Descent biology of disc         Data and desc of the mapping Regiment of the section of 149 and 4005 of the Employee Regiment of the Code).         Descent area         Descent area <thdescent area<="" th="">         Descent area         <t< th=""><th></th><th>m 5500-SF</th><th>Short Form Annu</th><th>oyee</th><th colspan="4">OMB Nos. 1210-0110 1210-0089</th></t<></thdescent>		m 5500-SF	Short Form Annu	oyee	OMB Nos. 1210-0110 1210-0089							
Engage backets biologic Constant         This Point is Open to Public Inspection           Part II         Annual Report Identification Information         and ending         Description           For catendary plan year 2018 or fiscal plan year beginning         (70/12018)         and ending         Description         Description           A         This return/report is for:         a single-employer plan         a broken plan         a dreading         Description         Description           B         This return/report is         a single-employer plan         a broken plan         a broken plan         Description         Description           B         This return/report is         a nen-eparticipant plan         a broken plan year telun/report         a single-employer information         Description           B         This return/report is         In the first terur/report         a short plan year telun/report         a short plan year telun/report         In more the terur/report           B         This return/report is         In the first terur/report         a short plan year telun/report         In the first terur/report           B         This return/report is         In the first terur/report         In the first terur/report         In the first terur/report           B         This return/report is         In the first terur/report all return/report         In the first ter							2018					
Society Columns  Socie							•					
For calendar plan year 2018 or filted plan year beginning       0/2012015       and ending       000000000000000000000000000000000000												
A       This return/report is for: <ul> <li>a single-employer plan</li> <li>a stortign plan</li> <li>b This return/report is</li> <li>a one-participant plan</li> <li>b The frame-odd return/report</li> <li>b This return/report is</li> <li>b This return/report</li> <li>b The frame-odd return/report</li> <li>b a one-participant plan</li> <li>b the first return/report</li> <li>b a one-participant plan</li> <li>b for participant plan</li> <li>b for participant plan</li> <li>b for participant plan</li> <li>c for participant plan</li> <lic for="" li="" participant="" plan<=""> <li>c for participant pla</li></lic></ul>												
A This return/report is for: <ul> <li></li></ul>	For calend											
B       This return/report is       in the first return/report       in a mended return/report       in a mended return/report         C       Check box if filing under:       in pecial extension (enter description)       DFVC program         Part II       Basic Plan Information—enter all requested information       Ib       Three-digit, plan to momentation—enter all requested information         18       Name of plan       001       Ic       Effective date of plan         1003(8) THRIFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       1b       Three-digit, plan         102       Plan aponsor's name (employer, if for a single-employer plan)       001       Ic       Effective date of plan         003(8) THRIFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       1b       Three-digit, plan       11:3167245         20       Sponsor's telephone number       11:3167245       2c       Sponsor's telephone number         11:3167245       2c       Sponsor's telephone number       62:4100       62:4100         30       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'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<	A This ret	turn/report is for:		list of participating e			-					
Image: Section of the section of the plan requirement of the plan requ	<b>B</b> This retu	ım/report is	a one-participant plan									
C Check box if filing under:               Porm 5558												
a minute control and a standard means and address in the plan name has changed since the last return/report filed for the plan sponsor's name.       10 Three-digit plan momber (RN) = 001         c Effective date of plan (03(B) THREFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       10 Three-digit plan number (RN) = 001         c Effective date of plan (03(B) THREFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       001         c Effective date of plan (03(B) THREFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       001         c Employer identification Number (RN) with a solution of the single-employer plan) (Mailing address (include room, apt, suite no. and street, or P.O. Box) (City of town, state or province, country, and 21P of foreign postal code (if foreign, see instructions)       2b Employer identification Number (EN) 11:3167245         c C OCOURT ST STE 3 (ROOKLYN, NY 11201-6274       3b Administrator's telephone number 71:84:43-8000       2d Business code (see instructions)         3a Plan administrator's name and address in Same as Plan Sponsor.       3b Administrator's telephone number 6 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 from the last return/report filed for bis term)       4b EIN         c Namber of participants at the beginning of the plan year.       5a (17)       5b (22)         c Number of participants at the beginning of the plan year (only defined contribution plan soc soc participants at the beginning of the plan year (only defined contribution plan soc soc g = 0 (11) Total number of active participants at the end of the plan year (only	_		an amended return/report	a short plan year ret	urn/report (less than 12 mo	onths)						
