

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 2019 This Form is Open to Public Inspection
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Part I Annual Report Identification Information			
For calendar plan year 2019 or fiscal plan year beginning <u>01/01/2019</u> and ending <u>12/31/2019</u>			
A This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)	
	<input type="checkbox"/> a one-participant plan	<input type="checkbox"/> a foreign plan	
B This return/report is	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report	
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)	
C Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension	<input type="checkbox"/> DFVC program
	<input type="checkbox"/> special extension (enter description)		

Part II Basic Plan Information —enter all requested information				
1a Name of plan	<u>ELLINGSEN ENDODONTICS, PLLC DEFINED BENEFIT PLAN</u>		1b Three-digit plan number (PN) ►	<u>002</u>
			1c Effective date of plan	<u>01/01/2007</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>ELLINGSEN ENDODONTICS, PLLC</u> <u>1005 N. EVERGREEN, SUITE 201</u> <u>SPOKANE, WA 99201-3103</u>			2b Employer Identification Number (EIN)	<u>01-0852652</u>
			2c Sponsor's telephone number	<u>509-921-5666</u>
			2d Business code (see instructions)	<u>621210</u>
3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. <u>ELLINGSEN ENDODONTICS, PLLC</u> <u>1005 N. EVERGREEN, SUITE 201</u> <u>SPOKANE, WA 99201-3103</u>			3b Administrator's EIN	<u>01-0852652</u>
			3c Administrator's telephone number	<u>509-921-5666</u>
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name			4b EIN	
			4d PN	
5a Total number of participants at the beginning of the plan year	5a	<u>6</u>		
b Total number of participants at the end of the plan year	5b	<u>7</u>		
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)	<u>5</u>		
d(2) Total number of active participants at the end of the plan year	5d(2)	<u>5</u>		
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	<u>1</u>		

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
 Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	09/18/2020	MICHELLE ELLINGSEN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.		
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☒ No ☐ Not determined
- If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	964993	1235695
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	964993	1235695
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	90199	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	196584	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		286783
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	16081	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		16081
i Net income (loss) (subtract line 8h from line 8c)	8i		270702
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:
1A 3D
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		300000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h			
i If 10h was answered "Yes," check the box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	10i			

Part VI Pension Funding Compliance

11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and lines 11a and b below.) If this is a defined contribution pension plan, leave line 12 below..... ☒ Yes ☐ No

a Enter the unpaid minimum required contributions for all years from Schedule SB (Form 5500) line 40 **11a** 0

b PBGC missed contribution reporting requirements. If the plan is covered by PBGC and the amount reported on line 11a is greater than \$0, has PBGC been notified as required by ERISA sections 4043(c)(5) and/or 303(k)(4)? Check the applicable box:

- ☐ Yes.
- ☐ No. Reporting was waived under 29 CFR 4043.25(c)(2) because contributions equal to or exceeding the unpaid minimum required contribution were made by the 30th day after the due date.
- ☐ No. The 30-day period referenced in 29 CFR 4043.25(c)(2) has not yet ended, and the sponsor intends to make a contribution equal to or exceeding the unpaid minimum required contribution by the 30th day after the due date.
- ☐ No. Other. Provide explanation _____

12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA? ☐ Yes ☒ No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.) If this is a defined benefit pension plan, leave line 12 blank and complete line 11 above.

a If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the letter ruling granting the waiver. Month _____ Day _____ Year _____

If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.

b Enter the minimum required contribution for this plan year **12b**

c Enter the amount contributed by the employer to the plan for this plan year **12c**

d Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount) **12d**

e Will the minimum funding amount reported on line 12d be met by the funding deadline? ☐ Yes ☐ No ☐ N/A

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ☐ Yes ☒ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year..... **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ Yes ☒ No

c If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500 or 5500-SF.	OMB No. 1210-0110 2019 This Form is Open to Public Inspection
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For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

► **Round off amounts to nearest dollar.**

► **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

A Name of plan <u>ELLINGSEN ENDODONTICS, PLLC DEFINED BENEFIT PLAN</u>	B Three-digit plan number (PN) ►	<u>002</u>
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>ELLINGSEN ENDODONTICS, PLLC</u>	D Employer Identification Number (EIN) <u>01-0852652</u>	
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		
F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500		

