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.

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 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) Basic Plan Information—enter all requested information Part II 1a Name of plan 1b Three-digit SPOKANE OMS 401(K) PLAN plan number (PN) ▶ 001 1c Effective date of plan 01/01/1998 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number SPOKANE OMS, PLLC (EIN) 20-1575311 Sponsor's telephone number 509-926-7106 12109 E. BROADWAY AVE., BUILDING C SPOKANE VALLEY, WA 99206 Business code (see instructions) 621210 **3a** Plan administrator's name and address XSame as Plan Sponsor. Administrator's EIN **3c** Administrator's telephone number 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 51 **b** Total number of participants at the end of the plan year..... 5b 46 Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c 46 complete this item) 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 5e 4 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 t | 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 individ | ual signing as employer or plan sponsor | | | | |
| Preparer's | name (including firm name, if applicable) and address (include r | Preparer's telephone number (optional) | | | | | | |
| JODI CALHO | OUN | | | 500 000 5500 | | | | |
| RANDALL & | HURLEY INC. | | | 509-838-5500 | | | | |
| 601 W. RIVE | ERSIDE | | | | | | | |
| SUITE 1600 | | | | | | | | |

SPOKANE, WA 99201

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|----------|--|-------------|---------------------------------|-------|-----------|-----------------|---------|---------------------|--------|--|
| b | Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) | | | | | | | X Yes | | |
| | f the plan is a defined benefit plan, is it covered under the PBGC in | surance p | orogram (see ERISA section 40 |)21)? | | Yes | No | Not dete | rmined | |
| Par | t III Financial Information | 1 | 1 | | | | | | | |
| | Plan Assets and Liabilities | | (a) Beginning of Yea | | | | (b) End | | 101 | |
| | Total plan assets | 7a | 30927 | 771 | | | | 3550 | 101 | |
| | Total plan liabilities | 7b | 30927 | 771 | | | | 2550 | 101 | |
| | Net plan assets (subtract line 7b from line 7a) | 7c | | 7.1 | 355010 | | | | 101 | |
| | Income, Expenses, and Transfers for this Plan Year Contributions received or receivable from: | | (a) Amount | | (b) Total | | | | | |
| | (1) Employers | 8a(1) | 1595 | 512 | | | | | | |
| | (2) Participants | 8a(2) | 1248 | 313 | | | | | | |
| | (3) Others (including rollovers) | 8a(3) | 1452 | | | | | | | |
| <u>b</u> | Other income (loss) | 8b | 1114 | 199 | | | | | | |
| | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | | 541 | 086 | |
| | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 684 | 125 | | | | | | |
| | Certain deemed and/or corrective distributions (see instructions) | 8e | | | | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | 153 | 331 | | | | | | |
| g | Other expenses | 8g | | | | | | | | |
| h | Total expenses (add lines 8d, 8e, 8f, and 8g) | 8h | | | | | | 83 | 756 | |
| i | Net income (loss) (subtract line 8h from line 8c) | 8i | | | | | | 457 | 330 | |
| j | Transfers to (from) the plan (see instructions) | 8j | | | | | | | | |
| Par | t IV Plan Characteristics | | | | | | | | | |
| | 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 | | | | | | | | 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) | | | | | X | | | | |
| | Were there any nonexempt transactions with any party-in-interest 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 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.) | | | | | X | | | | |
| 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 e | end.) | 10g | | X | | | | |
| h | h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) | | | | | Х | | | | |
| 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 | Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below) | | | | | | | Yes | s No | |
| 11a | Enter the unpaid minimum required contribution for current year fr | | | | | 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 | s X No | |
| | (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, | | | | | | | | | |
| а | If a waiver of the minimum funding standard for a prior year is beir granting the waiver. | - | | | , and 6 | enter th Day | | ie letter r Year | uling | |

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|--|---|----------------------------|----------------------|---------|---------|-----------------|------|
| lf : | you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For | m 5500), and skip to lin | e 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 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 the | nis year | | 13a | | | |
| b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the of the PBGC? | | | | | | Yes | (No |
| С | If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.) | in to another plan(s), ide | ntify the plan(s) to |) | | | |
| 1 | 3c(1) Name of plan(s): | | 130 | c(2) EI | N(s) | 13c(3) P | N(s) |
| | | | | | | | |
| | | | 1 | | | l | |

