## 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).

1210-0089

OMB Nos. 1210-0110

2013

This Form is Open to Public Inspection

Pension Be	enefit Guaranty Corporation	▶ Complete all entries in accord	rdance with the instruc	ctions to the Form 550	0-SF.		
Part I		dentification Information					
For calenda	ar plan year 2013 or fise	cal plan year beginning 01/01/201	13	and ending 1	2/31/20	013	
A This ret	urn/report is for:	x a single-employer plan	a multiple-employer p	lan (not multiemployer)		a one-partici	pant plan
<b>B</b> This ret	urn/report is:	the first return/report	the final return/report				
		an amended return/report	a short plan year retur	n/report (less than 12 mo	onths)		
C Check b	box if filing under:	X Form 5558	automatic extension			DFVC progra	am
		special extension (enter descripti	on)				
Part II	Basic Plan Infor	mation—enter all requested inform	nation				
1a Name	of plan				1b -	Three-digit	
RIVER CITY	ANESTHESIA 401(K)	PROFIT SHARING PLAN				plan number	
						(PN) ▶	001
					1c	Effective date o	
						01/01	/2004
	ponsor's name and add ′ ANESTHESIA ASSOC	dress; include room or suite number ( CIATES, PLLC	employer, if for a single-	employer plan)			fication Number 96803
4500 E DOL	OTON AVENUE				2c :	Sponsor's telep	
POST FALL	STON AVENUE S, ID 83854				2d F		(see instructions)
						62139	` ,
3a Plan a	dministrator's name and	d address XSame as Plan Sponsor I	Name Same as Plar	Sponsor Address	3b /	Administrator's	EIN
					3c /	Administrator's	telephone number
							•
		plan sponsor has changed since the	last return/report filed for	or this plan, enter the	4b	EIN	
name,	, EIN, and the plan num	plan sponsor has changed since the nber from the last return/report.	last return/report filed for	or this plan, enter the			
name, <b>a</b> Sponse	, EIN, and the plan num or's name	nber from the last return/report.	· 	· 	4c		6
name, a Sponse 5a Total r	, EIN, and the plan num or's name number of participants a				4c		6
name, a Sponso 5a Total r b Total r c Numb	, EIN, and the plan num or's name number of participants a number of participants a er of participants with a	at the beginning of the plan year at the end of the plan year	plan year (defined bene	efit plans do not	4c   5a   5b		7
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Form 5500-SF 2013 Page **2** 

Pa	rt III   Financial Information										
7	Plan Assets and Liabilities		(a) Beginning of Yea	r			(b) End	of Vo	ar .		
	al plan assets						(b) Lilu (		56166		
	Fotal plan liabilities				+						
	et plan assets (subtract line 7b from line 7a)			4				25	56166		
	Income, Expenses, and Transfers for this Plan Year	70	(a) Amount	,-			(b) To	ıtal			
	Contributions received or receivable from:		(a) Amount				(10) 10	ıaı			
	(1) Employers	8a(1)	17198	1							
	(2) Participants	8a(2)									
	(3) Others (including rollovers)	8a(3)	1860	3							
b	Other income (loss)	8b	34707	8							
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						53	37662		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	5250	0							
е	Certain deemed and/or corrective distributions (see instructions)	8e									
f	Administrative service providers (salaries, fees, commissions)	. 8f	1223	0							
g	Other expenses	8g									
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						(	64730		
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						4	72932		
j	Transfers to (from) the plan (see instructions)	8j									
Pai	t IV Plan Characteristics										
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2J 2K 2R 3B 3D	feature co	des from the List of Plan Char	acteris	tic Co	des in	the instruct	ions:			
b	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	es from the List of Plan Chara	cteristi	c Cod	es in t	he instruction	ns:			
Par	V Compliance Questions										
10	During the plan year:				Yes	No		Amo	unt		
a				10a		X		A1110	unt		
b	Were there any nonexempt transactions with any party-in-interest	? (Do not i	include transactions reported			X					
	on line 10a.)			10b		X					
				10c							
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?	-	•	10d		X					
е	Were any fees or commissions paid to any brokers, agents, or oth										
	insurance service, or other organization that provides some or all instructions.)		' '	10e		X					
f	·			10f		Χ					
g						X					
h				10g		V					
	2520.101-3.)			10h		X					
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i							
Part	VI Pension Funding Compliance										
11											
11a	1a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39										
12								No			
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,			, O. 3C	J	JUL 01					
а	If a waiver of the minimum funding standard for a prior year is beir	ng amortize	ed in this plan year, see instru		and e	_				ing	
	granting the waiver			ιn		Day		Year			
	Enter the minimum required contribution for this plan year	•			T	12b	1				
IJ	Enter the minimum required contribution for this plan year				[		i e				

Page	3 -		1
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С	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		
е	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?	Y	es X 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 coof the PBGC?	ontrol		Yes X No
С	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.)	)		
1	<b>3c(1)</b> Name of plan(s):	c(2) Ell	V(s)	<b>13c(3)</b> PN(s)
Part	VIII Trust Information (optional)			
14a	Name of trust	<b>4b</b> Tr	ust's EIN	

## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration 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).

