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 section 6058(a) of the Internal Revenue Code (the Code).

2009

Inspection

This Form is Open to Public

OMB Nos. 1210-0110 1210-0089

Internal Revenue Code (the Code).

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

| A This return/report is for: This return/report is for: If first return/report If first r | | art I | | scal plan year beginning 01/01/20 | 000 | and andian | 10/21/ | 2000 | | |
|--|-----|---|--------------------------|--|----------------|---------------------------------------|----------------------|--------------|--|--|
| B This return/report is for: Train Internation Inte | FU | Calenda | ar plan year 2009 or ils | | | g | 12/31/2 | | | |
| C Check box if filing under: | Α | This ret | urn/report is for: | single-employer plan | multiple-e | employer plan (not multiemployer) | one-participant plan | | | |
| C Check box if filing under: | В | This ret | urn/report is for: | first return/report | x final retur | n/report | | | | |
| Part II Basic Plan Information—enter all requested information 1 | | | | x an amended return/report | short plar | n year return/report (less than 12 mo | onths) | | | |
| Part | С | Check b | oox if filing under: | Form 5558 | automatio | extension | | DFVC program | | |
| 1a Name of plans | | | | special extension (enter descrip | tion) | | | | | |
| 1a Name of plans | Р | art II | Basic Plan Info | rmation—enter all requested infor | mation | | | | | |
| 22 Plan sponsor's name and address (employer, if for single-employer plan) 30 OB SAMARITAN HOSPITAL 50 OB SAMARITAN HOSPI | 1a | Name | | • | | | 1b | Three-digit | | |
| 22 Plan sponsor's name and address (employer, if for single-employer plan) 22 Effective date of plan | GO | OD SAM | ARITAN HOSPITAL E | MPLOYEES PENSION PLAN | | | | | | |
| 2a Plan sponsor's name and address (employer, if for single-employer plan) 3DO SAMARITAN HOSPITAL 20 DE TRIPOSE (EIN) 91-0961134 21 Plan sponsor's tame and address (employer, if for single-employer plan) 22 DE TRIPOSE (EIN) 91-0961134 22 Plan sponsor's telephone number 253-403-1306 23 DE TRIPOSE (EIN) 91-0961134 24 CP Plan sponsor's telephone number 253-403-1306 25 Business code (see instructions) 82200 26 Business code (see instructions) 82200 27 PLAN SUBSTITUTION AD 1141 AVENUE SE PUYALLUP, WA 98371-0192 28 Administrator's clephone number 253-403-1306 29 Administrator's clephone number 253-403-1306 20 Business code (see instructions) 82200 30 Plan administrator's name and address (if same as Plan sponsor, enter "Same") 40 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. Sponsor's name 40 EIN 41 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. Sponsor's name 40 EIN 41 CPN 53 Total number of participants at the end of the plan year. 54 Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 55 Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 55 Total number of participants with account balances as of the end of the plan year invested in eligible assets? (See instructions). 65 Total number of participants with account balances and report of an independent qualified public accountant (IQPA) under 26 CFR 2250.104-467 (See instructions on wavere eligibility and conditions). 65 Total plan assets and Liabilities 67 Total plan assets and Liabilities 68 (a) Beginning of Year 69 Participants 69 Total plan assets (subtract line 7b from line 7a). 70 Total plan assets (subtract line 7b fr | | | | | | | 4. | (PN) F | | |
| 22 Plan sponsor's name and address (employer, if for single-employer plan) 30-0 SAMARTAN HOSPITAL 22 Plan sponsor's telephone number 253-403-1306 24 Elin 39-10961134 25 Plan sponsor's telephone number 253-403-1306 26 Business code (see instructions) 263-403-1306 27 Business code (see instructions) 27 Plan Sponsor's telephone number 283-403-1306 284 Business code (see instructions) 284 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, elin, and the plan number from the last return/report. Sponsor's name 285 Total number of participants at the beginning of the plan year 285 Total number of participants at the end of the plan year. 286 Total number of participants at the end of the plan year. 287 Total number of participants at the end of the plan year (defined benefit plans do not complete this item). 386 Were all of the plan's assets during the plan year invested in eligible assets? (See instructions). 387 Total number of participants at the end of the plan year invested in eligible assets? (See instructions). 388 Administrator's tellophone number for participants at the end of the plan year. 389 Administrator's tellophone number 2264-03-1-300. 390 Are you claiming a waver of the annual examination and report of an independent qualified public accountant (IOPA) under 22 CFR 2520:104-497 (See instructions on waiver eligible) assets? (See instructions). 380 Administrator's tellophone number for participants at the end of the plan year. 390 Are you claiming a waver of the annual examination and report of an independent qualified public accountant (IOPA) under 22 CFR 2520:104-497 (See instructions on waiver eligibility and conditions). 390 Are you claiming a waver of the annual examination and report of an independent qualified public accountant (IOPA) under 22 CFR 2520:104-497 (See instructions on waiver eligibility and conditions). 391 Agministrative service providers (selenting the plan year of the intensity of the annual examination and repor | | | | | | | 10 | | | |