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

Form 5500-SF

Department of the Treasury

Short Form Annual Return/Report of Small Employee Benefit Plan

| Internal Revenue Service This | I his form is required to be filed under sections 104 and 4065 of the Employee Retirement 4014 | | | | | | | | |
|---|--|------------------------------|--|--|--|--|--|--|--|
| CITIACASE DECISION SECURITY ACTIONS (1980) | Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). This Form is Open | | | | | | | | |
| Pension Benefit Guaranty Corporation | Public Inspection | | | | | | | | |
| Part I Annual Report Identif | ication Information | | | | | | | | |
| For calendar plan year 2014 or fiscal plan- | | /01/2014 | and ending | | 31/2014 | | | | |
| A This return/report is for: | | | | | | | | | |
| A This return/report is for: 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 ar | | | n/report (less than 12 m | onths) | | | | | |
| C Check box if filling under: | | autometic extension | Company of the control of the | | m 2-a | | | | |
| is interest and galleon. | lal extension (enter description) | | | ∏ nr | FVC program | | | | |
| | | • | | | | | | | |
| Part II Basic Plan Information 1a Name of plan | 1-enter all requested informat | lon. | | | | | | | |
| Spokane OMS 401(k) Plan | | | | 1b Three | | | | | |
| * 100 O T T T T T T T T T T T T T T T T T T | | | | (PN) | number 0.01 | | | | |
| | | | | 1c Effec | live date of plan | H^{-} | | | |
| 2a Plan sponsor's name and address; inc | ude room or suite number (em | ninver if for a single | | Production of the last | 01/1998 | | | | |
| Spokane OMS, PLLC | and the second of agree the second second | biokei' ii fol g sindle | -employer plan) | 2b Employer Identification Number (EIN) 20-1575311 | | | | | |
| 12109 E. Broadway Ave., Bu | utldfnæ 0 | | | 2c Sponsor's telephone number | | | | | |
| and a second of the second of | reraing to | | | 509-926-7106 | | | | | |
| Spokane Valley WA 99206 | | | | | 2d Business code (see instructions) 621210 | | | | |
| 3a Plan administrator's name and address XSame as Plan Sponsor. | | | | | 3b Administrator's EIN | | | | |
| | | | | | | | | | |
| * | | | | | 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 a Sponsor's name | the last return/report. | | CONTRACTOR SECTION ASSESSMENT | | | ╂┼─ | | | |
| 5a Total number of participants at the beg | inning of the plan year | | · · · · · · · · · · · · · · · · · · · | 4c PN | | <u> </u> | | | |
| b Total number of participants at the end | of the plan year | **************************** | *************************************** | 5a | | 51 | | | |
| C Number of participants with account ba | lances as of the end of the olar | n vear (defined bone | Et plana da nat | 5b. | | 46 | | | |
| Complete tills item) | and other and a served from the serve of the | 7 37 | | 5c | | 46 | | | |
| -(1) 1 distribution of active participants a | it the beginning of the plan year | r | green tif kan to to en en en en en en en | 5d(1) | | 31 | | | |
| d(2) Total number of active participants a | t the end of the plan year | | | 5d(2) | r de la la langua de | 26 | | | |
| Number of participants that terminated a less than 100% vested | imployment during the plan yea | ar with accrued benef | fits that were | 5e | ing and the same of the same o | 11 | | | |
| Caution: A penalty for the fate or incomp | late filling of this return from | Fuill be seened. | -1 | in the contribution | | 4 | | | |
| Under penalties of perjury and other penalties SB or Schedule MB completed and stoned by | s set forth in the instructions, I | declare that I have e | mess reasonable cau | se is establi | shed. | | | | |
| SB or Schedule MB completed and signed belief, it is true, correct, and complete. | y an enrolled actuary, as well a | as the electronic vers | ion of this return/report, | and to the b | est of my knowledge an | d | | | |
| SIGN /// | | 10/14/18 | MARK PAXTON | ''' | | ++- | | | |
| HERE Signature of plan administrat | or | Date | | | | 1 | | | |
| SIGN | | Dato | Enter name of Individu | iai signing as | plan administrator | #- | | | |
| HERE Signature of employer/plan sp | ponsar | Date | Enter name of Individu | al cigning on | employer or plan spons | H | | | |
| Preparer's name (including firm name, if app Jodi Calhoun | licable) and address (include re | oom or suite number |) (optional) | Preparer's to | employer or plan spons elephone number (option | ra() | | | |
| Randall & Hurley Inc. | | 2 | : | 100.0 | 19-838-5500 | | | | |
| 601 W. Riverside | | | 1 | f., | | | | | |
| Sulte 1600 | | | | | A 100 | in Page | | | |
| Spokane WA | 99201 | | | | d | | | | |

