## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

SIGN **HERE** 

JODI CALHOUN

RANDALL & HURLEY, INC.

SPOKANE, WA 99201

601 W RIVERSIDE AVE., SUITE 1600

## 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).

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

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection** 

**Annual Report Identification Information** For calendar plan year 2014 or fiscal plan year beginning and ending 12/31/2014 X a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list A This return/report is for: of participating employer information in accordance with the form instructions) a one-participant plan a foreign plan the final return/report **B** This return/report is the first return/report an amended return/report a short plan year return/report (less than 12 months) DFVC program Form 5558 automatic extension C Check box if filing under: special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan **1b** Three-digit SPOKANE COUNTY MEDICAL SOCIETY 401(K) PLAN plan number (PN) ▶ 001 1c Effective date of plan 01/01/2002 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) **2b** Employer Identification Number SPOKANE COUNTY MEDICAL SOCIETY (EIN) 91-6053239 Sponsor's telephone number 509-325-5010 ORANGE FLAG BUILDING 104 S. FREYA, SUITE 114 Business code (see instructions) SPOKANE, WÁ 99202 621111 3b Administrator's EIN **3a** Plan administrator's name and address | Same as Plan Sponsor. 91-6053239 SPOKANE COUNTY MEDICAL SOCIETY ORANGE FLAG BUILDING 104 S. FREYA, SUITE 114 SPOKANE, WA 99202 **3c** Administrator's telephone number 509-325-5010 4b EIN 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. 4c PN a Sponsor's name Total number of participants at the beginning of the plan year ...... 5a 11 **b** Total number of participants at the end of the plan year..... 5b Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c 6 complete this item) ..... d(1) Total number of active participants at the beginning of the plan year..... 5d(1) 8 d(2) Total number of active participants at the end of the plan year..... 5d(2) 6 e Number of participants that terminated employment during the plan year with accrued benefits that were 0 5e less than 100% vested. 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 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 Filed with authorized/valid electronic signature 03/13/2015 KAREN HAGENSEN **SIGN HERE** Signature of plan administrator Date Enter name of individual signing as plan administrator

Date

Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)

Signature of employer/plan sponsor

Enter name of individual signing as employer or plan sponsor

Preparer's telephone number (optional)

509-838-5500

	Form 5500-SF 2014		Page <b>2</b>						
<b>b</b> .	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of a cunder 29 CFR 2520.104-46? (See instructions on waiver eligibility a figure answered "No" to either line 6a or line 6b, the plan cannot with the contraction of the plan cannot will be seen that the plan cannot will be seen the contraction of the plan cannot will be seen that the plan cannot will be seen the plan cannot will be seen the plan cannot will be seen that the pla	an indepe and condi ot use Fo	ndent qualified public accounta tions.) orm 5500-SF and must instead	nt (IQ	PA)  <b>Form</b>	5500.	Xes No		
	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	orogram (see ERISA section 40	121)? .		Yes	No Not determined		
Par									
7	Plan Assets and Liabilities		(a) Beginning of Yea				(b) End of Year		
	Fotal plan assets	7a	2754	123			285726		
0	Fotal plan liabilities	7b	275	100			285726		
		plan assets (subtract line 7b from line 7a)							
	ncome, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total		
	Contributions received or receivable from:  1) Employers	8a(1)	339	940					
	2) Participants	8a(2)	98	300					
	3) Others (including rollovers)	8a(3)							
-	Other income (loss)	8b	132	202					
C	Fotal income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					56942		
d I	Benefits paid (including direct rollovers and insurance premiums		450	204					
	o provide benefits)	8d	450	)91					
	Certain deemed and/or corrective distributions (see instructions)	8e	4.5	10					
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f	15	548					
<u>g</u> (	Other expenses	8g							
	Fotal expenses (add lines 8d, 8e, 8f, and 8g)	8h					46639		
	Net income (loss) (subtract line 8h from line 8c)	8i					10303		
	Fransfers to (from) the plan (see instructions)	8j							
b	2E 2F 2G 2J 2K 2R 3D  If the plan provides welfare benefits, enter the applicable welfare fe  V Compliance Questions	eature cod	les from the List of Plan Charad	cterist	ic Cod	les in t	he instructions:		
10	During the plan year:				Yes	No	Amount		
b	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)								
	on line 10a.)	`	•	10b		X			
С	Was the plan covered by a fidelity bond?			10c	X		90000		
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 other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)								
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		X			
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of year	end.)	10g		X			
h	If this is an individual account plan, was there a blackout period? (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								
Part	VI Pension Funding Compliance								
11	Is this a defined benefit plan subject to minimum funding requirements 5500) and line 11a below)								
11a	Enter the unpaid minimum required contribution for current year from	om Sched	dule SB (Form 5500) line 39			11a			
12	Is this a defined contribution plan subject to the minimum funding	requirem	ents of section 412 of the Code	or se	ction	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 bein granting the waiver.	-			, and 6 	enter th Day			

