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

2017

This Form is Open to Public Inspection

Parti	Annuai Repor	t identification information									
For calenda	ar plan year 2017 or	fiscal plan year beginning 01/01/2	2017	and ending 12	2/31/2017						
A This ret	turn/report is for:	X a single-employer plan		olan (not multiemployer) (F mployer information in ac	_						
D		a one-participant plan	a foreign plan	foreign plan							
B This retu	urn/report is	the first 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	m					
		special extension (enter desc	ription)								
Part II	Basic Plan Inf	ormation—enter all requested in	formation								
1a Name	of plan				1b Three-digit	t l					
		NTER PLLC 401K PROFIT SHARIN	IG PLAN		plan numb	er					
					(PN) •	001					
					1c Effective d	ate of plan 01/01/2009					
2a Plan si	ponsor's name (emp	loyer, if for a single-employer plan)				dentification Number					
Mailing	g address (include ro	om, apt., suite no. and street, or P.O				82-0506680					
-		nce, country, and ZIP or foreign post	tal code (if foreign, see ins	tructions)	,	telephone number					
GRAND TET	ON SURGICAL CEN	NTER PLLC				8-524-3800					
				-	2d Business o	ode (see instructions)					
2290 COROI	NADO STREET					621111					
IDAHO FALL	S, ID 83404					021111					
3a Plan a	dministrator's name	and address X Same as Plan Spo	nsor.		3b Administra	tor's EIN					
				-	3c Administra	tor's telephone number					
					Administra	tor 3 telepriorie namber					
4 If the r	name and/or EIN of t	he plan sponsor or the plan name h	as changed since the last	return/report filed for	4b EIN						
•		onsor's name, EIN, the plan name a	and the plan number from	the last return/report.	4.1						
•	or's name				4d PN						
C Plan N	lame										
5a Total r	number of participant	ts at the beginning of the plan year.			5a	18					
b Total r	number of participant	ts at the end of the plan year			5b	19					
C Numb	er of participants with	n account balances as of the end of	the plan year (only define	d contribution plans	5c	19					
	,	participants at the beginning of the p		T T T T T T T T T T T T T T T T T T T	5d(1)	13					
` '	•	participants at the end of the plan ye	•	<u> </u>	5d(2)	13					
		no terminated employment during the		F	` '						
than	100% vested				5e	0					
		e or incomplete filing of this retur									
		other penalties set forth in the instru and signed by an enrolled actuary, a									
	true, correct, and cor				, 10 110 0001	,omoago and					
SIGN	Filed with authorize	d/valid electronic signature.	04/06/2018	TODD WILLIAMS, M.E).						
HERE	Signature of plan	administrator	Date	Enter name of individu	n administrator						
SIGN											
HERE	Signature of emp	loyer/plan sponsor	Date	Enter name of individu	ual signing as em	ployer or plan sponsor					
		2 P	* · · · *			, , , ,					

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6a 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.)							X Yes X Yes	No 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 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year									
Pa	rt III Financial Information	1								
7	Plan Assets and Liabilities		(a) Beginning (of Year			(b) End	of Year		
а	Total plan assets	7a	2:	24086				301030		
<u>b</u>	Total plan liabilities	tal plan liabilities								
<u> </u>	Net plan assets (subtract line 7b from line 7a)	7c	22	24086				301030		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	ıt			(b) ⁻	Total		
<u>а</u>	Contributions received or receivable from: (1) Employers	8a(1)		18276						
	(2) Participants	8a(2)	,	32586						
	(3) Others (including rollovers)	8a(3)		2193						
<u>b</u>	Other income (loss)	8b	:	25293						
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						78348		
d 	Benefits paid (including direct rollovers and insurance premiums to provide benefits)									
е	Certain deemed and/or corrective distributions (see instructions)	tain deemed and/or corrective distributions (see instructions) 8e								
f	Administrative service providers (salaries, fees, commissions)	dministrative service providers (salaries, fees, commissions) 8f								
g	Other expenses	8g								
<u>h</u>	h Total expenses (add lines 8d, 8e, 8f, and 8g)							1404		
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i						76944		
j	Transfers to (from) the plan (see instructions)	ransfers to (from) the plan (see instructions)								
Pa	t IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2J 2K 2T 3D	feature co	des from the List of Pl	an Cha	racteris	stic Co	des in the ins	tructions:		
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	acterist	ic Cod	les in the instr	uctions:		
Par	t V Compliance Questions									
10	During the plan year:				Yes	No		Amount		
а	Was there a failure to transmit to the plan any participant contributed described in 29 CFR 2510.3-102? (See instructions and DOL's V	oluntary F	iduciary Correction	100		X				
b	Program) Were there any nonexempt transactions with any party-in-interest reported on line 10a.)	? (Do not	include transactions	10a 10b		X				
c				10c	Χ			250	00	
d		fidelity bo	nd, that was caused	10d		X		200		
е	 by fraud or dishonesty? 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?	<u></u>	10f		Χ				
g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year-e	end.)	10g	X			210	30	
h	If this is an individual account plan, was there a blackout period? (2520.101-3.)	•		10h		Χ				
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						

