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).

OMB Nos. 1210-0110

1210-0089

2011

This Form is Open to Public Inspection

| | Complete all entries in accord | dance with | n the instructions to the Form 550 |)0-SF. | | | | |
|----------|---|---|---------------------------------------|---------|---|--|--|--|
| | art I Annual Report Identification Information | | | | | | | |
| For | calendar plan year 2011 or fiscal plan year beginning 01/01/201 | 1 | and ending | 12/31/2 | 011 | | | |
| Α . | This return/report is for: $\overline{\mathbb{X}}$ a single-employer plan \Box | a multiple-employer plan (not multiemployer) a one-participant plan | | | | | | |
| В | This return/report is: the first return/report | ne first return/report the final return/report | | | | | | |
| | an amended return/report | a short pla | n year return/report (less than 12 n | nonths) | | | | |
| C | Check box if filing under: X Form 5558 | automatic | extension | | DFVC program | | | |
| _ | special extension (enter descriptio | n) | | ı | | | | |
| Da | Irt II Basic Plan Information—enter all requested information | , | | | | | | |
| | · | ation | | 1h | Three-digit | | | |
| | Name of plan ATRIC CRITICAL CARE ASSOCIATES 401(K) PLAN | | | | plan number | | | |
| | THE STATISTIC STATE TROOPS IN THE TOTAL TOTAL STATE | | | | (PN) • 002 | | | |
| | | | | 1c | Effective date of plan | | | |
| | | | | | 01/01/1996 | | | |
| 2a | Plan sponsor's name and address; include room or suite number (er | mployer, if | for a single-employer plan) | | Employer Identification Number | | | |
| PED | ATRIC CRITICAL CARE ASSOCIATES, P.S. | | | | (EIN) 91-1603823 | | | |
| | | | | 2c | Sponsor's telephone number 509-458-5233 | | | |
| | VEST 8TH AVENUE | | | 24 | | | | |
| SPUI | KANE, WA 99204 | | | Zu | Business code (see instructions) 621111 | | | |
| 32 | Plan administrator's name and address (if same as plan sponsor, er | otor "Samo | ,"\ | 3h | Administrator's EIN | | | |
| | ATRIC CRITICAL CARE ASSOCIATES, P.S. 101 WEST 8T | TH AVENU | | 36 | 91-1603823 | | | |
| | SPOKANE, W | /A 99204 | | 3c | Administrator's telephone number | | | |
| | | | | 4. | 509-458-5233 | | | |
| 4 | If the name and/or EIN of the plan sponsor has changed since the landame, EIN, and the plan number from the last return/report. | ast return/i | report filed for this plan, enter the | 4b EIN | | | | |
| а | Sponsor's name | | | 4c | PN | | | |
| 5a | - | | | | | | | |
| b | Total number of participants at the end of the plan year | 5b | | | | | | |
| | | | | ac | | | | |
| С | Number of participants with account balances as of the end of the p complete this item) | | | 5c | 2 | | | |
| 6a | Were all of the plan's assets during the plan year invested in eligible | e assets? | (See instructions.) | | X Yes No | | | |
| b | Are you claiming a waiver of the annual examination and report of a | | | | | | | |
| | under 29 CFR 2520.104-46? (See instructions on waiver eligibility a | | • | | X Yes No | | | |
| | If you answered "No" to either 6a or 6b, the plan cannot use Fo | orm 5500- | SF and must instead use Form 5 | 500. | | | | |
| Pa | rt III Financial Information | | T | | | | | |
| 7 | Plan Assets and Liabilities | | (a) Beginning of Year | | (b) End of Year | | | |
| а | Total plan assets | . 7a | 3345424 | | 194242 | | | |
| b | Total plan liabilities | . 7b | 7524 | | 0 | | | |
| C | Net plan assets (subtract line 7b from line 7a) | 7c | 3337900 | | 194242 | | | |
| 8 | Income, Expenses, and Transfers for this Plan Year | | (a) Amount | | (b) Total | | | |
| а | Contributions received or receivable from: | 90(4) | 24000 | | | | | |
| | (1) Employers | 8a(1) | | | | | | |
| | (2) Participants | 8a(2) | | | | | | |
| L | (3) Others (including rollovers) | 8a(3) | -246706 | | | | | |
| b | Other income (loss) | | -240700 | | -222706 | | | |
| C | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | -222706 | | | |
| d | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 2904452 | | | | | |
| е | Certain deemed and/or corrective distributions (see instructions) | . 8e | | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | 16500 | | | | | |
| g | Other expenses | 8g | | | | | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | 2920952 | | | |
| i | Net income (loss) (subtract line 8h from line 8c) | | | | -3143658 | | | |
| j | Transfers to (from) the plan (see instructions) | | | | | | | |
| • | · · · · · · · · · · · · · · · · · · · | ı Oj | İ | | | | | |

