Form 5500-SF Short Form Annual Return/Report of Small E Benefit Plan						OMB Nos. 1210-0110 1210-0089				
	Department of the Treasury Internal Revenue Service	Denent Flan This form is required to be filed under sections 104 and 4065 of the Employe				2011				
En	Department of Labor nployee Benefits Security Administration	SA), and sections 6057(b) and 6058 Code (the Code).	B(a) of This Form is Open to Public							
P	Pension Benefit Guaranty Corporation         Inspection <ul> <li>Complete all entries in accordance with the instructions to the Form 5500-SF.</li> </ul>									
-		entification Information								
For	calendar plan year 2011 or fisca				2/29/2					
Α -	This return/report is for:	a single-employer plan	a multiple	-employer plan (not multiemployer)		a one-particip	pant plan			
Β.	This return/report is:	the first return/report		eturn/report						
		an amended return/report	a short pla	n year return/report (less than 12 mc	onths)	_				
C Check box if filing under:										
	Special extension (enter description)									
Part II Basic Plan Information—enter all requested information										
	Name of plan	ANE, PS 401K PROFIT SHARING I			1b	Three-digit plan number				
INLAI	ND ORTHOPAEDICS OF SPOR	ANE, PS 40TK PROFIT SHARING	PLAN			(PN) ►	001			
					1c	Effective date of 10/01				
	Plan sponsor's name and address ND ORTHOPAEDICS OF SPO	ess; include room or suite number (e	mployer, if	for a single-employer plan)	2b	Employer Identii (EIN) 91-16	fication Number			
					2c	Sponsor's telep	hone number			
	S. MCCLELLAN, SUITE 300 KANE, WA 99204				2d	509-838 Business code (	see instructions)			
		address (if same as plan sponsor, er			3b	62139 Administrator's I	-			
INLAI	ND ORTHOPAEDICS OF SPOP	(ANE, PS 820 S. MCCL SPOKANE, W		JITE 300	3c	Administrator's	elephone number			
4	If the name and/or EIN of the n	lan sponsor has changed since the la	act roturn/	conart filed for this plan, optor the	4h	509-838 EIN	3-7100			
-	name, EIN, and the plan numb		astretumn	eport med for this plan, enter the	40	EIIN				
a	Sponsor's name				4c	PN				
5a	Total number of participants at	the beginning of the plan year			5a		8			
b	Total number of participants at	the end of the plan year			5b	)				
С		count balances as of the end of the p	• •		5c		0			
6a	//						X Yes No			
	<b>b</b> Are you claiming a waiver of the annual examination and report of an independent gualified 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			
а	Total plan assets		7a	1830682		(=) =	0			
b	·						0			
С	Net plan assets (subtract line 7	'b from line 7a)	7c	1830682			0			
8	Income, Expenses, and Transf	ers for this Plan Year		(a) Amount		(b) 1	otal			
а	Contributions received or received		<b>•</b> (1)	0						
			8a(1)	0	_					
	., .		8a(2)	0	_					
b		)		-14503	_					
c	( )	8a(2), 8a(3), and 8b)	80	11000			-14503			
d		rollovers and insurance premiums								
		· · · · · · · · · · · · · · · · · · ·	8d	1812918	_					
е		ive distributions (see instructions)	8e	0						
f		s (salaries, fees, commissions)		3261	_					
g				0			4040470			
h		Be, 8f, and 8g)					1816179			
:		e 8h from line 8c)		0			-1830682			
	i ransfers to (from) the plan (se	ee instructions)	8j	0						

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## 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:

2A 2E 2F 2G 2J 2R 3D

**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	Du	ring the plan year:		Yes	No			٩mou	unt	
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)				Х					
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)         10				Х					
С	C Was the plan covered by a fidelity bond?								5	00000
d										
е					х					
f	Ha	is the plan failed to provide any benefit when due under the plan?	10f		Х					
g	Die	d the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		Х					
h		his is an individual account plan, was there a blackout period? (See instructions and 29 CFR 20.101-3.)	10h		Х					
i		Oh was answered "Yes," check the box if you either provided the required notice or one of the ceptions to providing the notice applied under 29 CFR 2520.101-3	10i							
Part	VI	Pension Funding Compliance								
11										
lf y c d <u>e</u> Part 13a b c	(If If a gra you En En Su ney Wi VII Ha If " We of	this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as applicable.) waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instruct inting the waiver	ctions, th of a	, and e	12b 12c 12d 	he da	te of th			 N/A 0 No
1	<u> </u>			13	<u>u(∠)</u> ⊏	v(S)			<u>50(3)</u>	F IN(S)
Caut	ion:	A penalty for the late or incomplete filing of this return/report will be assessed unless reasonab	le cau	use is	estab	lishe	d.	1		
Unde	r ne	nalties of periury and other penalties set forth in the instructions. I declare that I have examined this retu	irn/rei	oort ir	ncludir	na if:	applicat	ole a	Sche	dule

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.	06/27/2012	ARNOLD G. PETERSON, MD
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN			
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

Department of the Treasury Internal Revenue Service       Benefit Plan       201         Department of Labor       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).       This Form is Optimised This Form is Optimised Cuaranty Corporation         Pension Benefit Guaranty Corporation       • Complete all entries in accordance with the instructions to the Form 5500-SF.       This Form is Optimised Inspection         Part I       Annual Report Identification Information       • Complete all entries in accordance with the instructions to the Form 5500-SF.       This Form is Optimised Inspection         For calendar plan year 2011 or fiscal plan year beginning       10/01/2011       and ending       02/29/2012         A       This return/report is for:       a single-employer plan       a multiple-employer plan (not multiemployer)       a one-participant p         B       This return/report is:       the first return/report       x a short plan year return/report (less than 12 months)       DFVC program         C       Check box if filing under:       Form 5558       automatic extension       DFVC program         gecial extension (enter description)       Part II       Basic Plan Information—enter all requested information       Ib       Three-digit plan number (PN) )       001         Int       NLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHA	en to Public on							
Department of Labor       Refirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).       This Form is Optimised (the Code).         Pension Benefit Guaranty Corporation       > Complete all entries in accordance with the instructions to the Form 5500-SF.       This Form is Optimised (the Code).         Part I       Annual Report Identification Information       10/01/2011       and ending       02/29/2012         A This return/report is for:       X a single-employer plan       a multiple-employer plan (not multiemployer)       a one-participant p         B This return/report is:       the first return/report       X as short plan year return/report       DFVC program         C Check box if filing under:       Form 5558       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       10       10         1a Name of plan       Information—enter all requested information       10         Out Any or THOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       10       Three-digit plan number (PN)	en to Public on							
Pension Benefit Guaranty Corporation       Complete all entries in accordance with the instructions to the Form 5500-SF.       Inspecting         Part I       Annual Report Identification Information       Inspecting       Output State       Inspecting         For calendar plan year 2011 or fiscal plan year beginning       10/01/2011       and ending       02/29/2012         A       This return/report is for:       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.         B       This return/report is for:       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.         B       This return/report is for:       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.         B       This return/report is for:       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.       Image: Complete all entries in accordance with the instructions to the Form 5500-SF.         B       This return/report is:       Image: Complete all entries in accordance with the instruction in a multiple-employer plan information in a multiple-employer plan information in a multiple employer plan information in the first return/report is:       Image: Complete all entries information information information information infor	on							
