Form 5500-SF

Department of the Treasury Internal Revenue Service

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

A This return/report is for. a neparticipant plan a single-employer plan a multiple-employer plan (not multiemployer) (Files checking this box must attach a list of participating employer information in accordance with the form instructions.) a rotering plan a single-employer plan a core participant plan a neparticipant plan a membraded return/report the first return/report the first return/report a short plan year return/report (less than 12 months) B This return/report is from 5558 automatic extension DPVC program Part II Basic Plan Information—enter all requested information 1a Namo of plan STRATS CRTH-ORABDICS, INC. 401(K) PLAN Part II Basic Plan Information—enter all requested information 1a Namo of plan STRATS CRTH-ORABDICS, INC. 401(K) PLAN 2b File powers in name (employer, if for a single-employer plan) 001 1c Effective date of plan 1c Effective date of plan 1c DPVC program 0010/12/2005 2b Employer floating in number (PN) 001 1c Effective date of plan 1c Effective date of plan 1c DPVC program 0010/12/2005 2c Demployer in number (PN) 001 1c Effective date of plan 1d Effective date of plan 1d Effective date of plan 1d DPVC program 0010/12/2005 2c Demployer in number (PN) 001 1c Effective date of plan 1d Effective date of plan 1d DPVC program 0010/12/2005 2c Demployer in number (PN) 001 1c Effective date of plan 1d Effective date of plan 1d Effective date of plan 1d DPVC program 0010/12/2005 2c Demployer in number 0100/12/2005 2d Supersion 0100/12/2005 2d Demployer in number 0100/12/2005 2d Demplo	Part I	Annual Report	Identification Information	<u>n</u>									
A This return/report is for: a one-participant plan a foreign plan a short plan year return/report (less than 12 months) C C Check box if filing under:	For calend	lar plan year 2018 or fi	scal plan year beginning 01/01/2	/2018		and ending 12	2/31/2018						
B This return/report is	M a single chiployer plan						=						
me tinst return/report me tinst return/report me tinst return/report me tinst return/report me tinst return/report (less than 12 months)		·	a one-participant plan a foreign plan					,					
C Check box if filing under:	B This ret	This return/report is the first return/report the final return/report											
Special extension (enter description)			an amended return/report	a sho	ort plan year return	/report (less than 12 m	onths)						
Part II Basic Plan Information—enter all requested information 1a Name of plan STRATS ORTHOPAEDICS, INC. 401(K) PLAN 1c Effective date of plan CPN) + 001 1c Effective date of plan 001 1c Effective date of	C Check	box if filing under:	X Form 5558	auto	matic extension	DFVC program							
1			special extension (enter desc	cription)									
Pan number (PN) 001 C Effective date of plan 1010/12005 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) 2b Employer Identification Number (EIN) 20-1682831 2c Sponsor's telephone number 380-953-8884 2d Business code (see instructions) 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 380-953-8884 2d Business code (see instructions) 621111 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 3c Administrator 3c Admi	Part II	Basic Plan Info	ormation—enter all requested in	nformation									
Pan number (PN) 001 C Effective date of plan 1010/12005 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) 2b Employer Identification Number (EIN) 20-1682831 2c Sponsor's telephone number 380-953-8884 2d Business code (see instructions) 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 380-953-8884 2d Business code (see instructions) 621111 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 3c Administrator 3c Admi	1a Name	of plan					1b Three	e-diait					
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) Mailing address (include room, apt., suite no. and street, or P.O. Box) STRAITS ORTHOPAEDICS, INC. 2c Sponsor's Lelephone number 300-93-8384 2d Business code (see instructions) 6211111 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number this plan, enter the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name c Plan Name 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report. a Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year 5b 2 5 Total number of participants at the end of the plan year 5c 2 6 Number of participants with account belances as of the end of the plan year (not) defined contribution plans complete this item). 6 Number of participants at the beginning of the plan year 5c 2 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6 Under penalties of pertury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule Nepper Signature of plan administrator 5 Internal Plan administrator 5 Date 5 Entername of individual signing as plan administrator 5 Internal Plan administrator 5 Date 5 Entername of individual signing as plan administrator		•	401(K) PLAN				plan	number	001				
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) 2c Sponsor's telephone number 360-953-8384 2d Business code (see instructions) 621111 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's telephone number 360-953-8384 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 5a Total number of participants at the beginning of the plan year 5b 2 5a Total number of participants at the end of the plan year 5b 2 5c Number of participants with account balances as of the end of the plan year 5d(1) 2 6d(1) Total number of participants at the beginning of the plan year 5d(1) 2 6d(2) Total number of active participants at the end of the plan year 5d(2) 1 6 E Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 100%							•						
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) STRATS ORTHOPAEDICS, INC. 2C Sponsor's telephone number 360-953-8384 2d Business code (see instructions) 621111 3a Plan administrator's name and address Same as Plan Sponsor. 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 5a Total number of participants at the beginning of the plan year 5b Total number of participants with account balances as of the end of the plan year 6c Number of participants with account balances as of the end of the plan year 6d(1) Total number of active participants at the beginning of the plan year 6d(2) Total number of active participants at the beginning of the plan year 6d(2) Total number of active participants at the beginning of the plan year 6d(2) Total number of active participants at the beginning of the plan year 6d(2) Total number of participants with account balances as of the end of the plan year 6d(2) Total number of participants with account balances as of the end of the plan year 6d(3) Total number of active participants at the beginning of the plan year 6d(1) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 6d(1) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 6d(1) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 6d(1) Total number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested 6d(1) Total number of participants who terminated employment during the plan year with accrued													
### STRAITS ORTHOPAEDICS, INC. ### 25 ponsor's telephone number 360-053-93844 ### 26 Business code (see instructions) 621111 ### 27 Business code (see instructions) 621111 ### 28 Business code (see instructions) 62111 ### 28 Business code (see instructions) 6211 ### 28 Business co	Mailing	g address (include roo	m, apt., suite no. and street, or P.0	O. Box)	f foreign oog ingtr	untion a)							
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 5a Total number of participants at the beginning of the plan year. 5 Total number of participants at the end of the plan year. 5 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4d PN 5a Total number of active participants at the beginning of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants who terminated employment during the plan year. 5 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6 Number of participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that the were less to the participants who terminated employment during the plan year with accrued bene	•		e, country, and zir or toreign posi	stai code (i	i ioreign, see instit	actions)							
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 5a Total number of participants at the beginning of the plan year. 5 Total number of participants at the end of the plan year. 5 Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). 4d PN 5a Total number of active participants at the beginning of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants with account balances as of the end of the plan year. 5 Number of participants who terminated employment during the plan year. 5 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested. 6 Number of participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that were less to the participants who terminated employment during the plan year with accrued benefits that the were less to the participants who terminated employment during the plan year with accrued bene							2d Busir	ness code (see instructions)				
3a Plan administrator's name and address Same as Plan Sponsor. 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 5a Total number of participants at the beginning of the plan year													
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 5a Total number of participants at the beginning of the plan year	CAMAS, WA	A 98607						02					
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 5a Total number of participants at the beginning of the plan year													
4b EIN 4b EIN 4d PN 5a Total number of participants at the beginning of the plan year	3a Plan a	administrator's name a	nd address X Same as Plan Spo	onsor.			3b Administrator's EIN						
4b EIN 4b EIN 4d PN 5a Total number of participants at the beginning of the plan year							3c Administrator's tolonhone number						
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							JC Aum	ilistrator s t	elephone number				
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 Sponsor's name c Plan Name 5a Total number of participants at the beginning of the plan year							4b EIN						
5a Total number of participants at the beginning of the plan year			onsor's name, EIN, the plan name a	and the pl	an number from th	e last return/report.	Ad PN						
5a Total number of participants at the beginning of the plan year								TO FIN					
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 complete this item). d(1) Total number of active participants at the beginning of the plan year	5a Total	number of participants	at the beginning of the plan year.						5				
d(1) Total number of active participants at the beginning of the plan year							5b		2				
d(2) Total number of active participants at the end of the plan year					•	5c		2					
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	d(1) Total number of active participants at the beginning of the plan year					5d(1)		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. SIGN HERE Filed with authorized/valid electronic signature. Date Enter name of individual signing as plan administrator SIGN HERE	d(2) Total number of active participants at the end of the plan year					5d(2)		1					
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 Filed with authorized/valid electronic signature. Date Enter name of individual signing as plan administrator SIGN HERE						5e		0					
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 Filed with authorized/valid electronic signature. Date Enter name of individual signing as plan administrator SIGN HERE	Caution: A	A penalty for the late	or incomplete filing of this retur	rn/report v	will be assessed u	unless reasonable car	use is estal	olished.					
HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE	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												
Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE	SIGN			0	9/30/2019	RICK JACKSON							
SIGN HERE	HERE	Signature of plan a	administrator		Date	Enter name of individual signing as plan administrator							
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor													
	HERE	Signature of emplo	oyer/plan sponsor	ı	Date	Enter name of individ	f individual signing as employer or plan sponsor						

