

**Part I Annual Report Identification Information**

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

**A** This return/report is for:  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.)

**B** This return/report is:  a one-participant plan  a foreign plan  
 the first return/report  the final return/report  
 an amended return/report  a short plan year return/report (less than 12 months)

**C** Check box if filing under:  Form 5558  automatic extension  DFVC program  
 special extension (enter description)

**Part II Basic Plan Information - enter all requested information**

<b>1a</b> Name of plan LANDMARK SERVICES, INC. HEALTH & WELFARE PLAN	<b>1b</b> Three-digit plan number (PN) <b>502</b>
	<b>1c</b> Effective date of plan 07/01/2002
<b>2a</b> 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 instr.) LANDMARK SERVICES, INC. C/O TRUST MANAGEMENT SERVICES 1 ALMADEN BOULEVARD, SUITE 950 SAN JOSE CA 95113	<b>2b</b> Employer Identification Number (EIN) 33-0943980
	<b>2c</b> Sponsor's telephone number (408) 377-3441
	<b>2d</b> Business code (see instructions) 238900
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	<b>3b</b> Administrator's EIN
	<b>3c</b> Administrator's telephone number
<b>4</b> If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. <b>a</b> Sponsor's name	<b>4b</b> EIN
	<b>4c</b> PN
<b>5a</b> Total number of participants at the beginning of the plan year	<b>5a</b> 66
<b>b</b> Total number of participants at the end of the plan year	<b>5b</b> 63
<b>c</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>5c</b>
<b>d (1)</b> Total number of active participants at the beginning of the plan year	<b>5d(1)</b>
<b>d (2)</b> Total number of active participants at the end of the plan year	<b>5d(2)</b>
<b>e</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>5e</b>

**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.

<b>SIGN HERE</b> <i>DJ Voska</i>	<u>8/10/17</u>	<u>DONALD J. VOSKA, CFO</u>
Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b> <i>DJ Voska</i>	<u>8/10/17</u>	<u>DONALD J. VOSKA, CFO</u>
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Preparer's name (including firm name, if applicable) and address (include room or suite number)		Preparer's telephone number

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)  Yes  No
- 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.)  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.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?  Yes  No  Not determined

**Part III Financial Information**

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
<b>a</b> Total plan assets	7a	473,975	510,614
<b>b</b> Total plan liabilities	7b	22,411	15,864
<b>c</b> Net plan assets (subtract line 7b from line 7a)	7c	451,564	494,750
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers	8a(1)	522,461	
(2) Participants	8a(2)	186	
(3) Others (including rollovers)	8a(3)		
<b>b</b> Other income (loss)	8b	1,005	STATEMENT 1
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		523,652
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	364,599	STATEMENT 2
<b>e</b> Certain deemed and/or corrective distributions (see instructions)	8e		
<b>f</b> Administrative service providers (salaries, fees, commissions)	8f	99,087	STATEMENT 3
<b>g</b> Other expenses	8g	16,780	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		480,466
<b>i</b> Net income (loss) (subtract line 8h from line 8c)	8i		43,186
<b>j</b> Transfers to (from) the plan (see instructions)	8j		

**Part IV Plan Characteristics**

- 9a** If the 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:  
4A 4D 4E 4F 4L

**Part V Compliance Questions**

10 During the plan year:		Yes	No	N/A	Amount
<b>a</b> 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		X		
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X		
<b>c</b> Was the plan covered by a fidelity bond?	10c	X			50,000
<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		
<b>e</b> 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		
<b>f</b> Has the plan failed to provide any benefit when due under the plan?	10f		X		
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X		
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		X		
<b>i</b> 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				

**Part VI Pension Funding Compliance**

**11** 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)  Yes  No

**11a** Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a** 0

**12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)  Yes  No

**a** 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. Month Day Year

If you 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**

**c** 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**

**e** 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  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  No

**c** 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.)

<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

**Part VIII Trust Information**

**14a** Name of trust **14b** Trust's EIN

**14c** Name of trustee or custodian **14d** Trustee's or custodian's telephone number

**Part IX IRS Compliance Questions**

**15a** Is the plan a 401(k) plan? If "No," skip b  Yes  No

**15b** How did the plan satisfy the nondiscrimination requirements for employee deferrals under section 401(k)(3) for the plan year? Check all that apply:  Design-based safe harbor  "Prior year" ADP test  "Current year" ADP test  N/A

**16a** What testing method was used to satisfy the coverage requirements under section 410(b) for the plan year? Check all that apply:  Ratio percentage test  Average benefit test  N/A

**16b** Did the plan satisfy the coverage and nondiscrimination requirements of sections 410(b) and 401(a)(4) for the plan year by combining this plan with any other plan under the permissive aggregation rules?  Yes  No

**17a** If the plan is a master and prototype plan (M&P) or volume submitter plan that received a favorable IRS opinion letter or advisory letter, enter the date of the letter and the serial number

**17b** If the plan is an individually-designed plan that received a favorable determination letter from the IRS, enter the date of the most recent determination letter

**18** Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?  Yes  No

**19** Was any plan participant a 5% owner who had attained at least age 70 1/2 during the prior plan year?  Yes  No

FORM 5500-SF OTHER INCOME (LOSS) STATEMENT 1

DESCRIPTION	AMOUNT
INTEREST BEARING CASH	1,005.
TOTAL TO FORM 5500-SF, LINE 8B	1,005.

FORM 5500-SF BENEFITS PAID STATEMENT 2

DESCRIPTION	AMOUNT
PAYMENTS DIRECTLY TO PARTICIPANTS OR BENEFICIARIES	364,599.
TOTAL TO FORM 5500-SF, LINE 8D	364,599.

FORM 5500-SF ADMINISTRATIVE SERVICE PROVIDERS STATEMENT 3

DESCRIPTION	AMOUNT
PROFESSIONAL FEES	25,214.
ADMINISTRATIVE SERVICE PROVIDERS	73,873.
TOTAL TO FORM 5500-SF, LINE 8F	99,087.

# Application for Extension of Time To File Certain Employee Plan Returns

▶ For Privacy Act and Paperwork Reduction Act Notice, see instructions.  
▶ Information about Form 5558 and its instructions is at [www.irs.gov/form5558](http://www.irs.gov/form5558)

**File With IRS Only**

**Part I Identification**

<b>A</b> Name of filer, plan administrator, or plan sponsor (see instructions)  <b>LANDMARK SERVICES, INC.</b> Number, street, and room or suite no. (If a P.O. box, see instructions) <b>C/O TRUST MANAGEMENT SERVICES</b> City or town, state, and ZIP code <b>SAN JOSE, CA 95113</b>	<b>B</b> Filer's identifying number (see instr) Employer identification number (EIN) (9 digits XX-XXXXXXX) <b>33-0943980</b>
	Social security number (SSN) (9 digits XXX-XX-XXXX) _____

<b>C</b>	Plan name	Plan number	Plan year ending -		
			MM	DD	YYYY
	<b>LANDMARK SERVICES, INC. HEALTH &amp; WELFARE PLAN</b>	<b>502</b>	<b>12</b>	<b>31</b>	<b>2016</b>

**Part II Extension of Time To File Form 5500 Series, and/or Form 8955-SSA**

- 1  Check this box if you are requesting an extension of time on line 2 to file the first Form 5500 series return/report for the plan listed in Part 1, C above.
- 2 I request an extension of time until 10/16/2017 to file Form 5500 series (see instructions).  
**Note.** A signature IS NOT required if you are requesting an extension to file Form 5500 series.
- 3 I request an extension of time until \_\_\_\_\_ to file Form 8955-SSA (see instructions).  
**Note.** A signature IS NOT required if you are requesting an extension to file Form 8955-SSA.
- The application is **automatically approved** to the date shown on line 2 and/or line 3 (above) if: (a) the Form 5558 is filed on or before the normal due date of Form 5500 series, and/or Form 8955-SSA for which this extension is requested, and (b) the date on line 2 and/or line 3 (above) is not later than the 15th day of the third month after the normal due date.

**Part III Extension of Time To File Form 5330 (see instructions)**

- 4 I request an extension of time until \_\_\_\_\_ to file Form 5330.  
You may be approved for up to a 6 month extension to file Form 5330, after the normal due date of Form 5330.
- |  |     |  |
|--|-----|--|
| a Enter the Code section(s) imposing the tax .....   | ▶ a |  |
| b Enter the payment amount attached .....  | ▶ b |  |
| c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date ..... | ▶ c |  |

5 **State in detail why you need the extension:**

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

**Signature** ▶ \_\_\_\_\_ **Date** ▶ \_\_\_\_\_