## 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

2018

This Form is Open to Public Inspection

Part I		t Identification Information				
For calend	ar plan year 2018 or	fiscal plan year beginning 01/01/	2018	and ending 12	2/31/2018	
A This re	turn/report is for:	X a single-employer plan		plan (not multiemployer) ( employer information in ac	_	
_		a one-participant plan	a foreign plan			
<b>B</b> This ret	urn/report is	the first return/report	the final return/repor	t		
		an amended return/report	a short plan year ret	urn/report (less than 12 m	onths)	
C Check	box if filing under:	X Form 5558	automatic extension	า	DFVC progra	ım
		special extension (enter desc	cription)			
Part II	Basic Plan Inf	ormation—enter all requested ir	nformation			
1a Name DAVID R DA	•	EDIC SURGEON PS 401(K) PROFI	T SHARING PLAN		<b>1b</b> Three-diginal plan number (PN) ▶	
					1c Effective of	date of plan 01/01/1996
		loyer, if for a single-employer plan)			<b>2b</b> Employer	Identification Number
		om, apt., suite no. and street, or P.once, country, and ZIP or foreign pos		structions)	(EIN)	91-1684371
-	WSON ORTHOPAE		(ii			s telephone number 53-946-1800
					2d Business	code (see instructions)
	320TH STREET SU /AY, WA 98003	ITE G				621399
, EBEIOLE VI	777, 777 00000					
3a Plan a	dministrator's name	and address 🛛 Same as Plan Spo	onsor.		<b>3b</b> Administra	ator's EIN
					3c Administra	ator's tolonhono numbor
					3C Administra	ator's telephone number
		he plan sponsor or the plan name honsor's name, EIN, the plan name			4b EIN	
•	or's name	ondor o name, Env, the plan name	and the plan number non	r the last retain, report.	4d PN	-
C Plan N	lame					
<b>5a</b> Total	number of participan	ts at the beginning of the plan year.			5a	3
<b>b</b> Total number of participants at the end of the plan year					5b	3
<b>C</b> Numb	er of participants with	h account balances as of the end of	the plan year (only define	ed contribution plans	5c	3
•	,	participants at the beginning of the p			5d(1)	3
		participants at the end of the plan ye			5d(2)	3
<b>e</b> Numl	per of participants wh	no terminated employment during th	e plan year with accrued	benefits that were less	5e	0
		e or incomplete filing of this retur				ed.
Under pen SB or Sche	alties of perjury and	other penalties set forth in the instru and signed by an enrolled actuary,	ictions, I declare that I have	ve examined this return/re	port, including, if	applicable, a Schedule
SIGN	Filed with authorize	ed/valid electronic signature.	10/14/2019	DAVID DAWSON MD		
HERE	Signature of plan administrator  Date  Enter name of individual signing as plan administrator		an administrator			
SIGN						
HERE	Signature of emp	loyer/plan sponsor	Date	Enter name of individ	ual signing as en	nployer 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.)						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	
	f you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.					Ц			
С	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No						lo Not	determined	
	If "Yes" is checked, enter the My PAA confirmation number from the	e PBGC p	remium filing for this pl	lan yea	r			(See ii	nstructions.)
Pa	rt III Financial Information								
7	Plan Assets and Liabilities		(a) Beginning (	of Year			(b) E	nd of Year	•
а	Total plan assets	7a	82	28551				8148	315
b	Total plan liabilities	7b							
C	Net plan assets (subtract line 7b from line 7a)	7c	82	28551		814815			315
8	Income, Expenses, and Transfers for this Plan Year		(a) Amoun	t		(b) Total			
а	Contributions received or receivable from: (1) Employers	8a(1)		4501					
	(2) Participants	8a(2)		9428					
	(3) Others (including rollovers)	8a(3)							
b	Other income (loss)	8b	-2	26866					
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						-129	937
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d							
е	Certain deemed and/or corrective distributions (see instructions)	8e							
f	Administrative service providers (salaries, fees, commissions)	8f		799					
g	Other expenses	8g							
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							799
i	Net income (loss) (subtract line 8h from line 8c)	8i						-137	736
j	Transfers to (from) the plan (see instructions)	8j							
Pai	rt IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension 2E 2G 2J	feature co	odes from the List of Pla	an Cha	racteri	stic Co	des in the	instructions	:
b	b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:								
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	itions withi	n the time period					Amount	
	described in 29 CFR 2510.3-102? (See instructions and DOL's V Program)	oluntary F	Fiduciary Correction	10a		X			
b	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)			10b		X			
С	C Was the plan covered by a fidelity bond?			10c	X				95000
d	<b>d</b> 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 som the plan? (See instructions.)	ne or all of	the benefits under	10e		X			
f	<b>f</b> Has the plan failed to provide any benefit when due under the plan?			10f		X			
g	g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)			10g	Х				16521
h	If this is an individual account plan, was there a blackout period? 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		X			