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lf :	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				
b	Enter the minimum required contribution for this plan year	12b			
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?	X	Yes N	10	
	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 PBGC?	e control		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) which assets or liabilities were transferred. (See instructions.)	s) to			
1	3c(1) Name of plan(s):	13c(2) E	IN(s)	13c(3	B) PN(s)
			_		

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

## 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).

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OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

Revenue Code (the Code).

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

For calen	dar plan year 2014 or f	iscal plan ye	ear beginning	01/01	/2014	and ending		12/31/203	1.4				
	eturn/report is for:		e-employer plan	a muli	iple-employer	plan (not multiemploye	r) (Filers	checking this b	ox must attach a list				
71 1111011	otalimoport is for.	∏ a one.	participant plan	or par	ticipating empli	oyer information in acc	cordance with the form instructions)						
R This re	As some face as as at the	$\exists$		=	ign plan								
D mis re	turn/report is	H	t return/report ended return/report	=	al return/report	rn/report (less than 12							
C Check	box if filing under:		DFVC program										
	Part II Basic Plan Information—enter all requested information												
	Basic Plan Info	rmation-	enter all requested in	nformation									
1a Name of plan SPOKANE COUNTY MEDICAL SOCIETY 401(K) PLAN							1b	Three-digit plan number (PN)	001				
							1c Effective date of plan 01/01/2002						
2a Pian s SPOKAN	sponsor's name and ad E COUNTY MEDIO	2b Employer Identification Number (EIN) 91-6053239											
ORANGE	FLAG BUILDING	3					2c Sponsor's telephone number 509-325-5010						
	FREYA, SUITE	114					2d Business code (see instructions)						
SPOKAN		WA	99202					621111	ood mondonone)				
	idministrator's name ar		L.,	sor.			3b Administrator's EIN						
SPOKAN	E COUNTY MEDIC	CAL SOC	ETY					91-605323					
							3c Administrator's telephone number						
	FLAG BUILDING						5	509-325-50	10				
	FREYA, SUITE	114											
SPOKAN		WA	99202										
name	name and/or EIN of the , EIN, and the plan nur	plan spons nber from th	or has changed since le last return/report.	the last retur	n/report filed fo	or this plan, enter the	4b EIN						
<del></del>	or's name	4c PN											
	number of participants												
<b>b</b> Total	number of participants	at the end o	f the plan year				. 5b	,	$\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$				
comple	er of participants with a ete this item)						5c						
<b>d(1)</b> Tota	al number of active par	ticipants at t	the beginning of the pl	an year			5d(1	)					
<b>d(2)</b> Tota	al number of active par	ticipants at t	the end of the plan yea	ar			5d(2	8					
e Numbe	r of participants that te	minated em	ployment during the p	lan vear with	accrued bene	fits that were							
	an 100% vested						5e		0				
SB or Sche	penalty for the late of alties of perjury and othe dule MB completed an rue, correct, and comp	er penaities d signed by	set forth in the instruc	ctions I decla	re that I have a	evamined this return/re	nort ina	luding if applies	ible, a Schedule knowledge and				
SIGN Have Avegended)					KAREN HAGENSI			EN					
HERE	Signature of plan administrator				3/6/15	Enter name of individ	individual signing as plan administrator						
SIGN					<del></del>	and the state of t							
HERE	Signature of employ	er/plan spo	onsor	Date	)	Enter name of individ	lual signi	ing as employer	or plan sponsor				
Preparer's i	name (including firm na	me, if applic	cable) and address (in	clude room o	r suite number	) (optional)	Prepai	rer's telephone r	number (optional)				
Jodi Ca								509-838-	· · · · · · · · · · · · · · · · · · ·				
	& Hurley, Indiverside Ave.		1600					JUJ-038-	3300				
Spokane		WA	99201										
Eor Penerus		WAY	33401				<u> </u>						

