Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

less than 100% vested.

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 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 first return/report the final return/report **B** This return/report is 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 BLUEGRASS COMPREHENSIVE UROLOGY AFFILIATES, LLC 401K plan number (PN) ▶ 001 1c Effective date of plan 10/01/2014 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number BLUEGRASS COMPREHENSIVE UROLOGY AFFILIATES, LLC (EIN) 46-5116442 Sponsor's telephone number 603-324-4404 336 29TH STREET, SUITE 101 ASHLAND, KY 41101-1976 Business code (see instructions) 812990 **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 0 **b** Total number of participants at the end of the plan year..... 5b 0

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Number of participants with account balances as of the end of the plan year (defined benefit plans do not

complete this item) d(1) Total number of active participants at the beginning of the plan year.....

d(2) Total number of active participants at the end of the plan year.....

e Number of participants that terminated employment during the plan year with accrued benefits that were

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.	07/16/2015	TIMOTHY K. DIXON				
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN		sponsor Date Enter name of individual signing as employer or					
HERE	Signature of employer/plan sponsor	Date	Enter name of individ	ual 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)			

5c

5d(1)

5d(2)

5e

0

0

0

0

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_	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 a second or line 6b.	an indepe and condi	endent qualified public accounta	ınt (IQ	PA)				X Yes	
С	If the plan is a defined benefit plan, is it covered under the PBGC in	nsurance	program (see ERISA section 40	21)?		Yes	No	N	ot deter	mined
Pai	t III Financial Information									
7	Plan Assets and Liabilities		(a) Beginning of Yea	ır			(b) Eı	nd of	Year	
<u>a</u>	Total plan assets	. 7a		0						0
b	Total plan liabilities	. 7b								
C	Net plan assets (subtract line 7b from line 7a)	. 7c		0						0
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Tota	al	
а	Contributions received or receivable from: (1) Employers	. 8a(1)		0						
	(2) Participants	. 8a(2)		0						
	(3) Others (including rollovers)									
b	Other income (loss)	. 8b								
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	. 8c								0
d	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	. 8d								
	Certain deemed and/or corrective distributions (see instructions)	. 8e								
f	Administrative service providers (salaries, fees, commissions)	. 8f								
g	Other expenses	. 8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	. 8h								0
i	Net income (loss) (subtract line 8h from line 8c)	. 8i								0
j	Transfers to (from) the plan (see instructions)	. 8i								
Par	t IV Plan Characteristics		•							
9a b	If the plan provides pension benefits, enter the applicable pension 2E 2F 2G 2J 2K 3D If the plan provides welfare benefits, enter the applicable welfare f									
Part	V Compliance Questions									
10	During the plan year:				Yes	No		Ar	nount	
а	Was there a failure to transmit to the plan any participant contribu									
	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fide		<u> </u>	10a		X				
	Were there any nonexempt transactions with any party-in-interes on line 10a.)			10b		X				
С	Was the plan covered by a fidelity bond?			10c		X				
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 ber	nefits under the plan? (See	10e		X				
f	Has the plan failed to provide any benefit when due under the pla	ın?		10f		Х				
q	Did the plan have any participant loans? (If "Yes," enter amount a	as of vear	end.)	10g		X				
— h				iug						
	2520.101-3.)			10h		Х				
i	If 10h was answered "Yes," check the box if you either provided t 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)	,					•		Yes	No
11a	Enter the unpaid minimum required contribution for current year f	rom Sche	dule SB (Form 5500) line 39			11a				
12	Is this a defined contribution plan subject to the minimum funding				•	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 bei		,	ctions	and a	antar th	atch a	of the	lattar ri	lina

. 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

Form 5500-SF

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

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**

Parti		t Identification Information							
For calend	lar plan year 2014 or f	iscal plan year beginning	10/01/2014	and ending	12/31	/2014			
A This re	turn/report is for:	x a single-employer plan	a multiple-employed of participating em	r plan (not multiemployer) ployer information in acco	(Filers checking	this box must attach a list			
		a one-participant plan a foreign plan							
B This ret	urn/report is	x the first return/report	the final return/report						
		an amended return/report	X a short plan year re	turn/report (less than 12 n	nonths)				
C Check	box if filing under:	Form 5558	automatic extension	n	DFVC	program			
		special extension (enter descri							
Part II	Basic Plan Info	ormation—enter all requested info	ormation						
1a Name Bluegra		sive Urology Affiliate	es, LLC 401K		1b Three-dig plan num (PN)				
					1c Effective				
2a Plans Bluegra	ponsor's name and ac ass Comprehen	ddress; include room or suite numbe sive Urology Affiliat	r (employer, if for a singes, LLC	le-employer plan)	10.53 92.00	Identification Number -5116442			
336 291	th Street, Su	ite 101				s telephone number			
Ashland	d	KY 41101-1976	5		2d Business code (see instructions) 812990				
3a Plan a	dministrator's name a	nd address XSame as Plan Sponso			3b Administra				
4 If the r	name and/or EIN of th	e plan sponsor has changed since th	ne last return/report files	I for this plan, enter the	4b EIN				
name	, EIN, and the plan nu or's name	mber from the last return/report.	io last returnireport med	To this plan, enter the	4c PN				
5a Total	number of participants	at the beginning of the plan year	***************************************						
		at the end of the plan year			3.5000000000000000000000000000000000000				
c Numb	er of participants with	account balances as of the end of th	ne plan year (defined be	nefit plans do not	5c				
d(1) Tota	al number of active pa	rticipants at the beginning of the pla	n year		5d(1)				
		articipants at the end of the plan year			5d(2)				
e Numbe less th	er of participants that to an 100% vested	erminated employment during the plant	an year with accrued be	nefits that were	5e				
Caution: A	penalty for the late	or incomplete filing of this return/	report will be assesse	d unless reasonable car	use is establishe	ed.			
SB or Sche	alties of perjury and ot	her penalties set forth in the instructi nd signed by an enrolled actuary, as	ions. I declare that I have	e examined this return/re	port including if	annlicable a Schedule			
SIGN	- TXL-	D HAD		Timothy K. Di	xon				
HERE	Signature of plan a	dministrator	Date	Enter name of individ	lual signing as pla	an administrator			
SIGN									
HERE	Signature of emplo	yer/plan sponsor	Date	Enter name of individ	ployer or plan sponsor				
Preparer's	name (including firm r	name, if applicable) and address (inc	lude room or suite num	ber) (optional)		phone number (optional)			