Form 5500-SF (2018)	Page <b>3-</b> 1
---------------------	------------------

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	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 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	<b>3c(1)</b> Name of plan(s):	(2) EIN(s)	)	<b>13c(3)</b> PN(s)

Fram:

10/14/2019 13:25

Form 5500-SF Short Form Annual Return/Report of Small Employee OMB Nos. 1210-0110 Benefit Plan Separtment of the Treesury Internal Revenue Service 1210-0089 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). 2018 Department of Lebor Employee Benefits Security Administration This Form is Open Pension Benefit Quaranty Corporation Complete all entries in accordance with the instructions to the Form 6500-SF. to Public Inspection Annual Report Identification Information For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 12/31/2018 and ending This return/report is for: X 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 the first return/report the final return/report an amended return/report a short plan year return/report (less than 12 months) C Check box if filing under: Form 5556 automatic extension DFVC program special extension (enter description) Part II Basic Plan Information - enter all requested information 18 Name of plan Three-digit plan number (PN) DAVID R DAWSON ORTHOPAEDIC SURGEON PS 001 401(K) PROFIT SHARING PLAN Effective date of plan 01/01/1996 Za Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box) Employer Identification Number (EIN) 91-1684-371 City of town, state or province country, and ZIP or foreign postal code (if foreign, see instr.)
DAVID R DAWSON ORTHOPASDIC SURGEON PS 2c Sponsor's telephone number 720 SOUTH 320TH STREET SUITE G **253-946-1800 2**d Business code (see instructions) FEDERAL WAY 98003 621399 3a Plan administrator's name and address X Same as Plan Sponsor. 36 Administrator's EIN Administrator's telephone number 4 If the name and/or EIN of the plan aponsor or the plan name has changed since the last 4b EIN 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. Sponsor's name **4**d PN C Plan Name 5a Total number of participants at the beginning of the plan year 58 b Total number of participants at the end of the plan year 5b C Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 5c d (1) Total number of active participants at the beginning of the plan year 5d(1) d (2) Total number of active participants at the end of the plan year 5d(2)6 Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested Caution: A pensity for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perlury 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. RIGH 10 7115 DAVID DAWSON MD HERE Enter name of individual eigning as plan administrator Date SIGN HERE Signature of employer/plan sponsor Date Enter name of individual algning as employer or plan sponsor

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

Form 5500-SF (2018)

v. 171027

h if this is an individual account plan, was there a blackout period? (See instructions

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

10/14/2019 13:25

10a

10h

#402 P.003

Form 5500-SF (2018) Page 2 6a Were all of the plan's assets during the plan year invested in eligible assets? (See Instructions.) X Yes No Are you claiming a waiver of the annual examination and report of an independent quastied public accountant (IOPA) under 29 CFR 2520.104-467 (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 6600-8F and must instea<u>d</u> use For<u>m</u> 5500. 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 Plan Assets and Liabilities (a) Beginning of Year (b) End of Year Total plan assets <u>8</u>28,551 814,815 Zπ b Total plan Rabilities 7b 828,551 C Net plan assets (subtract line 7b from line 7a) 814.815 7c 8 Income, Expenses, and Transfers for this Plan Year (a) Amount (b) Total 3 Contributions received or receivable from: 4.501 (1) Employers 8a(1) (2) Participants 9,428 8e(2) (3) Others (including rollovers) Ba(3) **b** Other income (loss) STATEMENT 1 -26,866 8b C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) -12.937₿¢. Benefits paid (including direct rollovers and insurance premiums to provide benefita) Certain deemed and/or corrective distributions (see instructions) 8e Administrative service providers (salaries, fees, commissions) ... STMT ... 2 799 31 Other expenses 80 Total expenses (add lines 8d, 8e, 8f, and 8d) 799 8h Net income (loss) (subtract line 8h from line 8c) 8i 736 Transfers to (from) the plan (see instructions) 81 Part IV Plan Characteristics 9a If the plan provides pension benefits, enter the applicable penaion feature codes from the List of Plan Characteristic Codes in the instructions: 2E 2G 2J 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 During the plan yeer: Yes No Amount 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 b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) 10b C Was the plan covered by a fidelity bond? 100 95,000 d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or distronesty? ..... 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.) 100 f Has the plan failed to provide any benefit when due under the plan? X 101 g Did the plan have any participant loans? (if "Yes," enter amount as of year and.) 16,521

and 29 CFR 2520.101-3.)