Description         Description         2017           Description         This form is explicited to be file under sections 10 by and 4055 of the Employee Retirement Revenue Code (the Code).         This Form is Open to Public Memory           Prant Bendin Council Section         Description         This Form is Open to Public Memory           Prant Bendin Council Section         Description         This Form is Open to Public Memory           Part II         Annual Report Identification Information is an one-participant pain genetication         and ending 1001/027         and ending 1002/027         1001/027           A         This return/report is for genetication         a one-participant pain genetication         a one-participant pain genetication         a one-participant pain genetication         a one-participant pain genetication         a one-participant pain genetication formation         DFVC program           B         This return/report is geneticat extension         genetication formation         genetication formation         10         There-digit pain an anneodo return/report         a dending is a dord pain pain geneticat extension         genetication formation           C         Check box if filing under: geneticat extension         geneticat extension         genetication formation           C         Check box if filing under: geneticat extension         genetication formation         10         There-digit pain manemode for plan geneticat extension	_	m 5500-SF	Short Form Annual Return/Report of Small Emplo Benefit Plan					OMB Nos. 1210-0110 1210-0089				
Import lister discription         This Form is Open 10           Part II         Annual Report Identification Information         and ending         1201/2017           For calendar plan year 2017 or financipal year beginning         0101/2017         and ending         1201/2017           A This return/report is for         a single employer plan         a foreign plan         a foreign plan         a foreign plan           B This return/report is         a one-participant plan         a foreign plan         a foreign plan         Device the fill plan plan return instructions.)           B This return/report is         a one-participant plan         a foreign plan         Device the fill plan return/report           B This return/report is         a one-participant plan         a short plan year return/report         Device the fill plan return/report           B This return/report is         general extension         DFVC program           Special extension (enter description)         DFVC program           PART III Basic Plan Information—enter all requested information         1b         Thirse-digit           POKANE CRAL SURGERY 401(K) PLAN         1c         Effective date of plan           POKANE CALLY VK E_200         2b         Engloyer Identification Number           E(N) of two state of province, country, and 2IP or foreign postal code (if foreing, see instrun/report 1fel for 201/201/201/201/200			This form is required to be filed under sections 104 and 4065 of the Employee R					2017				
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For calendar plan year 2017 or fiscal plan year beginning       0.01/2017       and ending       12/21/217         A This return/report is tor:       a single-employer plan       a multiple-employer plan (minutemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)         B This return/report is       a one-participant plan       a toreign plan       a toreign plan         B This return/report       an anendod return/report       a be final return/report       a be final return/report         an amendod return/report       a short plan year return/report       a be final return/report       a be final return/report         B This return/report       a short plan year return/report       a bend plan year return/report       DFVC program         Special extension (enter description)       Pert II       Basic Plan Information—enter all requested information       1b       Three-digit (PN)         PGKANE ORAL SURGERY 401(K) PLAN       1b       Three-digit (PN)       001       1c       Effective date of plan (PN)         C Not KC : PAXTON DS, P. 3.       Sum end all streed, or P.O. Box)       000       01/201190       2c       Sponsor's telephone number (PN)         C Sponsor's telephone number       Ge No. System       Sis and all streed, or P.O. Box)       2c       Sponsor's telephone number (PN)       621210         209 E. BROADW	Pension Be	Public Inspection										
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this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year												
this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name C Plan Name 5a Total number of participants at the beginning of the plan year	A If the r	ama and/ar EIN of the	a plan apapager or the plan name ha	an abangad	aince the last re	turn/ronort filed for						
c       Plan Name         5a       Total number of participants at the beginning of the plan year       5a       38         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 (only defined contribution plans       5c       37         c       Number of participants with account balances as of the end of the plan year (only defined contribution plans       5c       37         d(1)       Total number of active participants at the beginning of the plan year       5d(1)       20         d(2)       Total number of active participants at the end of the plan year       5d(2)       19         e       Number of participants who terminated employment during the plan year with accrued benefits that were less       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.												
5a       Total number of participants at the beginning of the plan year       5a       38         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 (only defined contribution plans       5c       37         c       Number of participants with account balances as of the end of the plan year (only defined contribution plans       5c       37         d(1)       Total number of active participants at the beginning of the plan year       5d(1)       20         d(2)       Total number of active participants at the end of the plan year       5d(2)       19         e       Number of participants who terminated employment during the plan year with accrued benefits that were less       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.       Implemented to the plan year of t	•						<b>4d</b> PN					
b       Total number of participants at the end of the plan year	C Plan N	C Plan Name										
b       Total number of participants at the end of the plan year	5a Total r	number of participants	at the beginning of the plan year				5a		38			
C       Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	-						5b		37			
d(1) Total number of active participants at the beginning of the plan year       5d(1)       20         d(2) Total number of active participants at the end of the plan year       5d(2)       19         e Number of participants who 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.	C Numb	er of participants with a	account balances as of the end of t	the plan yea	ar (only defined o	contribution plans	5c	3.				
d(2) Total number of active participants at the end of the plan year       5d(2)       19         e       Number of participants who terminated employment during the plan year with accrued benefits that were less       5e       2         Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.       2         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.									20			
Number of participants who terminated employment during the plan year with accrued benefits that were 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.	e Number of participants who terminated employment during the plan year with accrued benefits that were less							5e 2				
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.	than '	than 100% vested										
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.									ule			
	SB or Sche	edule MB completed an	id signed by an enrolled actuary, a									
	SIGN			09/2	26/2018	DIANE PAXTON						
HERE         Signature of plan administrator         Date         Enter name of individual signing as plan administrator	HERE	Signature of plan ac	dministrator	Da	ite	Enter name of individ	ual signing	as plan administrator				
SIGN	SIGN											
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor	HERE	Signature of employ	yer/plan sponsor	Da	te	Enter name of individ	ual signing	as employer or plan spons	sor			

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6a	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)									
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.)									
•	If you answered "No" to either line 6a or line 6b, the plan cann									
C	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									
	If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)									
Pa	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning o	of Year			(b) End o	f Year		
а	Total plan assets	7a	171	12678				593302		
b	Total plan liabilities	7b	1	12212				0		
С	Net plan assets (subtract line 7b from line 7a)	7c	170	00466				593302		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t			(b) To	tal		
а	Contributions received or receivable from:									
	(1) Employers	8a(1)		9197	_					
	(2) Participants	8a(2)		19233	-					
	(3) Others (including rollovers)									
b	Other income (loss)									
	C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)									
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)									
е	Certain deemed and/or corrective distributions (see instructions)	8e		0						
f	Administrative service providers (salaries, fees, commissions)	8f		8063						
a	Other expenses	8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						1463067		
i	Net income (loss) (subtract line 8h from line 8c)	8i					-	-1107164		
j	Transfers to (from) the plan (see instructions)	8i								
Pa	rt IV Plan Characteristics	•,								
9a	If the plan provides pension benefits, enter the applicable pension	feature co	odes from the List of Pla	an Cha	racteri	stic Co	des in the instru	ictions:		
	2A 2E 2G 2J 2K 2R 3D									
b	<b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:									
_										
Pa	rt V Compliance Questions									
10	During the plan year:				Yes	No	Ar	nount		
č	Was there a failure to transmit to the plan any participant contribu described in 29 CFR 2510.3-102? (See instructions and DOL's V									
	Program)			10a		x				
k	Were there any nonexempt transactions with any party-in-interest					×				
	reported on line 10a.)			10b		Х				
C	Was the plan covered by a fidelity bond?			10c	X			400000		

**d** Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused

Were any fees or commissions paid to any brokers, agents, or other persons by an insurance

f Has the plan failed to provide any benefit when due under the plan? .....

g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.) .....

If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR

2520.101-3.) .....

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.....

carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.).....

е

h

i

by fraud or dishonesty? .....

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Х

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400000

58214

10c

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10f

10g

10h

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Page 3- 1

Part	VIF	ension 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	ERISA	a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or sec ? 	tion	302 o	f	[	Ye	s X No	
а	lf a wa	iver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, ig the waiver.	and	enter _ Da		of the le		uling	
If y	you co	npleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.							
b	Enter th	e minimum required contribution for this plan year		12b					
С	Enter th	e amount contributed by the employer to the plan for this plan year		12c					
d		ct the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a ve amount)		12d					
е	Will th	e minimum funding amount reported on line 12d be met by the funding deadline?			Yes	No		N/A	
Part	VII   F	Plan Terminations and Transfers of Assets							
13a	Has a	resolution to terminate the plan been adopted in any plan year?			Yes	6 X	No		
	lf "Yes	," enter the amount of any plan assets that reverted to the employer this year		13a					
b		all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under I of the PBGC?				Yes	X	No	
С		ng this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan assets or liabilities were transferred. (See instructions.)	ו(s) י	to					
1	3c(1) Ւ	lame of plan(s): 13c	:(2)	EIN(s)		13	c(3)	PN(s)	

Fo	rm 5500-SF	Short Form Annual R	eturn/Report Senefit Plan	of Small Empl	oyee	OMB Nos. 1210-0110 1210-0089				
	artment of the Treasury ernal Revenue Service	1065 of the Employee R	etirement	2017						
Employee E	Department of Labor Benefits Security Administration	Income Security Act of 1974 (ERIS Reve	Internal	This Form is Open to Public Inspection						
Pension B	enefit Guaranty Corporation	Complete all entries in accord	lance with the instr	uctions to the Form 5	500-SF.	Public Inspection				
Part I		Identification Information								
For calend	lar plan year 2017 or fis		01/2017	and ending		31/2017				
A This re	turn/report is for:					ing this box must attach a ith the form instructions.)				
<b>B</b> This ret	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:	ox if filing under: X Form 5558 automatic extension DFVC program								
		special extension (enter description)	)							
Part II	Basic Plan Info	rmation-enter all requested informati	on							
1a Name	ofplan Oral Surgery	401(k) Plan			1b Three-digit plan number 001					
opokulie	orar bargery					▶ tive date of plan 1 / 1 9 98				
		ver, if for a single-employer plan)			2b Employer Identification Number (EIN) 91-1691190					
Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Mark C. Paxton, DDS, P.S.					<b>2c</b> Sponsor's telephone number 509-926-7106					
12109 E. Broadway Ave., Building C					2d Business code (see instructions) 621210					
Spokane	e Valley	WA 99206			0010					
		d address 🛛 Same as Plan Sponsor.			3b Administrator's EIN					
					3c Admi	nistrator's telephone number				
		plan sponsor or the plan name has char	•		4b EIN					
	sor's name	isor's name, EIN, the plan name and the	plan number a om tr	ie last returniteport.	4d PN					
5a Total	number of participants	at the beginning of the plan year			5a	38				
<b>b</b> Total	number of participants	at the end of the plan year			5b	37				
	per of participants with a lete this item)		5c	37						
<b>d(1)</b> Tot	al number of active par	ticipants at the beginning of the plan yea	۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰		5d(1)					
<b>d(2)</b> Tot	tal number of active par	5d(2)								
	ber of participants who t 100% vested	5e								
Caution: A	A penalty for the late o	or incomplete filing of this return/repor	t will be assessed	unless reasonable cau						
SB or Sche	alties of perjury and oth edule MB completed an true, correct, and comp	er penalties set forth in the instructions, I d signed by an enrolled actuary, as well lete.	declare that I have as the electronic ver	examined this return/re sion of this return/repor	port, includir t, and to the	ng, if applicable, a Schedule best of my knowledge and				
SIGN	Diane &	Parton	9-26-18	Diane Paxton						
HERE	Signature of plan ac	Iministrator	Date	Enter name of individ	ual signing a	as plan administrator				
SIGN										
HERE	Circulations of employ									

 
 Sign HERE
 Signature of employer/plan sponsor
 Date
 Enter name of individual signing as employer or plan sponsor

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 Form 5500-SF (2017) V.170203
 Form 5500-SF 2017

	Were all of the plan's assets during the plan year invested in eligib Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility If you answered "No" to either line 6a or line 6b, the plan cann	an independ and condition	dent qualified public a	account	ant (IC	(PA)			Yes 🗌 No Yes 🗍 No
С	If the plan is a defined benefit plan, is it covered under the PBGC ir If "Yes" is checked, enter the My PAA confirmation number from th						, _		determined
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) End	of Year	
а	Total plan assets	7a	1,	712,	678		10.2		593,302
b	Total plan liabilities	7b		12,	212				0
С	Net plan assets (subtract line 7b from line 7a)	7c	1,	700,	466				593,302
8	Income, Expenses, and Transfers for this Plan Year		(a) Amour	nt			(b)	ſotal	
a	Contributions received or receivable from: (1) Employers	8a(1)	1k - 1-		197				
	(2) Participants	8a(2)		19,	233				
2	(3) Others (including rollovers)	8a(3)		154,	067				
b	Other income (loss)	8b		173,	406				
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							355,903
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1,	455,	004				
е	Certain deemed and/or corrective distributions (see instructions)			0					
f	Administrative service providers (salaries, fees, commissions)		8,	063					
g	Other expenses								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)					1	,463,067		
i	Net income (loss) (subtract line 8h from line 8c)	8i						-1	,107,164
j	Transfers to (from) the plan (see instructions)								
Pa	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2G 2J 2K 2R 3D	feature cod	es from the List of PI	an Cha	racteri	stic Co	ides in the ins	tructions	:
	If the plan provides welfare benefits, enter the applicable welfare for	eature code	s from the List of Pla	n Chara	acterist	ic Coo	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 contribut described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	/oluntary Fic	duciary Correction	10a		х			
b	Were there any nonexempt transactions with any party-in-interest reported on line 10a.).			10b		Х	2		
С	Was the plan covered by a fidelity bond?			10c	Х				400,000
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			
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.).					х			
f	Has the plan failed to provide any benefit when due under the plan?					Х			
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)								58,214
h						Х			
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								