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|---|---|--------------|---------------------------------|-------------------|----------|-----------|-----------|----------|------|--|--|
| b | 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) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) | | | | | | A) | | | | |
| | If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500. If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No | | | | | | | | ned | | |
| Par | t III Financial Information | · · | | | | | <u> </u> | | | | |
| | Plan Assets and Liabilities | | (a) Beginning of Yea | r | | | (b) End | of Year | | | |
| | Total plan assets | 7a | | 9277 | 1 | | (2) 2.1.4 | | 0101 | | |
| b | Total plan liabilities | 7b | - 12345678901234 | 5 | | | 1234 | 56789012 | 345 | | |
| С | Net plan assets (subtract line 7b from line 7a) | 7c | 309 | 9277 | 1 | 355010 | | | | | |
| 8 | Income, Expenses, and Transfers for this Plan Year | | (a) Amount | | | (b) Total | | | | | |
| | Contributions received or receivable from: (1) Employers | 8a(1) | 15 | 5951 | .2 | | | | | | |
| | (2) Participants | 8a(2) | | 2481 | | | | | | | |
| | (3) Others (including rollovers) | 8a(3) | | 1526 | | | | | | | |
| | Other income (loss) | 8b | 11 | L149 | 9 | | | | | | |
| | Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) | 8c | | | | | | 54 | 1086 | | |
| | Benefits paid (including direct rollovers and insurance premiums to provide benefits) | 8d | 6 | 842 | 25 | | | | | | |
| | Certain deemed and/or corrective distributions (see instructions) | 8e | - 12345678901234 | - 123456789012345 | | | | | | | |
| f | Administrative service providers (salaries, fees, commissions) | 8f | - 12345678901231 | L533 | 31 | | | | | | |
| g | Other expenses | | | | | | | | | | |
| <u>h</u> | Total expenses (add lines 8d, 8e, 8f, and 8g) | | | | | | -1234 | 8 | 3756 | | |
| | Net income (loss) (subtract line 8h from line 8c) | 8i | 8i | | | | 1234 | 45 | 7330 | | |
| | Transfers to (from) the plan (see instructions) | | | | | | | | | | |
| | Part IV Plan Characteristics | | | | | | | | | | |
| 9a | 9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 2A 2E 2G 2J 2K 2R 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 | Part V Compliance Questions | | | | | | | | | | |
| 10 | During the plan year: | | | | Yes | No | | Amount | | | |
| а | | tions withir | the time period described in | | | Х | | | | | |
| b | , , , , | ? (Do not i | nclude transactions reported | 10a | | X | | 56/89012 | | | |
| | on line 10a.) | | | 10b | | | - 1236 | 00/89012 | 4066 | | |
| С | Was the plan covered by a fidelity bond? | | | 10c | X | | - 1234 | 25 | 0000 | | |
| d | Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? | | | | | Х | - 1234 | 56789012 | 2345 | | |
| е | Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all cinstructions.) | of the bene | efits under the plan? (See | 10e | | Х | - 1234 | 56789012 | 2345 | | |
| f | Has the plan failed to provide any benefit when due under the plan | n? | | 10f | | X | - 1234 | | | | |
| g | Did the plan have any participant loans? (If "Yes," enter amount as | s of year e | nd.) | 10g | | X | - 1234 | 56789013 | 2345 | | |
| h | | | | 10h | | Х | | | | | |
| i | If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101 | • | | 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) | | | | | | | | | | |
| 11a | Enter the unpaid minimum required contribution for current year from | om Sched | ule SB (Form 5500) line 39 | | | 11a | | | | | |
| 12 | Is this a defined contribution plan subject to the minimum funding | requireme | ents of section 412 of the Code | orse | ection 3 | 302 of | ERISA? | Yes X | No | | |

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

(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)

granting the waiver.