Part I	Basic Information		
1	Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2019</u>		
2	Assets:		
	a Market value	2a	<u>964930</u>
	b Actuarial value	2b	<u>964930</u>
3	Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target
	a For retired participants and beneficiaries receiving payment.....	<u>0</u>	<u>0</u>
	b For terminated vested participants.....	<u>2</u>	<u>4267</u>
	c For active participants	<u>5</u>	<u>1027538</u>
	d Total.....	<u>7</u>	<u>1031805</u>
4	If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>		
	a Funding target disregarding prescribed at-risk assumptions	4a	
	b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	4b	
5	Effective interest rate	5	<u>5.72</u> %
6	Target normal cost.....	6	<u>55401</u>

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	<div style="border-bottom: 1px solid black; margin-bottom: 10px;"></div> <div style="text-align: center;">Signature of actuary</div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"></div> <div style="text-align: center;">Type or print name of actuary</div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"></div> <div style="text-align: center;">Firm name</div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"></div> <div style="text-align: center;">Address of the firm</div>	<div style="text-align: right; margin-bottom: 10px;"><u>09/17/2020</u></div> <div style="text-align: center;">Date</div> <div style="text-align: right; margin-bottom: 10px;"><u>20-06948</u></div> <div style="text-align: center;">Most recent enrollment number</div> <div style="text-align: right; margin-bottom: 10px;"><u>509-838-5500</u></div> <div style="text-align: center;">Telephone number (including area code)</div>
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

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

**Schedule SB (Form 5500) 2019
v. 190130**

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	91993
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	91993
10 Interest on line 9 using prior year's actual return of <u>-13.75</u> %	0	-12649
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		24679
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.92</u> %		1461
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance		26140
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	79344

Part III Funding Percentages

14 Funding target attainment percentage	14	85.77 %
15 Adjusted funding target attainment percentage	15	85.77 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	100.84 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
03/18/2019	5000	0	07/29/2019	5000	0
04/02/2019	5000	0	08/16/2019	5000	0
05/03/2019	7500	0	09/27/2019	5000	0
05/17/2019	5000	0	10/10/2019	5000	0
06/07/2019	7500	0	10/28/2019	6000	0
06/21/2019	5000	0	10/31/2019	5000	0
Totals ▶			18(b)	90199	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	86936

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)		
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)		
9 Amount remaining (line 7 minus line 8)		
10 Interest on line 9 using prior year's actual return of _____%		
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of _____%		
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		
c Total available at beginning of current plan year to add to prefunding balance		
d Portion of (c) to be added to prefunding balance		
12 Other reductions in balances due to elections or deemed elections		
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)		

Part III Funding Percentages

14 Funding target attainment percentage	14	%
15 Adjusted funding target attainment percentage	15	%
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	%
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
11/12/2019	5000	0			
12/05/2019	5000	0			
12/23/2019	3500	0			
12/30/2019	3059	0			
01/07/2020	1500	0			
05/04/2020	6140	0			
Totals ►			18(b)		18(c)

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years	19a	
b Contributions made to avoid restrictions adjusted to valuation date	19b	
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	

20 Quarterly contributions and liquidity shortfalls:

a Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☐ No

b If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No

c If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year			
(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

Part V Assumptions Used to Determine Funding Target and Target Normal Cost**21** Discount rate:**a** Segment rates:1st segment:
3.74 %2nd segment:
5.35 %3rd segment:
6.11 %☐ N/A, full yield curve used**b** Applicable month (enter code)**21b**

