-	m 5500-SF	Bonofit Plan					OMB Nos. 1210-0110 1210-0089		
Intern	tment of the Treasury nal Revenue Service	This form is required to be filed und			2014 This Form is Open to Public Inspection				
Employee Be	partment of Labor enefits Security Administration	Income Security Act of 1974 (ERIS Rev	Interna	This F					
	Complete all entries in accordance with the instructions to the Form 5500-SF.								
For calenda		Identification Information scal plan year beginning 01/01/2014		and ending 12/	31/201	4			
			a multiple-emplover p	<u> </u>			ox must attach a list		
A This retu	urn/report is for: rn/report is	 a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a lis of participating employer information in accordance with the form instructions) a one-participant plan a foreign plan the first return/report a short plan year return/report (less than 12 months) 							
C Check b	box if filing under:	Form 5558 automatic extension DFVC program special extension (enter description) DFVC program							
Part II	Basic Plan Info	prmation—enter all requested informat	ion						
1a Name of COMPASS H						Three-digit plan number (PN) ▶	007		
						Effective date o	f plan /1999		
2a Plan sp COMPASS H		ldress; include room or suite number (em	ployer, if for a single-	employer plan)	2b Employer Identification Number (EIN) 91-1180810				
4566 FEDER					2c Sponsor's telephone number 360-419-3526				
4566 FEDERAL AVE. BLDG 8 EVERETT, WA 98273-4209						2d Business code (see instructions) 621112			
3a Plan ac	dministrator's name a	nd address Same as Plan Sponsor.			3b Administrator's EIN 91-1180810				
		EVERETT, WA				360-41	telephone number 9-3526		
	EIN, and the plan nu	e plan sponsor has changed since the las mber from the last return/report.	st return/report filed fo	or this plan, enter the	4b 4c				
·		at the beginning of the plan year					89		
		at the end of the plan year			5k		81		
	· ·	account balances as of the end of the pla		•	50		81		
•	,	rticipants at the beginning of the plan yea			5d(1	1)	58		
d(2) Tota	al number of active pa	rticipants at the end of the plan year			5d(2)	47		
		erminated employment during the plan ye			5e	•	0		
Under pena SB or Sche	lties of perjury and ot	or incomplete filing of this return/report her penalties set forth in the instructions, nd signed by an enrolled actuary, as well plete.	I declare that I have	examined this return/rep	oort, in	cluding, if applic	able, a Schedule knowledge and		
SIGN Filed with authorized/valid electronic signature. 06/25/2015 JILL L. HENSON									
HERE	Signature of plan a	dministrator	Date	Enter name of individu	ual sigi	ning as plan adr	ninistrator		
SIGN HERE	.			 ,					
Signature of employer/plan sponsor Date Enter name of individ Preparer's name (including firm name, if applicable) and address (include room or suite number) (optional) Optional)				dual signing as employer or plan sponsor Preparer's telephone number (optional)					
	, .	, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,			- F.		(-1)		

	Were all of the plan's assets during the plan year invested in eligibl Are you claiming a waiver of the annual examination and report of a under 29 CFR 2520.104-46? (See instructions on waiver eligibility a If you answered "No" to either line 6a or line 6b, the plan canne	an indeper and condit	ident qualified public accountations.)	nt (IC	(PA)		X Yes No		
С	If the plan is a defined benefit plan, is it covered under the PBGC in								
Pa	t III Financial Information	-							
7	Plan Assets and Liabilities		(a) Beginning of Yea	r			(b) End of Year		
а	Total plan assets	7a	26325	643			2090888		
b	Total plan liabilities	7b							
С	Net plan assets (subtract line 7b from line 7a)	7c	26325	.543			2090888		
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total		
а	Contributions received or receivable from: (1) Employers	8a(1)		0					
	(2) Participants	8a(2)		0					
	(3) Others (including rollovers)	8a(3)		0					
b	Other income (loss)	8b	528	39					
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c					52839		
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	5701	36					
	Certain deemed and/or corrective distributions (see instructions)	8e							
f	Administrative service providers (salaries, fees, commissions)	8f	243	58					
g	Other expenses	8g							
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					594494		
i	Net income (loss) (subtract line 8h from line 8c)	8i			-541655				
j	Transfers to (from) the plan (see instructions)	8j							
Par	t IV Plan Characteristics								
9a b Par	If the plan provides pension benefits, enter the applicable pension in 2E 2F 2G 2J 3D If the plan provides welfare benefits, enter the applicable welfare feature of the second seco								
10	During the plan year:				Yes	No	Amount		
а				10a		х			
b	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	x		300000		
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?			10d		Х			
e	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.)	er person of the ben	s by an insurance carrier, efits under the plan? (See	10e		Х			
f	Has the plan failed to provide any benefit when due under the plan			10f		Х			
g				10q		Х			
h	h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR			10h		Х			
i	If 10h was answered "Yes," check the box if you either provided the required notice or one of the			10i					
Part	VI Pension Funding Compliance					-			
11	Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)								
11a	Enter the unpaid minimum required contribution for current year from	om Sched	ule SB (Form 5500) line 39			11a			
12	Is this a defined contribution plan subject to the minimum funding	requireme	ents of section 412 of the Code	or se	ection	302 of	ERISA? Yes X No		
	(If "Yes " complete line 12a or lines 12b, 12c, 12d, and 12e below								

Page 3 - 1

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 onegative amount)	of a	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?		· 🗆 ۲	Yes X 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 u of the PBGC?	inder the	control		Yes 🗙 No
C If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify th which assets or liabilities were transferred. (See instructions.)	e plan(s)	to		
13c(1) Name of plan(s):	1	3c(2) El	IN(s)	13c(3) PN(s)
Part VIII Trust Information (optional)				
14a Name of trust		14b ⊺⊧	rust's EIN	

we we will be the second se	T									
Form 5500-SF	Short Form Annua	loyee	OMB Nos. 1210-0110 1210-0089							
Department of the Treasury Internal Revenue Service	Internal Revenue Service This form is required to be filed under sections 104 and 4065 of the Employee									
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This Form is Open to									
Complete all entries in accordance with the instructions to the Form 5500-SF.										
Part. Annual Report Identification Information For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014										
		01/01/2014	and ending		/31/2014					
A This return/report is for:										
	a one-participant plan	a foreign plan								
B This return/report is	the first return/report	the final return/report								
	an amended return/report a short plan year return/report (less than 12 months)									
C Check box if filing under:	Form 5558	automatic extension			FVC program					
[special extension (enter descripti	on)								
Paolo Dion Inform										
	nation-enter all requested inform	nation								
1a Name of plan COMPASS HEALTH 401K P	T 33T			1b Thre						
COMPASS HEALTH 401K P	LAN				number 007					
				(PN)						
0					tive date of plan 01/1999					
2a Plan sponsor's name and addre COMPASS HEALTH	ess; include room or suite number (employer, if for a single	e-employer plan)		oyer Identification Number 91-1180810					
		8			sor's telephone number					
4566 FEDERAL AVE. BLD	G 8				-419-3526					
					ess code (see instructions)					
EVERETT	WA 98273-4209			621112						
3a Plan administrator's name and	address Same as Plan Sponsor.			3b Administrator's EIN						
COMPASS HEALTH				91-1180810						
				3c Administrator's telephone number						
4566 FEDERAL AVE. BLD	G 8			360-	419-3526					
EVERETT	WA 98273-4209									
4 If the name and/or EIN of the pl name, EIN, and the plan number	an sponsor has changed since the l	ast return/report filed f	or this plan, enter the	4b EIN						
a Sponsor's name	in the last return report.			4C PN						
5a Total number of participants at	the beginning of the plan year									
	the end of the plan year				89					
				5b	81					
C Number of participants with acc complete this item)	ount balances as of the end of the p	bian year (defined bene	efit plans do not	5c	01					
d(1) Total number of active partici	pants at the beginning of the plan ye	ear		5d(1)	81					
d(2) Total number of active partici	pants at the end of the plan year			5d(2)	58					
	nated employment during the plan y		an availability of the second s		47					
less than 100% vested				5e	0					
Caution: A penalty for the late or in	complete filing of this return/rep	ort will be assessed	unless reasonable cau	se is establi	shed.					
Under penalties of perjury and other SB or Schedule MB completed and s belief, it is true, correct, and complete	igned by an enrolled actuary, as we	, I declare that I have I as the electronic vers	examined this return/rep sion of this return/report,	ort, including and to the b	, if applicable, a Schedule est of my knowledge and					
	Venon	1	JILL L. HENSON							
70.01.9										
Signature of plan admi	nistrator	Date 6/15/15	Enter name of individu	al signing as	plan administrator					
Isich V										
Signature of employer	plan sponsor	Date	Enter name of individu	al eigning	omployee as al					
Preparer's name (including firm name	, if applicable) and address (include	room or suite number	r) (optional)	Preparer's to	employer or plan sponsor elephone number (optional)					
	o) pasta (173)		. ,	· · operior a le	septione number (optionat)					
			S. 199							
				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
For Paperwork Reduction Act Notice an	d OMB Control Numbers, see the Instr	uctions for Form 5500-S	SF.	-x -x-a						