| Earm | 5500 | CE | 2011 |
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| Page 2 - | 1 |
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| Part IV | Plan Characteristics |
|---------|----------------------|
| ralliv | L FIAN GNAIAGRENSIUS |

- If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 9a 2E 2F 2G 2J 2K 2R 3D
- If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

| art | V Compliance Questions | | | | | | | |
|---------|--|---------|----------|------------|-------|------|--------|--------|
| 0 | During the plan year: | | Yes | No | | Amo | ount | |
| | 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 | Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) | 10b | | X | | | | |
| С | Was the plan covered by a fidelity bond? | 10c | Χ | | | | | 250000 |
| 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 | | | | |
| е | 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 | | | | |
| f | Has the plan failed to provide any benefit when due under the plan? | 10f | | X | | | | |
| g | Did the plan have any participant loans? (If "Yes," enter amount as of year end.) | 10g | | X | | | | |
| h | If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | 10h | | X | | | | |
| 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 | | | | | | |
| art | /I Pension Funding Compliance | | | | | | | |
| 11 | Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and com 5500)) | | | | | F | Yes | No |
| 2 | Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code | | | | | | Yes | X No |
| | (If "Yes," complete 12a or 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 | | | | | | | |
| | ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13. | | | 12h | | | | |
| | Enter the minimum required contribution for this plan year | | | 12b | | | | |
| | Enter the amount contributed by the employer to the plan for this plan year | of a | | 12c 12d | | | | |
| • | negative amount) | | <u>-</u> | | ☐ Yes | | No [| N/A |
| | Will the minimum funding amount reported on line 12d be met by the funding deadline? Plan Terminations and Transfers of Assets | | | | 103 | — Ш. | 10 | IN//A |
| art | | | | | Vaa V | No | | |
| ısa | Has a resolution to terminate the plan been adopted in any plan year? | | | | Yes X | INO | | |
| <u></u> | If "Yes," enter the amount of any plan assets that reverted to the employer this year | | | | | | | |
| D | Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought up of the PBGC? | unaer i | tne co | ntroi | | | Yes | X No |
| С | If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the which assets or liabilities were transferred. (See instructions.) | ne plar | n(s) to | | | | _ | _ |
| 1 | Sc(1) Name of plan(s): | | 130 | c(2) E | IN(s) | | 13c(3) | PN(s) |
| | | | | | | | | |
| | on: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable | | | | | | | |
| | penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this retu Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/ | | | | | | | |

belief, it is true, correct, and complete.

| SIGN | Filed with authorized/valid electronic signature. | 09/28/2012 | PETER W GRAVES, M.D. |
|------|---|------------|--|
| HERE | | | 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 |

