Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2011

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A This return/report is for:
- [ ] a multiemployer plan;
- [ ] a multiple-employer plan; or
- [X] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report;
- [X] the final return/report;
- [ ] an amended return/report;
- [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SPOKANE EMERGENCY MEDICINE ASSOCIATES, P.S. 401(K) PROFIT SHARING PLAN

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 07/01/1992

2a Plan sponsor's name and address, including room or suite number (Employer, if for single-employer plan)

SPOKANE EMERGENCY MEDICINE ASSOCIATES PS

PO BOX 2163
SPOKANE, WA 99210-2163

218 N BERNARD ST.
SPOKANE, WA 99201

2b Employer Identification Number (EIN)
91-1552633

2c Sponsor's telephone number
509-458-7100

2d Business code (see instructions)
621111

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 accompanying schedules, statements and attachments, 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.	09/30/2012	THOMAS TOBIN
	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
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SPOKANE EMERGENCY MEDICINE ASSOCIATES PS

PO BOX 2163
SPOKANE, WA 99210-2163

3b Administrator's EIN
91-1552633

3c Administrator's telephone number
509-458-7100

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:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	5
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**).		
a	Active participants	**6a**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a**, **6b**, and **6c**	**6d**	0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	0
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	0
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 2G 2J

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

9a Plan funding arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1)		Insurance
(2)		Code section 412(e)(3) insurance contracts
(3)	X	Trust
(4)		General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1)		**R** (Retirement Plan Information)
(2)		**MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
(3)		**SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1)		**H** (Financial Information)
(2)	X	**I** (Financial Information – Small Plan)
(3)		**A** (Insurance Information)
(4)		**C** (Service Provider Information)
(5)		**D** (DFE/Participating Plan Information)
(6)		**G** (Financial Transaction Schedules)

SCHEDULE I (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information—Small Plan

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2011

This Form is Open to Public Inspection

For calendar plan year 2011 or fiscal plan year beginning 01/01/2011 and ending 12/31/2011

A Name of plan
SPOKANE EMERGENCY MEDICINE ASSOCIATES, P.S. 401(K) PROFIT SHARING PLAN

B Three-digit plan number (PN) ▶ 001

C Plan sponsor's name as shown on line 2a of Form 5500
SPOKANE EMERGENCY MEDICINE ASSOCIATES PS

D Employer Identification Number (EIN)
91-1552633

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

			(a) Beginning of Year	**(b)** End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	1a	1040	0
b	Total plan liabilities	1b		
c	Net plan assets (subtract line 1b from line 1a)	1c	1040	0
2	**Income, Expenses, and Transfers for this Plan Year:**		**(a)** Amount	**(b)** Total
a	Contributions received or receivable:			
	(1) Employers	2a(1)		
	(2) Participants	2a(2)		
	(3) Others (including rollovers)	2a(3)		
b	Noncash contributions	2b		
c	Other income	2c	81	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		81
e	Benefits paid (including direct rollovers)	2e	1171	
f	Corrective distributions (see instructions)	2f		
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Administrative service providers (salaries, fees, and commissions)	2h		
i	Other expenses	2i	-50	
j	Total expenses (add lines 2e, 2f, 2g, 2h, and 2i)	2j		1121
k	Net income (loss) (subtract line 2j from line 2d)	2k		-1040
l	Transfers to (from) the plan (see instructions)	2l		

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	**No**	**Amount**
a	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	
c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	

		Yes	No	Amount
3f Loans (other than to participants)	3f		X	
g Tangible personal property	3g		X	

Part II Compliance Questions

4 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of plan year or classified during the year as uncollectible? Disregard participant loans secured by the participant's account balance.	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e Was the plan covered by a fidelity bond?	4e		X	
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If "No," attach an IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?
If "Yes," enter the amount of any plan assets that reverted to the employer this year ..... [X] **Yes** [ ] **No** **Amount:** 0

5b 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.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

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Annual Return/Report of Employee Benefit Plan

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

OMB Nos. 1210 - 0110
1210 - 0089

2011

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Part I Annual Report Identification Information

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B This return/report is: [ ] the first return/report; [ ] an amended return/report; [X] the final return/report; [ ] a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ▶ [ ]

D Check box if filing under: [X] Form 5558; [ ] automatic extension; [ ] the DFVC program; [ ] special extension (enter description)

Part II Basic Plan Information - enter all requested information

1a Name of plan
Spokane Emergency Medicine Associates, P.S.
401(k) Profit Sharing Plan

1b Three-digit plan number (PN) ▶ 001

1c Effective date of plan 07/01/1992

2a Plan sponsor's name and address, including room or suite number (Employer, if for a single-employer plan)

Spokane Emergency Medicine Associates PS

PO Box 2163

Spokane WA 99210-2163
218 N Bernard St.

Spokane WA 99201

2b Employer Identification Number (EIN) 91-1552633

2c Sponsor's telephone number (509) 458-7100

2d Business code (see instructions) 621111

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 accompanying schedules, statements and attachments, as well as this electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	[signature]	09/30/2012	Thomas Tobin
	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
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2011)
V.012611

118401
11-15-11

461012 784831 4522-9A 2011.04030 Spokane Emergency Medicine 4522-9A1

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")	3b Administrator's EIN
Same	3c Administrator's telephone 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:	4b EIN
a Sponsor's name	4c PN

5 Total number of participants at the beginning of the plan year	5	5
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
a Active participants	6a	
b Retired or separated participants receiving benefits	6b	
c Other retired or separated participants entitled to future benefits	6c	0
d Subtotal. Add lines 6a, 6b, and 6c	6d	0
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	0
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	0
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
2E 2G 2J

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

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) ☐ Insurance	(1) ☐ Insurance
(2) ☐ Code section 412(e)(3) insurance contracts	(2) ☐ Code section 412(e)(3) insurance contracts
(3) ☒ Trust	(3) ☒ Trust
(4) ☐ General assets of the sponsor	(4) ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules	b General Schedules
(1) ☐ R (Retirement Plan Information)	(1) ☐ H (Financial Information)
(2) ☐ MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) ☒ I (Financial Information - Small Plan)
(3) ☐ SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) ☐ A (Insurance Information)
	(4) ☐ C (Service Provider Information)
	(5) ☐ D (DFE/Participating Plan Information)
	(6) ☐ G (Financial Transaction Schedules)

Service Provider Affidavit

I certify that I have been specifically authorized in writing by the plan administrator/employer, as applicable, to enter my EFAST2 PIN on this return/report in order to electronically submit this return/report. I further certify that: (1) I will retain a copy of the administrator's/employer's specific written authorization in my records; (2) I have attached to this electronic filing, in addition to any other required schedules or attachments, a true and correct PDF copy of the first two pages of the completed Form 5500 or Form 5500-SF return/report bearing the manual signature of the plan administrator/employer under penalty of perjury; (3) I advised the plan administrator/employer that by selecting this electronic signature option the PDF image of that manual signature will be included with the rest of the return/report posted by the Department of Labor (DOL) on the Internet for public disclosure; and (4) I will communicate to the plan administrator/employer any inquiries and information that I receive from EFAST2, DOL, IRS or PBGC regarding this annual return/report.

Signature of service provider (optional)	Date	Enter name of individual signing as service provider
	9-30-2012	KEMPER ROJAS