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

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection**

Annual Report Identification Information For calendar plan year 2014 or fiscal plan year beginning and ending 12/31/2014 a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list A This return/report is for: of participating employer information in accordance with the form instructions) a one-participant plan a foreign plan the final return/report **B** This return/report is the first return/report an amended return/report a short plan year return/report (less than 12 months) DFVC program Form 5558 automatic extension C Check box if filing under: special extension (enter description) Basic Plan Information—enter all requested information Part II 1a Name of plan **1b** Three-digit UROLOGY NORTHWEST, P.S. 401(K) PROFIT SHARING PLA plan number (PN) ▶ 001 1c Effective date of plan 01/01/2002 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) **2b** Employer Identification Number UROLOGY NORTHWEST, P.S. (EIN) 91-1685391 Sponsor's telephone number 425-275-5555 6005 244TH STREET SW STE 111 MOUNTLAKE TERRACE, WA 98043-5400 Business code (see instructions) 621111 **3a** Plan administrator's name and address XSame as Plan Sponsor. Administrator's EIN **3c** Administrator's telephone number 4b EIN If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. 4c PN a Sponsor's name Total number of participants at the beginning of the plan year 5a 44 **b** Total number of participants at the end of the plan year..... 5b 38 Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c 38 complete this item) d(1) Total number of active participants at the beginning of the plan year..... 5d(1) 28 d(2) Total number of active participants at the end of the plan year..... 5d(2) 22 e Number of participants that terminated employment during the plan year with accrued benefits that were 0 5e less than 100% vested. 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 Filed with authorized/valid electronic signature. 03/17/2015 KARNY JACOBY, M.D.

HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN **HERE** Enter name of individual signing as employer or plan sponsor Signature of employer/plan sponsor Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Preparer's telephone number (optional) JODI CALHOUN 509-838-5500 RANDALL & HURLEY, INC.

601 W. RIVERSIDE AVE., SUITE 1600 SPOKANE, WA 99201

SIGN

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b .	Were all of the plan's assets during the plan year invested in eligible Are you claiming a waiver of the annual examination and report of a runder 29 CFR 2520.104-46? (See instructions on waiver eligibility a figure of you answered "No" to either line 6a or line 6b, the plan cannot with the plan cannot want to the pl	an indepe and condi ot use Fo	ndent qualified public accounta tions.) orm 5500-SF and must instead	nt (IQ	PA) Form	5500.					
	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	program (see ERISA section 40)21)? .		Yes	No Not determined				
Par	III Financial Information		1								
7	Plan Assets and Liabilities		(a) Beginning of Yea				(b) End of Year				
	Total plan assets	7a	25955		2704333						
0	Total plan liabilities	7b		233							
	Net plan assets (subtract line 7b from line 7a)	7c	25952	293	2704333						
	ncome, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total				
	Contributions received or receivable from: 1) Employers	8a(1)	459	923							
	2) Participants	8a(2)	1135	78							
	3) Others (including rollovers)	8a(3)									
-	Other income (loss)	8b	1202	267							
	Fotal income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					279768				
	Benefits paid (including direct rollovers and insurance premiums										
t	o provide benefits)	8d	1558	885							
e (Certain deemed and/or corrective distributions (see instructions)	8e									
<u>f</u>	Administrative service providers (salaries, fees, commissions)	8f	148	343							
<u>g</u> (Other expenses	8g									
	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					170728				
	Net income (loss) (subtract line 8h from line 8c)	8i					109040				
_ J	Fransfers to (from) the plan (see instructions)	8j									
b Part	ZA ZE ZF ZG ZJ ZT 3B If the plan provides welfare benefits, enter the applicable welfare fe V Compliance Questions	eature cod	des from the List of Plan Charad	cterist	ic Coc	les in t	he instructions:				
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)					X					
	on line 10a.)	`	•	10b		X					
С	Was the plan covered by a fidelity bond?			10c	Χ		350000				
d						X					
е	Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)			10e		X					
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	end.)	10g		X					
h	f 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 2520.101			10i							
Part	VI Pension Funding Compliance										
11	Is this a defined benefit plan subject to minimum funding requirements 5500) and line 11a below)										
11a	Enter the unpaid minimum required contribution for current year from	om Sched	dule SB (Form 5500) line 39			11a	<u> </u>				
12	Is this a defined contribution plan subject to the minimum funding	requirem	ents of section 412 of the Code	or se	ction	302 of	ERISA? Yes X No				
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,										
a	If a waiver of the minimum funding standard for a prior year is bein granting the waiver.	-			, and 6	enter th Day					

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lf :	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For	m 5500), and skip to line 13.			
b	Enter the minimum required contribution for this plan year		12b		
С	Enter the amount contributed by the employer to the plan for this plan year		12c		
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result negative amount)		1 124		
е	Will the minimum funding amount reported on line 12d be met by the funding	g 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	13a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred the PBGC?	inder the control		Yes X No	
С	If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.)	an to another plan(s), identify th	e plan(s) to		
1	3c(1) Name of plan(s):		13c(2) EI	N(s)	13c(3) PN(s)

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

Multiple-Employer Plan Participating Employer Information

Urology Northwest, P.S. 401(k) Profit Sharing Plan

EIN: 91-1685391

PN: 001

Name of Participating Employer	EIN	Percent of Total
Urology Northwest, P.S.	91-1685391	Contributions 96%
Integrity Medical Research, LLC	91-1986008	4%

Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

A This return/report is for:

Part I

Pension Benefit Guaranty Corporation

For calendar plan year 2014 or fiscal plan year beginning

a single-employer plan

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. **Annual Report Identification Information**

01/01/2014

and ending

X a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list

of participating employer information in accordance with the form instructions)