Form 5500-SF (2018) Page **2**

	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)							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 determine "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instruction)										
Pai	rt III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning	of Year			(b) I	End of Year		
a	Total plan assets	7a	` , , ,	11638			103627			
_	Total plan liabilities	7b		866			883			
С	Net plan assets (subtract line 7b from line 7a)	7c	2	210772			102744			
	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	nt		(b) Total				
	Contributions received or receivable from: (1) Employers	8a(1)	0							
	(2) Participants	8a(2)		0						
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)	8b		-653						
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					-653			
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d	1	106153						
<u>e</u>	Certain deemed and/or corrective distributions (see instructions) \dots	8e								
f	Administrative service providers (salaries, fees, commissions)	8f		1222						
g	Other expenses	8g								
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					107375			
<u> </u>	Net income (loss) (subtract line 8h from line 8c)	8i						-1080	028	
J	Transfers to (from) the plan (see instructions)									
	t IV Plan Characteristics									
9a 	9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions: 3D 2E 2F 2G 2J 2K 2T									
b	If the plan provides welfare benefits, enter the applicable welfare for	eature cod	les from the List of Pla	n Chara	acteris	tic Co	des in the i	nstructions:		
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 contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)					X				
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)					X				
С	C Was the plan covered by a fidelity bond?				X				50000	
d	d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?					X				
е	• 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				6	
f	f Has the plan failed to provide any benefit when due under the plan?					X				
	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)					X				
h	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 exceptions to providing the notice applied under 29 CFR 2520.10			10i						

Form 5500-SF (2018)	Page 3- 1

Part	VI Pension Funding Compliance								
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and con (Form 5500) and line 11a below)			В		es 🗌 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 ERISA?	e or section	n 302 of		. Y	es 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 instru granting the waiver.		d enter t Day		of the letter Year	ruling			
lf :	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.								
b	b Enter the minimum required contribution for this plan year								
C Enter the amount contributed by the employer to the plan for this plan year									
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)									
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	13a Has a resolution to terminate the plan been adopted in any plan year?					X 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 control of the PBGC?			Yes X	No				
С	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)	the plan(s)	to						
1	3c(1) Name of plan(s):	13c(2)	EIN(s)		13c(3)	PN(s)			