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	Form 5500-SF 2014		Page 2						
b	 Sa Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) 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.) 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)?								
-	Financial Information	iourance		021)	[Tes	No Not determined		
Contraction of the local division of the loc		The state of the s				-	and the second		
<u>7</u> a	Plan Assets and Liabilities Total plan assets	······································	(a) Beginning of Ye	ar 325	42		(b) End of Year		
-	Total plan liabilities	7a 7b	20	525	4.3		2090888		
	Net plan assets (subtract line 7b from line 7a)	70	26	325	43	209088			
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	040					
a	Contributions received or receivable from:	The Part of the Part	(a) Amount		1		(b) Total		
	(1) Employers	8a(1)			0				
-	(2) Participants	8a(2)			0				
	(3) Others (including rollovers)	8a(3)			0	and the second s			
	Other income (loss)	8b		528	39		10 M.		
d	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8c 8d	and the second	701	36		52839		
-	Certain deemed and/or corrective distributions (see instructions)	8e	1						
f	Administrative service providers (salaries, fees, commissions)	8f		243	58		1. MAR		
g	Other expenses	8g				····			
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					594494		
	Net income (loss) (subtract line 8h from line 8c)	8i	1	25	-		-541655		
j	Transfers to (from) the plan (see instructions)	8j			4	41. ²			
Par	Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension to 2E 2F 2G 2J 3D	feature co	des from the List of Plan Char	acteri	stic Co	ides in	the instructions:		
b	If the plan provides welfare benefits, enter the applicable welfare fe	ature cod	es from the List of Plan Chara	cterist	tic Cod	es in t	the instructions:		
Part	Compliance Questions				and the second second				
10	During the plan year:				Yes	No	Amount		
a	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	ciary Corr	ection Program)	10a		x			
b	Were there any nonexempt transactions with any party-in-interest? 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 for dishonesty?			10d		x			
e	Were any fees or commissions paid to any brokers, agents, or other insurance service, or other organization that provides some or all or instructions.)	of the bene	efits under the plan? (See	10e		x			
f	Has the plan failed to provide any benefit when due under the plan	?		10f		х			
g	Did 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			
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			101					
1	Pension Funding Compliance								
	Is this a defined benefit plan subject to minimum funding requireme 5500) and line 11a below)					ule SB	(Form		
11a	Enter the unpaid minimum required contribution for current year fro			_	_	11a			
12	Is this a defined contribution plan subject to the minimum funding r	equiremer	nts of section 412 of the Code	orse	ction 3	02 of E	ERISA? Yes X No		
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, a	as applica	ble.)						
a	If a waiver of the minimum funding standard for a prior year is being granting the waiver.	amortize	a in this plan year, see instruc	tions, h	and er	Day	e date of the letter ruling Year		

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lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For	m 5500), and skip to line 13				
	Enter the minimum required contribution for this plan year			12b		
Ċ	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)	(enter a minus sign to the left		12d		and the second
e	Will the minimum funding amount reported on line 12d be met by the funding	deadline?			Yes	No NA
Part	Plan Terminations and Transfers of Assets	-				
13a	Has a resolution to terminate the plan been adopted in any plan year?			1	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, transferre of the PBGC?	d to another plan, or brought	under the r	control		TYes X No
C	If during this plan year, any assets or liabilities were transferred from this plan which assets or liabilities were transferred. (See instructions.)	n to another plan(s), identify t	ne plan(s) t	to		
1	3c(1) Name of plan(s):		13	3c(2) Ell	N(s)	13c(3) PN(s)
	Trust Information (optional)					
14.2	ame of trust					
1-74			1	140 Tru	ust's EIN	

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