

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).

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

OMB Nos. 1210-0110
1210-0089

2014

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

- A** This return/report is for:
- a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)
- a one-participant plan a foreign 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 SPOKANE OMS DEFINED BENEFIT PLAN		1b Three-digit plan number (PN) ▶	002
		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) SPOKANE OMS, PLLC 12109 E. BROADWAY AVE., BUILDING C SPOKANE VALLEY, WA 99206		2b Employer Identification Number (EIN)	20-1575311
		2c Sponsor's telephone number	509-926-7106
		2d Business code (see instructions)	621210
3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. SPOKANE OMS, PLLC 12109 E. BROADWAY AVE., BUILDING C SPOKANE VALLEY, WA 99206		3b Administrator's EIN	20-1575311
		3c Administrator's telephone number	509-926-7106
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	
5a Total number of participants at the beginning of the plan year		5a	63
b Total number of participants at the end of the plan year.....		5b	37
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)		5c	
d(1) Total number of active participants at the beginning of the plan year.....		5d(1)	31
d(2) Total number of active participants at the end of the plan year.....		5d(2)	26
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....		5e	2

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.

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2015	MARK PAXTON
	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
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional)			Preparer's telephone number (optional)

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Yes 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.) Yes No
- 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)? Yes No Not determined

Part III | Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1429029	1413876
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	1429029	1413876
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)		
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	26504	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		26504
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	26549	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	15108	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		41657
i Net income (loss) (subtract line 8h from line 8c)	8i		-15153
j Transfers to (from) the plan (see instructions)	8j		

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:
1A 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 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? (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	
c Was the plan covered by a fidelity bond?	10c	X		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	
e 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			
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			

Part VI | Pension Funding Compliance

- 11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below) Yes No
- 11a** Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 **11a** 0
- 12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? .. Yes No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)
- 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 granting the waiver. Month _____ Day _____ Year _____

If 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	
c 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	
e Will the minimum funding amount reported on line 12d be met by the funding deadline?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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 control of the PBGC?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
c 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.)		

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Part VIII Trust Information (optional)

14a Name of trust	14b Trust's EIN

**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2014

**This Form is Open to Public
Inspection**

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>SPOKANE OMS DEFINED BENEFIT PLAN</u>	B Three-digit plan number (PN) ▶	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>SPOKANE OMS, PLLC</u>	D Employer Identification Number (EIN) <u>20-1575311</u>	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		
F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500		

Part I Basic Information			
1	Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2014</u>		
2	Assets:		
	a Market value	2a	<u>1425296</u>
	b Actuarial value	2b	<u>1425296</u>
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment.....	<u>0</u>	<u>0</u>
	b For terminated vested participants.....	<u>32</u>	<u>25649</u>
	c For active participants.....	<u>31</u>	<u>1154518</u>
	d Total.....	<u>63</u>	<u>1180167</u>
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>		
	a Funding target disregarding prescribed at-risk assumptions	4a	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	4b	
5	Effective interest rate	5	<u>6.37%</u>
6	Target normal cost	6	<u>69723</u>

Statement by Enrolled Actuary
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	
Signature of actuary <u>MARC M. MCCALL</u> Type or print name of actuary <u>RANDALL & HURLEY, INC.</u> Firm name <u>601 W. RIVERSIDE, SUITE 1600</u> <u>SPOKANE, WA 99201</u> Address of the firm	<u>10/14/2015</u> Date <u>14-06948</u> Most recent enrollment number <u>509-838-5500</u> Telephone number (including area code)

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

Part II Beginning of Year Carryover and Prefunding Balances		(a) Carryover balance	(b) Prefunding balance
7	Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	24532
8	Portion elected for use to offset prior year's funding requirement (line 35 from prior year)		
9	Amount remaining (line 7 minus line 8)	0	24532
10	Interest on line 9 using prior year's actual return of <u>19.99</u> %	0	4904
11	Prior year's excess contributions to be added to prefunding balance:		
a	Present value of excess contributions (line 38a from prior year)		55574
b(1)	Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.29</u> %		3496
b(2)	Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c	Total available at beginning of current plan year to add to prefunding balance		59070
d	Portion of (c) to be added to prefunding balance		0
12	Other reductions in balances due to elections or deemed elections		
13	Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	29436

Part III Funding Percentages			
14	Funding target attainment percentage	14	117.41 %
15	Adjusted funding target attainment percentage	15	119.89 %
16	Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	102.44 %
17	If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls					
18 Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
Totals ▶			18(b)	0	18(c)
					0

19	Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:	
a	Contributions allocated toward unpaid minimum required contributions from prior years	0
b	Contributions made to avoid restrictions adjusted to valuation date	0
c	Contributions allocated toward minimum required contribution for current year adjusted to valuation date	0
20	Quarterly contributions and liquidity shortfalls:	
a	Did the plan have a "funding shortfall" for the prior year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b	If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c	If line 20a is "Yes," see instructions and complete the following table as applicable:	
Liquidity shortfall as of end of quarter of this plan year		
(1) 1st	(2) 2nd	(3) 3rd
(4) 4th		

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:

1st segment: 4.99%	2nd segment: 6.32%	3rd segment: 6.99%	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code)..... **21b** 1

22 Weighted average retirement age **22** 59

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment..... **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years **28** 0

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)..... **29** 0

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6)..... **31a** 69723

b Excess assets, if applicable, but not greater than line 31a **31b** 69723

32 Amortization installments:

	Outstanding Balance	Installment
a Net shortfall amortization installment.....	0	0
b Waiver amortization installment.....	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33** 0

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)..