| Complete Section Sec | 22 | Plan sr | onsor's name and add | dress (employer if for single-employ | er plan) | | 2b | | | |
| 253-403-1306 225 225 225 235 2 | | | | arese (empleyer, in let single empley | or plany | | | | | |
| 37 14T AVENUE SE 22000 38 Plan administrator's name and address (if same as Plan sponsor, enter "Same") 20 30 Administrator's EIN 91-0801134 30 | | | | | | | 2c | | | |
| 3a Plan administrator's name and address (if same as Plan sponsor, enter "Same") (MBERLY LINTOTT P.O. BOX. 1247 407 14TH AVENUE SE PUYALLUP, WA 98371-0192 4. 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. Sponsor's name 4. 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. Sponsor's name 4. 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. Sponsor's name 4. 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. Sponsor's name 4. 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 of participants at the end of the plan year. 5a Total number of participants at the end of the plan year. 5b Total number of participants at the end of the plan year invested in eligible assets? (See instructions). 5c | | | | | | | 24 | | | |
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| ## AUTIFIED AND PATE OF TOTAL INCOME SEPPORTS | 3a | Plan ad | dministrator's name an | nd address (if same as Plan sponsor, | enter "Same | e") | 3b | | | |
| 4 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. Sponsor's name 4 b EIN 4 c PN 5 a Total number of participants at the beginning of the plan year. 5 b Total number of participants at the end of the plan year. 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item). 5 c Total number of participants as of the end of the plan year (defined benefits) and under 20 CPR 2520.104-46? (See instructions on waiver eligibility and conditions). 6 c Net plan assets and Labilities 6 (a) Beginning of Year 7 a 34196 6 (b) End of Year 7 a 34196 6 (c) Net plan assets (subtract line 7b from line 7a). 7 a 34196 6 (c) Net plan assets (subtract line 7b from line 7a). 7 a 34196 6 (c) Net plan assets (subtract line 7b from line 7a). 7 a 34196 6 (c) Participants 8 a(1) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | KIM | BERLY I | LINTOTT | | | | | | | |
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| b Total number of participants at the end of the plan year | | | | | | | 4c | PN | | |
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| Ga Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) | C | | | | | • | 50 | 0 | | |
| 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.) If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. Part III Financial Information 7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year 1 Total plan assets. 7 a 34196 b Total plan liabilities. 7 b 0 0 c Net plan assets (subtract line 7b from line 7a) 7 c 34196 8 Income, Expenses, and Transfers for this Plan Year a Contributions received or receivable from: (1) Employers. (2) Participants. (3) Others (including rollovers) 8 a(1) 0 (2) Participants. (3) Others (including rollovers) 8 a(3) 0 0 b Other income (loss) 8 b -201 c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) 8 c -20 d Benefits paid (including direct rollovers and insurance premiums to provide benefits) 8 d 33995 e Certain deemed and/or corrective distributions (see instructions) 8 d 33995 e Certain deemed and/or corrective distributions (see instructions) 8 d 0 9 Other expenses 8 g 0 1 Total expenses (add lines 8d, 8e, 8f, and 8g) 8 h 33996 i Net income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (loss) (subtract line 8h from line 8c) 8 let income (| 62 | | | | | | | | | |
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| Part III | | | | | | | | X Yes No | | |
| 7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year a Total plan assets. 7a 34196 (a) Total plan liabilities (b) Total plan liabilities (c) Ret plan assets (subtract line 7b from line 7a). 7c 34196 (d) Amount (e) Total plan liabilities (e) Participants (e) Amount (b) Total (e) Total | _ | | | | Form 5500- | SF and must instead use Form 55 | 500. | | | |
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| d Benefits paid (including direct rollovers and insurance premiums to provide benefits) | _ | | ` , | | | 20 | | -201 | | |
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| The self-report (form) the relations of the self-report (form) the relations (form) the relat | h | 1 Total e | expenses (add lines 8d | d, 8e, 8f, and 8g) | 8h | | | 33995 | | |
| j Transfers to (from) the plan (see instructions) | i | Net inc | come (loss) (subtract li | ine 8h from line 8c) | 8i | | | -34196 | | |
| | j | Transf | ers to (from) the plan (| (see instructions) | ···· 8j | | | | | |

