## 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

▶ Complete all entries in accordance with the instructions to the Form 5500-SF.

Revenue Code (the Code).

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection** 

Part I		rt Identification Information	า							
For calend	dar plan year 2014 o	r fiscal plan year beginning 01/01/2	2014	and ending 12	/31/2014					
<b>A</b> This re	eturn/report is for:	a single-employer plan		plan (not multiemployer) loyer information in accor						
		a one-participant plan								
<b>B</b> This ref	turn/report is	the first return/report								
		an amended return/report	a short plan year ret	urn/report (less than 12 m	nonths)					
C Check	box if filing under:	Form 5558	automatic extension		DFVC p	rogram				
	_	special extension (enter desc								
Part II	•	formation—enter all requested in	nformation							
1a Name WOMEN'S	•	TES, PLLC 401(K) PROFIT SHARIN	IG PLAN		<b>1b</b> Three-digir plan numb (PN) ▶					
					1c Effective d	late of plan 05/01/1995				
	sponsor's name and HEALTH ASSOCIATE	address; include room or suite num ES, PLLC	ber (employer, if for a singl	e-employer plan)		dentification Number 82-0504370				
333 NORTH	I 1ST STREET, SUIT	TE 240				telephone number 08-338-8900				
BOISE, ID 8						code (see instructions) 621111				
3a Plan a	administrator's name	and address XSame as Plan Spor	nsor.		<b>3b</b> Administra	tor's EIN				
		_			20 Administra	tor's telephone number				
		the plan sponsor has changed since	e the last return/report filed	for this plan, enter the	4b EIN					
	e, EIN, and the plan i sor's name	number from the last return/report.			4c PN					
<b>5a</b> Total	number of participar	nts at the beginning of the plan year			5a	49				
<b>b</b> Total	number of participar	nts at the end of the plan year			5b	62				
		th account balances as of the end o		•	5c	58				
<b>d(1)</b> To	tal number of active	participants at the beginning of the p	olan year		5d(1)	26				
<b>d(2)</b> To	otal number of active	participants at the end of the plan ye	ear		5d(2)	40				
		t terminated employment during the			5e	4				
Caution:	A penalty for the la	te or incomplete filing of this retu	rn/report will be assesse	d unless reasonable car	use is establishe	d.				
SB or Sch		other penalties set forth in the instru I and signed by an enrolled actuary, emplete.								
SIGN		ed/valid electronic signature.	02/27/2015	SUZANNE R. RICE M	1D					
HERE	Signature of plan	n administrator	Date	Enter name of individ	n administrator					
SIGN HERE										
		oloyer/plan sponsor	Date		idual signing as employer or plan sponsor  Preparer's telephone number (optional)					
i reparers	a name (moluumg IIII	n name, if applicable) and address (	indiade room of Suite Hulli	oci / (optional)	i Teparer s telep	none number (optional)				

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b	Are you claiming a waiver of the annual examination and report of a	y and conditions.)							X Y		No No
C	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	rogram (see ERISA section 40	21)?	[	Yes	No	N	ot det	ermir	ned
Par	t III Financial Information										
7	Plan Assets and Liabilities		(a) Beginning of Yea	ar			(b) En	d of	Year		
a	Total plan assets	7a	52130	)62					508	0331	
b	Total plan liabilities	7b		0						0	
С	Net plan assets (subtract line 7b from line 7a)	7c	52130	)62					508	0331	
	ncome, Expenses, and Transfers for this Plan Year		(a) Amount				(b)	Tota	ıl		
	Contributions received or receivable from: (1) Employers	8a(1)	2842	232							
	(2) Participants	8a(2)	1719	945							
	(3) Others (including rollovers)		28	346							
	Other income (loss)	8b	2210	)58							
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							68	0081	
	Benefits paid (including direct rollovers and insurance premiums		8119	103							
	o provide benefits)  Certain deemed and/or corrective distributions (see instructions)	8d	0110	0							
	Administrative service providers (salaries, fees, commissions)	8e 8f	8	319							
	Other expenses	8g		0							
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							81	2812	
	Net income (loss) (subtract line 8h from line 8c)	8i							-13	2731	
	Transfers to (from) the plan (see instructions)										
Par	IV Plan Characteristics	٠,									
b Part	If the plan provides welfare benefits, enter the applicable welfare for V Compliance Questions	eature code	es from the List of Plan Chara	cterist	tic Cod	les in t	he instru	ction	S:		
10	During the plan year:				Yes	No		Ar	noun	t	
	Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidulation)	ciary Corr	ection Program)	10a		X					
b	Were there any nonexempt transactions with any party-in-interest on line 10a.)			10b		X					
С	Was the plan covered by a fidelity bond?			10c	X					35	50000
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?			10d		X					
е	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.)	of the bene	efits under the plan? (See	10e	X					1	1778
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		X					
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of year e	nd.)	10g		X					
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)					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							
Part	VI Pension Funding Compliance										
11	Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)								Y	es 🔀	No
11a	Enter the unpaid minimum required contribution for current year fr					11a					
12	Is this a defined contribution plan subject to the minimum funding					302 of	ERISA?		Y	es X	No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,										
а	If a waiver of the minimum funding standard for a prior year is beir granting the waiver.	-			, and e	enter th Day			letter ear	rulin	g 

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lf :	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For	m 5500), and skip to lin	e 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 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?			Y	es X No		
	If "Yes," enter the amount of any plan assets that reverted to the employer the	nis year		13a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred the PBGC?		•	ontrol		Yes	( No
С	If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.)	in to another plan(s), ide	ntify the plan(s) to	)			
1	3c(1) Name of plan(s):		130	c(2) EI	N(s)	<b>13c(3)</b> P	N(s)
			1			l	

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

## Form 5500-SF

Cepartment of the Treasury Internal Revenue Service

## 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 Socurity Act of 1974 (ERISA), and section 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210-0110 1210-0089

2014

	Employed Benefit Gueranty Corporation  Formion Benefit Gueranty Corporation										
Ponsion Benefit Gueranty Corporation ► Complete all entries in accordance with the instructions to the Form 5500-SF. ► Part I Annual Report Identification Information											
	ender plan year 2014 or fis	cai plan year beginn	ng	01/01/2014	and ending	12/3	31/2014				
A This return/report is for:  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 foreign plan  the first return/report  an amended return/report  a short plan year return/report (less than 12 months)											
C Che	eck box if filing under:	Form 5558 special extension	n (enter description	automalic extension on)			DFVC program				
Part		rmation onter	all requested infor	mation		47. 11	1.14				
	amo of plan omen's Health Asso	ciates, PLLC 4	101(k) Profi	t Sharing Plan	ı	pla	ree-digit in number				
		·		·			ective date of plan /01/1995				
2a Pl	an sponsor's name and adomens Health Assoc	dress; include room	or suite number (e	employer, if for a sing	le-employer plan)		ployer identification Number N) 82-0504370				
		•				2C Sponsor's telephone number (208) 338-8900					
	3 North 1st Street, Su	ite 240			i.		siness code (see instructions)				
	Bolse ID 83702 an administrator's name an	id addrage W Same	as Plan Spanso	z Namo	· · · · · · · · · · · · · · · · · · ·	3h Adr	ministrator's EIN				
	he name and/or EIN of the me, EIN, and the plan num			ast return/report filed	for this plan, enter the	4b EIN	l				
a Sp	onsor's name			·····		4c PN					
_	tal number of participants a	-	•				49				
	tal number of participants a					5b	62				
	mber of participants with a mplete this item)						58				
	otal number of active parti		•			<del></del>	26				
	otal number of active parti mber of participants that te	•				5d(2)	40				
				•	promo thet were	5e	4				
Under I	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 epplicable, 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	1 Judan		Q	12615	x sugar	Q K	vece my				
HERE	Signature of plan admir	nistrator		Date	Enter name of Individu	al signing as	s plan administrator				
SIGN HERE	SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor										
	er's name (including firm na		d address; Include	e room or sulte numb			telephone number (optional)				

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6a	Were all of the plan's assets during the plan year invested in eligible	e assets?	(See instructions.)	,,,,,,,			XYesNo	<del></del>		
	and the second s									
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.) """"""""""""""""""""""""""""""""""""							0		
	If you answered "No" to either line 6a or line 6b, the plan cann	ot use Fo	orm 5500-SF and must instead	d use	Form	5500.				
	If the plan is a defined benefit plan, is it covered under the PBGC in	ISUIANCE	program (see EKISA section 4)	21)1	*******	<u> </u>	as No Not determin	116		
_Pa	art III Financial Information	7			<del></del>		415			
7_	Plan Assets and Liabilities	11:"	(a) Beginning of Ye		-		(b) End of Year			
<u>a</u>	Total plan assets		5,213,0			5,080,331				
<u>p</u>	et plan assets (subtract line 7b from line 7a)						5,080,331	_		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount		1		(b) Total			
a	Contributions received or receivable from:	0-40	284,2	200		,				
	(1) Employers	8a(1) 8a(2)	171,5							
	(2) Participants	8a(3)	2,8					<del>:</del>		
ь	Other income (loss)	8b	221,0		1::		And the state of the state of the			
C	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	Elisabeth State				680,081	_		
d	Benefits paid (including direct rollovers and insurance premiums	0.4	811,9							
	to provide benefits)	8d 8e	041,5	0	- 1:1:1 		There will be a second of the			
	Administrative service providers (salaries, fees, commissions)	8f	1 8	19						
g	Other expenses	89		0		a a a				
_	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	Co. Market Service Total Tele				812,612			
	Net income (loss) (subtract line 8h from line 8c)	18				(132,731)				
I	Transfers to (from) the plan (see instructions)	8]		0	1.6		Comment of the State of the Sta			
Pa	Plan Characteristics					•				
	2A 2E 2G 2J 2K 3D  If the plan provides welfare benefits, enter the applicable welfare fee  TV: Compliance Questions	ture code	s from the List of Plan Charact	eristic	Code	s in th	e Instructions:	_ _		
10	During the plan year.	<del></del>			Yes	No	Amount	_		
-	Was there a failure to transmit to the plan any participant contribut 29 CFR 2510.3-1027 (See Instructions and DOL's Voluntary Fiduc	ions within	n the time period described in action Program)	10a		*	Asilvani			
b		(Do not I	nclude transactions reported	10b		×	·	_		
_ <u>c</u>	Was the plan covered by a fidelity band?			10c	ж		350,00	٥		
d	Did the plan have a loss, whether or not reimbursed by the plan's for dishonesty?	idelity bor	nd, that was caused by fraud	10d	[ ]	x				
				100						
	insurance service, or other organization that provides some or all o	f the beni	afits under the plan? (See	10e	ж		11,77	8		
f_	Has the plan falled to provide any benefit when due under the plan	?	prigy).pl:palfffciainisteessiagaaqiigg;	10f		х		_		
g	Old the plan have any participant loans? (If "Yes," enter amount as	of year e	nd.) ,	10g		x		_		
h	If this is an individual account plan, was there a blackout period? (\$2520.101-3.)	see Instru	ctions and 29 CFR	10h		x		-:		
ī	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101-	required	notice or one of the	101				_		
Par			···	<u> </u>						
11	is this a defined benefit plan subject to minimum funding requireme 5500) and line 11a below)	nts? (If "Y	es," see instructions and comp	lete S	Schedu	ile SB	(Form Yes X No	<del>-</del>		
11a	Enter the unpaid minimum required contribution for current year from					T		_		
12	is this a defined contribution plan subject to the minimum funding re			_		2 of E	RISA? Yes X No	_		
	(If "Yes." complete line 12s or lines 12b, 12c, 12d, and 12e below,	s applica	ble.)				· · · · · · · · · · · · · · · · · · ·	-		
a	If a walver of the minimum funding standard for a prior year is being granting the walver	amortize	d in this plan year, see instructi	ons, a	and en	ter the Day	e date of the letter ruling Year	_		

02-26-15;11:12AM;From:Women`s Health Assoc

To:18012814014

;9471222

# 8/ 8

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lf y	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13	3, "					
b	Enter the minimum required contribution for this plan year		12b				
C	Enter the amount contributed by the amployer 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 le		12d				
e	Will the minimum funding amount reported on line 12d be met by the funding doadline?	***************************************		Yes	No NA		
Part	VII Plan Terminations and Transfers of Assets						
13a	Has a resolution to terminate the plan been adopted in any plan year?	*****************	Yes X No				
	if "Yes," enter the amount of any plan assets that roverted to the employer this year		13a				
b	Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brough of the PBGC?			Yes X No			
	If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.)	the plan(s) to	•				
13	c(1) Name of plan(s);	13c(	2) EIN(	3)	13c(3) PN(s)		
Part	/iii Trust Information (optional)						
14a N	ame of trust		14b Trust's EIN				
	,	1,					