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**

For celedar plan year 2018 or fiscal plan year tegraning 0.01/2019 multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) a one-participant plan a toreign plan		eport identification 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 filling under: Form 5558 automatic extension DFVC program DFVC program peculiar destination DFVC program DFVC	For calendar plan year 20	18 or fiscal plan year beginning 01/01/2	2019	and ending 09/3	0/2019	
B This return/report is	A This return/report is fo	a single-employer plan			_	
me interstrut/report me interstrut/report me interstrut/report me interstrut/report me interstrut/report me interstrut/report (less than 12 months)			_ ' ' "	, ,,		,
C Check box if filing under:	B This return/report is	the first return/report	X the final return/report			
Special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Three-digit plan number (PN) 001 1c Effective date of plan 0101/2001 2a Plan sponsor's name (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) 90-0138125 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2d Employer Identification Number (EIN) 90-0138125 2c Sponsor's telephone number 300-736-9100 2d Business code (see instructions) 2d Business code (see instructions) 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 300-736-9100 3c Administrator's telephone number 300-736-9100 3d Plan administrator's name and the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name 3d 4d PN 4d PN 5d PN		an amended return/report	X a short plan year return	n/report (less than 12 mont	ths)	
Part II Basic Plan Information—enter all requested information 1a Name of plan JAMES P. KING, DDS, PLLC 401(K) PROFIT SHARING PLAN 1e Effective date of plan 1.	C Check box if filing und	er: Form 5558	automatic extension		DFVC program	m
18 Name of plan JAMES P. KING, DDS, PLLC 401(K) PROFIT SHARING 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) JAMES P. KING, DDS, PLLC 2b Employer Identification Number (EIN) 2c Sponsor's telephone number 360-736-5100 2d Business code (see instructions) 2d Business code (see instructions) 621210 2d Business code (see instructions) 621210 6210 6210 6210 6210 6210 6210 62		special extension (enter desc	ription)	_		
18 Name of plan JAMES P. KING, DDS, PLLC 401(K) PROFIT SHARING 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) JAMES P. KING, DDS, PLLC 2b Employer Identification Number (EIN) 2c Sponsor's telephone number 360-736-5100 2d Business code (see instructions) 2d Business code (see instructions) 621210 2d Business code (see instructions) 621210 6210 6210 6210 6210 6210 6210 62	Part II Basic Pla	n Information—enter all requested in	formation			
JAMES P. KING, DDS, PLLC 401(K) PROFIT SHARING PLAN	•	•		1	h 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 ZIP or foreign postal code (if foreign, see instructions) JAMES P. KING, DDS, PLLC 228 HARRISON AVENUE CENTRALIA, WA 98531-1324 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 380-736-5100 2d Business code (see instructions) 621210 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. 2 Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year 5 Total number of participants at the beginning of the plan year 6 Number of participants with account balances as of the end of the plan year 6 Number of participants with care the head of the plan year 6 Number of participants with care the head of the plan year 7 Septimental the participants at the beginning of the plan year 8 Quality of participants with care and the beginning of the plan year 9 Septimental the participants with secure balances as of the end of the plan year 9 Septimental the participants with the participants at the beginning of the plan year 9 Septimental the participants with secure balances as of the end of the plan year 9 Septimental the participants with the participants at the beginning of the plan year 9 Septimental the participants with terminated employment during the plan year with accrued benefits that were less than 100% vested. 10 Namber of participants with terminated employment during the plan year with accrued benefits that were less than 100% vested. 11 Number of participants with terminated employment during the plan year with accrued benefits that were less than 100% vested. 11 Number of participants with terminated employment during the plan year with accrued benefits that were le	·	.C 401(K) PROFIT SHARING PLAN		'	plan numb	er
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)				1	C Effective d	•
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) 22 Sponsor's telephone number 360-736-5100 23 Business code (see instructions) 621210 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number this plan, enter the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year 5b 0. Number of participants with account balances as of the end of the plan year 5c 0. Number of participants with account balances as of the end of the plan year 5d(2) 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 5 er complete this item). 4c(2) Total number of participants at the beginning of the plan year with accrued benefits that were less than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less 1 than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less 1 than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less 1 than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less 1 than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less 1 than 100% vested 0. e Number of participants who terminated employment during the plan year with accrued benefits that were less 1 tha	0					
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3a 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 c Plan Name 5a Total number of participants at the beginning of the plan year			tal code (il foreign, see instr	actions) 2	•	•
3a Plan administrator's name and address Same as Plan Sponsor. 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 2 Sponsor's name 2 Plan Name 5a Total number of participants at the beginning of the plan year				2	2d Business o	ode (see instructions)
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. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year. 5b 0 C Number of participants at the end of the plan year. 5c 0 C Number of participants at the beginning of the plan year (only defined contribution plans complete this item) 4d(1) Total number of active participants at the beginning of the plan year (only defined contribution plans complete this item) 5c 0 C Number of participants at the beginning of the plan year (only defined contribution plans complete this item) 5c 0 C Number of participants at the beginning of the plan year (only defined contribution plans complete this item) 5c 0 C Number of participants at the beginning of the plan year (only defined contribution plans complete this item) 5c 0 C Number of participants at the beginning of the plan year (only defined contribution plans complete this item) 5c 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 5c 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less be 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less be 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less be 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less be 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less be 0 C Number of participants who terminated employment during the plan year with accrued benefits that were less be 0 C Number of		0.4				621210
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year	CENTRALIA, WA 98531-13	24				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year						
4b EIN 4b EIN 4d PN 5a Total number of participants at the beginning of the plan year (only defined contribution plans complete this item). 5c Number of participants at the beginning of the plan year (only defined contribution plans complete this item). 5d(2) Total number of participants at the beginning of the plan year (only defined contribution plans complete this item). 6c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 6c Number of participants with account balances as of the plan year (only defined contribution plans complete this item). 6d(1) Total number of active participants at the beginning of the plan year (only defined contribution plans complete of active participants at the end of the plan year (only defined contribution plans complete of active participants at the end of the plan year (only defined contribution plans complete of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of active participants at the end of the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 7d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 7d(2) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 8d(3) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 8d(3) Total number of partici	3a Plan administrator's r	ame and address 🔀 Same as Plan Spo	nsor.	3	b Administra	tor's EIN
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year				3	C Administra	tor'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 Total number of participants at the beginning of the plan year						
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a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year					b EIN	
Total number of participants at the beginning of the plan year		an sponsor's name, EIN, the plan name a	and the plan number from th		ld PN	
5a Total number of participants at the beginning of the plan year				-		
b Total number of participants at the end of the plan year						
C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). d(1) Total number of active participants at the beginning of the plan year	5a Total number of parti	cipants at the beginning of the plan year.			+	6
d(1) Total number of active participants at the beginning of the plan year					5b	0
d(2) Total number of active participants at the end of the plan year						0
Provided the second straight of 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. Date Enter name of individual signing as plan administrator	d(1) Total number of ac	tive participants at the beginning of the p	lan year			5
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. Date Enter name of individual signing as plan administrator SIGN HERE	` '				5d(2)	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 HERE Filed with authorized/valid electronic signature. Date Enter name of individual signing as plan administrator SIGN HERE	than 100% vested					
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. Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE						
SIGN HERE Filed with authorized/valid electronic signature. 11/04/2019 JAMES P. KING Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE	SB or Schedule MB comp	leted and signed by an enrolled actuary,				
Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERF			11/04/2019	JAMES P. KING		
HERE	HERE Signature of	plan administrator	Date	Enter name of individual	signing as pla	n administrator
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor						
	HERE Signature of	employer/plan sponsor	Date	Enter name of individual	signing as em	ployer or plan sponsor

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6a	Were all of the plan's assets during the plan year invested in eligib	le assets?	(See instructions.)					X Ye	s No
b Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)								X Ye	s \square No
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)								3 NO
С	If the plan is a defined benefit plan, is it covered under the PBGC in							o ∏ Not de	termined
	If "Yes" is checked, enter the My PAA confirmation number from th		-						uctions.)
Do	rt III Financial Information								
_ Pa			()5						
	Plan Assets and Liabilities	- -	(a) Beginning	of Year 11313			(b) En	od of Year	
_ <u>a</u>	Total plan liabilities	7a	19	11313					
	Total plan liabilities	7b	10	11313				0	<u> </u>
8	Net plan assets (subtract line 7b from line 7a)	7c	(a) Amoun				(h)) Total	'
a	Contributions received or receivable from:		(a) Allioun	ıı			(D)	TOLAI	
	(1) Employers	8a(1)							
	(2) Participants	8a(2)							
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b	20	07065					
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						207065	
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	210	08459					
е	Certain deemed and/or corrective distributions (see instructions) \dots	8e							
f	Administrative service providers (salaries, fees, commissions)	8f		9919					
g	Other expenses	8g							
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						2118378	}
<u>_i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						-1911313	
	Transfers to (from) the plan (see instructions)	8j							
Pa	rt IV Plan Characteristics								
9a 	If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 3B 3D 2K	feature co	odes from the List of Plant	an Cha	racteri	stic Co	odes in the ir	structions:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	acteris	tic Cod	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								
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)			10a		X			
b				Tou					
	reported on line 10a.)	•		10b		Х			
				10c	X			191	132
	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		Х			
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		Χ			
9	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		X			
h	If this is an individual account plan, was there a blackout period? 2520.101-3.)	•		10h	L	X			
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i					
	•								