	Form 5500-SF 2014	N2	Page <b>2</b>						
6a b	<ul> <li>Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)</li> <li>Are you claiming a waiver of the annual examination and report of an independent qualified public accounder 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)</li> <li>If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must inst</li> </ul>							X Ye	ш
С	If the plan is a defined benefit plan, is it covered under the PBGC i							Not dete	rmined
	rt III Financial Information	770					<u> </u>		
7	Plan Assets and Liabilities	] ]	(a) Beginning of Ye	ar			(b) End	of Year	
a	Total plan assets	7a		754	23		(3) 2.70		28572
b	Total plan liabilities	. 7b							
<u>c</u>	Net plan assets (subtract line 7b from line 7a)	754	23				28572		
_8_	Income, Expenses, and Transfers for this Plan Year		(a) Amount			ï	(b) T	otal	
а	Contributions received or receivable from:	0-40		339	40			- · · · · ·	
	(1) Employers				<del></del>				
	(2) Participants	<del>                                     </del>		98	00				
	(3) Others (including rollovers)			132	0.2				
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)			134	02			<del></del>	5.004
d	Benefits paid (including direct rollovers and insurance premiums	80			+				5694
	to provide benefits)	. 8d		4509	91				
	Certain deemed and/or corrective distributions (see instructions)	8e							
_ <u>f</u>	Administrative service providers (salaries, fees, commissions)	. 8f	**	154	18				
	Other expenses	<del></del>							
	Total expenses (add lines 8d, 8e, 8f, and 8g)						46639		
	Net income (loss) (subtract line 8h from line 8c)								10303
	Transfers to (from) the plan (see instructions)	8j							
	t IV Plan Characteristics  If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2K 2R 3D	feature code	es from the List of Plan Char	acteri	stic Co	odes in	the instruct	ions:	
b	If the plan provides welfare benefits, enter the applicable welfare for	eature codes	from the List of Plan Charac	cterist	ic Cod	les in t	the instruction	ons:	
Part	V Compliance Questions								
10	During the plan year:				Yes	No		Amount	
a 	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	iciary Correc	ction Program)	10a		Х			
b	Were there any nonexempt transactions with any party-in-interest	? (Do not inc	clude transactions reported			Х			
	on line 10a.)			10b		Λ.		_	
<u>c</u>	Was the plan covered by a fidelity bond?		10c	Х	ļ 			90000	
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?	fidelity bond	, that was caused by fraud	10d		х			
е	Were any fees or commissions paid to any brokers, agents, or oth	er persons t	by an insurance carrier,						
	insurance service, or other organization that provides some or all instructions.)	of the benefi	its under the plan? (See	10e		Х			
f	Has the plan failed to provide any benefit when due under the plan			10e		Х	<del></del>		
g									
h h	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)					Х		_	
	2520.101-3.)					Х	<u> </u>		
•	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								
Part				10i			l		
11	Is this a defined benefit plan subject to minimum funding requirements 5500) and line 11a below)	ents? (If "Ye	s," see instructions and com	plete	Sched	ule SB	(Form	Yes	∏ No
11a	Enter the unpaid minimum required contribution for current year from					11a	1.		<del></del>
12	Is this a defined contribution plan subject to the minimum funding						ERISA?	Yes	X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below.								<del></del>

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling

.. Month

Day

Year

granting the waiver. .....