Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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

2018

This Form is Open to Public Inspection

Part I	Annual Report	Identification Information								
For calend	ar plan year 2018 or fi	scal plan year beginning 01/01/20	018	and ending 12	2/31/2018					
A This ret	turn/report is for:) (Filers checking this box must attach a accordance with the form instructions.)							
R This rote	urn/report is	a one-participant plan	a foreign plan the final return/report							
D IIIIs lett	um/report is	the first return/report								
		an amended return/report	a short plan year return	n/report (less than 12 m	nonths)					
C Check	box if filing under:	X Form 5558	automatic extension		DFVC program					
	,	special extension (enter descri	, ,							
Part II	Basic Plan Info	ormation—enter all requested info	ormation			_				
1a Name OLYMPAS N	of plan MEDICAL SERVICES,	LLC 401(K) PLAN			1b Three-digit plan number					
					(PN) •	001				
					1c Effective date 01/	or pian 01/2015				
Mailing	g address (include roo	oyer, if for a single-employer plan) m, apt., suite no. and street, or P.O.		uotiono)	2b Employer Iden (EIN) 46-	tification Number 2128468				
•	MEDICAL SERVICES	ce, country, and ZIP or foreign posta LLC	ii code (ii Toreign, see instr	uctions)	2c Sponsor's tele	ephone number 85-4843				
				2d Business code	e (see instructions)					
	R STREET, STE. 107 NSEND, WA 98368		621111							
3a Plan a	dministrator's name a	nd address 🛛 Same as Plan Spon		3b Administrator's EIN						
					3c Administrator's	s telephone number				
		e plan sponsor or the plan name ha nsor's name, EIN, the plan name ar			4b EIN					
a Spons C Plan N	or's name lame				4d PN					
5a Total i	number of participants	at the beginning of the plan year			5a	8				
b Total i	number of participants	at the end of the plan year			5b	8				
		account balances as of the end of the		-	5c	8				
d(1) Tota	al number of active pa	articipants at the beginning of the pla	n year		5d(1)	5				
` '	•	articipants at the end of the plan yea			. 5d(2) 3					
		terminated employment during the			5e	0				
Caution: A	A penalty for the late	or incomplete filing of this return	report will be assessed	unless reasonable cau						
SB or Sche		ther penalties set forth in the instruction and signed by an enrolled actuary, as plete.								
SIGN		/valid electronic signature.	08/20/2019	JAMES ROTCHFORD	HFORD					
HERE	Signature of plan a	administrator	Date	Enter name of individ	ual signing as plan a	dministrator				
SIGN	Filed with authorized	SIGN Filed with authorized/valid electronic signature. 08/20/2019 JAMES ROTCHFORD								

Date

Enter name of individual signing as employer or plan sponsor

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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)							Vaa □ Na		
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)							Yes No		
C	If the plan is a defined benefit plan, is it covered under the PBGC in						_	Not determined		
	If "Yes" is checked, enter the My PAA confirmation number from th						-	. (See instructions.)		
Do				,				_ (,		
7			(a) Danimaina	-f V	1		(b) F.	d of Voca		
<u>'</u>	Plan Assets and Liabilities Total plan assets	7a	(a) Beginning o	or Year 29937	-+		(b) En	(b) End of Year 107056		
	Total plan liabilities	7b	12	20001				107000		
	Net plan assets (subtract line 7b from line 7a)	7c	1:	29937				107056		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun				(b)	Total		
	Contributions received or receivable from:		(u) Amoun				(6)	Total		
	(1) Employers	8a(1)		4145						
	(2) Participants	8a(2)	2	27501						
	(3) Others (including rollovers)	8a(3)								
<u>b</u>	Other income (loss)	8b		-4306						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						27340		
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	s paid (including direct rollovers and insurance premiums ide benefits)								
е	Certain deemed and/or corrective distributions (see instructions)									
f	Administrative service providers (salaries, fees, commissions)	·								
g	Other expenses	8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h				50221				
i	Net income (loss) (subtract line 8h from line 8c)	8i				-22881				
j	Transfers to (from) the plan (see instructions)	tions)8j								
Pai	Part IV Plan Characteristics									
9a	If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2J 2K 2R 2T 3D	feature co	des from the List of Pla	an Cha	racteri	stic Co	odes in the in	structions:		
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	es from the List of Plan	n Chara	cteris	tic Cod	des in the inst	ructions:		
Par	t V Compliance Questions									
10	During the plan year:				Yes	No		Amount		
	Was there a failure to transmit to the plan any participant contribu	ıtions withi	n the time period		100	110		Amount		
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	iduciary Correction	10a	X			12524		
b	Were there any nonexempt transactions with any party-in-interest							12021		
		reported on line 10a.)				X				
c	· · · · · · · · · · · · · · · · · · ·			10c		Х				
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				
е	Were any fees or commissions paid to any brokers, agents, or oth									
	carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)					Χ				
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 a	Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)			X			0		
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			10h		X				
ī	If 10h was answered "Yes," check the box if you either provided the	he require	d notice or one of the							
	exceptions to providing the notice applied under 29 CFR 2520.10	ロ-3		10i		<u> </u>				