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

12/31/2014

		a one-participant plan	foreign plan			~				
B This ret	turn/report is									
		an amended return/report a short plan year return/report (less than 12 months)								
C Check	box if filing under:	f filling under: Form 5558 automatic extension DFVC program								
	special extension (enter description)									
Part II	Basic Plan In	ormation—enter all requested informati	ion							
1a Name	of plan				1b Th	ree-digit				
UROLOG	Y NORTHWEST,	P.S. 401(K) PROFIT SHARIN	NG PLA		E	an number 001 N) ▶				
			fective date of plan ./01/2002							
2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) UROLOGY NORTHWEST, P.S.						2b Employer Identification Number (EIN) 91-1685391				
6005 2	44TH STREET	SW STE 111			2c Sponsor's telephone number 425-275-5555					
MOUNTL	AKE TERRACE	WA 98043-5400			2d Business code (see instructions) 621111					
3a Plan a	dministrator's name	and address XSame as Plan Sponsor.			3b Administrator's EIN					
					3c Administrator's telephone number					
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the						4b EIN				
name, EIN, and the plan number from the last return/report.					4c PN					
5a Total number of participants at the beginning of the plan year					5a					
b Total number of participants at the end of the plan year					5b					
C Numb	er of participants witlete this item)	account balances as of the end of the pla	n year (defined bene	fit plans do not	5c					
complete this item)					5d(1)	28				
		articipants at the end of the plan year			5d(2)	22				
Number of participants that 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/repor	t will be assessed	unless reasonable caus	se is esta	ablished.				
SB or Sche	alties of perjury and o edule MB completed a true, correct, and con	ther penalties set forth in the instructions, and signed by an enrolled actuary, as well applete.	I declare that I have as the electronic vers	examined this return/rep sion of this return/report,	ort, include and to the	ding, if applicable, a Schedule be best of my knowledge and				
SIGN	-	haroln	3/12/15	KARNY JACOBY,	M.D.					
HERE	Signature of plan administrator Date Enter name of indivi					idual signing as plan administrator				
SIGN HERE										
Signature of employer/plan sponsor Date Enter name of individu					dual signing as employer or plan sponsor					
Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Jodi Calhoun					Preparer's telephone number (optional)					
Randall & Hurley, Inc.						509-838-5500				
		e., Suite 1600		-						
Spokane	2	WA 99201,								
For Panerwo	ork Reduction Act Noti	ce and OMB Control Numbers, see the instru	otions for Form FEON	25		Form FF00 SF (2014)				

Y anasa	Form 5500-SF 2014		Page 2									
b	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility If you answered "No" to either line 6a or line 6b, the plan cannot be plan in a defined benefit plan, is it covered under the PBGC in	an indepe and condi not use Fo	ndent qualified public account tions.) orm 5500-SF and must instea	ant (IC	QPA) • Forn	n 5500.			Yes Yes	No No		
	rt III Financial Information			JZ 1).] 103			deteri	Illiteu		
7	Plan Assets and Liabilities		(a) B - i - i - i - i - i - i - i - i - i -		\neg				, /			
a			(a) Beginning of Ye	ar 955:	26	(b) End of Year						
b		7a	25			270433				0433.		
	Net plan assets (subtract line 7b from line 7a)	. 7b	25	233 2595293				070400				
8	Income, Expenses, and Transfers for this Plan Year	. 7c		332	93	270433						
	Contributions received or receivable from:	ENGAGE PARK	(a) Amount		127.70	(b) Total						
	(1) Employers	. 8a(1)		4592	23							
	(2) Participants	. 8a(2)	1	135	78					94 SEA		
	(3) Others (including rollovers)	8a(3)								4 (\$16		
b	Other income (loss)	8b	1	2026	57	57						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c			E S	27976						
d	Benefits paid (including direct rollovers and insurance premiums	- 55	Participate the manufacture of the participate of t							73700		
	to provide benefits)	8d	1	5588	35							
e	Certain deemed and/or corrective distributions (see instructions)	8e			650							
f	Administrative service providers (salaries, fees, commissions)	8f		1484			3					
g	Other expenses	8g										
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						17072				
i	Net income (loss) (subtract line 8h from line 8c)	8i	THE REPORT OF THE PARTY OF	E WIT						09040		
j	Transfers to (from) the plan (see instructions)									diagram		
Pai	t IV Plan Characteristics	1 9			9.5%			A Paris	17. Sept. 18	- 1.5 · 2 · 1 ·		
b	If the plan provides pension benefits, enter the applicable pension 2A 2E 2F 2G 2J 2T 3B If the plan provides welfare benefits, enter the applicable welfare for											
Par	t V Compliance Questions											
10	During the plan year:				Yes	No		Am	ount			
a 	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	ciary Corr	ection Program)	10a		Х						
	Were there any nonexempt transactions with any party-in-interest on line 10a.)			10b		Х						
с	Was the plan covered by a fidelity bond?			10c	Х				3	50000		
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		Х						
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		Х						
f	VALUE OF THE PROPERTY OF THE P			10f		Х						
g				10g		Х						
h	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)					Х						
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			10h 10i								
Part	Constitution of the Consti			101			WALL STATE			2000		
11	Is this a defined benefit plan subject to minimum funding requirements 5500) and line 11a below)	ents? (If "\	es," see instructions and com	plete	Sched	ule SB	(Form	Тг	Yes	П №		
11a	Enter the unpaid minimum required contribution for current year fro	om Schedi	ule SB (Form 5500) line 30			11a						
12												
	and plant to the minimum fullding	. a quin cinic	or occurred the of the code	01 56	OUOII C	JUZ UI	-INIOM!		. 00	F) 140		

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

Day

Year

(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)