| Form 5500-SF Short F | | Report of Small Emplo | yee | OMB Nos. 1210-0110 1210-0089 | |
|--|---|---|-------------|---|--|
| Department of the Treesury Internal Revertué Service | tment of the Transury and Revenue Service This form is required to be filled under sections 104 and 4065 of the Employee | | | | |
| Department of Labor Retirement Employee Benefita Security Administration | i8(a) of | This Form is Open to Public inspection | | | |
| Pension Benefit Guaranty Composition • Complete | 00-SF. | 11134441171 | | | |
| Part I Annual Report Identificatio For calendar plan year 2011 or fiscal plan year be | n Information | 2011 and ending | | 12/31/2011 | |
| - V a single-am | <u> </u> | re-employer plan (not multiemployer | | a one-participant plan | |
| | · · · · · · · · · · · · · · · · · · · | return/report | , , | T a Alia barraharri birri | |
| B This return/report is: | | ian year return/report (less than 12 | nontha) | | |
| 片 | | | ((Origina) | DFVC program | |
| C Check box if filing under: | U | ic extension | | D beac brodian | |
| | ension (enter description) | | | | |
| Part II Basic Plan Information—ent | er all requested information | , <u>, , , , , , , , , , , , , , , , , , </u> | 1b | Three-digit | |
| Pediatric Critical Care Assoc | iates 401(k) Plan | | | plan number | |
| | | | 4. | (PN) F [| |
| | | | | Effective date of plan 01/01/1996 | |
| 2a Plan sponsor's name and address; include ro | om or sulte number (emplayer, | If for a single-employer plan) | 2b | Employer Identification Number | |
| Pediatric Critical Care Assoc | iates, P.S. | | | (EIN) 91-1603823 | |
| | | | 2c | Sponsor's telephone number | |
| 101 West 8th Avenue | | | 24 | 509-458-5233 Business code (see instructions) | |
| Spokane WA | 99204 | | 24 | 621111 | |
| - H | | ne") | 3b | Administrator's EIN | |
| 38 Plan administrator's name and address (if se Pediatric Critical Care Associations) | iates, P.S. | , | | 91-1603823 | |
| lol West 8th Avenue | 00004 | | 30 | Administrator's telephone number 509-458-5233 | |
| Spokane WA If the name and/or EIN of the plan sponsor h | 99204 has changed since the last retur | n/report filed for this plan, enter the | 4b | EIN | |
| neme, EIN, and the plan number from the la | st return/report. | , , , | 4 | | |
| 8 Sponsor's name | | | | PN | |
| 5a Total number of participants at the beginning | | | | 2 | |
| b Total number of participants at the end of th | | | <u>5h</u> | | |
| C Number of participants with account balance complete this item) | as as of the end of the plan yea | L (GGIIUGO DAUGIIT biaus do vot | 5c | 2 | |
| 6a Were all of the plan's assets during the plan | n year invested in eligible asset | s? (See instructions.) | ,,,,,,,,,,, | X Yes No | |
| Are you claiming a waiver of the applied Axe | mination and report of an inder | endent qualified public accountant (| IQPA) | | |
| under 29 CFR 2520.104-467 (See instruction if you answered "No" to either 6a or 6b, | ons on waiver eligibility and con the nian cannot use Form 55(| 00-SF and must instead use Form | 5500, | | |
| Part III Financial Information | | | · | | |
| 7 Plan Assets and Liabilities | | (a) Beginning of Year | | (b) End of Year | |
| a Total plan assets | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 3345 | | 194242 | |
| b Total plan liabilities | | | 524 | <u>(</u> | |
| C Net plan assets (subtract line 7b from line 7 | | 3337 | 900 | 194242 | |
| 8 Income, Expenses, and Transfers for this P | lan Year | (a) Amount | | (b) Total | |
| Contributions received or receivable from: (1) Employers | 8a(1 | 24 | 000 | | |
| (2) Participants | | | | | |
| (3) Others (including rollovers) | 1 |) | | | |
| b Other Income (loss) | | -246 | 706 | | |
| C Total income (add lines 8a(1), 8a(2), 8e(3), | | | | -22270 | |
| d Benefits paid (including direct rollovers and to provide benefits) | Insurance premiums 8d | 2904 | 452 | | |
| Certain deemed and/or corrective distribution | | | | | |
| f Administrative service providers (salaries, t | | | 500 | | |
| g Other expenses | | | | | |
| h Total expenses (add lines 8d, 8e, 8f, and 8 | 1 | | | 292095 | |
| I Net Income (loss) (subtract line 8h from line | | | | -314365 | |
| j Transfers to (from) the plan (see instruction | | | | F 2008 OF (0034) | |
| For Paparwork Reduction Act Notice and OMB Control Nun | ibere, see the instructions for Form 55 | 00-SF. | | Form 6600-9F (2011) v.012811 | |