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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 (Form 5500) and line 11a below)			Yes 🛚 No				
11a	11a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40							
12	Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or se ERISA?		of	Yes X No				
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)							
а	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, granting the waiver	and enter Da		e of the letter ruling Year				
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						
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?		Yes	□ No □ N/A				
Part '	VII Plan Terminations and Transfers of Assets							
13a	Has a resolution to terminate the plan been adopted in any plan year?		Ye	s 🔀 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 control of the PBGC?	the		Yes X No				
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plant which assets or liabilities were transferred. (See instructions.)	n(s) to						
1	3c(1) Name of plan(s):	(2) EIN(s))	13c(3) PN(s)				

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pansion Benefit Guaranty Corporation

Part I

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 section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

In Guaranty Corporation ► Complete all ontries in accordance with the Instructions to the Form 5500-SF.

Annual Report Identification Information

OMB Nos. 1210-0110 1210-0089

v.171027

2018

This Form is Open to Public Inspection

Fo	r calendar plan year 2018 or f	iscal plan year beginning	01/01/2018 ar	nd ending 1	2/31/2018			
_		x a single-employer plan	a multiple-employer plan (not					
Α	his return/report is for:		a list of participating employer	information in accords	ance with the form instructions.)			
_		a one-participant plan	a foreign plan					
В	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)	ı			
С	Check box if filing under:	X Form 5558	automatic extension	į	DFVC program			
<u> </u>	d	special extension (enter desc						
	art II Basic Plan Inf	ormation enter all requested	<u>information</u>					
ıa	Name of plan			1b	Three-digit			
	OLYMPAS MEDICAL SE	RVICES, LLC 401(k) PLAN	N	İ	plan number (PN) ► 001			
		1c	Effective date of plan					
2-	Discontinuity		1100		01/01/2015			
2a	— Malling Address (include ro	oyer, if for a single-employer plan) om, apt., suite no. and street, or P.	O Boy)		Employer Identification Number			
	City or town, state or provin	ce, country, and ZIP or foreign pos	stal code (if foreign, see instructions)		(EIN) 46-2128468			
	OLYMPAS MEDICAL SE	RVICES LLC		2c	Sponsor's telephone number			
				-	(360) 385-4843			
	1136 WATER STREET,	STE. 107		20	Business code (see instructions) 621111			
					021111			
3a	US PORT TOWNSEND WA 983	68 and address X Same as Plan Sp	- Constant	25				
~	The south house of a harrier	ا مد	3b Administrator's EIN					
	_							
				3c	Administrator's telephone number			
4	If the name and/or EIN of th	e plan sponsor or the plan name h	as changed since the last return/repo	ort filed for 4b	EIN			
_		nsor's name, EIN, the plan name a	ind the plan number from the last ret					
a	Sponsor's name Plan Name				PN			
G	- ((d) 1400G							
52	Total number of participants	at the beginning of the plan year		5a	8			
b								
c			the plan year (only defined contributi	! (_			
	complete this item)		***************************************		8			
d(Total number of active par	tloipants at the beginning of the pla	an year	5d(1) 5			
d(2) Total number of active par	rticipants at the end of the plan yea	ır	5d(2	2) 3			
0	Number of participants who less than 100% vested		plan year with accrued benefits that) 0			
	·				-			
			n/report will be assessed unless r		11 1111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
			ictions, I declare that I have examine as well as the electronic version of th					
bal	lief, it is true, corregt, and coff	iplate. V. A.						
	IGN ///	Palh Hook	8/20/2019	mer K. 1	CATCHFORM			
Dec. 40005	ERE Syspanify of play age	ilniktrator		ame of individual signing	ng ĝs plan administrator			
7 (F) (F)		STELLESOIN						
	ERE algnature of employe	Molen seancar	Date Enterna	TNA ()	ng as employer or plan sponsor			
<u> </u>	·····	Notice see the instructions for i	Enter 13	arre or marviousi signin	Form 5500-SE (2018)			

