05-1-1-1-1-1-1-1-1-1-1		a short plan year return	weport (tess than 12 mont	ns)			
Pairt II   Basic Plan Information—enter all requested Information   1a Name of plan   1a Name of plan   1a Name of plan   1c Efficiene date of plan   1c Efficiene date of plan   1d   1d   1d   1d   1d   1d   1d   1	Check box it tiling under:		<b>—</b>		DFVC program			
1 Tri-County Economic Development Corporation  Retizement Plan  2 Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box)  2 Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box)  2 Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box)  2 Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box)  2 Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box)  2 Plan sponsor's name (employer, if for a single-employer plan)  3 Description  3 Description  3 Description  3 Description  4 Description  5	Stop have experience and a							
Tri-County Economic Development Corporation  Retirement Plan  2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., sulte no. and street, or P.O. Box) City or fown, state or province, county, and ZiP or foreign postal code (if foreign, see instructions)  Tri-County Economic Development  Corporation  300 Buttermilk Pike Suite 332  Lakeside Park  KY 41017  Sa Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's telephone number (859) 344-0040  2d Business code (see Instructions)  3c Administrator's telephone number (159) and Administrator (159) a		ormation—enter all requested in	nformation					
Retizement Plan  1c. Effective date of plan 01/01/1997  2a. Plan sponsor's name (employer, if for a single-employer plan) Mailing address (includes room, apt., suite no, and street, or P.O. Box) City or town state or province, bourshy, and 2 ff. or foreign postal code (if foreign, see instructions) Tri-country Economial Development Corporation 300 Buttermilk Pike Suite 332  Lakeside Park KY 41017  3a. Plan administrator's name and address Same as Plan Sponsor.  3b. Administrator's EIN 3c. Administrator's telephone number (859) 344-0040  3d. Administrator's EIN 3d. Administrator's telephone number (859) 3d. Administrator's telephone number (859) 3d. Administrator's EIN 3d. 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 has changed since the last return/report. a Sponsor's name Plan name and the plan name and the plan number from the last return/report. b. Total number of participants at the beginning of the plan year.  5a. 16 b. Total number of participants at the beginning of the plan year.  5b. 14 c. Number of participants with account balances as of the end of the plan year.  5d. 13 d(1) Total number of active participants at the beginning of the plan year.  5d. 13 d(2) Total number of active participants at the beginning of the plan year.  5d. 20 c. Number of participants with account balances as of the plan year.  5d. 20 c. Number of participants with account balances as of the plan year.  5d. 21 d(1) Total number of active participants at the beginning of the plan year.  6d. 20 c. Number of participants who terminated employment during the plan year with account benefits that were less than 100% vested.  6d. 20 c. Number of participants who terminated employment during the plan year with account benefits that were less than 100% vested.  6d. 20 c.	•			1	_			
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)61-1125577		**						
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, act, 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)  30 Buttermilk Pike Suite 332  Lakeside Park  All If the 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 Plan Name  5a Total number of participants at the beginning of the plan year Complete this item).  5b Total number of participants at the beginning of the plan year Complete this item).  5c Number of participants at the beginning of the plan year Complete this item).  5c Number of participants at the beginning of the plan year Complete this item).  5c Number of participants at the the of the plan year Complete this item).  5c Number of participants at the end of the plan year Complete this item).  5c Number of participants at the end of the plan year Complete this item).  5c Number of participants at the end of the plan year Complete this item).  5c Number of participants at the end of the plan year Complete this item).  5c Number of participants at the end of the plan year Complete this item).  5c Number of participants at the end of the plan year Complete this item).  5c Number of participants with account balances as of the end of the plan year with accound benefits that were less Than 100% vested.  6caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  6caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  6caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.  6caution: A penalty for the late or incomplet	Retirement Plan			1				
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)  20 Sponsor's telephone number (859) 344-0040  21 Business code (see instructions)  30 Buttermilk Pike Suite 332  Lakeside Park  32 Plan administrator's name and address Same as Plan Sponsor.  33 Plan administrator's name and address Same as Plan Sponsor.  34 If the name and/or EIN of the plan sponsor or the plan name has changed since 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.  35 Ponsor's name  36 Plan Name  47 If the name and/or EIN of the plan sponsor or the plan name has changed since 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.  48 EIN  49 PN  40 PN  50 Total number of participants at the beginning of the plan year  51 C Number of participants with account balances as of the end of the plan year (only defined contribution plans)  52 C Juntal number of active participants at the end of the plan year  63 C Juntal number of active participants at the end of the plan year (only defined contribution plans)  64 Number of participants with account balances as of the end of the plan year (only defined contribution plans)  65 C Juntal number of active participants at the end of the plan year (only defined contribution plans)  65 C Juntal number of active participants at the end of the plan year (only defined contribution plans)  66 Caution: A penalty for the late or incomplete filling of this return/report, including, if applicable, a Schedule SB or Schedule MB complete participants who terminated employment during the plan year with accrued benefits that were less than 100% wested  68 Caution: A penalty for the late or incomplete filling of this return/report including, if applicable, a Schedule SB or Schedule MB complete participants are co								
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)  2c Sponsor's telephone number (859) 344-0040  2d Business code (see instructions)  300 Buttermilk Pike Suite 332  Lakeside Park KY 41017  813000  3a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN  3c Administrator's EIN  4b EIN  4d PN  4d PN  5a 164  Fit 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.  4 If the name and/or EIN of the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.  4 Sponsor's name  5 Plan Name  5 Total number of participants at the beginning of the plan year.  5 D Total number of participants at the end of the plan year.  5 D Total number of participants at the end of the plan year.  5 D Total number of participants at the end of the plan year.  5 D Total number of participants at the end of the plan year.  5 D Total number of participants at the end of the plan year.  5 D Total number of participants at the end of the plan year.  5 D Total number of active participants at the beginning of the plan year.  5 D Total number of active participants at the end of the plan year.  5 D Total number of active participants at the end of the plan year.  5 D Total number of participants who terminated employment during the plan year with accrued benefits that were less for participants who terminated employment during the plan year with accrued benefits that were less for Schedule Mid complete year of greated years who terminated employment during the plan year with accrued benefits that were less for Schedule Mid complete year of greated years of greated yea	2a Plan sponsor's name (emplo	yer, if for a single-employer plan)	O Paul	2	<b>b</b> Employer Identi	ification Number		
2d Business code (see instructions)  2d Business code (see instructions)  2a Plan administrator's name and address Same as Plan Sponsor.  3b Administrator's EIN  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.  a Sponsor's name  Plan Name  5a Total number of participants at the beginning of the plan year.  5b 14  D Total number of participants at the end of the plan year.  5c 13  d(1) Total number of active participants at the beginning of the plan year.  6d(2) Total number of active participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(3) Total number of participants at the end of the plan year.  6d(2) Total number of participants at the end of the plan year.  6d(3) Total number of participants at the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the plan year.  6d(3) Total number of participants with account beliances as of the end of the p	City or town, state or province	ce, country, and ZIP or foreign pos	o. box) ital code (if foreign, see instr	uctions)				
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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.  3 Sponsor's name  5a Total number of participants at the beginning of the plan year	3a Plan administrator's name a	nd address X Same as Plan Spo	onsor.	3		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.  a Sponsor's name  C Plan Name  5a 16  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.  a Sponsor's name c Plan Name  5a 16  b Total number of participants at the beginning of the plan year				3	C 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.  a Sponsor's name c Plan Name  5a 16  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.  3 Sponsor's name C Plan Name  5a 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.  3 Sponsor's name C Plan Name  5a Total number of participants at the beginning of the plan year	4 If the name and/or EIN of th	e plan sponsor or the plan name h	as changed since the last re	sturn/report filed for	h EIN			
Total number of participants at the beginning of the plan year	this plan, enter the plan spo	nsor's name, EIN, the plan name	and the plan number from th	e last return/report.				
5a Total number of participants at the beginning of the plan year	•			4	d PN			
Total number of participants at the end of the plan year	O Flantivanie							
Total number of participants at the end of the plan year	5a Total number of participants	s at the heginning of the plan year			50	1.6		
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	C Number of participants with	account balances as of the end of	the plan year (only defined	contribution plans		14		
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	complete this item)	***************************************			5c	13		
Number of participants who terminated employment during the plan year with accrued benefits that were less  than 100% vested					5d(1)	8		
Caution: A penalty for the late or incomplete filling 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 agened 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 controlled.  Sign  HERE  Signature of plan administrator  Date  Enter name of individual signing as plan administrator  Lee Crume  Signature of employer/plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	d(2) Total number of active pa	articipants at the end of the plan ye	ear		5d(2)	_ 3		
Caution: A penalty for the late or incomplete filling 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 adjunct 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 controlled.  SIGN  SIGN  Lee Crume  Signature of plan administrator  Date  Enter name of individual signing as plan administrator  Lee Crume  Signature of employer/plan sponsor	e Number of participants who terminated employment during the plan year with accrued benefits that were less				5e			
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 argued 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 controlled.  SIGN HERE Signature of plant administrator Date Enter name of individual signing as plan administrator  Lee Crume  SIGN: HERE Signature of employer/plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	Caution: A penalty for the late	or incomplete filing of this retur	m/report will be assessed :	uniess reasonable cause	is established.			
Signature of plan administrator  Signature of employer/plan sponsor  Date  Enter name of individual signing as plan administrator  X 15 Ax 16  Lee Crume  Lee Crume  Figure of employer or plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	Under penalties of penury and of	ther penalties set forth in the instru	ictions. I declare that I have a	evamined this return/rener	t including if and	icable, a Schedule		
Signature of plan administrator  Signature of employer/plan sponsor  Date  Enter name of individual signing as plan administrator  X 15 Ax 16  Lee Crume  Lee Crume  Figure of employer or plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	belief, it is true, correct, and com	plete.	as well as the electronic ver	sion of this return/report, a	na to the best of m	iy knowledge and		
Signature of plan administrator  Signature of employer/plan sponsor  Date  Enter name of individual signing as plan administrator  Lee Crume  Figure of employer/plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	SIGN K V							
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	Signature of plant	adiffinistrator	Date	Enter name of individual	signing as plan ac	iministrator		
Signature of employer/plan sponsor  Date  Enter name of individual signing as employer or plan sponsor	HEDE TO K 1997 U	<u>/ˈ~</u>	x15 Ang 19	Lee Crume				
For Paperwork Reduction Act Notice, see the Instructions for Form 5500-SF.	Signature of emplo	oyer/plan sponsor	Date	Enter name of individual				