Part I       Annual Report Identification Information         For calendar plan year 2011 or fiscal plan year beginning       10/01/2011       and ending       02/29/2012         A This return/report is for:       X a single-employer plan       a multiple-employer plan (not multiemployer)       a one-participant p         B This return/report is:       I the first return/report       X the final return/report       a one-participant p         C Check box if filing under:       Form 5558       automatic extension       DFVC program         general special extension (enter description)       DFVC program       DFVC program         Part II       Basic Plan Information—enter all requested information       1b         INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       001	lan							
A This return/report is for:       X a single-employer plan       a multiple-employer plan (not multiemployer)       a one-participant p         B This return/report is:       I the first return/report       X the final return/report       a one-participant p         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         1a Name of plan       INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       1b Three-digit plan number (PN) →         001	lan 							
B       This return/report is:       i the first return/report       i the final return/report         iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	lan							
an amended return/report         an amended return/report         X a short plan year return/report (less than 12 months)         automatic extension         automatic extension         IDFVC program         DFVC program         Special extension (enter description)         Part II         Basic Plan Information—enter all requested information         Intraction ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN         Ib         Three-digit         plan number         (PN)         001								
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         1a Name of plan       INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       1b Three-digit plan number (PN) ▶								
Image: Special extension (enter description)         Part II       Basic Plan Information—enter all requested information         1a Name of plan       1b Three-digit plan number (PN) ▶         INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       001								
Part II       Basic Plan Information—enter all requested information         1a Name of plan       1b Three-digit plan number (PN) ▶         INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       001								
1a Name of plan       1b Three-digit         INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN       1b Three-digit         plan number       (PN) ▶         001								
INLAND ORTHOPAEDICS OF SPOKANE, PS 401K PROFIT SHARING PLAN (PN) ► 001								
(PN) ► 001								
10/01/1983								
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b Employer Identification         INLAND ORTHOPAEDICS OF SPOKANE, PS       CIND 01 1 CO0400								
(EIN) 91-169842(								
820 S. MCCLELLAN, SUITE 300 2C Sponsor's telephone r 509-838-7100	umber							
2d Business code (see in	structions)							
SPORANE WA 99204 621399	,							
3a Plan administrator's name and address (if same as plan sponsor, enter "Same")       3b Administrator's EIN         INLAND ORTHOPAEDICS OF SPOKANE, PS       91-1698420								
820 S. MCCLELLAN, SUITE 300       91-1698420         SDOWANE       300	na numbar							
<u>SPOKANE WA 99204</u> 509-838-7100	he number							
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. 4 b EIN								
a Sponsor's name 4c 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	0							
C Number of participants with account balances as of the end of the plan year (defined benefit plans do not								
complete this item)	0							
6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	res   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.)								
If you answered "No" to either 6a or 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.	L_J							
Part III Financial Information								
7 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year								
a Total plan assets       7a       1830682         b Total plan liabilities       7b	0							
	0							
8 Income Expenses and Transfers for this Plan Yoar	0							
a Contributions received or receivable from:								
(1) Employers								
(2) Participants								
(3) Others (including rollovers)								
b Other income (loss)								
C     Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)     8c       d     Benefits paid (including direct rollovers and insurance premiums	-14503							
to provide benefits)								
Certain deemed and/or corrective distributions (see instructions)								
f Administrative service providers (salaries, fees, commissions)								
g Other expenses								
	1816179							
i Net income (loss) (subtract line 8h from line 8c)	1830682							
j Transfers to (from) the plan (see instructions)								

