Department Revenue Security Action 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).       2018         Persone Benefits Guaranty Corporation       > Complete all entries in accordance with the instructions to the Form 5500-SF.       This Form is Open to Public Inspection         Persone Benefits Guaranty Corporation       > Complete all entries in accordance with the instructions to the Form 5500-SF.       This Form is Open to Public Inspection         Part I       Annual Report Identification Information       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       in the first return/report       a short plan year return/report (less than 12 months)       DFVC program         C       Check box if filing under:       Form 5558       automatic extension       DFVC program         special extension (enter description)       Ib Three-digit plan number (PN) b       001         12       Rela sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) Cit or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b Employer Identification Number (EIN) 91-0387719	For	rm 5500-SF	Short Form Annua	Short Form Annual Return/Report of Small Emplo Benefit Plan								
Emigrate bindle Sonzy Administrator         Revenue Code (the Code).         This Form is Open to Public Inspection           Part I         Annual Report Identification Information         and ending         1/2/3/2018           For calendar plan year 2018 or fiscal plan year beginning         0.101/2018         and ending         1/2/3/2018           A         This return/report is         a single-employer plan         and ending         1/2/3/2018           B         This return/report is         a one-participanty plan         a foreign plan         Instructions on the form isocendar with the form instructions.)           B         This return/report is         a one-participanty plan         a foreign plan         DFVC program           B         This return/report         a single-employer plan         a short plan year return/report (less than 12 months)         DFVC program           C         Check box if filing under:         Form SS58         automatic extension         DFVC program           B         This return/report         a single-employer plan         Ib         Three-digit plan nomber           Mailing address (include rown, and, suite on a single-employer plan)         Mailer address (include rown, and street, or P.O. Box)         Cite(N 91-0627719)           C         Check box if fling under:         P.S.         Sec instructions)         C2           <	Department of the readily           Internal Revenue Service           Department of Labor           This form is required to be filed under sections 104 and 4065 of the Employee           Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the						2018					
Pert I A multiple-employer plan a single-employer plan and ending 12/31/2018   A This return/report is for: a single-employer plan a foreign plan a foreign plan   B This return/report is a one-participant plan a foreign plan a foreign plan   B This return/report is the first return/report a short plan year return/report B first return/report   G C Check box if filing under: provide states in accordance with the form instructions.) DFVC program   Special extension (enter description) a short plan year return/report (less than 12 months) DFVC program   Part II Basic Plan Information—enter all requested information 1b Three-digit plan number (PN) / 001   12 C Check box if filing under: provide states of the state of the state of the state state of the state of the state of the state state of the state state of the state state of the state of the state state of the state state state												
For catendar plan year 2018 or fiscal plan year beginning       01/01/2018       and ending       12/31/2018         A       This return/report is for:       a single-employer plan       a fulliple-employer information in accordance with the form instructions.)         B       This return/report is       a one-participant plan       a foreign plan         B       This return/report is       the first return/report       the first neturn/report         G       Check box if filing under:       Form 5658       automatic extension       DFVC program         generation       special extension (enter description)       DFVC program       one-religit plan number (PN)       001         12       Enter NAL MEDICINE 401(K) PLAN       Ib Three-digit plan number (PN)       001       1C Effective date of plan 0/101/2020         24       Plan sponsor's name (employer, if for a single-employer plan)       Mailing address (include room, apt., suite no. and street, or P.O. Box)       001       1C Effective date of plan 0/101/2020         245 N. MCDONALD RD, SUTE 101       Sopeax-1860       2d Business code (see instructions)       62/1111         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b Administrator's telephone number 509-624-1860         24       If the name and/or EIN of the plan sponsor or the plan name and the plan number from the last return/report filed for this plan, enter the plan s												
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.)         B This return/report is       a one-participant plan       a short plan type         B This return/report is       the first return/report       a short plan year return/report       b form instructions.)         C Check box if filing under:       Form 5558       automatic extension       DFVC program         special extension (enter description)       Form 5558       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       1       The re-digit plan number (PN)       001         1c       Effective date of plan Option       001       1c       Effective date of plan Option (PO)       001         2a Plan sponsor's name (employer, if for a single-employer plan) Maling address (include room, apt., suite no. and street, or P.O. Box)       2b       Employer Identification Number (EN)       001         POCKANE INTERNAL MEDICINE, P.S.       21b or foreign postal code (if foreign, see instructions)       2c       Sponsor stelephone number 509-924-1950         21b N. MCDONALD RD, SUTE 101       62 This name and address [N the plan name has changed since the last return/report filed for this plan, enter the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter t	Part I Annual Report Identification Information											