| Part IV | Plan | Charac | teristics |
|---------|------|--------|-----------|

If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2C 2G 3D 3H

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

| art | ٧ | Compliance Questions | | | | | | | | | |
|-----|---|--|--------|----------|--------|---------|------|------------------|-----|--|--|
| 0 | Duri | ng the plan year: | | Yes | No | | Amou | unt | | | |
| а | | Nas there a failure to transmit to the plan any participant contributions within the time period described i 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program) | | | | 10a X | | | | | |
| b | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | | | | X | | | | | | |
| С | C Was the plan covered by a fidelity bond? | | | | | | | 100000 | | | |
| d | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | | | | | | | | | |
| е | insu | 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.) | | | | | | 2 | 151 | | |
| f | Has | as the plan failed to provide any benefit when due under the plan? | | | X | | | | | | |
| g | Did 1 | oid the plan have any participant loans? (If "Yes," enter amount as of year end.) | | | | | | | | | |
| h | | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | | | | | | | | | |
| 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 | | | | | | | | | |
| art | VI | Pension Funding Compliance | | | | | | | | | |
| 1 | | s a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com | | | | |] | Yes X | No | | |
| 2 | Is th | is a defined contribution plan subject to the minimum funding requirements of section 412 of the Code | or se | ction 3 | 302 of | ERISA? | X | Yes | No | | |
| | | es," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.) | | | | | | | | | |
| | gran | vaiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructing the waiver | th | | | | | | | | |
| - | | ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13. | | Г | 12b | 1 | | | 0 | | |
| | | r the minimum required contribution for this plan year | | | | | | | | | |
| | | r the amount contributed by the employer to the plan for this plan year | | | 12c | | | | 0 | | |
| a | 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) | | | | | | | | 0 | | |
| е | Will the minimum funding amount reported on line 12d be met by the funding deadline? | | | | | | | Α | | | |
| art | VII | Plan Terminations and Transfers of Assets | | | | | | | | | |
| 3a | Has | a resolution to terminate the plan been adopted during the plan year or any prior year? | | <u>.</u> | | | X | Yes | No | | |
| | If "Ye | es," enter the amount of any plan assets that reverted to the employer this year | | | 13a | | | | 0 | | |
| b | | | | | | | | | | | |
| С | | ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify th h assets or liabilities were transferred. (See instructions.) | ne pla | n(s) to |) | | | | | | |
| 1 | 3c(1) | Name of plan(s): | | 13 | c(2) E | IN(s) | 1: | 3c(3) PN(| s) | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| aut | on: / | penalty for the late or incomplete filing of this return/report will be assessed unless reasonab | le cau | ıse is | estab | lished. | | | | | |
| Во | Sche | alties of perjury and other penalties set forth in the instructions, I declare that I have examined this retu edule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/ true, correct, and complete. | | | | | | | | | |

| SIGN | Filed with authorized/valid electronic signature. | 07/27/2010 | KIMBERLY A LINTOTT |
|------|---|------------|--|
| HERE | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN | Filed with authorized/valid electronic signature. | 07/27/2010 | KIMBERLY A LINTOTT |
| HERE | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |