

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 <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold;">2019</div> 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 01/01/2019 and ending 12/31/2019			
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 SPOKANE DIGESTIVE DISEASE CENTER, P.S. CASH BALANCE PENSION PLAN	1b Three-digit plan number (PN) ►	002	
	1c Effective date of plan	01/01/2009	
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) SPOKANE DIGESTIVE DISEASE CENTER, P.S. 105 W. 8TH AVE., SUITE 6010 SPOKANE, WA 99204-2873	2b Employer Identification Number (EIN)	91-1013238	
	2c Sponsor's telephone number	509-838-5950	
	2d Business code (see instructions)	621111	
3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	3b Administrator's EIN		
	3c Administrator's telephone number		
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report. a Sponsor's name c Plan Name	4b EIN		
	4d PN		
5a Total number of participants at the beginning of the plan year	5a	71	
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)	53	
d(2) Total number of active participants at the end of the plan year	5d(2)	0	
e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0	
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.	10/06/2020	SCOTT GLENNIE
	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 4226222. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	3595946	67898
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	3595946	67898
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	50700	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	145442	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		196142
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	3709234	
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	14956	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		3724190
i Net income (loss) (subtract line 8h from line 8c)	8i		-3528048
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 1C 1I 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		<input checked="" type="checkbox"/>	
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		<input checked="" type="checkbox"/>	
c Was the plan covered by a fidelity bond?	10c	<input checked="" type="checkbox"/>		500000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		<input checked="" type="checkbox"/>	
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		<input checked="" type="checkbox"/>	
f Has the plan failed to provide any benefit when due under the plan?	10f		<input checked="" type="checkbox"/>	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		<input checked="" type="checkbox"/>	
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	10h		<input checked="" type="checkbox"/>	
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** 0

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) Department of the Treasury Internal Revenue Service Department 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
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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>SPOKANE DIGESTIVE DISEASE CENTER, P.S. CASH BALANCE PENSION 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>SPOKANE DIGESTIVE DISEASE CENTER, P.S.</u>	D Employer Identification Number (EIN) <u>91-1013238</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>3577086</u>
b Actuarial value	2b <u>3577086</u>
3 Funding target/participant count breakdown	
a For retired participants and beneficiaries receiving payment.....	(1) Number of participants <u>0</u> (2) Vested Funding Target <u>0</u> (3) Total Funding Target <u>0</u>
b For terminated vested participants.....	<u>18</u> <u>86895</u> <u>86895</u>
c For active participants	<u>59</u> <u>3295843</u> <u>3305680</u>
d Total.....	<u>77</u> <u>3382738</u> <u>3392575</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>5.09</u> %
6 Target normal cost.....	6 <u>0</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		<u>10/05/2020</u>
Signature of actuary		Date
<u>PATRICK W ANTHONY, ASA, EA</u>		<u>20-08028</u>
Type or print name of actuary		Most recent enrollment number
<u>RANDALL & HURLEY, INC.</u>		<u>509-838-5500</u>
Firm name		Telephone number (including area code)
<u>1328 N WHITMAN LN</u> <u>LIBERTY LAKE, WA 99019</u>		
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	126339
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	126339
10 Interest on line 9 using prior year's actual return of <u>-0.19</u> %	0	-240
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		377842
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>4.84</u> %		18288
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		396130
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	126099

Part III Funding Percentages

14 Funding target attainment percentage	14	101.72 %
15 Adjusted funding target attainment percentage	15	105.43 %
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	104.18 %
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
02/11/2020	33000	0			
06/19/2020	17700	0			
Totals ▶			18(b)	50700	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	47685

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 4
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 checked="" type="checkbox"/> Yes <input 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	0	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	0	0	
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	0	
	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	0	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	47685	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	47685	
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

Schedule SB, line 26 - Schedule of Active Participant Data

YEARS OF CREDITED SERVICE

Attained Age	Under 1		1 To 4		5 To 9		10 To 14		15 To 19		20 To 24		25 To 29		30 To 34		35 To 39		40 & Up	
	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp	No.	Avg. Comp
Under 25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25 to 29	1	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30 to 34	0	0	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35 to 39	3	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
40 to 44	0	0	6	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45 to 49	2	0	3	0	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
50 to 54	1	0	5	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
55 to 59	0	0	4	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
60 to 64	1	0	0	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
65 to 69	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70 & Up	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Name of plan: Spokane Digestive Disease Center, PS Cash Balance Plan
Plan sponsor's name: Spokane Digestive Disease Center P.S.

Plan number: 002
EIN: 91-1013238

Spokane Digestive Disease Center, PS Cash Balance Pension Plan
EIN: 91-1013238
Plan Number: 002
Schedule SB, Part V – Statement of Actuarial Assumptions/Methods

ECONOMIC ASSUMPTIONS

	<u>January 1, 2019</u>
Interest rates for 430 and 436 Calculations:	
1st Segmented Interest Rate (0-5 years)	3.74%
2nd Segmented Interest Rate (5-20 years)	5.35%
3rd Segmented Interest Rate (20+ years)	6.11%
Effective Interest Rate	5.09%
Interest rates for 404 Calculations:	
1st Segmented Interest Rate (0-5 years)	1.75%
2nd Segmented Interest Rate (5-20 years)	3.76%
3rd Segmented Interest Rate (20+ years)	4.66%
Traditional funding	5.50%
FAS 35 liability	5.50%
Salary scale:	
ERISA funding	0.00%
Maximum compensation limit	\$280,000
Maximum benefit limit	\$225,000
Expenses	\$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
Traditional funding methods	
Normal cost and accrued liability	Projected Unit Credit

Spokane Digestive Disease Center, PS Cash Balance Pension Plan
EIN: 91-1013238
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	2019 Applicable Mortality Table
Pre-retirement	None
Probability of Lump Sum	100%
Termination	None
Disability	None
Retirement Age	Age 62
Early Retirement Age	None

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
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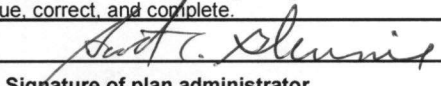
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		1c Effective date of plan	01/01/2009
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		2c Sponsor's telephone number	509-838-5950
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		4d PN	
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e Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0	

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		10-6-20	Scott Glennie
	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 4226222. (See instructions.)

Part III Financial Information

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	3,595,946	67,898
b Total plan liabilities	7b		
c Net plan assets (subtract line 7b from line 7a)	7c	3,595,946	67,898
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	50,700	
(2) Participants	8a(2)		
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	145,442	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		196,142
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	3,709,234	
e Certain deemed and/or corrective distributions (see instructions) ...	8e		
f Administrative service providers (salaries, fees, commissions)	8f	14,956	
g Other expenses	8g		
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		3,724,190
i Net income (loss) (subtract line 8h from line 8c)	8i		-3,528,048
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 1C 1I 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		500,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X	
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X	
f Has the plan failed to provide any benefit when due under the plan?	10f		X	
g Did the plan have any participant loans? (If "Yes," enter amount as of year-end.)	10g		X	
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 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 Service Department 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
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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.

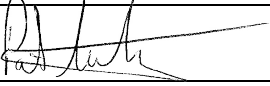
A Name of plan SPOKANE DIGESTIVE DISEASE CENTER, P.S. CASH BALANCE PENSION PLAN	B Three-digit plan number (PN) 002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF SPOKANE DIGESTIVE DISEASE CENTER, P.S.	D Employer Identification Number (EIN) 91-1013238
E Type of plan: <input checked="" 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 01 Day 01 Year 2019			
2 Assets:			
a Market value.....	2a	3,577,086	
b Actuarial value	2b	3,577,086	
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	18	86,895	86,895
c For active participants	59	3,295,843	3,305,680
d Total	77	3,382,738	3,392,575
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	5.09%	
6 Target normal cost	6	0	

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	Patrick Anthony 	10/05/2020
Signature of actuary		Date
Patrick W Anthony, ASA, EA		2008028
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 Ln		
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	126,339
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	126,339
10 Interest on line 9 using prior year's actual return of <u>-0.19%</u>	0	-240
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year).....		377,842
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>4.84%</u>		18,288
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.....		396,130
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	126,099

Part III Funding Percentages

14 Funding target attainment percentage	14	101.72%
15 Adjusted funding target attainment percentage.....	15	105.43%
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	104.18%
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
02/11/2020	33,000	0			
06/19/2020	17,700	0			
Totals ▶			18(b)	50,700	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	47,685

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 4
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 checked="" type="checkbox"/> Yes <input 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	0	
b Excess assets, if applicable, but not greater than line 31a	31b	0	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	0	0	
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	0	
	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	0	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	47,685	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	47,685	
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

Spokane Digestive Disease Center, PS Cash Balance Pension Plan

EIN: 91-1013238

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.

Spokane Digestive Disease Center, PS Cash Balance Pension Plan

EIN: 91-1013238

Plan Number: 002

Schedule SB, Part V – Summary of Plan Provisions

BACKGROUND

This section presents a summary of the current Plan provisions. If any discrepancies exist between this summary and the adopted Plan document, the Plan document shall govern.

Effective Date	January 1, 2003
Latest Amendment Date	January 1, 2019
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 an employee.
Vesting Service	Each Plan year in which 1,000 hours are completed while an employee.
Normal Retirement Age	First day of month coincident with or following the attainment of age 62.

ELIGIBILITY PROVISIONS

Eligibility for Participation	All employees become eligible to participate in the Plan on the January 1st or July 1st following the completion of Eligibility Service and the attainment of age 21.
Excluded Employee Classes	Union, Non-Resident Aliens, and leased employees

Spokane Digestive Disease Center, PS Cash Balance Pension Plan

EIN: 91-1013238

Plan Number: 002

Schedule SB, Part V – Summary of Plan Provisions

BENEFITS

Benefits

Cash Balance Contribution Credits

Contribution Credits are based on the following groups identified by their date of hire:

Group	Description	Credit
A	Drs. Hong, Kestell, Durnford	\$170,000
B	All Other Highly-Comp EE	\$0
C	All Other Participants	2.50%

Interest Credit

3.5%

Death, Disability, and Termination

Hypothetical Account Balance accrued to date.

Normal Form of Benefit

Single Life Annuity

Vesting Percent

Years of Vesting Service	Vested Percentage
Less than 3	0%
3	100%

PLAN PROVISION CHANGES

Changes in Plan Provisions

The contribution credits for all Participants were frozen effective May 25, 2019.

Plan Provisions Effective After
Valuation Date

The contribution credits for all Participants were frozen effective May 25, 2019.

PLAN TRUSTEE(S)

Plan Trustee(s)

Scott Glennie
Robert Durnford
James Goff