Form	5500-	·SF	/201	8

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Pя	а	6	2

6a b	Were all of the plan's assets during the plan year invested in eligible Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility If you answered "No" to either line 6a or line 6b, the plan cannot the plan is a defined benefit plan, is it covered under the PBGC in	an indepe and condi not use Fo	ndent qualified public a lions.) orm 5500-SF and must	ccount	ent (IQ	PA) Form	
	If "Yes" is checked, enter the My PAA confirmation number from the	nsurance p ne PBGC p	program (see ERISA se premium filing for this pl	iction 4 Ian yea	U21)?. !	··· [_	Yes No Not determined . (See instructions.)
Pa	TEMPORAL INFORMATION			<del></del>		··.	
7	Plan Assets and Liabilities		(a) Beginning (	of Year			(b) End of Year
а	Total plan assets	7a		044,			808,359
<u>b</u>	Total plan liabilities	7b					
c	Net plan assets (subtract line 7b from line 7a)	7c	2,	044,	283		808,359
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) Total
a	Contributions received or receivable from: (1) Employers	8a(1)		34,	368		
	(2) Participants	8a(2)		67,	770		
	(3) Others (including rollovers)	8a(3)			が必要	LAT SEA	
b	Other income (loss)	8b		-88,	430		
_ <u>c</u>	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		-141 - 154 V 1520-0			13,708
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1,	249,	407		
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	8e			\$1 50 20 40		
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f	225				
<u>g</u>	Other expenses	8g	8			e e de la composition della co	
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h				1,249,632	
<u></u>	Net income (loss) (subtract line 8h from line 8c)					No reactificate	-1,235,924
1000 AND 1000	Transfers to (from) the plan (see instructions)	8j			e e	erig or New Mil	
9a b Par	If the plan provides pension benefits, enter the applicable pension 2 E 2 F 2 G 2 J 2 K 2 T 3 D  If the plan provides welfare benefits, enter the applicable welfare f						
10	During the plan year:		<del></del>		<b>V</b>		
a	Was there a fallure to transmit to the plan any participant contributes cribed in 29 CFR 2510.3-102? (See instructions and DOL's Norgram)	oluntary f	iduciary Correction	10a	Yes	No X	Amount
b	Were there any nonexempt transactions with any party-in-interes reported on line 10a.)	t? (Do not	include transactions	10b		Х	
C				10c	Х		250,000
-		fidelity bo	nd, that was caused	10d		х	200,000
		her persor	s by an insurance	10e		X	
f				10f		Х	
	Did the plan have any participant loans? (If "Yes," enter amount a	as of year-	end.)	10g	Х		49,283
	2520.101-3.)			10h		Х	
i		the require	d notice or one of the	10i			

_	Form 5500-SF (2018) Page 3-		_			
Pair.	Pension Funding Compliance					
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Sci (Form 5500) and line 11a below)	nedule S	В	. [	Yes	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 ERISA?  (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	n 302 o	f		Yes	X No
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, an granting the waiver.	d enter Da		of the le		ling
<u> </u>	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.			100		1.00
	Enter the minimum required contribution for this plan year	12b				
	Enter the amount contributed by the employer to the plan for this plan year	12c				<u> </u>
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
Pair		<u> </u>			<del></del> -	
13a	Has a resolution to terminate the plan been adopted in any plan year?		Yes	<u> </u>	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	Xи	0
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s which assets or liabilities were transferred. (See instructions.)	) to	<u> </u>	<del></del>	<del></del>	

13c(2) EIN(s)

13c(3) PN(s)

13c(1) Name of plan(s):