2013

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation Complete all entries in accordance with the instructions to the Form 5500-SF. Annual Report Identification Information For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013 X a single-employer plan a multiple-employer plan (not multiemployer) A This return/report is for: a one-participant plan B This return/report is: 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 1a Name of plan 1b Three-digit River City Anesthesia 401(k) Profit Sharing Plan plan number 001 (PN) ▶ 1c Effective date of plan 01/01/2004 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number RIVER CITY ANESTHESIA ASSOCIATES, PLLC (EIN) 87-0696803 2c Sponsor's telephone number 1593 E POLSTON AVENUE 208-262-2300 2d Business code (see instructions) POST FALLS TD 83854 621399 3a Plan administrator's name and address XSame as Plan Sponsor Name XSame as Plan Sponsor Address 3b Administrator's EIN 3c Administrator's telephone number If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the 4b EIN name, EIN, and the plan number from the last return/report. a Sponsor's name 4c PN 5a Total number of participants at the beginning of the plan year ..... 5a 6 **b** Total number of participants at the end of the plan year ..... 7 5b C Number of participants with account balances as of the end of the plan year (defined benefit plans do not Yes Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) X Yes under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)..... 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)? ...... Not determined 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 prolled 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. RAYMOND BERTONI SIGN HERE lignature of plan administrator 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 Preparer's telephone number (optional) Preparer's name (including firm name, if applicable) and address; include room or suite number (optional) Jodi Calhoun 509-838-5500 Randall & Hurley, Inc 601 W Riverside

99201

Suite 1600

Pa	rt III   Financial Information						
7	Plan Assets and Liabilities		(a) Beginning of Year		ar		(b) End of Year
а	Total plan assets	. 7a	20	8323	34		2556166
b	Total plan liabilities	. 7b					
С	Net plan assets (subtract line 7b from line 7a)	. 7c	20	8323	34		2556166
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total
а	Contributions received or receivable from: (1) Employers	. 8a(1)	1719		981		
	(2) Participants	8a(2)			15 A		
	(3) Others (including rollovers)	8a(3)		1860	)3		
b	Other income (loss)	. 8b	34	4707	78		
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			S.A		537662
d	Benefits paid (including direct rollovers and insurance premiums				<u>,                                    </u>		
	to provide benefits)	. 8d		5250	,0		
<u>e</u>	Certain deemed and/or corrective distributions (see instructions)	. 8e		1000			
	Administrative service providers (salaries, fees, commissions)	. 8f		1223	30		
<u>g</u>	Other expenses	. 8g		Fe. 10 17	5.5		
<u>_n</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)						64730
<u> </u>	Net income (loss) (subtract line 8h from line 8c)						472932
	Transfers to (from) the plan (see instructions)	- 8j			145		
	t IV Plan Characteristics  If the plan provides pension benefits, enter the applicable pension						
b Par	2A 2E 2F 2G 2J 2K 2R 3B 3D     If the plan provides welfare benefits, enter the applicable welfare for the compliance Questions	eature cod	les from the List of Plan Chara	cterist	ic Coc	les in t	he instructions:
10	During the plan year:				Yes	No	Amount
а	Was there a failure to transmit to the plan any participant contribu 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu			10a		х	
b	Were there any nonexempt transactions with any party-in-interest on line 10a.)			10b		х	
C	Was the plan covered by a fidelity bond?			10c		х	
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?	fidelity bo	nd, that was caused by fraud	10d		Х	
е	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.)	her person of the ber	s by an insurance carrier, nefits under the plan? (See	10e		х	
f	Has the plan failed to provide any benefit when due under the pla	in?	***************************************	10f		Х	
g	Did the plan have any participant loans? (If "Yes," enter amount a	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)				Х	
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			10h		х	
ì	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i			
Par	VI Pension Funding Compliance						
11	Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)	nents? (If "	Yes," see instructions and com	plete	Sched	lule Si	3 (Form Yes No
11a	Enter the unpaid minimum required contribution for current year fi					11a	
12	Is this a defined contribution plan subject to the minimum funding	requirem	ents of section 412 of the Code	or se	ection	302 of	ERISA? Yes X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below						
a	If a waiver of the minimum funding standard for a prior year is being ranting the waiver.	ng amortiz	ed in this plan year, see instru	ctions ith	, and e	enter th Day	
If	you completed line 12a, complete lines 3, 9, and 10 of Schedul	e MB (Fo	rm 5500), and skip to line 13.				
<u>b</u>	Enter the minimum required contribution for this plan year				<u></u>	12b	