

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 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2017</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2017 or fiscal plan year beginning <u>01/01/2017</u> and ending <u>12/31/2017</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input type="checkbox"/> a one-participant plan <input type="checkbox"/> a foreign plan
B This return/report is	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)

Part II Basic Plan Information —enter all requested information				
1a Name of plan	<u>L. ERIK HOLMBERG, DDS 401(K) PROFIT SHARING PLAN</u>		1b Three-digit plan number (PN) ►	<u>001</u>
			1c Effective date of plan	<u>01/01/2004</u>
2a Plan sponsor's name (employer, if for a single-employer plan) 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)	<u>L. ERIK HOLMBERG, DDS PLLC</u> <u>222 N. MISSION STREET</u> <u>WENATCHEE, WA 98801-6643</u>		2b Employer Identification Number (EIN)	<u>20-2041099</u>
			2c Sponsor's telephone number	<u>509-663-1161</u>
			2d Business code (see instructions)	<u>621210</u>
3a Plan administrator's name and address	<input type="checkbox"/> Same as Plan Sponsor. <u>L. ERIK HOLMBERG, DDS PLLC</u> <u>222 N. MISSION STREET</u> <u>WENATCHEE, WA 98801-6643</u>		3b Administrator's EIN	<u>20-2041099</u>
			3c Administrator's telephone number	<u>509-663-1161</u>
4 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.	a Sponsor's name c Plan Name		4b EIN	
			4d PN	
5a Total number of participants at the beginning of the plan year			5a	<u>11</u>
b Total number of participants at the end of the plan year.....			5b	<u>9</u>
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....			5c	<u>9</u>
d(1) Total number of active participants at the beginning of the plan year.....			5d(1)	<u>7</u>
d(2) Total number of active participants at the end of the plan year			5d(2)	<u>7</u>
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested			5e	<u>0</u>
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	<u>Filed with authorized/valid electronic signature.</u>	<u>10/11/2018</u>	<u>L. ERIK HOLMBERG, DDS</u>	
	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	

- 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
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1838043	2302493
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	1838043	2302493
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	60218	
(2) Participants	8a(2)	70103	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	397582	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		527903
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	63403	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	50	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		63453
i Net income (loss) (subtract line 8h from line 8c)	8i		464450
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:
2E 2F 2G 2J 2K 3B 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		50000
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		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	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 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 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? ☐ 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? ☐ Yes ☒ 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 ☒ 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)

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits 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 4085 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 8057(b) and 8058(a) of the Internal Revenue Code (the Code). Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1510-0110 1510-0089 2017 This Form is Open to Public Inspection
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Part II Basic Plan Information—enter all requested information			
1a Name of plan		1b Three-digit plan number (PN) ▶	001
L. ERIK HOLMBERG, DDS 401(K) PROFIT SHARING PLAN		1c Effective date of plan 01/01/2004	
2a Plan sponsor's name (employer, if for a single-employer plan) 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)		2b Employer identification Number (EIN) 20-2041099	
L. ERIK HOLMBERG, DDS PLLC		2c Sponsor's telephone number 509-663-1161	
222 N. MISSION STREET		2d Business code (see instructions) 621210	
WENATCHEE WA 98801-6643		3b Administrator's EIN 20-2041099	
3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. L. ERIK HOLMBERG, DDS PLLC		3c Administrator's telephone number 509-663-1161	
222 N. MISSION STREET			
WENATCHEE WA 98801-6643		4b EIN	
4 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 Total number of participants at the beginning of the plan year		5a	11
b Total number of participants at the end of the plan year		5b	9
c Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		5c	9
d(1) Total number of active participants at the beginning of the plan year		5d(1)	7
d(2) Total number of active participants at the end of the plan year		5d(2)	7
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested		5e	0

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		10-11-18	L. ERIK HOLMBERG, DDS
	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

For Paperwork Reduction Act Notice, see the Instructions for Form 5500-SF.

Form 5500-SF (2017)
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- 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
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1,838,043	2,302,493
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	1,838,043	2,302,493
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	60,218	
(2) Participants	8a(2)	70,103	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	397,582	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		527,903
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	63,403	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	50	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		63,453
i Net income (loss) (subtract line 8h from line 8c)	8i		464,450
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:
2E 2F 2G 2J 2K 3B 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		50,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	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		X	
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 302 of ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 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)	13c(2)	13c(3)
Name of plan(s):	EIN(s)	PN(s)

**ELECTRONIC FILING AUTHORIZATION
OF THE FORM 5500-SF**

L. Erik Holmberg, D.D.S. 401(k) Profit Sharing Plan
Plan Year Ending: December 31, 2017

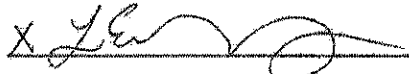
Part I: Authorization to Electronically Sign and File

I hereby authorize Midwest Pension Administrators, Inc. to electronically sign and file the above-named return/report through EFAST2.

I understand that in granting this authority:

- ◆ I must manually sign and date page 1 of Form 5500-SF and provide a copy of that signature page to Midwest Pension Administrators, Inc. before the electronic filing can be submitted;
- ◆ A copy of my signature, as it appears on page 1 of Form 5500-SF, will be included with the return/report posted by the Department of Labor on the Internet for public disclosure.
- ◆ Midwest Pension Administrators, Inc. shall not be deemed an administrator or other fiduciary with respect to this Plan solely on account of the services performed under this authorization;
- ◆ Midwest Pension Administrators, Inc. will retain a copy of the written authorization in its records; and
- ◆ Midwest Pension Administrators, Inc. will notify you about any inquiries and information it receives from EFAST2, the DOL, or the IRS regarding this annual return/report.

This authorization is applicable only to the filing for the above-named Plan and applies only for the Plan year end stated above.

Plan Administrator: X  Date: 10-11-18

Part II: Acknowledgment of Receipt by Midwest Pension Administrators, Inc.

On behalf of Midwest Pension Administrators, Inc., I hereby certify that the firm will use the authorization granted only for the express purpose described above.

For Midwest Pension Administrators, Inc.: _____
(Sandy Ohlhausen, Director of Pension Administration)

Date: _____