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....			0
36 Additional cash requirement (line 34 minus line 35).....			0
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....			0

34 0

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36) **38a** 0

b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b**

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0

40 Unpaid minimum required contributions for all years **40** 0

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

42 Amount of acceleration adjustment **42**

43 Excess installment acceleration amount to be carried over to future plan years **43**

Schedule SB, line 26 - Schedule of Active Participant Data

YEARS OF CREDITED SERVICE

Attained Age	Under 1		1 To 4		5 To 9		10 To 14		15 To 19		20 To 24		25 To 29		30 To 34		35 To 39		40 & Up	
	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp
Under 25	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25 to 29	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30 to 34	0	0	2	0	4	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
35 to 39	0	0	1	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
40 to 44	0	0	3	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 49	0	0	4	0	3	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
50 to 54	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55 to 59	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
60 to 64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65 to 69	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70 & Up	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Name of plan: Spokane OMS Defined Benefit Plan
 Plan sponsor's name: Spokane Oral & Maxillofacial Surgery

Plan number: 002
 EIN: 91-1691190

Spokane OMS Defined Benefit Plan

EIN: 20-1575311

Plan Number: 002

Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

Economic Assumptions

	<u>January 1, 2013</u>	<u>January 1, 2014</u>
Interest rates for Calculations Under IRC 430 and IRC 436:		
1st Segmented Interest Rate (0-5 years)	4.94%	4.99%
2nd Segmented Interest Rate (5-20 years)	6.15%	6.32%
3rd Segmented Interest Rate (20+ years)	6.76%	6.99%
Effective Interest Rate	6.29%	6.37%
Interest rates for Calculations Under IRC 404:		
1st Segmented Interest Rate (0-5 years)	1.66%	1.28%
2nd Segmented Interest Rate (5-20 years)	4.47%	4.05%
3rd Segmented Interest Rate (20+ years)	5.52%	5.07%
Traditional funding	6.50%	6.50%
FAS 35 liability	6.50%	6.50%
Salary scale:		
ERISA funding	0.00%	0.00%
Maximum compensation limit	\$255,000	\$260,000
Maximum benefit limit	\$205,000	\$210,000
Expenses	\$0	\$0

Actuarial Methods

Minimum and maximum contributions	
Actuarial value of assets	Market value of assets
Plan Year	January 1 to December 31
Measurement date	January 1
Traditional funding methods	
Normal cost and accrued liability	Individual Aggregate Cost Method

Spokane OMS Defined Benefit Plan

EIN: 20-1575311

Plan Number: 002

Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

Demographic Assumptions

Mortality - Funding (Post PPA)	
Post-retirement	2014 Optional Small Plans Male/Female
Pre-retirement	None
Mortality - 417(e) (Post PPA)	
Post-retirement	2014 Applicable Mortality Table
Pre-retirement	None
Mortality - Traditional (Pre PPA)	
Post-retirement	1983 Group Blended Annuity (GA83GATT)
Pre-retirement	None
Probability of Lump Sum	95%
Termination	None
Disability	None
Retirement Age	Later of age 59 and 5 years of participation.
Subsidized Retirement Age	100% at age 59. Unreduced from Normal Retirement Age.

Form 5500-SF

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Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Short Form Annual Return/Report of Small Employee Benefit Plan

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OMB Nos. 1210-0110
1210-0089

2014

This Form Is Open to Public Inspection

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

Part I Annual Report Identification Information

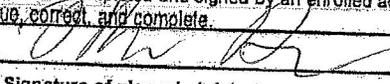
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 - a foreign plan
- B** This return/report is:
- the first return/report
 - the final return/report
 - an amended return/report
 - a short plan year return/report (less than 12 months)
- C** Check box if filing under:
- Form 5558
 - automatic extension
 - special extension (enter description)
 - DFVC program

Part II Basic Plan Information—enter all requested information

1a Name of plan Spokane OMS Defined Benefit Plan	1b Three-digit plan number (PN) ▶	002
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) Spokane OMS, PLLC 12109 E. Broadway Ave., Building C Spokane Valley WA 99206	1c Effective date of plan	01/01/2004
3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor, Spokane OMS, PLLC 12109 E. Broadway Ave., Building C Spokane Valley WA 99206	2b Employer identification Number (EIN) 20-1575311	
	2c Sponsor's telephone number	509-926-7106
	2d Business code (see instructions)	621210
	3b Administrator's EIN	20-1575311
	3c Administrator's telephone number	509-926-7106
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	
5a Total number of participants at the beginning of the plan year	5a	63
b Total number of participants at the end of the plan year	5b	37
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c	
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e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	2

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.

SIGN HERE		10/14/15	MARK PAXTON
	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
Preparer's name (including firm name, if applicable) and address (include room or suite number.) (optional)			Preparer's telephone number (optional)

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Yes 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.) Yes No
- 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)? Yes No Not determined

Part III | Financial Information

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b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	1429029	1413876
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)		
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	26504	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		26504
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	26549	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	15108	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		41657
i Net income (loss) (subtract line 8h from line 8c)	8i		-15153
j Transfers to (from) the plan (see instructions)	8j		

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:
1A 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 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? (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	
c Was the plan covered by a fidelity bond?	10c	X		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	
e 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			
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			

Part VI | Pension Funding Compliance

- 11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below) Yes No
- 11a** Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 **11a** 0
- 12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ... Yes No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)
- 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 granting the waiver. Month _____ Day _____ Year _____

**SCHEDULE SB
(Form 5500)**

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

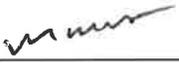
▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan Spokane OMS Defined Benefit Plan		B Three-digit plan number (PN) ▶	002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF Spokane OMS, PLLC		D Employer Identification Number (EIN) 20-1575311	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500	

Part I Basic Information			
1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2014</u>			
2 Assets:			
a Market value		2a	1425296
b Actuarial value		2b	1425296
3 Funding target/participant count breakdown			
	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	0	0	0
b For terminated vested participants	32	25649	25649
c For active participants	31	1154518	1163136
d Total	63	1180167	1188785
4 If the plan is in at-risk status, check the box and complete lines (a) and (b) <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions		4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor		4b	
5 Effective interest rate		5	6.37%
6 Target normal cost		6	69723

Statement by Enrolled Actuary
To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	Marc M. McCall 	10/14/2015
Signature of actuary		Date
Marc M. McCall		1406948
Type or print name of actuary		Most recent enrollment number
Randall & Hurley, Inc.		509-838-5500
Firm name		Telephone number (including area code)
601 W. Riverside, Suite 1600		
Spokane WA 99201		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:

a Segment rates:

1st segment: 4.99%	2nd segment: 6.32%	3rd segment: 6.99%	<input type="checkbox"/> N/A, full yield curve used
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b Applicable month (enter code) **21b** 1

22 Weighted average retirement age **22** 59

23 Mortality table(s) (see instructions) Prescribed - combined Prescribed - separate Substitute

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment Yes No

25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment Yes No

26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment Yes No

27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment **27**

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years **28** 0

29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) **29** 0

30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):

a Target normal cost (line 6) **31a** 69723

b Excess assets, if applicable, but not greater than line 31a **31b** 69723

32 Amortization installments:	Outstanding Balance	Installment
a Net shortfall amortization installment	0	0
b Waiver amortization installment	0	0

33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33** 0

34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) ... **34** 0

	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement			0

36 Additional cash requirement (line 34 minus line 35) **36** 0

37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 0

38 Present value of excess contributions for current year (see instructions)

a Total (excess, if any, of line 37 over line 36) **38a** 0

b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b**

39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0

40 Unpaid minimum required contributions for all years **40** 0

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:

a Schedule elected 2 plus 7 years 15 years

b Eligible plan year(s) for which the election in line 41a was made 2008 2009 2010 2011

42 Amount of acceleration adjustment **42**

43 Excess installment acceleration amount to be carried over to future plan years **43**

Spokane OMS Defined Benefit Plan

EIN: 20-1575311

Plan Number: 002

Schedule SB, Line 22 – Description of Weighted Average Retirement Age

Age	Percent of Remaining Active Population Retiring at Age	Percent of Original Population Retiring at Age	Percent of Original Population Remaining at Age	Age times Percent of Population Retiring at Age
59	100.00%	100.00%	0.00%	59.00
60	0.00%	0.00%	0.00%	0.00
61	0.00%	0.00%	0.00%	0.00
62	0.00%	0.00%	0.00%	0.00
			Total	<u>59.00</u>
Weighted Average Retirement Age (Nearest Whole Age):				<u>59.00</u>

Spokane OMS Defined Benefit Plan
EIN: 20-1575311
Plan Number: 002
Schedule SB, Part V – Summary of Plan Provisions

Background

Effective Date	January 1, 2004
Latest Amendment Date	May 15, 2009
Plan Year	January 1 to December 31

Definitions

Eligibility Service	Each Plan year in which 1,000 hours are completed while an employee.
Benefit Service	Each Plan year in which 1,000 hours are completed while a participant.
Vesting Service	Each Plan year in which 1,000 hours are completed while an employee. No vesting service was granted prior to the effective date of the plan.
Average Monthly Compensation	The average compensation is based on all Plan years (career average).
Normal Retirement Age	Accrued benefits through 1/1/2009: January 1st nearest age 59 and 5 years of participation. Accrued benefit post 1/1/2009: January 1st nearest age 62 and 5 years of participation.

Eligibility

Eligibility for Participation	All employees become eligible to participate in the Plan on the January 1st or July 1st following the completion of Eligibility Service and the attainment of age 21.
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