1

22 Weighted average retirement age**22**

62

23 Mortality table(s) (see instructions) ☒

Prescribed - combined

☐ Prescribed - separate☐ Substitute**Part VI Miscellaneous Items****24** Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**25** Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**26** Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ☐ Yes ☒ No**27** If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.**27****Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years****28** Unpaid minimum required contributions for all prior years **28** 0**29** Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) **29** 0**30** Remaining amount of unpaid minimum required contributions (line 28 minus line 29) **30** 0**Part VIII Minimum Required Contribution For Current Year****31** Target normal cost and excess assets (see instructions):**a** Target normal cost (line 6) **31a** 55401**b** Excess assets, if applicable, but not greater than line 31a **31b** 0**32** Amortization installments:**a** Net shortfall amortization installment Outstanding Balance 146808 Installment 23855**b** Waiver amortization installment 0 0**33** If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount **33****34** Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) **34** 79256**35** Balances elected for use to offset funding requirement Carryover balance 0 Prefunding balance 0 Total balance 0**36** Additional cash requirement (line 34 minus line 35) **36** 79256**37** Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) **37** 86936**38** Present value of excess contributions for current year (see instructions)**a** Total (excess, if any, of line 37 over line 36) **38a** 7680**b** Portion included in line 38a attributable to use of prefunding and funding standard carryover balances **38b** 0**39** Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) **39** 0**40** Unpaid minimum required contributions for all years **40** 0**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)****41** If an election was made to use PRA 2010 funding relief for this plan:**a** Schedule elected ☐ 2 plus 7 years ☐ 15 years**b** Eligible plan year(s) for which the election in line 41a was made ☐ 2008 ☐ 2009 ☐ 2010 ☐ 2011

Ellingsen Endodontics, P.S. Defined Benefit Plan
EIN: 01-0852652
Plan Number: 002
Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

Economic Assumptions							
						January 1, 2018	January 1, 2019
Interest rates for Calculations Under IRC 430 and IRC 436:							
1st Segmented Interest Rate (0-5 years)						3.92%	3.74%
2nd Segmented Interest Rate (5-20 years)						5.52%	5.35%
3rd Segmented Interest Rate (20+ years)						6.29%	6.11%
Effective Interest Rate						5.92%	5.72%
Interest rates for Calculations Under IRC 404:							
1st Segmented Interest Rate (0-5 years)						1.79%	2.50%
2nd Segmented Interest Rate (5-20 years)						3.70%	3.92%
3rd Segmented Interest Rate (20+ years)						4.56%	4.50%
Traditional funding						6.50%	6.50%
FAS 35 liability						6.50%	6.50%
Salary scale:							
ERISA funding						0.00%	0.00%
Maximum compensation limit						\$275,000	\$280,000
Maximum benefit limit						\$220,000	\$225,000
Expenses						\$0	\$0
Actuarial Methods							
Minimum and maximum contributions							
Actuarial value of assets						Market value of assets	
Plan Year						January 1 to December 31	
Measurement date						January 1	

Ellingsen Endodontics, P.S. Defined Benefit Plan

EIN: 01-0852652

Plan Number: 002

Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

Demographic Assumptions							
Mortality - Funding (Post PPA)							
Post-retirement						2019 Optional Small Plans Male/Female	
Pre-retirement						None	
Mortality - 417(e) (Post PPA)							
Post-retirement						2019 Applicable Mortality Table	
Pre-retirement						None	
Mortality - Traditional (Pre PPA)							
Post-retirement						GAR94 Projected to 2002	
Pre-retirement						None	
Probability of Lump Sum						95%	
Termination						None	
Disability						None	
Retirement Age						Age 62	

Form 5500-SFDepartment of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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1210-0089**2019****This Form is Open to
Public Inspection****Part I Annual Report Identification Information**

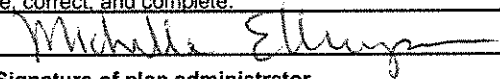
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Part II Basic Plan Information—enter all requested information

1a Name of plan Ellingsen Endodontics, PLLC Defined Benefit Plan		1b Three-digit plan number (PN) ▶	002
		1c Effective date of plan	01/01/2007
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) ELLINGSEN ENDODONTICS, PLLC 1005 N. EVERGREEN, SUITE 201 SPOKANE WA 99201-3103		2b Employer Identification Number (EIN)	01-0852652
		2c Sponsor's telephone number	509-921-5666
		2d Business code (see instructions)	621210
3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. ELLINGSEN ENDODONTICS, PLLC 1005 N. EVERGREEN, SUITE 201 SPOKANE WA 99201-3103		3b Administrator's EIN	01-0852652
		3c Administrator's telephone number	509-921-5666
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name		4b EIN	
		4d PN	
5a Total number of participants at the beginning of the plan year	5a		6
b Total number of participants at the end of the plan year	5b		7
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)		5
d(2) Total number of active participants at the end of the plan year	5d(2)		5
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e		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		9-18-20	MICHELLE ELLINGSEN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor

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

Form 5500-SF (2019)
v.190130

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ☒ Yes ☐ No
- b** Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) ☒ Yes ☐ No
If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ☐ Yes ☒ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	964,993	1,235,695
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	964,993	1,235,695
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	90,199	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	196,584	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		286,783
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d		
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	16,081	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		16,081
i Net income (loss) (subtract line 8h from line 8c)	8i		270,702
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:
1A 3D
- b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X	
c Was the plan covered by a fidelity bond?	10c	X		300,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h			
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			

**SCHEDULE SB
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Single-Employer Defined Benefit Plan
Actuarial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500 or 5500-SF.**

OMB No. 1210-0110

2019**This Form is Open to Public
Inspection**For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019▶ **Round off amounts to nearest dollar.**▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

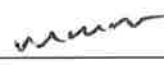
A Name of plan ELLINGSEN ENDODONTICS, PLLC DEFINED BENEFIT PLAN		B Three-digit plan number (PN) ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF ELLINGSEN ENDODONTICS, PLLC		D Employer Identification Number (EIN) 01-0852652
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B		F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

Part I Basic Information

1 Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2019</u>			
2 Assets:			
a Market value.....		2a	964,930
b Actuarial value		2b	964,930
3 Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment	0	0	0
b For terminated vested participants	2	4,267	4,267
c For active participants	5	1,027,538	1,028,127
d Total	7	1,031,805	1,032,394
4 If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions		4a	
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor		4b	
5 Effective interest rate		5	5.72%
6 Target normal cost		6	55,401

Statement by Enrolled Actuary

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

SIGN HERE	Marc M. McCall 	09/17/2020
Signature of actuary		Date
Marc M. McCall		2006948
Type or print name of actuary		Most recent enrollment number
Randall & Hurley, Inc.		509-838-5500
Firm name		Telephone number (including area code)
1328 N. Whitman Lane		
Liberty Lake WA 99019		
Address of the firm		

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐**For Paperwork Reduction Act Notice, see the Instructions for Form 5500 or 5500-SF.****Schedule SB (Form 5500) 2019
v. 190130**

Part II Beginning of Year Carryover and Prefunding Balances

	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year).....	0	91,993
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8).....	0	91,993
10 Interest on line 9 using prior year's actual return of <u>-13.75%</u>	0	-12,649
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year).....		24,679
b(1) Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>5.92%</u>		1,461
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		0
c Total available at beginning of current plan year to add to prefunding balance.....		26,140
d Portion of (c) to be added to prefunding balance.....		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12).....	0	79,344

Part III Funding Percentages

14 Funding target attainment percentage	14	85.77%
15 Adjusted funding target attainment percentage.....	15	85.77%
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	100.84%
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage.	17	%

Part IV Contributions and Liquidity Shortfalls**18** Contributions made to the plan for the plan year by employer(s) and employees:

(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
03/18/2019	5,000	0	12/23/2019	3,500	0
04/02/2019	5,000	0	12/30/2019	3,059	0
05/03/2019	7,500	0	01/07/2020	1,500	0
05/17/2019	5,000	0	05/04/2020	6,140	0
06/07/2019	7,500	0			
06/21/2019	5,000	0			
07/29/2019	5,000	0			
08/16/2019	5,000	0			
09/27/2019	5,000	0			
10/10/2019	5,000	0			
10/28/2019	6,000	0			
10/31/2019	5,000	0			
11/12/2019	5,000	0			
12/05/2019	5,000	0			
Totals ▶			18(b)	90,199	18(c) 0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

a Contributions allocated toward unpaid minimum required contributions from prior years.....	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date.....	19c	86,936

20 Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year?..... ☐ Yes ☒ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner?..... ☐ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th
---------	---------	---------	---------

Part V Assumptions Used to Determine Funding Target and Target Normal Cost

21 Discount rate:				
a Segment rates:	1st segment: 3.74 %	2nd segment: 5.35 %	3rd segment: 6.11 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code).....				21b 1
22 Weighted average retirement age				22 62
23 Mortality table(s) (see instructions)	<input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute			

Part VI Miscellaneous Items

24 Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25 Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

28 Unpaid minimum required contributions for all prior years	28	0
29 Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a)	29	0
30 Remaining amount of unpaid minimum required contributions (line 28 minus line 29)	30	0

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	55,401	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment.....	146,808	23,855	
b Waiver amortization installment	0	0	
33 If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)....	34	79,256	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....	0	0	0
36 Additional cash requirement (line 34 minus line 35).....	36	79,256	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	37	86,936	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	7,680	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37).....	39	0	
40 Unpaid minimum required contributions for all years	40	0	

Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)

41 If an election was made to use PRA 2010 funding relief for this plan:	
a Schedule elected	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years
b Eligible plan year(s) for which the election in line 41a was made	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011

Ellingsen Endodontics, P.S. Defined Benefit Plan

EIN: 01-0852652

Plan Number: 002

Schedule SB, Line 22 – Description of Weighted Average Retirement Age

Age	Rate of Retirement
62	100%

The weighted average retirement age is the Normal Retirement Age as specified by the Plan.

Ellingsen Endodontics, P.S. Defined Benefit Plan
EIN: 01-0852652
Plan Number: 002
Schedule SB, Part V – Summary of Plan Provisions

Background									
Effective Date				January 1, 2007					
Latest Amendment Date				January 1, 2017					
Plan Year				January 1 to December 31					
Definitions									
Eligibility Service				Each Plan year in which 1,000 hours are completed while an employee.					
Benefit Service				Each Plan year in which 1,000 hours are completed while a participant.					
Vesting Service				Each Plan year in which 1,000 hours are completed while an employee; excluding service prior to effective date of plan.					
Average Monthly Compensation				Average of all plan years of compensation (career average).					
Normal Retirement Age				First day of month coincident with or following the later of the date of age 62 and 5 years of participation.					
Eligibility									
Eligibility for Participation				All employees become eligible to participate in the Plan on the January 1st or July 1st coincident with or following the completion of Eligibility Service and attainment of age 21.					

Ellingsen Endodontics, P.S. Defined Benefit Plan
EIN: 01-0852652
Plan Number: 002
Schedule SB, Part V – Summary of Plan Provisions

Benefits			
Normal Retirement		Group 1 consisting of owners with date of hire before 1/1/2002 will accrue benefit equal to 2.0% of Average Monthly Compensation for Years of Benefit Service after January 1, 2017 plus accrued benefit as of December 31, 2016. Group 2 will consist of all plan participants not in Group 1 and will accrue a benefit equal to 0.5% of Average Monthly Compensation.	
Death, Disability, and Termination		Actuarial equivalent of the Normal Retirement benefit accrued to date.	
Normal Form of Benefit		Single Life Annuity	
Vesting Percent		Years of Vesting Service	Vested Percentage
		Less than 5	0%
		2	20%
		3	40%
		4	60%
		5	80%
		6	100%
Plan Provision Changes			
Changes in Plan Provisions		There have been no changes in Plan provisions since the prior actuarial valuation.	
Plan Provisions Effective After Valuation Date		No Plan provisions effective after the valuation date were recognized in the actuarial valuation.	
Plan Trustee(s)			
Plan Trustee(s)		Michelle Ellingsen Lisa Ellingsen	

Ellingsen Endodontics, P.S. Defined Benefit Plan
EIN: 01-0852652
Plan Number: 002
Schedule SB, Line 32 – Schedule of Amortization Bases

Shortfall Amortization										
Valuation Year					Years Left	Original Base		Intallment Amount		Present Value at 1/1/2019
2019					7	146,808		23,855		146,808
2018					6	0		0		0
2017					5	0		0		0
2016					4	0		0		0
2015					3	0		0		0
2014					2	0		0		0
2013					1	0		0		0
								23,855		146,808