| | Form 5500-SF 2011 | | Page 2 | 2 | _ | | | | | |
|-------|---|---------------------------------|---|---|------------------|------------------|--------------------|--------------------------------|------------------------|--------------|
| Par | t IV Plan Characteristics | | - | | | | , | | | . |
| 9a | If the plan provides pension benefits, enter the applicable 2E 2F 2G 20 2K 2R 3D | e pension fe | ature codes from t | the List of Plan Char | acteris | stic Co | des in | the instructi | ons: | |
| b | If the plan provides welfare benefits, enter the applicable | welfare fea | lure codes from th | e List of Plan Chara | cterist | lc Cod | es in ti | ne instructio | ns: | |
| Part | V Compliance Questions | | ···· | | - | | | | | |
| 10 | During the plan year: | | | | | Yes | No | | mount | |
| | Was there a failure to transmit to the plan any participan 29 CFR 2510.3-102? (See instructions and DOL's Volu | ntary Fiduci | ary Correction Pro | gram) | 10a | | х | • | _ | · |
| b | Were there any nonexempt transactions with any party-tion line 10a.) | n-interest? (| (Do not Include tra | nsactions reported | 10b | | х | | | |
| c | Was the plan covered by a fidelity bond? | | | | 10c | Х | | | 2 | 50000 |
| đ | or dishonesty? | | ····· | | 10d | | Х | | | |
| Ð | Were any fees or commissions paid to any brokers, age insurance service or other organization that provides sor instructions.) | me or all of t | the benefits under | the plan? (See | 109 | | х | | - | |
| f | Has the plan failed to provide any benefit when due under | er the plan? | | *************************************** | 10f | | Х | | , | |
| g | Did the plan have any participant loans? (if "Yes," enter a | amount as d | of year end.), | | 10a | | х | ······• | | |
| h | If this is an individual account plan, was there a blackout 2520.101-3.) | period? (S | ee instructions and | 1 29 CFR | 10h | | х | <u> </u> | | |
| i | if 10h was answered "Yes," check the box if you either pre- exceptions to providing the notice applied under 29 CFR | rovided the | required notice or | one of the | 101 | | | | | |
| Part | | | | | t | | | | | |
| 11 | Is this a defined benefit plan subject to minimum funding | requiremen | its? (If "Yes," see i | nstructions and com | plete : | Sched | ule \$8 | (Form | п | |
| 12 | ls this a defined contribution plan subject to the minimum (if "Yes," complete 12e or 12b, 12c, 12d, and 12e below, | n funding re as applicab | quirements of sec ole.) | tion 412 of the Code | orse | ction 3 | 02 of [| ERISA? | Yes Yes | _ |
| | If a waiver of the minimum funding standard for a prior ye granting the waiver. | ar is being | amortized in this p | Mon | th | and e | nter th Day | e date of the | letter ruli 'ear | ing |
| | you completed line 12s, complete lines 3, 9, and 10 of | Schedule N | MB (Form 5500), a | and skip to line 13. | | | | | | |
| | Enter the minimum required contribution for this plan yea | | | | | | 12b | | | |
| Ç | Enter the amount contributed by the employer to the plan | for this pla | n year | | | ··· | 12¢ | | | |
| | Subtract the amount in line 12c from the amount in line 1 negative amount) | | \-41771814 6889542841484-44 81 | | | ∟ | 12d | | | |
| | Will the minimum funding amount reported on line 12d be | | funding deadline | ? <u></u> | | ····· | | Yes | Νo | N/A |
| Part | | | | | | | | | | |
| 13a | Has a resolution to terminate the plan been adopted in any plants. | | | | | | Y | es X No | | |
| | If "Yes," enter the amount of any plan assets that reverte- | | | | | | | | | |
| | | | | *************************************** | | | ntrol | | Yes | No 🗵 |
| | If during this plan year, any assats or liabilities were trans which assats or liabilities were transferred. (See instruction | ons.) | i this plan to anoth | er plan(s), identify if | 18 plar | 1(\$) to | | 7 | | |
| 1; | 3c(1) Name of plan(s): | | | | ļ | 130 | (2) EII | <u>/(s)</u> | 13c(3) | PN(s) |
| | | | | | | | | | | |
| | on: A penalty for the late or incomplete filing of this re | | | | | | | | <u>'</u> | |
| 2R OL | r penalties of perjury and other penalties set forth in the in Schedule MB completed and signed by an enrolled actue , It is true, correct, app ⊈omplete. | structions, i ary, as well i | I declare that I hav as the electronic v | e examined this return/ ersion of this return/ | rn/rep report | ort, in and t | cluding o the b | ı, if applicab est of my kr | le, a Sche iowledge | and |
| SIGN | . \/J | - 9 | 127/12 | Peter W Gra | aves | , M. | D. | | | |
| HERE | | | Date | Enter name of in | | | | plan admin | strator | |
| SIGN | | | | | | | | | | |
| пск | Signature of employer/plan sponsor | | Date | Enter name of Ir | <u>id</u> lvidu | al sigr | as gnlf | employer o | r plan spo | nsor |