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Part	VI Pension Funding Compliance					
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and cor (Form 5500) and line 11a below)			В	. Y	es 🗌 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 Cod ERISA?	e or section	n 302 of			es X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)					
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instrugranting the waiver		d enter t Day		of the letter Year _	ruling
lf :	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 negative amount)	of a	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?			X Yes	. 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 control of the PBGC?				X Yes	No
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)	the plan(s)) to			
1	3c(1) Name of plan(s):	13c(2)	EIN(s)		13c(3)	PN(s)

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500-SF.

OMB Nos. 1210-0110 1210-0089

2018

This Form is Open to Public Inspection

Part	Annual Repo	ort Identification Information				
For calend	dar plan year 2018 c	or fiscal plan year beginning	01/01/2019	and ending	09/30/2	019
A This re	eturn/report is for:	x a single-employer plan		an (not multiemployer) (aployer information in ac		
D		a one-participant plan	a foreign plan			
B This re	turn/report is	the first return/report	X the final return/report			
		an amended return/report	🛚 a short plan year retur	n/report (less than 12 m	onths)	
C Check	box if filing under:	Form 5558	automatic extension		DFVC program	n
		special extension (enter desc				
Part II	Basic Plan Ir	nformation—enter all requested in	formation			
1a Name Jame	•	DDS, PLLC 401(k) PROFI	T SHARING PLAN		1b Three-digit plan numb (PN) ▶	
					1c Effective d 01/01/	ate of plan
2a Plan s Mailin	sponsor's name (em ig address (include r	ployer, if for a single-employer plan) oom, apt., suite no. and street, or P.C	D. Box)			dentification Number
City o	r town, state or prov es P. King,	ince, country, and ZIP or foreign post	al code (if foreign, see instr	ructions)	2c Sponsor's	telephone number
	_				360-736	6-5100 ode (see instructions)
228	Harrison Av	enue			a Bacinoco o	odo (odo mondonono)
	tralia	WA 98531-			621210	
3a Plan a	administrator's name	and address X Same as Plan Spor	nsor.		3b Administra	tor's EIN
					3c Administra	tor's telephone number
A 1541-					41	
this p	lan, enter the plan s	the plan sponsor or the plan name he ponsor's name, EIN, the plan name a	as changed since the last re and the plan number from the	eturn/report filed for ne last return/report.	4b EIN	
a Spons c Plan N	sor's name				4d PN	
- Tiani	vuine					
5a Total	number of participar	nts at the beginning of the plan year				6
		nts at the end of the plan year			5b	0
C Numb comp	per of participants wi lete this item)	th account balances as of the end of	the plan year (only defined	contribution plans	5c	0
		participants at the beginning of the pl			5d(1)	5
		participants at the end of the plan ye			5d(2)	0
than	100% vested	ho terminated employment during the			5e	0
Caution: A	A penalty for the lat	te or incomplete filing of this retur	n/report will be assessed	unless reasonable ca	use is establishe	ed.
SB or Sche	alties of perjury and edule MB completed true correct, and co	other penalties set forth in the instruct l and signed by an enrolled actuary, a mplete.	ctions, I declare that I have as well as the electronic ver	examined this return/resion of this return/repo	eport, including, if rt, and to the best	applicable, a Schedule of my knowledge and
SIGN	James	Thatig	11/04/19	JAMES P. KING		
HERE	Signature of plan	n administrator	Date	Enter name of individ	dual signing as pla	ın administrator
SIGN HERE						
HENE	Signature of emp	oloyer/plan sponsor	Date	Enter name of individ	dual signing as em	ployer or plan sponsor