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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 contributions for all years from Schedule SB (Form 5500) line 40	11a						
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section ERISA?	n 302 of			es X No			
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and granting the waiver	d enter t		of the letter Year	ruling			
lf y	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						
e Will the minimum funding amount reported on line 12d be met by the funding deadline?								
Part '	VII Plan Terminations and Transfers of Assets							
13a	Has a resolution to terminate the plan been adopted in any plan year?		Yes	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 control of the PBGC?			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.)) to						
1	3c(1) Name of plan(s): 13c(2)	EIN(s)		13c(3)	PN(s)			

Form 5500-SF

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).

This Form is Open to

OMB Nos. 1210-0110

1210-0089

2017

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

Annual Report Identification Information For calendar plan year 2017 or fiscal plan year beginning and ending 01/01/2017 12/31/2017 a multiple-employer plan (not multiemployer) (Filers checking this box must attach a x a single-employer plan list of participating employer information in accordance with the form instructions.) A This return/report is for: a foreign plan 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 **1b** Three-digit 1a Name of plan plan number GRAND TETON SURGICAL CENTER PLLC (PN) ▶ 001 401K PROFIT SHARING PLAN 1c Effective date of plan 01/01/2009 2a Plan sponsor's name (employer, if for a single-employer plan) 2b Employer Identification Number Mailing address (include room, apt., suite no. and street, or P.O. Box) (EIN)82-0506680 City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2c Sponsor's telephone number. GRAND TETON SURGICAL CENTER PLLC (208) 524-3800 2d Business code (see instructions) 2290 CORONADO STREET IDAHO FALLS ID 83404 621111 3a Plan administrator's name and address X Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 4b EIN If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. 4d PN a Sponsor's name c Plan Name 5a 5a Total number of participants at the beginning of the plan year 18 5b 19 b Total number of participants at the end of the plan year c Number of participants with account balances as of the end of the plan year (only defined contribution plans 5c 19 complete this item) 5d(1) d(1) Total number of active participants at the beginning of the plan year 13 5d(2) 13 d(2) Total number of active participants at the end of the plan year Number of participants who terminated employment during the plan year with accrued benefits that were less 5e 0 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 TODD WILLIAMS, M.D. SIGN HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE Enter name of individual signing as employer or plan sponsor Signature of employer/plan sponsor Date

