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 X 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) Form 5558 DFVC program automatic extension C Check box if filing under: special extension (enter description) Part II Basic Plan Information—enter all requested information 1a Name of plan **1b** Three-digit THREE TREE WOMEN'S CLINIC, PLLC 401(K) PROFIT SHARING PLAN plan number (PN) ▶ 001 Effective date of plan 01/01/2006 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number THREE TREE WOMEN'S CLINIC, PLLC (EIN) 20-3138541 Sponsor's telephone number 206-242-9000 P.O. BOX C-96012 BELLEVUE, WA 98009 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 16 Total number of participants at the end of the plan year..... 5b 15 Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c 15 complete this item) d(1) Total number of active participants at the beginning of the plan year..... 5d(1) 12 d(2) Total number of active participants at the end of the plan year..... 5d(2) 12 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 t	true, correct, and complete.						
SIGN	Filed with authorized/valid electronic signature.						
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN							
HERE	Signature of employer/plan sponsor	Date	Enter name of individ	lual signing as employer or plan sponsor			
Preparer's	name (including firm name, if applicable) and address (include r	oom or suite number	r) (optional)	Preparer's telephone number (optional)			

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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 under 29 CFR 2520.104-46? (See instructions on waiver eligibility a lf you answered "No" to either line 6a or line 6b, the plan cannot be a continuous control of the plan cannot be a control of the plan cannot	an indeper and condit ot use Fo	ndent qualified public accounta ions.) rm 5500-SF and must instea	nt (IQ	PA) Form	5500.			X Yes	□ No
	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	orogram (see ERISA section 40	21)?		Yes	No	N	ot deter	mined
Par	t III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning of Yea				(b) E	nd of		
a	Total plan assets	7a	13309						13548	
b	Total plan liabilities	7b		0						0
С	Net plan assets (subtract line 7b from line 7a)	7c	13309	942					13548	851
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(k) Tota	al	
	Contributions received or receivable from:	90(1)	225	82						
	(1) Employers	8a(1)	911							
	(2) Participants	8a(2)		0						
	(3) Others (including rollovers)	8a(3)	686							
	Other income (loss)	8b	000	,00					1000	002
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							1823	003
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	1457	' 41						
е	Certain deemed and/or corrective distributions (see instructions)	8e		0						
	Administrative service providers (salaries, fees, commissions)	8f	126	553						
	Other expenses	8g		0						
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h							1583	394
	Net income (loss) (subtract line 8h from line 8c)	8i							239	009
	Transfers to (from) the plan (see instructions)	8i		0						
Par	t IV Plan Characteristics	<u> </u>	l							
9a b Part	If the plan provides pension benefits, enter the applicable pension 2E 2G 2J 2K 2R If the plan provides welfare benefits, enter the applicable welfare fe									
10	During the plan year:				Yes	No		Ar	nount	
	Was there a failure to transmit to the plan any participant contribut 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu			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					100000
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 ben	efits under the plan? (See	10e		Х				
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		Χ				
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of vear e	end.)	10g		Χ				
h		(See instru	uctions and 29 CFR	10g		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	ne require	d notice or one of the	10ii						
Part										
11	Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)								Yes	X 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						FRISA	,	Yes	X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,			, UI 3C	JUIOTT	JUZ UI				
	If a waiver of the minimum funding standard for a prior year is being			rtions	and e	nter th	ne date	of the	letter ri	ılina

......Month

Day

Year

granting the waiver.

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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	his year	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

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

OMB Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

F	art I Annual Report	t Identification Information	1					
For	calendar plan year 2014 or f	iscal plan year beginning		01/01/2014	and ending	12	2/31/2014	
	This return/report is for: This return/report is:	x a single-employer plan a one-participant plan the first return/report	of p		an (not multiemployer) (/er information in accord			
		an amended return/report	as	hort plan year retur	n/report (less than 12 m	onths)		
С	Check box if filing under:	Form 5558		tomatic extension		[DFVC progra	nm
P	art II Basic Plan Inf	ormation enter all requested	Linformat	tion				
_	Name of plan	Clinic, PLLC 401(k) Pr					Three-digit plan number (PN) ▶ Effective date o	001
						10	01/01/2006	i pian
2a	Plan sponsor's name and a Three Tree Women's	address; include room or suite num a Clinic, PLLC	ber (emp	oloyer, if for a single	-employer plan)		Employer Identi (EIN) 20-31: Sponsor's telep (206) 242-	hone number
	P.O. Box C-96012 US Bellevue WA 98009					2d		(see instructions)
3a		and address X Same as Plan Sp	ponsor N	ame		3b	Administrator's	EIN
	.2					3с	Administrator's	telephone number
4		he plan sponsor has changed since umber from the last return/report.	e the last	return/report filed f	or this plan, enter the	4b	EIN	
a	Sponsor's name					4c	PN	
5a	Total number of participant	ts at the beginning of the plan year				5a		16
b		s at the end of the plan year				5k)	15
С		n account balances as of the end o				50	;	15
d	TO AGO SOCIAL	articipants at the beginning of the p				5d((1)	12
	• •	articipants at the end of the plan ye	-			5d(12
е	Number of participants that	t terminated employment during the	e plan ye	ar with accrued ber	nefits that were	5		0
C	aution: A penalty for the lat	te or incomplete filing of this retu	urn/repo	rt will be assessed	i unless reasonable ca	use is	established.	
U	nder penalties of perjury and	other penalties set forth in the insti and signed by an enrolled actuary	ructions,	I declare that I have	e examined this return/re	eport, i	ncluding, if appli	
	SIGN	[2/4/4]	5	7/14/201S	Pamela D. Lutz,	MD (Christre R.	A6/4
11112	HERE Signature of plan and	Iministrator		Date	Enter name of individua	al sign	ing as plan admi	inistrator
-	SIGN				Pamela D. Lutz,	MD		
1000	HERE Signature of employ	er/plan sponsor		Date	Enter name of individua	al sign	ing as employer	or plan sponsor
P	reparer's name (including firm	n name, if applic <mark>able)</mark> and address;	include (room or suite numb	er (optional)	Prep	arer's telephone	number (optional)