A       This return/report is for:       □ a one-participant plan       □ a foreign plan         B       This return/report is       □ a one-participant plan       □ a foreign plan         B       This return/report is       □ the final return/report       □ a short plan year 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)       □       Ib Three-digit plan number (PN) > 001       1c         Part II       Basic Plan Information—enter all requested information       1       Ib Three-digit plan number (PN) > 001       1c         IC       Plan sponsor's name (employer, if for a single-employer plan)       01       1c       Effective date of plan 0101/2000         2a       Plan sponsor's name (employer, if for a single-employer plan)       01       1c       Effective date of plan 0101/2000         2d       Plan sponsor's name (employer, if for a single-employer plan)       01       1c       Effective date of plan 0101/2000         2d       Plan sponsor's name (employer, if for a single-employer plan)       01       1c       Effective date of plan 0101/2000         2d       Plan sponsor's name (employer, if for a single-emp	For calenda	ar plan year 2018 or fis	cal plan year beginning 01/01/20									
B       This return/report is       the first return/report       the final return/report       a short plan year return/report       a short plan year return/report         C       Check box if filing under:       Form 5558       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       1       The ree-digit plan number (PN)       001         12       There-digit plan number       001       1       Three-digit plan number (PN)       001         24       Plan sponsor's name (employer, if for a single-employer plan) Mailing address (Include room, apt., suite no. and street, or P.O. Box) Crit or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2c       Sponsor's telephone number (EIN)       904241950         215 N. MCDONALD RD, SUITE 101       Sc Administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number (S0444194)         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number (BIN)         6       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 filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name	A This return/report is for:											
		····· /···· · · · ·	a one-participant plan	a foreign plan								
C       Check box if filing under:       □ prom 5558       □ automatic extension       □ DFVC program         Part II       Basic Plan Information—enter all requested information       1       Three-digit plan number       001         12       Name of plan       1       Drawe of plan number       001       1       C Effective date of plan number       001         24       Plan sponsor's name (employer, if for a single-employer plan)       1       C Effective date of plan other (PN) >       001         25       Sponsor's tabe or province, country, and ZIP or foreign postal code (if foreign, see instructions)       20       Employer Identification Number (EIN) = 91-0987719         26       Sponsor's tabephone number Sog-9224-1950       2d Business code (see instructions)       2d Business code (see instructions)         275 N. MCDONALD RD., SUITE 101       91-0987719       2d Business code (see instructions)       621111         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b Administrator's telephone number         4       If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report.       4b EIN         4       If the name and/or EIN of the plan sponsor's name, EIN, the plan name and the plan number from the last return/report.       4b EIN         5a       Total number of participants at the beginning of the plan year <t< td=""><td>D I NIS retu</td><td>urn/report is</td><td></td><td></td><td></td></t<>	D I NIS retu	urn/report is										
Image: Second Statustics       Image: Second Statustics         Image: Second Statustics			an amended return/report	a short plan year return	n/report (less than 12 mo	onths)						
Part II       Basic Plan Information—enter all requested information         1a Name of plan       1b       Three-digit plan number (PN) ▶         SPOKANE INTERNAL MEDICINE 401(K) PLAN       1b       Three-digit plan number (PN) ▶         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 towne, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2b       Employer Identification Number (EIN) 91-0987719         2ct S. N. MCDONALD RD, SUITE 101       2c Sponsor's telephone number 509-924-1950       2d Business code (see instructions)         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number 509-924-1950         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 filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report filed for this plan sponsor's name.       4d       PN         5a       Total number of participants at the end of the plan year       5a       72         b       Total number of participants at the end of the plan year       5b       62         c       Number of participants with account blances as of the end of the plan year (only defined contribution plans       5c	C Check I	box if filing under:	Form 5558	automatic extension		DFVC p	rogram					
1a Name of plan       1b Three-digit plan number (PN) ▶       001         2a Plan sponsor's name (employer, if for a single-employer plan)       1c Effective date of plan 0/101/2000         2a Plan sponsor's name (employer, if for a single-employer plan)       2b Employer Identification Number (EIN) 91-0987719         2t or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2c Sponsor's telephone number 509-924-1950         2d Business code (see instructions)       2d Business code (see instructions)         PPOKANE VALLEY, WA 99216       2d Business code (see instructions)         3a Plan administrator's name and address S Same as Plan Sponsor.       3b Administrator's 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.       4b EIN         4 Sponsor's name       C Plan Name       5a 722         5a Total number of participants at the end of the plan year			special extension (enter descri	otion)								