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b Are und	re all of the plan's assets during the plan year invested in eligibly you claiming a waiver of the annual examination and report of er 29 CFR 2520.104-467 (See instructions on waiver eligibility	an Indepe and condi	ndent qualified public a	ccount	ant (IC	QPA)			Yes No
C If the	ou answered "No" to either line 6a or line 6b, the plan cannel plan is a defined benefit plan, is it covered under the PBGC in Yes" is checked, enter the My PAA confirmation number from the	nsurance p	orogram (see ERISA se	ection 4	021)?	· [Yes N		determined
Part III	Financial Information	I	· · · · · · · · · · · · · · · · · · ·						····
7 Plan	n Assets and Liabilities	1410	(a) Beginning o	of Year			(b) Eı	nd of Yea	<u> </u>
a Tota	al plan assets	. 7a		224,	086				301,030
b Tota	al plan llabilities	7b							
c Net	plan assets (subtract line 7b from line 7a)	7c		224,	086				301,030
8 Inco	ome, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) Total	· · · · · · · · · · · · · · · · · · ·
	tributions received or receivable from:						Į.		Q. The state of th
(1)	Employers	8a(1)		18,					78%
(2)	Participants	8a(2)		32,	586				
(3)	Others (including rollovers)	8a(3)		2,	193				<u>. 144 – </u>
b Othe	er income (loss)	8b		25,	293	Mile		335	4 5 6 3
C Tota	al income (add lines 8a(1), 8a(2), 8a(3), and 8b)	. 8c			(PATT)				78,348
	efits pald (Including direct rollovers and insurance premiums rovide benefits)	8d			147				
e Cert	tain deemed and/or corrective distributions (see instructions)	8e				ja kitus		-Gwyd I	
f Adm	ninistrative service providers (salaries, fees, commissions)	8f		1,:	257	(Santa)	16517		
g Othe	er expenses	8g						1764	
h Tota	al expenses (add lines 8d, 8e, 8f, and 8g)						——————————————————————————————————————	· · · · · · · · · · · · · · · · · · ·	1,404
-	income (loss) (subtract line 8h from line 8c)				- (A. 4)				76,944
	nsfers to (from) the plan (see instructions)				A. 5 W. 3		Andrea 1	· Property is	
	Part IV Plan Characteristics					ar ara s	<u> Namera a Name</u>	<u> </u>	157 E.S.
	ne plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2J 2K 2T 3D	feature co	odes from the List of Pl	an Cha	racter	istic Co	odes in the i	nstruction	3:
b If th	ne plan provides welfare benefits, enter the applicable welfare t	feature cod	des from the List of Pla	n Chara	acteris	stic Cod	les in the in	structions	
Part V	Compliance Questions							· · · · · · · · · · · · · · · · · · ·	
	ring the plan year:	•			Yes	No		Amoun	
a Wa	as there a failure to transmit to the plan any participant contribuescribed in 29 CFR 2510.3-102? (See instructions and DOL's Virogram)	√oluntary F	Fiduciary Correction	10a		х		7 1110 2411	-
b W	ere there any nonexempt transactions with any party-in-interes ported on line 10a.)	t? (Do not	include transactions	10b		X			
c W	/as the plan covered by a fidelity bond?			10c	Х				25,000
	d the plan have a loss, whether or not reimbursed by the plan's fraud or dishonesty?			10d		X			23,000
e We	ere any fees or commissions paid to any brokers, agents, or ot rrier, insurance service, or other organization that provides son e plan? (See instructions.)	her persor ne or all of	ns by an insurance f the benefits under	10e		X			
	as the plan falled to provide any benefit when due under the pla			10f		х		· · · · · · · · · · · · · · · · · · ·	
g Die	d the plan have any participant loans? (If "Yes," enter amount a	as of year-	end.)	10g	Х				21,030
25	this is an individual account plan, was there a blackout period? 20,101-3.)			10h		Х			
	10h was answered "Yes," check the box if you either provided t ceptions to providing the notice applied under 29 CFR 2520.10			10i				45 11 1	

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Part \	VI Pensi	on Funding Compliance							
11	Is this a defi (Form 5500)	ned benefit plan subject to minimum funding and line 11a below)	requirements? (If "Yes," see in	structions and c	omplete Sch	edule SI	В	Y	es 🗌 No
11a	Enter the un	paid minimum required contributions for all y	ears from Schedule SB (Form	5500) Ilne 40		11a			
12	ERISA?	ined contribution plan subject to the minimun				302 of	***********	Y	es X No
	•	emplete line 12a or lines 12b, 12c, 12d, and 1							
	granting the	f the minimum funding standard for a prior ye walver.	***************************************	M	onth	l enter ti Day		the letter Year	ruling
lf y	you complete	ed line 12a, complete lines 3, 9, and 10 of	Schedule MB (Form 5500), ar	nd skip to line 1	3.				
b I	Enter the min	imum required contribution for this plan year	***************************************			12b			
c i	Enter the amo	ount contributed by the employer to the plan	for this plan year	*******	:	12c			
d		amount in line 12c from the amount in line 1 ount)				12d			
е	Will the minir	mum funding amount reported on line 12d be	met by the funding deadline?.				Yes	No [N/A
Part \	VII Plan	Terminations and Transfers of As	sets		•		_		
13a	Has a resolut	tion to terminate the plan been adopted in any pl	lan year?				Yes	X No)
	If "Yes," ente	er the amount of any plan assets that reverte	d to the employer this year			13a			
b		plan assets distributed to participants or ber e PBGC?						Yes X	No
C		s plan year, any assets or liabilities were tran s or liabilities were transferred. (See Instructi		er plan(s), identi	y the plan(s)	to			
4	0-/4\ Names =	-£-1/-\.			40 - (0)	CINI4-3		45 (0)	511/