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6a	Were all of the plan's assets during the plan year invested in eligible	assets? (See instructions.)					X Yes No
	Are you claiming a waiver of the annual examination and report of a		· ·	(IQP	'A)			
	under 29 CFR 2520.104-46? (See instructions on waiver eligibility a	nd condition	ons.)					XYes No
	If you answered "No" to either line 6a or line 6b, the plan cannot	t use For	m 5500-SF and must instead	use F	orm 5	5500.		
С	If the plan is a defined benefit plan, is it covered under the PBGC in	surance pi	ogram (see ERISA section 402	1)? .		Yes	S No	Not determine
Pa	rt III Financial Information							
7	Plan Assets and Liabilities		(a) Beginning of Year				(b) End of	f Year
а	Total plan assets	7a	1,330,94	12				1,354,851
b	Total plan liabilities	7b		0				0
С	Net plan assets (subtract line 7b from line 7a)	7c	1,330,94	12				1,354,851
	Income, Expenses, and Transfers for this Plan Year	STABLE	(a) Amount				(b) To	tal
a	Contributions received or receivable from: (1) Employers	8a(1)	22,58	32	210			
-	(2) Participants	8a(2)	91,11		12	A L	S IBA SWOLLS	A Comment
-	(3) Others (including rollovers)	8a(3)		0	JE II	Billis		1 - CIP-100 E-1034
b	Other income (loss)	8b	68,60)5	31012	41 0150	SAME	A PROPERTY OF STREET
_	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	TO A THE WAY STATE OF THE PARTY AND THE PART	Vella				182,303
	Benefits paid (including direct rollovers and insurance premiums		Manage Ma		(100)	SHAM	TOP SHICKEN	des fair de Maria
-	to provide benefits)	8d	145,74		1200	Storie	11. 11. 11. 11.	MALE PROPERTY AND
е	Certain deemed and/or corrective distributions (see instructions)	8e		0	magnic	of Column	guistic phila	in the state of the state of
f	Administrative service providers (salaries, fees, commissions)	8f	12,65		0,566	84.60		CONTRACTOR CONTO
g	Other expenses	8g		0	ASHIE	SANTA.	(Filmini pales	AND LONG BOTH STATE OF THE PARTY OF THE PART
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h	The Control of Control	464				158,394
<u>i</u>	Net income (loss) (subtract line 8h from line 8c)	8i	Ambigue Rendered And The	HARBI	b .	CO WALLES	Samuel Constitution	23,909
į_	Transfers to (from) the plan (see instructions)	8j		0	135-	688 a.	Control of	Tener LED BE
Pa	rt IV Plan Characteristics							
9a	If the plan provides pension benefits, enter the applicable pension for	eature cod	es from the List of Plan Charac	teristi	c Cod	es in t	he instruction	ons:
	2E 2G 2J 2K 2R							
b	If the plan provides welfare benefits, enter the applicable welfare fe	ature code	s from the List of Plan Characte	ristic	Code	s in the	e instruction	ns:
	W/A							
Pa	rt V Compliance Questions				ri		ř	
10	During the plan year:			r -	Yes	No	Δ	Mount
а	Was there a failure to transmit to the plan any participant contribution 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidure)			10a		x		
b	Were there any nonexempt transactions with any party-in-interest							
	on line 10a.)			10b		х		
C				10c	х			100,000
d								
-	or dishonesty?		The state of the s	10d		х		
е	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all							
	instructions.)		•	10e		х		
f	Has the plan failed to provide any benefit when due under the pla	n?		10f		х		
	Did the plan have any participant loans? (If "Yes," enter amount a	s of year e	and \ .	10g		х		
g	# A track to the control of the cont			iog			A SECTION AND INC.	A CONTRACTOR OF THE PARTY OF TH
h	2520.101-3.)			10h		x		
i	If 10h was answered "Yes," check the box if you either provided t	he required	d notice or one of the				in a land	and a some
	exceptions to providing the notice applied under 29 CFR 2520.10			10i				
Pa	rt VI Pension Funding Compliance							
11	Is this a defined benefit plan subject to minimum funding requiren 5500) and line 11a below)							Yes X No
11:	Enter the unpaid minimum required contribution for current year fi				- 1			
12	Is this a defined contribution plan subject to the minimum funding					02 of I	ERISA?	Yes X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below					T		
a				tions	and e	enter th	ne date of th	ne letter rulina
	granting the waiver							

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If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB	(Form 5500), and skip to line	e 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 y	ear		12c	•
d Subtract the amount in line 12c from the amount in line 12b. Enter the renegative amount)	-		12d	
e Will the minimum funding amount reported on line 12d be met by the ful	nding deadline?		🔲 Ye	s 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	X No
If "Yes," enter the amount of any plan assets that reverted to the employer	yer this year		13a	
b Were all the plan assets distributed to participants or beneficiaries, transof the PBGC?				
C If during this plan year, any assets or liabilities were transferred from this which assets or liabilities were transferred. (See instructions.)	s plan to another plan(s), iden	ntify the plan(s) to)	***
13c(1) Name of plan(s):		13c	(2) EIN(s)	13c(3) PN(s)
Part VIII Trust Information (optional)				
14a Name of trust	14b Trust's EIN			