## **Form 5500-SF**

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Department of Labor

## 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

A This return/report is or:    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.)   a non-e-participant plan   a toreign plan number   (PRI)   a toreign			dentification information								
A This return/report is for:    a one-participant plan   a foreign plan   a short plan year return/report (less than 12 months)    C Check box if filing under:   Form \$558   automatic extension   DFVC program	For calendar pla	n year 2018 or fisc	al plan year beginning 01/01/2	2018		and ending 12	2/31/2	2018			
B This return/report is	A This return/re	eport is for:	x a single-employer plan								
me tinal return/report   me tinal return/report (less than 12 months)   me anamended return/report   me tinal return/report (less than 12 months)   me anamended return/report   me about plan   me anamended return/report   me about plan   me anamended return/report   me about plan   me anamended return/report   me anamended return/r			a one-participant plan								
C Check box if filing under:	<b>B</b> This return/re	port is	the first return/report	the	e final return/report						
Special extension (enter description)   Special extension (enter description)			an amended return/report	a s	short plan year return	/report (less than 12 m	onths	3)			
Part II   Basic Plan Information—enter all requested information 1a Name of plan SYSTEM ERA 401(K) PLAN   1c Effective date of plan SYSTEM ERA 401(K) PLAN   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) SYSTEM ERA SOFTWORKS LLC   2b Employer Identification Number (EIN)   46-4649484   2c Sponsor's telephone number 206-529-4082   2d Business code (see instructions) SEATTLE, WA 98103   3a Plan administrator's name and address   Same as Plan Sponsor.   3b Administrator's telephone number 151210   3c Administrator's telephone number 151210   3c Administrator's telephone number 151210   3d Administrator's name and address   Same as Plan Sponsor.   4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.   a Sponsor's name   EIN of the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.   5a Total number of participants at the beginning of the plan year   5b 19   C Number of participants with account balances as of the end of the plan year   5d(1)   14   C Number of participants with account balances as of the end of the plan year   5d(2)   18   C Number of participants at the beginning of the plan year   5d(2)   18   C Number of participants at the beginning of the plan year   5d(2)   18   C Number of participants at the beginning of the plan year   5d(2)   18   C Number of participants at the beginning of the plan year with account balances as of the end of the plan year   5d(2)   18   C Number of participants with account balances as of the end of the plan year with account balances as of the end of the plan year   5d(2)   18   C Number of participants with account belances as of the end of the plan year   5d(2)   18   C Nu	C Check box if	filing under:	X Form 5558	au	utomatic extension		D	FVC program			
1			special extension (enter descri	ription)							
1	Part II Ba	sic Plan Inform	mation—enter all requested in	formation	on						
Pain number (PN)   001   C   Effective date of plan   1001/2017			•				1b	Three-digit			
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 2IP or foreign postal code (if foreign, see instructions) SYSTEM ERA SOFTWORKS LLC  2c Sponsor's telephone number 2D5-229-4082  2d Business code (see instructions) SEATTLE, WA 98103  3a Plan administrator's name and address Same as Plan Sponsor.  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. 3c Administrator's telephone number c Plan Name  4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. 3 Sponsor's name c Plan Name  5 Total number of participants at the beginning of the plan year c Number of participants at the beginning of the plan year 5 Number of participants with account balances as of the end of the plan year  6 Number of participants with account balances as of the end of the plan year  6 Number of participants with terminated the end of the plan year  7 Add Pin Station of participants with the end of the plan year  8 Number of participants with terminated employment during the plan year with accrued benefits that were less for an another of participants with terminated employment during the plan year with accrued benefits that were less for an another of participants with terminated employment during the plan year with accrued benefits that were less for an 100% vested.  6 Number of participants who terminated employment during the plan year with accrued benefits that were less for an 100% vested.  7 Section Plan administrator 8 Date Entername of individual signing as plan administrator 8 Date Entername of individual signing as plan administrator 8 Date Entername of individual signing as plan administrator	•							plan number	004		
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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.  Date  Enter name of individual signing as plan administrator  SIGN HERE											
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HERE	HERE Sig	nature of plan adı	ministrator		Date	Enter name of individ	idual signing as plan administrator				
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor											
	HERE Sig	nature of employe	er/plan sponsor		Date	Enter name of individ	idual signing as employer or plan sponsor				

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6a b	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)							X Yes No		
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a							X Yes No		
_	If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.							Not determined		
С	C If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year									
	If Yes is checked, enter the My PAA confirmation number from the	е РВСС р	remium illing for this p	ian yea	r			(See instructions.)		
Pa	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning (	(a) Beginning of Year			(b) End of Year			
a	Total plan assets	7a	8	84760				270078		
b	Total plan liabilities	7b								
c	Net plan assets (subtract line 7b from line 7a)	7c	8	84760				270078		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	(a) Amount			(b) <sup>-</sup>	(b) Total		
a	Contributions received or receivable from: (1) Employers	8a(1)	(	63566						
	(2) Participants	8a(2)	14	45033						
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)	8b	-2	23281	23281					
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						185318		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d								
е	Certain deemed and/or corrective distributions (see instructions)	8e								
f	Administrative service providers (salaries, fees, commissions)	8f								
g	Other expenses	8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h								
i	Net income (loss) (subtract line 8h from line 8c)	8i						185318		
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 2F 2G 2J 2K 2R 3D	feature co	odes from the List of Pla	an Cha	racteri	stic Co	des in the ins	tructions:		
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	les from the List of Plan	n Chara	acterist	tic Cod	es in the instr	uctions:		
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									
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	,	,	10a		X				
b	Were there any nonexempt transactions with any party-in-interest			IVa						
	reported on line 10a.)			10b		X				
	C Was the plan covered by a fidelity bond?			10c	X			25000		
d	<b>d</b> 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				
е	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				10f		X				
9	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)			10g		Χ				
h	h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			10h		X				
i				10i						
					-					

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Part	VI Pension Funding Compliance							
11	I1 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below)							
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40	11a						
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section ERISA?		f	Yes 🛛 N	Ю			
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)							
<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 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?		Yes X No					
	If "Yes," enter the amount of any plan assets that reverted to the employer this year	13a						
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	) 		Yes X No				
<b>c</b> If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)								
13c(1) Name of plan(s): 13c(2				13c(3) PN(s)				