Part II       Basic Plan Information—enter all requested information         1a Name of plan 003(B) THRIFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       1b       Three-digit plan number (PN)       001         2a Plan sponsor's name (employer, if for a single-employer plan) City of toom, gate or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b       Employer Identification Number (EIN)       2c         3a Plan administrator's name and address       Son country, and ZIP or foreign postal code (if foreign, see instructions)       2c       Sponsor's tabephone number 718-643-8000         3a Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's talephone number 718-643-800         3a Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's talephone number 75b         5a Total number of participants at the edgining of 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 to Total number of participants at the edgining of the plan year       5b       22 Soposer's name         5a Total number of participants at the edgining of the plan year       5d(1)       11 Sd(2)       11 Sd(2)         6       Number of participants with account blances as of the ed of the plan year       5d(1)       11 Sd(2)         6       Number of participants with accound tof the plan year       5d(1)	C Check	box if filing under:	X Form 5558	automatic extension	1	DFVC p	rogram					
1a Name of plan 103(B) THRIFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       1b Three-digit plan number (PN) *       001         2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include rom, apt., subte no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) HE ARAB AMERICAN FAMILY SUPPORT CENTER SROOKLYN, NY 11201-6274       2b Employer Identification Number (EIN) 11-3167245         3a Plan administrator's name and address       Same as Plan Sponsor.       3b 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. a Sponsor's name.       4b EIN         5a Total number of participants at the beginning of the plan year       5a       17         5b Total number of participants at the end of the plan year       5d(1)       11         5c(2)       5c a       22         c1(1) Total number of active participants at the end of the plan year       5d(1)       11         5c       22       22       10       11         5c       22       11       11       11         5c       22       22       11       11       11         5c       22       22       11       11       11       11				1 ,								
IO3(B) THRIFT PLAN OF THE ARAB AMERICAN FAMILY SUPPORT CENTER       plan number       plan number       0.01         2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt, sulle no. and street, or P.O. Box) City or fown, state or provine, country, and 2P or foreign postal code (if foreign, see instructions)       2b Employer Identification Number (EIN)       11: C Effective date of plan 04/01/2008         50 COURT STSTE 3 RCOOKLYN, NY 11201-6274       2b Employer Identification Number (EIN)       2d Business code (see instructions) 62/100         3a Plan administrator's name and address       Same as Plan Sponsor.       3b Administrator's EIN         3c Administrator's name and address in and 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 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 from the last return/report.       4b EIN         5a Total number of participants at the beginning of the plan year       5a 17       5b 222         c Number of participants at the end of the plan year       5d(1)       111         d(2) Total number of active participants at the end of the plan year       5d(2)       15         e Number of participants with account balances as of the end he plan year       5d(2)       <			ormation—enter all requested in	formation								
Image: Section 2 and a section		•	RAB AMERICAN FAMILY SUPPOR									
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer identification Number (EIN) 11.3167245         1:A RABA AMERICAN FAMILY SUPPORT CENTER       2c Sponsor's telephone number 718-843-84000         2d Business code (see instructions)       624100         50 COURT ST STE 3 RROOKLYN, NY 11201-6274       3b Administrator's telephone number 718-843-84000         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 filed for this plan, enter the plan sponsor's name, and the plan name and the plan number from the last return/report filed for this plan, and address as of the end of the plan year       5a       17         5a Total number of participants at the beginning of the plan year       5a       17       5b       22         c Number of participants at the beginning of the plan year       5d(1)       11       11         d(2) Total number of active participants at the beginning of the plan year       5d(2)       15       5e       0         c Number of participants who terminated employment during the plan year       5d(1)       11       11       11       11       11       11 <td< td=""><td>403(B) 111(I</td><td></td><td></td><td>(I CENTER</td><td></td><td>•</td><td></td></td<>	403(B) 111(I			(I CENTER		•						
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, api, suite no. and zifeet, or P.O. Box) Cry or fown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer Identification Number (EIN) 11-3167245         3c Court ST STE 3 RCOCKLYN, NY 11201-6274       2c Sponsor's telephone number 718-643-8000         3a Plan administrator's name and address S Same as Plan Sponsor.       3b 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 tis 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 filed for tis 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 and the plan number from the last return/report filed for tis 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       5a 17       17         b Total number of participants at the end of the plan year       5c 222       22         c Number of participants with account balances as of the end of the plan year with accrued benefits that were less       5c 22       22         c Otal number of actice participants at the end of the plan year						1c Effect	•					
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)            HE ARAB AMERICAN FAMILY SUPPORT CENTER              2c Sponsor's telephone number 718-643-8000              2d Business code (see instructions) 624100               2d Business code (see instructions) 624100               2d Business code (see instructions) 624100               2d Administrator's telephone number 718-643-8000               2d Business code (see instructions) 624100               2d Administrator's telephone number 718-643-8000               2d Business code (see instructions) 624100               624100               624100               2d Administrator's telephone number 718-643-8000               2d Business code (see instructions) 624100            3a Plan administrator's name and address Same as Plan Sponsor.              3b Administrator's telephone number               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 and the plan number from the last return/report.             3a Same as of the plan year             C Plan Name               5d 170               Tree telephone number             5d             17             5b             22				D. Box)		2b Employer Identification Number						