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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) 91-0827719         SPOKANE INTERNAL MEDICINE, P.S.       2c       Sponsor's telephone number 509-924-1950         215 N. MCDONALD RD, SUITE 101 PPOKANE VALLEY, WA 99216       621111         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's 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       4b       EIN         5a       Total number of participants at the beginning of the plan year       5a       72         b       Total number of participants at the end of the plan year       5b       62         c       Number of participants with account balances as of the end of the plan year (only defined contribution plans       5c       62	SPOKANE II	NTERNAL MEDICINE 4	401(K) PLAN			•						
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)         SPOKANE INTERNAL MEDICINE, P.S.       2c       Sponsor's telephone number 509-924-1950         215 N. MCDONALD RD., SUITE 101 PPOKANE VALLEY, WA 99216       2cd       Business code (see instructions)         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number 509-924-1950         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.       4b       EIN         5a       Total number of participants at the beginning of the plan year       5a       72         5b       62       62						1c Effec	•					
Mailing address (include room, apt., suite no. and street, or P.O. Box)       (EIN)       91-0987719         City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)       2c       Sponsor's telephone number         SpockANE INTERNAL MEDICINE, P.S.       2d       Business code (see instructions)         215 N. MCDONALD RD, SUITE 101       621111         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's EIN         3c       Administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number         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.       4b       EIN         4       If the name       Sponsor's name, EIN, the plan name and the plan number from the last return/report.       4b       EIN         5a       Total number of participants at the beginning of the plan year       5a       72         b       Total number of participants with account balances as of the end of the plan year (only defined contribution plans)       5c       62	2a Plan si	ponsor's name (employ	ver if for a single-employer plan)			2b Empl						
SPOKANE INTERNAL MEDICINE, P.S.       2C       Sponsor's telephone number 509-924-1950         215 N. MCDONALD RD., SUITE 101 PPOKANE VALLEY, WA 99216       2d       Business code (see instructions) 621111         3a Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's EIN 3c         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.       4b       EIN         5a       Otal number of participants at the beginning of the plan year       5a       72         b       Total number of participants at the end of the plan year       5b       62         c       Number of participants with account balances as of the end of the plan year (only defined contribution plans       5c       62	Mailing	g address (include room	n, apt., suite no. and street, or P.O.		uctions)							
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3a Plan administrator's name and address S Same as Plan Sponsor.       3b Administrator's EIN         3c Administrator's telephone number         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.       4b EIN         4 Sponsor's name       4d PN         5a Total number of participants at the beginning of the plan year						2d Business code (see instructions)						
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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.       4d PN         a Sponsor's name       Plan Name         5a Total number of participants at the beginning of the plan year						<b>3c</b> Administrator's telephone number						
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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.       4d PN         a Sponsor's name       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.       4d PN         a Sponsor's name       Plan Name         5a Total number of participants at the beginning of the plan year	4 If the r	name and/or EIN of the	plan sponsor or the plan name has	s changed since the last re	eturn/report filed for	<b>4b</b> EIN						
c       Plan Name         5a       Total number of participants at the beginning of the plan year	this pl	lan, enter the plan spon										
5a       Total number of participants at the beginning of the plan year       5a       72         b       Total number of participants at the end of the plan year       5b       62         c       Number of participants with account balances as of the end of the plan year (only defined contribution plans       5c       62	•					HU FN						
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 62	5a Total r	number of participants a	at the beginning of the plan year			5a	72					
						5b	62					
						5c	62					
d(1) Total number of active participants at the beginning of the plan year							58					
d(2) Total number of active participants at the end of the plan year							50					
than 100% vested	<ul> <li>Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested</li> </ul>											
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.	Caution: A	A penalty for the late o	r incomplete filing of this return	report will be assessed	unless reasonable cau							
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.	SB or Sche	edule MB completed an	d signed by an enrolled actuary, as									
SIGN         Filed with authorized/valid electronic signature.         05/28/2019         ASHLEY BARRETT				05/28/2019	ASHLEY BARRETT							
HERE         Signature of plan administrator         Date         Enter name of individual signing as plan administrator	HERE	Signature of plan ad	Iministrator	Date	Enter name of individu	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	/er/plan sponsor	Date	Enter name of individu	ual signing	as employer or plan sponsor					