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						•				
	Were all of the plan's assets during the plan year invested in eligible	assets7 (See Instructions.)		*******	******		X Yes No		
þ	- 44 Aga aranimia a Market of the difficult evaluitingtion and tebbli of all	n indepen	dent qualified public accor	untan	t (IQP/	A)				
	under 29 CFR 2520.104-467 (See Instructions on walver eligibility at If you answered "No" to either line 6a or line 6b, the plan canno	nd conditio	ons.)					XYes No		
C	If the plan is a defined benefit plan, is it covored under the PBGC ins	t dae ron Sidance of	m 5500-ar and must ins	1080	USB F0	orm :	5500.	- ()		
	If "Yes" is checked, enter the My PAA confirmation number from the	DBCC no	ogram (see ERISA sectio	m 402	:1) *		∐ Ye:			
	A CALE ENTER CALL	1 000 pii	endan ming for this year					(See instructions.)		
ा <u>ः</u> ७	Plan Assets and Liabilities	J. C. S. S. P. T. S. 200	4.5.							
a	Total plan assets	Sea Sec. Sec. 35	"				(b) End of Year			
b	Total plan liabilities	7a	. 12	29,9	937			107,056		
C	Net plan assets (subtract line 7b from line 7a)	7b								
8	Income, Expenses, and Transfers for this Plan Year	7c		29, <u>9</u>	37	-		107,056		
а	Contributions received or receivable from:	independent file big	(a) Amount	•		20080	OMA AND AC	(b) Total		
	(1) Employers	8a(1)		4,1	45	40 g) y	41.3	Bertholing ages of the state of		
	(2) Participants	8a(2)		27,5	01	1				
	(3) Others (including rollovers)	8a(3)					Y NAV			
b	Other income (loss)	8b		4,30						
c d	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	en errete litte open stand until beginnen in der	1101	A PARTY	Á Æ	27,340			
0	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		49,8	71					
e	Certain deemed and/or corrective distributions (see instructions)	8e	17			2	(7)			
f	Administrative service providers (salaries, fees, commissions)	8f	350			2		The state of the s		
<u>g</u>	Other expenses	8g		19 19 19				AND AND THE PARTY OF THE PARTY		
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	The state of the s					50,221		
Net income (loss) (subtract line 8h from line 8c)			The state of the s	aneri Parek	rentranen Siir Ozotiet			(22,881)		
<u> </u>	Transfers to (from) the plan (see Instructions)	8j				6. 19. 1. 19.	Alexandray	en er spelie de de la companya de l Companya de la companya de la compa		
	mt.IV. Plan Characteristics							****		
9a	If the plan provides pension benefits, enter the applicable pension fe	ature code	es from the List of Plan Ch	narac'	eristic	Code	es in th	e instructions:		
_	2A 2E 2F 2G 2J 2K 2R 2T 3D									
b	If the plan provides welfare benefits, enter the applicable welfare feat	ture codes	from the List of Plan Cha	aracte	ristic C	Codes	s in the	Instructions:		
	50000									
	int V Compliance Questions				1					
0 a	During the plan year: Was there a failure to transmit to the plan any participant contributi	one within	the time period		Yes	NO	/N/A	Amount		
ų	described in 29 CFR 2510.3-102? (See instructions and DOL's Vol		= -				100 100 100 100 100 100 100 100 100 100			
	Program)	-	-	10a	x		P STATE OF	12,524		
b		(Do not in	nclude transactions	10b		x				
C				10c	İ	x				
d	Did the plan have a loss, whether or not reimbursed by the plan's fi						12 1.4 10 05 1.5 10			
	by fraud or dishonesty?			10d		Х	Maria Santa			
e	Were any fees or commissions paid to any brokers, agents, or other carrier, insurance service, or other organization that provides some the plan? (See instructions.)	or all of t	he benefits under	10a		х				
f	Has the plan failed to provide any benefit when due under the plan			10f		х	12 A 12			
g	Did the plan have any participant loans? (If "Yes," enter amount as	of year e	nd.)	10g	х		24.4.74	0		
h	III I	See instruc	ctions and 29 CFR	10h		x		and the second s		
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101-	required	notice or one of the	101				Control of Control of		

	Form 5500-SF 2018	Page 3 -						
Sin S. C	### Security			_				
Par	Pension Funding Compliance							
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Ye (Form 5500 and line 11a below)	es," see instructions a	nd complete Sc	hedule :	SB	☐ Yes	X	No
<u>_11</u>	3 Enter the unpaid minimum required contributions for all years from Schedule 5	3B (Form 5500) line 4t	Ò	11a				
12	Is this e defined contribution plan subject to the minimum funding requiremen ERISA? (If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applications.	ts of section 412 of the	e Code or section	on 302 (************		_	No
a ————————————————————————————————————	If a waiver of the minimum funding standard for a prior year is being amortized granting the waiver		Month	nd enter Da		of the letter i	ruling	
——— b	/ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form			· · · · · ·				
	Enter the minimum required contribution for this plan year			12b				
C	Enter the amount contributed by the employer to the plan for the 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	12d				• "
е	Will the minimum funding amount reported on line 12d be met by the funding of				Yes 🗀	No 🗆	N/A	
Par	Plan Terminations and Transfers of Assets							
13a	Has a resolution to terminate the plan been adopted in any plan year?			Г	⊓ Yes	X No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this			13a		[EE] 140		
b	Were all the plan assets distributed to participants or beneficiaries, transferred control of the PBGC?				Y	es X I	Vo	
C	If, during this plan year, any assets or liabilities were transferred from this plan which assets or liabilities were transferred. (See instructions.)	to another plan(s), ide	entify the plan(s) to		11.11		
1	3c(1) Name of plan(s):		13c(2) Ei	N(s)		13¢(3) P	N(s)	
				<u></u>			, ,	