50 COURT ST STE 3 BROOKLYN, NY 11201-6274       624100         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 filed for this plan, enter the plan sponsor's name.       4b EIN         5 Plan Name       5a 172         5 Total number of participants at the beginning of the plan year       5a 17         5 Total number of participants at the beginning of the plan year       5b 222         c Number of participants at the end of the plan year       5b 222         d(1) Total number of active participants at the beginning of the plan year       5c 222         d(1) Total number of active participants at the end of the plan year       5d(1) 111         d(2) Total number of active participants at the end of the plan year with accrued benefits that were less than 100% vested       5e 0         Inder penalties of peny and other penalties set forth in the instructors. J declare that lave examined this return/report, and to the best of my knowledge and bellef, it is true, correct, and complete.       111         SIGN HERE       Fled with authorized/valid electronic signature.       07/14/2020       RAWA NANCY ALBILAL				tal code (if foreign, see in:	structions)	2c Sponsor's telephone number						
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 EIN         3c Administrator's telephone number       3c Administrator's telephone number         4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name.       4b EIN         c Plan Name       4d PN         5a Total number of participants at the beginning of the plan year       5a 17         b Total number of participants at the end of the plan year       5b 222         c Number of participants at the end of the plan year       5c 222         d(1) Total number of active participants at the beginning of the plan year (only defined contribution plans complete this item).       5c 222         d(1) Total number of active participants at the end of the plan year       5d(1) 111         d(2) Total number of active participants at the end of the plan year       5d(2) 15         e Number of participants who therminated employment during the plan year with accrued benefits that were less than 10% wested.       5e 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 BS or Schedule MS 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. <td></td> <td></td> <td></td> <td></td> <td></td> <td colspan="4">2d Business code (see instructions)</td>						2d Business code (see instructions)						
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 and the plan number from the last return/report.       4b       EIN         4       Byonsor's name       4d       PN       4d       PN         5a       Total number of participants at the beginning of the plan year       5a       17       5b       22         5       Total number of participants at the end of the plan year       5b       22       22         c       Number of participants with account balances as of the end of the plan year       5d(1)       11         d(2)       Total number of active participants at the beginning of the plan year       5d(2)       15         e       Number of active participants at the end of the plan year       5d(2)       15         e       Number of active participants at the end of the plan year       5d(2)       15         e       Number of active participants at the end of the plan year       5d(2)       15         e       Number of active participants at the end of the plan year       5d(2)       15         e       Number of active participants at the end of the plan year       5d(2)							624100					
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       17         5a Total number of participants at the beginning of the plan year       5a       17         b Total number of participants at the end of the plan year       5b       22         c Number of participants with account balances as of the end of the plan year       5c       22         d(1) Total number of active participants at the beginning of the plan year       5d(1)       11         d(2) Total number of active participants at the end of the plan year       5d(2)       15         e Number of participants who terminated employment during the plan year with accrued benefits that were less to departicipants who terminated employment during the plan year with accrued benefits that were less to get on the plan year with accrued benefits that were less to get on the plan year more participants who terminated employment during the plan year with accrued benefits that were less to get on the plan during of the plan year with accrued benefits that were less to get on the best of my knowledge and belief, it is true, correct, and complete.       5e       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	3a Plan a	dministrator's name a	nd address 🛛 Same as Plan Spo	nsor.		<b>3b</b> Admi	nistrator'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						<b>3c</b> Admi	nistrator's telephone number					
a Sponsor's name       4d PN         5a Total number of participants at the beginning of the plan year       5a       17         b Total number of participants at the end of the plan year       5b       22         c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)       5c       22         d(1) Total number of active participants at the beginning of the plan year       5d(1)       11         d(2) Total number of active participants at the end of the plan year       5d(2)       15         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.         SIGN       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL						4b EIN						
b       Total number of participants at the end of the plan year	a Sponsor's name					<b>4d</b> PN						
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       5d(1)       11         d(2) Total number of active participants at the end of the plan year       5d(2)       15         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.       07/14/2020       RAWAA NANCY ALBILAL         SIGN       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL	C Number of participants with account balances as of the end of the plan year (only defined contribution plans				ed contribution plans							
d(2) Total number of active participants at the end of the plan year       5d(2)       15         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 HERE       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL         SIGN HERE       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL						5d(1)	11					
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       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.       07/14/2020       RAWAA NANCY ALBILAL         SIGN       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL												
than 100% vested         Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.         Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.         SIGN HERE       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL         SIGN HERE       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL	e Number of participants who terminated employment during the plan year with accrued benefits that were less					. ,	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.       07/14/2020       RAWAA NANCY ALBILAL         SIGN       Filed with authorized/valid electronic signature.       07/14/2020       Enter name of individual signing as plan administrator         SIGN       Filed with authorized/valid electronic signature.       07/14/2020       RAWAA NANCY ALBILAL	than	100% vested	or incomplete filing of this retur	n/report will be assesse	d unless reasonable cau							
SIGN HERE         Filed with authorized/valid electronic signature.         07/14/2020         RAWAA NANCY ALBILAL           Signature of plan administrator         Date         Enter name of individual signing as plan administrator           SIGN         Filed with authorized/valid electronic signature.         07/14/2020         RAWAA NANCY ALBILAL	Under pena SB or Sche	alties of perjury and o edule MB completed a	ther penalties set forth in the instru and signed by an enrolled actuary, a	ctions, I declare that I have	e examined this return/rep	port, includi	ng, if applicable, a Schedule					
HERE         Signature of plan administrator         Date         Enter name of individual signing as plan administrator           SIGN         Filed with authorized/valid electronic signature.         07/14/2020         RAWAA NANCY ALBILAL				07/14/2020	RAWAA NANCY ALBI	LAL						
SIGN Filed with authorized/valid electronic signature. 07/14/2020 RAWAA NANCY ALBILAL			C C				as plan administrator					
	SIGN											
Signature of employer/plan sponsor         Date         Enter name of individual signing as employer or plan sponsor           For Paperwork Reduction Act Notice, see the Instructions for Form 5500-SF.         Form 5500-SF (2018)	HERE				Enter name of individu	ual signing a						

v.171027

<ul> <li>6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)</li> <li>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.)</li> <li>c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?</li> </ul>							
If "Yes" is checked, enter the My PAA confirmation number from th	е РВСС р	remium liling for this plan year	(See instructions.)				
Part III Financial Information							
7 Plan Assets and Liabilities	Plan Assets and Liabilities (a) Beginning of Year (b) End						
a Total plan assets	7a	152677	244898				
<b>b</b> Total plan liabilities	7b	0	0				
C Net plan assets (subtract line 7b from line 7a)	7c	152677	244898				

		2		
С	Net plan assets (subtract line 7b from line 7a)	7c	152677	244898
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
а	Contributions received or receivable from: (1) Employers	8a(1)	52293	
	(2) Participants	8a(2)	37409	
	(3) Others (including rollovers)	8a(3)	0	
b	Other income (loss)	8b	7327	
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		97029
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	4442	
е	Certain deemed and/or corrective distributions (see instructions)	8e	0	
f	Administrative service providers (salaries, fees, commissions)	8f		
g	Other expenses	8g	366	
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		4808
i	Net income (loss) (subtract line 8h from line 8c)	8i		92221
j	Transfers to (from) the plan (see instructions)	8j	0	
Pa	rt IV Plan Characteristics		· ·	

Part IV	Plan Characteristics
	e plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b 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		Х			
С	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		133		
f	Has the plan failed to provide any benefit when due under the plan?	10f		Х			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		Х			
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		Х			
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i					

Page **3-** 1

Part	VI	Pension Funding Compliance						
11		nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and rm 5500) and line 11a below)			B		Yes	X No
11a	Ent	er the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		11a				
12	ERI	his a defined contribution plan subject to the minimum funding requirements of section 412 of the C SA? "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)		n 302 o	f 	[	Yes	X No
а	lf a grai	the date	e of the le		ing			
lf	you o	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line	13.		-			
b	Ente	r the minimum required contribution for this plan year		12b				
С	Ente	r the amount contributed by the employer to the plan for this plan year		12c				
d		tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the ative amount)		12d				
е	Will	the minimum funding amount reported on line 12d be met by the funding deadline?			Yes	No		N/A
Part	VII	Plan Terminations and Transfers of Assets						
13a	Has	a resolution to terminate the plan been adopted in any plan year?			Ye	s X	No	
	lf "Y	es," enter the amount of any plan assets that reverted to the employer this year		13a				
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?					Yes	Yes 🗙 No	
С		luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), ident ch assets or liabilities were transferred. (See instructions.)	tify the plan(s)	to				
1	3c(1	<b>3c(1)</b> Name of plan(s): 13c(2) E					c(3) PN	۱(s)