6a b	Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibility	an indepen and condition	dent qualified public account	ant (IC	(PA)			X	1		No No
6a Were all of the plans assets during the plan year invested in eligible assets? (See instructions.)				mine	d						
Pa	rt III Financial Information							_			
7	Plan Assets and Liabilities		(a) Beginning of Ye	ar			(b) En	d of Y	ear		
a	Total plan assets	7a			0						-
b	Total plan liabilities	7b						-100			
С	Net plan assets (subtract line 7b from line 7a)	7c			0						(
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b)	Total			_
a	[B [[[]]] [[] [] [] [] [] [8a(1)			0						
	(2) Participants	8a(2)			0					Partie C	
_	(3) Others (including rollovers)	8a(3)									77
b	Other income (loss)	8b			18	3.					
C		8c									(
d	Benefits paid (including direct rollovers and insurance premiums					EL TY				ratij	
		200			EE						1000
No. 1											
					2						
·		5000		a 1,010	Single			all the			
÷					12						(
÷							100				
Po		8j				4					
р	If the plan provides welfare benefits, enter the applicable welfare fe										
10					Ves	No					
а	Was there a failure to transmit to the plan any participant contribut	tions within	the time period described in	10a	103	10.00		Amo	unt		
b	Were there any nonexempt transactions with any party-in-interest?	? (Do not in	clude transactions reported			Х					
С				100		х					
d	Did the plan have a loss, whether or not reimbursed by the plan's t	fidelity bond	d, that was caused by fraud			20000					
е	Were any fees or commissions paid to any brokers, agents, or other insurance service, or other organization that provides some or all of	er persons of the benef	by an insurance carrier, its under the plan? (See	41.57e(0.5		х					
f	Has the plan failed to provide any benefit when due under the plan	1?		10f		Х					
g	Did the plan have any participant loans? (If "Yes," enter amount as	of year en	d.)	10g		х			-		
h	If this is an individual account plan, was there a blackout period? (\$2520.101-3.)	See instruc	tions and 29 CFR	10g		Х			le F		
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	e required r	notice or one of the	10i							
Part											_
11	Is this a defined benefit plan subject to minimum funding requireme 5500) and line 11a below)	ents? (If "Ye	s," see instructions and com	plete S	Schedu	ıle SB	(Form	П	Yes	П	10
11a	Enter the unpaid minimum required contribution for current year fro	om Schedul	e SB (Form 5500) line 39			11a	***************************************	ш		П.	
12	Is this a defined contribution plan subject to the minimum funding r						RISA2	П	Yes	V V	10
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,			31 360	20011 3	02 01 0		Ш	100		
a	If a waiver of the minimum funding standard for a prior year is being granting the waiver.	g amortized	in this plan year, see instruc	tions,	and er	nter the	e date of t	he lett Year	er ruli	ng	
				_	_	/-		· cui			

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lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500	0), and skip to line 13.			
	Enter the minimum required contribution for this plan year		12	2b	
			300	•	
<u>C</u>	Enter the amount contributed by the employer to the plan for this plan year		12	2c	
a	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter negative amount)	a minus sign to the left of a	12	2d	
е	Will the minimum funding amount reported on line 12d be met by the funding deadli	ine?		Yes	□ No □ N/A
Part					
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 this year			a	
b	Were all the plan assets distributed to participants or beneficiaries, transferred to ar of the PBGC?			ol	☐ Yes ☒ No
С	If during this plan year, any assets or liabilities were transferred from this plan to an which assets or liabilities were transferred. (See instructions.)	other plan(s), identify the pl	lan(s) to		
1	13c(1) Name of plan(s):		13c(2) EIN(s)	13c(3) PN(s)
Part	: VIII Trust Information (optional)				
5992/10/07	Name of trust				
1741	ivanie oi tiust		14b	Trust's EIN	