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

Form 5500-SF (2018) v.171027

<ul> <li>6a Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)</li></ul>									
Pa	Part III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year					
а	Total plan assets	7a	5655787	3876735					
b	Total plan liabilities	7b							
С	Net plan assets (subtract line 7b from line 7a)	7c	5655787	3876735					
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total					
а	Contributions received or receivable from: (1) Employers	8a(1)	162930						
	(2) Participants	8a(2)	284389						
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b	-279640						

	(3) Others (including rollovers)	8a(3)		
b	Other income (loss)	8b	-279640	
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		167679
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1945634	
е	Certain deemed and/or corrective distributions (see instructions)	8e		
f	Administrative service providers (salaries, fees, commissions)	8f	1097	
g	Other expenses	8g		
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		1946731
i	Net income (loss) (subtract line 8h from line 8c)	8i		-1779052
j	Transfers to (from) the plan (see instructions)	8j		
Pa	t IV Plan Characteristics			
9a	If the plan provides pension benefits, enter the applicable pension	feature co	des from the List of Plan Characteristic	Codes in the instructions:

**9a** If p p app 2E 2F 2G 2J 2K 2R 2T 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
а	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		Х	
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions	10b		х	
С	Was the plan covered by a fidelity bond?	10c	X		500000
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		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.)	10e		X	
f	Has the plan failed to provide any benefit when due under the plan?	10f		Х	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g	Х		16510
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		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	10i			

Page **3-** 1

Part	VI	Pension Funding Compliance								
11		nis a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete rm 5500) and line 11a below)			SB	\$		<b>Y</b>	es	No
11a	Ent	er the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40		11a						
12	ERI	his a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or se SA?			of			Y	es 🗡	No
		"Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)								
а		waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, nting the waiver			r th ay			letter ear	ruling	g 
lf	you o	completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.								
b	Ente	r the minimum required contribution for this plan year		12b						
с	Ente	r the amount contributed by the employer to the plan for this plan year		12c						
d		tract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a ative amount)		12d						
e	Will	the minimum funding amount reported on line 12d be met by the funding deadline?				Yes	N	0	N/.	A
Part	VII	Plan Terminations and Transfers of Assets								
13a	Has	a resolution to terminate the plan been adopted in any plan year?				X Yes		Nc	)	
	lf "۱	es," enter the amount of any plan assets that reverted to the employer this year		13a						0
b		re all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under trol of the PBGC?	the			[	Ye	÷s 🗙	No	
С		luring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the pla ch assets or liabilities were transferred. (See instructions.)	ın(s)	to						
1	3c(1	) Name of plan(s): 13	c(2)	EIN(s	5)		1	3c(3)	PN(s	5)

Form 5500-SF	Short Form Annu		t of Small Employee	OMB Nos. 1210-0110 1210-0089		
Department of the Treasury Internal Revenue Service	This form is required to be file	Benefit Plan ad under sections 104 and	4065 of the Employee Retirement	2018		
Department of Labor Employee Benefits Security Administration						
Pension Benefit Guaranty Corporation	Complete all entries in	accordance with the inst	ructions to the Form 5500-SF.	Public Inspection		
Part I Annual Report I	dentification Information					
For calendar plan year 2018 or fise	cal plan year beginning	01/01/2018	and ending 127	31/2018		
A This return/report is for:	X a single-employer plan		lan (not multiemployer) (Filers cheo nployer information in accordance	-		
	a one-participant plan	a foreign plan				
<b>B</b> This return/report is	the first return/report	the final return/report				
	an amended return/report	a short plan year retu	rn/report (less than 12 months)			
C Check box if filing under:	[] Form 5558	automatic extension		program		
	special extension (enter desc					
Part II Basic Plan Infor	mation-enter all requested in	formation		an the second second		
1a Name of plan			1b Three			
Spokane Internal M	Medicine 401(k) Plan		piar (PN	number 001		
				ctive date of plan		
				/01/2000		
2a Plan sponsor's name (employed Mailing address (include room	, apt., suite no. and street, or P.C	). Box)	(FIN	loyer Identification Number		
City or town, state or province, Spokane Internal M	country, and ZIP or foreign post ledicine, P.S.	al code (if foreign, see inst	ZC Spo	nsor's telephone number		
			P	9-924-1950 ness code (see instructions)		
1215 N. McDonald F	d., Suite 101					
Spokane Valley	WA 9921	16	621	.111		
3a Plan administrator's name and	address 🛛 Same as Plan Spor	nsor.	3b Adm	inistrator's EIN		
			3c Adm	inistrator's telephone number		
				·		
	plan sponsor or the plan name ha sor's name, EIN, the plan name a					
a Sponsor's name c Plan Name			4d PN			
5a Total number of participants a	t the beginning of the plan year.	<b></b>		7:		
	t the end of the plan year			62		
	count balances as of the end of			6:		
d(1) Total number of active parti				58		
d(2) Total number of active parti				5(		
<ul> <li>Number of participants who te</li> </ul>	erminated employment during the	plan year with accrued be		1		
Caution: A penalty for the late or	incomplete filing of this return	/report will be assessed	unlass reasonable cause is esta	( hlished		
Under penalties of perjury and othe SB or Schedule MB completed and belief, it is true, corpect, and completed	r penalties set forth in the instruction signed by an enrolled actuary, a	ctions. I declare that I have	examined this return/report, includ	ing, if applicable, a Schedule		
SIGN	n	105-28-19	Ashley Barrett			
HERE Signature of plan ade	ministrator	Date		on alon administrator		
SIGN		Vale	Enter name of individual signing	as pian administrator		
HERE Signature of employe	rinlan shancar	Date	Enter name of individual signing			

Form 5500-SF (2018)

6a	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	X 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.)	X 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.	
С	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.)

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	5,655,787	3,876,735
b Total plan liabilities	7b		
C Net plan assets (subtract line 7b from line 7a)	7c	5,655,787	3,876,735
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
Contributions received or receivable from:     (1) Employers	8a(1)	162,930	
(2) Participants	8a(2)	284,389	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	-279,640	
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		167,679
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1,945,634	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	1,097	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		1,946,731
i Net income (toss) (subtract line 8h from line 8c)	8i		-1,779,052
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 2R 2T 3D

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Parl	V Compliance Questions				
10	During the plan year:		Yes	No	Amount
а	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	
С	Was the plan covered by a fidelity bond?	10c	X		500,000
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	Х		16,510
h	If this is an Individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		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	10i			