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 Were all of the plan's assets during the plan year invested in eligib 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 cann If the plan is a defined benefit plan, is it covered under the PBGC in 	an indepe and condi ot use Fo	ndent qualified public a tions.) orm 5500-SF and mus	account t instea	ant (IC	PA) Form	5500.	X YesX YesNot dete	
If "Yes" is checked, enter the My PAA confirmation number from the	-	- :					(See instru	
Part III Financial Information								
7 Plan Assets and Liabilities		(a) Beginning	of Year			(b) End	d of Year	
a Total plan assets	7a	1,	911,	313				(
b Total plan liabilities	7b							
C Net plan assets (subtract line 7b from line 7a)	7c	1,	911,	313				
8 Income, Expenses, and Transfers for this Plan Year		(a) Amoun	nt			(b)	Total	
a Contributions received or receivable from: (1) Employers	8a(1)				· · · · · · · · · · · · · · · · · · ·			
(2) Participants	8a(2)							
(3) Others (including rollovers)	8a(3)							
b Other income (loss)	8b		207,	065				
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						20	07,06
Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	2,	108,	459				
e Certain deemed and/or corrective distributions (see instructions)	8e					···		
f Administrative service providers (salaries, fees, commissions)	8f		9,	919				
g Other expenses	8g							
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							18,37
i Net income (loss) (subtract line 8h from line 8c)	8i						-1,9	11,31
j Transfers to (from) the plan (see instructions)	8j							
Part IV Plan Characteristics								
9a If the plan provides pension benefits, enter the applicable pension 2A 2E 2J 3B 3D 2K	feature co	odes from the List of PI	an Cha	racteri	stic Coo	des in the in	structions:	
b If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	acteris	ic Code	es in the inst	ructions:	
Part V Compliance Questions								
10 During the plan year:				Yes	No		Amount	
a 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	oluntary F	iduciary Correction	40		х			
b Were there any nonexempt transactions with any party-in-interest	? (Do not	include transactions	10a 10b		Х			
reported on line 10a.) C Was the plan covered by a fidelity bond?			10b	Х			1:	91,13
d Did the plan have a loss, whether or not reimbursed by the plan's by fraud or dishonesty?			10d		Х			
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.)	ner persor ne or all of	s by an insurance the benefits under	10e		х			
f Has the plan failed to provide any benefit when due under the plan			10f		Х			
g Did the plan have any participant loans? (If "Yes," enter amount a	s of year-	end.)	10g		Х			
h If this is an individual account plan, was there a blackout period? (2520.101-3.)			10h		Х			
i If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10	ne require	d notice or one of the	10i					1
			<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)	Schedule S	3B	Yes No
11a	Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40			
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or s ERISA?		of	. Yes X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruction granting the waiver.	s, and enter Da		of the letter ruling Year
If	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		
	Enter the amount contributed by the employer to the plan for this plan year			
d d	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	12d		
e	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	No N/A
Part	/II Plan Terminations and Transfers of Assets	-		
13a	Has a resolution to terminate the plan been adopted in any plan year?		X Yes	No 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?	er the		X Yes No
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the p which assets or liabilities were transferred.	lan(s) to		
1	3c(1) Name of plan(s):	3c(2) EIN(s))	13c(3) PN(s)