Form 5500-SF 2011

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~go	-		f

Part IV         Plan Characteristics           Pa         If the plan provides pension benefits, enter the applicable p 2A 2E 2F 2G 2J 2R 3D           b         If the plan provides welfare benefits, enter the applicable we Part V           Compliance Questions           0         During the plan year: a Was there a failure to transmit to the plan any participant c 29 CFR 2510.3-102? (See instructions and DOL's Volunta	elfare feature codes from the List of Plan Chara ontributions within the time period described in ry Fiduciary Correction Program)	icterist					
<ul> <li>Ba If the plan provides pension benefits, enter the applicable p 2A 2E 2F 2G 2J 2R 3D</li> <li>b If the plan provides welfare benefits, enter the applicable we part V Compliance Questions</li> <li>0 During the plan year:</li> <li>a Was there a failure to transmit to the plan any participant c</li> </ul>	elfare feature codes from the List of Plan Chara ontributions within the time period described in ry Fiduciary Correction Program)	icterist	c Coo				
<ul> <li>b If the plan provides welfare benefits, enter the applicable welfare benefits, enter the applicable welfare V</li> <li>Compliance Questions</li> <li>0 During the plan year:</li> <li>a Was there a failure to transmit to the plan any participant c</li> </ul>	elfare feature codes from the List of Plan Chara ontributions within the time period described in ry Fiduciary Correction Program)	icterist	c Coo				
Part V       Compliance Questions         0       During the plan year:         a       Was there a failure to transmit to the plan any participant c	ontributions within the time period described in ry Fiduciary Correction Program)				the instruc	ctions:	
<ul><li>0 During the plan year:</li><li>a Was there a failure to transmit to the plan any participant c</li></ul>	ry Fiduciary Correction Program)	r	Vaa				
a Was there a failure to transmit to the plan any participant c	ry Fiduciary Correction Program)		Vaa				
Was there a failure to transmit to the plan any participant c 29 CFR 2510.3-102? (See instructions and DOL's Volunta	ry Fiduciary Correction Program)		res	No	1	Amount	
	terest? (Do not include transactions reported	10a		x			
b Were there any nonexempt transactions with any party-in-in on line 10a.)	· · · · · · · · · · · · · · · · · · ·	10b		X			
C Was the plan covered by a fidelity bond?		10c	Х				50000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the or dishonesty?	plan's fidelity bond, that was caused by fraud	10d		X			
e Were any fees or commissions paid to any brokers, agents, insurance service or other organization that provides some instructions.)	or other persons by an insurance carrier, or all of the benefits under the plan2 (See	10e		x			
${f f}$ Has the plan failed to provide any benefit when due under t		10f		х			
g Did the plan have any participant loans? (If "Yes," enter am	ount as of year end.)	10g		x			
h If this is an individual account plan, was there a blackout pe 2520.101-3.)	riod? (See instructions and 29 CER			x			
I If 10h was answered "Yes," check the box if you either proviexceptions to providing the notice applied under 29 CFR 25.	ded the required notice or one of the	10h 10i					
nt VI Pension Funding Compliance		101					
<ol> <li>Is this a defined benefit plan subject to minimum funding req 5500).</li> <li>Is this a defined contribution plan subject to the minimum fu (If "Yes," complete 12a or 12b, 12c, 12d, and 12e below, as</li> <li>If a waiver of the minimum funding standard for a prior year i granting the waiver.</li> </ol>	nding requirements of section 412 of the Code applicable.) s being amortized in this plan year, see instruc Mont	or sect	ion 3	02 of E	RISA?	Yes	X No
ir you completed line 12a, complete lines 3, 9, and 10 of Sch	edule MB (Form 5500), and skip to line 13.						
<b>b</b> Enter the minimum required contribution for this plan year				12b			
<b>c</b> Enter the amount contributed by the employer to the plan for <b>d</b> Subtract the amount in line 12c from the amount in line 12b	this plan year	••••••		12c			
<b>d</b> Subtract the amount in line 12c from the amount in line 12b. negative amount)	Enter the result (enter a minus sign to the left c	fa	1	2d			
e Will the minimum funding amount reported on line 12d be me				Г	Yes	No	] N/A
rt VII Plan Terminations and Transfers of Asse							<u></u>
a Has a resolution to terminate the plan been adopted in any plan y	ear?			X Ye	s N	 C	
If "Yes," enter the amount of any plan assets that reverted to	the employer this year	13a			<u>L</u>		(
Were all the plan assets distributed to participants or benefici of the PBGC?	aries, transferred to another plan, or brought u	nder th	e con	trol			
If during this plan year, any assets or liabilities were transferr which assets or liabilities were transferred. (See instructions.)	ed from this plan to another plan(s), identify the	e plan(s	s) to			X Yes	∐ No
13c(1) Name of plan(s):			13c()	2) EIN	(s)	13c(3)	PN(s)
							<u>···(</u> )
ution: A penalty for the late or incomplete filing of this return	/report will be assessed unless reasonable	causo	is or	tablie	hed	<u> </u>	
fer penalties of perjury and other penalties set forth in the instructor or Schedule MB completed and signed by an enrolled actuary, a ef, it is true, correct, and complete.	tions. I declare that I have examined this rotur	lronor	t in al	Idina	if an all as h	ole, a Sche nowledge a	dule and

SIGN	and A durp	6-26-12	Arnold G. Peterson, MD
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN	and Alta	6-26-12	Arnold G. Peterson, MD
HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor