Form 5500-SF Short Form Annual Re			al Return/Report Benefit Plan	t of Small Emplo	ууее	OMB Nos. 1210-0110 1210-0089				
	artment of the Treasury rnal Revenue Service	This form is required to be filed		4065 of the Employee Re	etirement	i	2014			
	epartment of Labor Benefits Security Administration	Income Security Act of 1974 (		057(b) and 6058(a) of the I		This F	orm is Open to			
Pension Be	enefit Guaranty Corporation	<ul> <li>Complete all entries in a</li> </ul>	Υ.		00- <u>SF.</u>	lic Inspection				
Part I	-	dentification Information		1						
For calenda	lar plan year 2014 or fisc ]		_	ŭ	31/2014					
	turn/report is for: urn/report is	a single-employer plan     a one-participant plan     the first return/report     an amended return/report	the first return/report							
C Check	box if filing under:	☐ Form 5558 ☐ special extension (enter descrip	automatic extension			DFVC progra	ım			
Part II	Basic Plan Infor	mation—enter all requested info	ormation							
<b>1a</b> Name THE GALLE		RGERY 401K PROFIT SHARING	PLAN		pla	nree-digit an number PN) ▶	001			
							f plan /2006			
<b>2a</b> Plan sp THE GALLEF	ponsor's name and addr RY OF COSMETIC SUR	Iress; include room or suite number	r (employer, if for a single	employer plan)		mployer Identi	fication Number			
3500 188TH STREET SW #670					<b>2c</b> Sponsor's telephone number 425-775-3561					
_YNNWOOD, WA 98037					<b>2d</b> Bu	Business code (see instructions) 621111				
<b>3a</b> Plan administrator's name and address $X$ Same as Plan Sponsor.					<b>3b</b> Ad	dministrator's				
		plan sponsor has changed since the structure of the state of the last return/report.	he last return/report filed	for this plan, enter the	<b>4b</b> EI		telephone number			
	sor's name				<b>4c</b> PN	N				
5a Total r	number of participants a	at the beginning of the plan year			5a		14			
<b>b</b> Total r	number of participants a	at the end of the plan year			5b		13			
comple	lete this item)	ccount balances as of the end of th		· · · · · · · · · · · · · · · · · · ·	5c		9			
<b>d(1)</b> Tota	al number of active parti	icipants at the beginning of the pla	n year		5d(1)		5			
		ticipants at the end of the plan year		-	5d(2)	1	5			
e Numbe less th	r of participants that terr an 100% vested	minated employment during the pla	an year with accrued ben	efits that were	5e		0			
Caution: A Under pena SB or Sche	A penalty for the late or alties of perjury and othe	r incomplete filing of this return/ er penalties set forth in the instruct d signed by an enrolled actuary, as	/report will be assessed tions, I declare that I have	d unless reasonable cause e examined this return/rep	ort, inclu	iding, if applic	able, a Schedule knowledge and			
SIGN		alid electronic signature.	10/14/2015	CRAIG R. JONOV, MD	)					
HERE	Signature of plan ad	ministrator	Date	Enter name of individu	ual signin	ng as plan adr	ninistrator			
SIGN										
HERE	Signature of employe	ployer/plan sponsor Date Enter name of individ m name, if applicable) and address (include room or suite number ) (optional)								
Preparers	name (including firm ha	me, ir applicable) and address (inc	Juae room or suite numb	er ) (optional)	Prepare	r's telephone	number (optional)			

6a	Were all of the plan's assets during the plan year invested in eligib	le assets?	? (See instructions.)					×	Yes	No
b	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 cann							$\sim$	163	NO
С	If the plan is a defined benefit plan, is it covered under the PBGC in					-		Not c	determ	ined
	t III Financial Information									
7	Plan Assets and Liabilities		(a) Paginning of Vac				(b) End	of Vo	<b>.</b>	
<u>′</u>		70	(a) Beginning of Yea				(b) End		ar 27912	2
	Total plan assets Total plan liabilities	7a 7b								_
	Net plan assets (subtract line 7b from line 7a)	70 70	2661	77					27912	2
8	Income, Expenses, and Transfers for this Plan Year	10	(a) Amount				(b) T	otal		
	Contributions received or receivable from:							otai		
	(1) Employers	8a(1)		0						
	(2) Participants	8a(2)		0						
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)	8b	145	553						
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							1455	3
d	Benefits paid (including direct rollovers and insurance premiums	04	16	608						
	to provide benefits) Certain deemed and/or corrective distributions (see instructions)	8d								
 f		8e								
	Administrative service providers (salaries, fees, commissions)	8f								
	Other expenses Total expenses (add lines 8d, 8e, 8f, and 8g)	8g							160	8
<u></u>		8h							1294	
÷	Net income (loss) (subtract line 8h from line 8c) Transfers to (from) the plan (see instructions)	8i			-				1204	<u> </u>
,		8j								
9a	Part IV         Plan Characteristics           9a         If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:									
34	2A 2E 2F 2G 2J 3D			acten				10113.		
b	<b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:									
-										
Par	V Compliance Questions				1	1				
10	During the plan year:			1	Yes	No		Amo	unt	
а	Was there a failure to transmit to the plan any participant contribu			100		x				
b	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu Were there any nonexempt transactions with any party-in-interest			10a		~				
	on line 10a.)		-	10b		X				
С	Was the plan covered by a fidelity bond?			10c	х					50000
d	Did the plan have a loss, whether or not reimbursed by the plan's	fidelitv bo	nd. that was caused by fraud							
	or dishonesty?			10d		Х				
е		•								
	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			10f		Х				
g				-	Х					17818
9 h				10g	^					17010
	2520.101-3.)			10h		Х				
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	1-3		10i						
Part	• •									
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 fr	om Scheo	dule SB (Form 5500) line 39			11a				
12	Is this a defined contribution plan subject to the minimum funding	requirem	ents of section 412 of the Code	e or se	ection	302 of	ERISA?		Yes	X No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,									
-								1		

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If you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.						
<b>b</b> Enter the minimum required contribution for this plan year		12b				
<b>C</b> Enter the amount contributed by the employer to the plan for this plan year		12c				
<b>d</b> 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 under the of the PBGC?				Yes 🗙 No		
<b>C</b> 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)	<b>13c(3)</b> PN(s)		
Part VIII Trust Information (optional)						
14a Name of trust			rust's EIN			

The form is return to perform a control of and cost of the Employee Return management of the first under a cost on and cost of the Employee Return management of the first under a cost on a cost of the Cost of th	Form 5500-SF Short Form Annual Return/Report of Small Emp Benefit Plan					oyee	OMB Nos. 1210-0110 1210-0089				
Calescientistication         Revenue Code (m. Code):         The Form is Open 10           Parta Tauda Calescie Consulta         > Complete all entries in accordance with the instructions to the Form 5500-SF.         The form is Open 10           Parta Tauda Calescie Consulta         Second Edit (m. Code):         and militing         12/33/2014           A must Report Identification Information         and militing         12/33/2014         information           Calescie Consulta         and militing         12/33/2014         information information         information           Calescie Consulta         an energitic part (m. Consulta)         and militing         12/33/2014         information           B This returningent is         an energitic part (m. Consulta)         a short plan returningent (m. Consulta)         information)         information           C Check back If ling under:         Form 5588         utunate extension         DFVC program           The Gallery of Cosmettic Surgery 401K Profit Sharing Plan         10         The cellost plan construction           The Gallery of Cosmettic Surgery 401K Profit Sharing Plan         10         Enterpoly confidence Number (m) 2/31/2016           20 198th Street SW #670         20         Soot 188th Street SW #670         20           Lymmvood         WA         98037         30           3a Plan untrinstrator'E	Inte	rnal Revenue Service			2014						
Part I       Annual Report Identification Information         For selectar plan year Delta rised paining       0.701/2014       and ending       12/31/2014         A This return/report is       a single employer plan       D FVC program         Part II       Basic Plan Information - enter all requested information       a single employer plan       D FVC program       D FVC program         The Gallery of Coametic Surgery       401K Profit Sharring Plan       D Twee-digit plan mumber (employer, if for a single-employer plan)       D Employee diantification information         4       If the name antific ElN of the plan sponsor has onaged since the sat return/report filed for the plan, senter the single	Employee Benefits Security Administration Revenue Code (the Code).					Internal	•				
For calcular genu year 2014 of fisce plan year beginning       01/01/2014       an ending       12/21/2014         A This return/report is for:       a one-participant (an inc)       a one-participant (an inc)       a one-participant (an inc)       a one-participant (an inc)         B This return/report is       a one-participant (an inc)       a one-participant (an inc)       a one-participant (an inc)       a one-participant (an inc)         C Check box if fling under:       If for motion       inc)       a one-participant (an inc)       a bot (plan year return/report inscription)         Part III Basic Plan Informationenter all requested information       in the fissi return/report is short (plan year return/report if an information (enter description)       in the fissi return/report is information (enter description)         Part III Basic Plan Informationenter all requested information       in the fissi return/report is information (enter description)       in the fissi return/report is information (enter description)         24 Flins sponeoris name and address; Include room or sulle number (employer, if for a single-employer plan)       25 Employer identification Number (EIN) (20 - 5):518190         25 Joint 18 Noneo El N & fissi return/report       36 Administration's EIN       36 Administration's EIN         36 Administration's number from the list return/report field for this plan, enter the single-employer plan)       36 Administration's EIN         36 Transment of pathispents with acoount balances as of the end of the plan year.<	Complete all entries in accordance with the instructions to the Form 5500-SF.						Fubic inspection				
A This return report is for: <ul> <li>a angle-employer plan</li> <li>a non-participants gamployer information in accordance with the form instructions)</li> </ul> B This return report is for:              a non-participant gam             in a foreign plan             in the first return report               for a manned end return report            Part III         Bacic Plan Information—enter all requested information               for a single-employer plan               for Bacic Plan               for Bacic Plan            A The regulation of the data return report               for a single-employer plan               for Bacic Plan					and ending	10/	31/2014				
A This return/toport is for       a one participant plan       a one participant genologies information in accordance with the form instructions)         B This return/toport is       a namedial return/toport       a short plan year return/toport (less than 12 months)         C Check box if fling under:       B Form 5558       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       10 FVC program       DFVC program         24 Plan sponsor's name of plan       10 FVC program       10 FVC program       10 FVC program         25 On 1982 Lh Surgery       40 IK Profit Sharing Plan       10 FVC program       10 FVC program         25 On 1982 Lh Surgery       40 IK Profit Sharing Plan       10 FVC program       10 FVC program         26 Sponsors telephone number       01 (2006)       20 Sponsors telephone number       20 Sponsors telephone number         35 On 1982 Lh Surgery       10 N A 98037       20 Sponsors telephone number       20 Sponsors telephone number         37 A Plan administrator's name and address [x]Same as Plan Sponsor.       30 Administrator's telephone number       20 Administrator's telephone number         4 If the name and/or FIN of the plan sponsor has changed since the last return/report filed for this plan, enter the       40 FN       40 FN         3 Administrator's formits at the beginning of the glan year											
an amended return/report       a short plan year return/report (less than 12 months)         C Check box if filing under:       Form 6658       automatic extension       DFVC program         Part II       Basic Plan Information—enter all requested information       1       Three digit plan number       pol1         The Gallery of Cosmetic Surgery 401K Profit Sharing Plan       1b Three digit plan number       pol1       (PN)         The Gallery of Cosmetic Surgery 401K Profit Sharing Plan       1b Three digit plan number       (PN)       1d (21/2016)         2a Plan sponsor's name and address: include room or suite number (employer, if for a single-employer plan)       1b Three digit plan number       (PN)         3500 188th Street SW #670       2b Employer Identification Number (EN) 20 - 5318130       2c Sponsor's telephone number 425 - 775-3651         Lynnwood       WA 98037       3b Administrator's telephone number 425 - 775-3651       3d Plan administrator's telephone number 53111         3a Plan administrator's nume and address:       Same as Plan Sponsor.       3b Administrator's telephone number 53111         4 If the name and/or EN of the plan sponsor has changed since the last return/report filed for this plan, enter the name from the last return/report.       4c PN         5a Tot number of participants at the edgrining of the plan year       5a 14       5b 133         61 Tota number of participants at the edgrining of the plan year       5c 133		turn/report is for:	a one-participant plan	of participating emp	loyer information in accor		-				
Part II Basic Plan Information—enter all requested information     1a Name of plan     The Gallery of Cosmetic Surgery 401K Profit Sharing Plan     1b Three-digit plan number     01     (PN)     1c Effective date of plan     (PN)     1c Effective date     1c Effective date	B This ret	urn/report is				onths)					
Part II       Basic Plan Information—enter all requested information         1a Name of pian       1b Three-digit         The Gallery of Cosmetic Surgery 401K Profit Sharing Plan       1b Three-digit         1c       Enderse data         2a Plan sponsor's name and address include room or suite number (employer, if for a single-employer plan)       1c         2a Plan sponsor's name and address include room or suite number (employer, if for a single-employer plan)       2b Employer identification Number (EN) 0.20-351.8100         2500 188th Street SM #670       2c Sponsor's telephone number (employer, if for a single-employer plan)       2c Sponsor's telephone number (EN) 0.20-351.8100         24       Plan administrator's name and address [2]Same as Plan Sponsor.       3b Administrator's telephone number (employer, 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 form the last return/report.       3c Administrator's telephone number for a telephone number for the plan sponsor has changed since the last return/report.       3c Administrator's telephone number for a formation is the end of the plan year.         5a       Total number of participants at the end of the plan year.       5b       13         complet this telephone at the end of the plan year.       5c       9         64(1) Total number of adviopantia at the end of the plan year.       5c       9         64(2) Total number of adviopantis at the end of the plan year. <t< td=""><td>C Check</td><td>box if filing under:</td><td>X Form 5558</td><td>automatic extension</td><td>1</td><td></td><td>VC program</td></t<>	C Check	box if filing under:	X Form 5558	automatic extension	1		VC program				
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The Gallery of Cosmetic Surgery 401K Profit Sharing Plan       in number of patient (PN)         2a Plan sponsor's name and address; include room or sulle number (employer, if for a single-employer plan)       The Effective date of plan 0.1/01/2006         2a Plan sponsor's name and address; include room or sulle number (employer, if for a single-employer plan)       Zb Employer Identification Number (PN 20-3518190         2b Disposer Stelephone number (PN 20-3518190       Zb Employer Identification Number (PN 20-3518190         3500 188th Street SW #670       Zb Employer Identification Number (PN 20-3518190         Lynnwood       WA 98037         3a Plan administrator's name and eddress       Sgame as Plan Sponsor.         3b Administrator's telephone number (employer, if for a single-employer of filed for this plan, enter the name, EIN, and the plan number from the last return/report.       4c PN         3c Tail number of participants at the beginning of the plan year.       5a       14         5a Totai number of participants at the beginning of the plan year.       5c       9         d(1) Totai number of participants at the beginning of the plan year.       5c       9         d(2) Totai number of participants at the edd in the plan year.       5c       9         d(2) Totai number of participants at the edd in the plan year.       5c       9         d(2) Totai number of participants at the edd in the plan year.       5c       9         d(2) Tota	Part II	Basic Plan Infor	mation—enter all requested inf	ormation							
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2a       Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan)       2b       Employer identification Number (EIN 20 - 35161 9)         3500       188th Street SW #670       2c       Sponsor's telephone number 425 - 773 - 3561.         2ymwood       WA       98037       3d         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's telephone number 425 - 773 - 3561.         3b       Administrator's name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the agonsor name. EN, and the plan number from the last return/report.       3c       Administrator's telephone number 425 - 773 - 3561.         3c       Name, EIN, and the plan number from the last return/report.       5a       14         b       Total number of participants at the end of the plan year.       5a       14         c       Number of participants at the end of the plan year.       5c       9         d(1)       Total number of active participants at the end of the plan year.       5d(1)       5d(2)       5d(2)         c       Number of participants at the end of the plan year.       5d       5d(2)       5d(2)       5d(2)         c       Number of participants at the end of the plan year.       5d       5d(2)       5d(2)       5d(2)       5d(2)       5d(											
The Gallery of Cosmetic Surgery       (EN) 20-3518190         3500 188th Street SW #670       2c Sponsors telephone number 425-775-3561         Lynnwood       WA 98037         3a Plan administrator's name and address (Same as Plan Sponsor.       3b Administrator's EIN         4       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 form the last return/report.       3b Administrator's telephone number         5a Total number of participants at the beginning of the plan year.       5a       14         5a Total number of participants at the end of the plan year.       5b       13         c Number of participants at the end of the plan year.       5b       13         c Number of participants at the end of the plan year.       5b       13         c Number of participants at the end of the plan year.       5b       13         c Number of participants at the end of the plan year.       5b       13         c Number of participants at the end of the plan year.       5b       13         d(1) Total number of active participants at the end of the plan year.       5b       13         d(2) Total number of active participants at the end of the plan year.       5b       13         d(2) Total number of active participants at the end of the plan year.       5b       5c       9											
3500 188Eh Street SW #670       425-775-3561         Lynnwood       WA       98037         3a Plan administrator's name and address Same as Plan Sponsor.       3b Administrator's EIN         3c Administrator's name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the sponsor name. EIN, and the plan number from the last return/report.       4b EIN         3c Administrator's name       4c PN         3c Administrator's name       5a         14b Total number of participants at the beginning of the plan year.       5a         5c Number of participants at the beginning of the plan year.       5b         6l(1)       5c         9       5d(1)       5c         9       5d(2)       5c         9       5d(1)       5c         9       5d(2)       5c         9       5c       0 </td <td><b>2a</b> Plans The Ga</td> <td>ponsor's name and add llery of Cosme</td> <td>ress; include room or suite numbe tic Surgery</td> <td>er (employer, if for a singl</td> <td>e-employer plan)</td> <td>(EIN)</td> <td>20-3518190</td>	<b>2a</b> Plans The Ga	ponsor's name and add llery of Cosme	ress; include room or suite numbe tic Surgery	er (employer, if for a singl	e-employer plan)	(EIN)	20-3518190				
Lynnwood       WA       98037       2d Business code (see instructions) 621111         3a Plan administrator's name and address       Same as Plan Sponsor.       3b Administrator's EIN         3c Administrator's name and address       Same as Plan Sponsor.       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 name, EIN, and the plan number from the last return/report.       4b EIN         5a Total number of participants at the end of the plan year       5a       14         b Total number of participants at the end of the plan year       5b       13         c Number of participants at the end of the plan year       5c       9         d(1) Total number of active participants at the end of the plan year       5c       9         d(2) Total number of active participants at the end of the plan year       5c       9         d(2) Total number of active participants at the end of the plan year       5c       9         d(2) Total number of active participants at the end of the plan year       5c       9         d(2) Total number of active participants at the end of the plan year       5c       5e       0         cauthor: A penally for the late or incomplete filling of this return/report will be assessed unless reasonable cause is ostablished.       0         Cauthor: A penallities of poly and other penallies set forth	3500 18	88th Street SW	#670								
Lynnwood       WA       98037       621111         3a       Plan administrator's name and address       Same as Plan Sponsor.       3b       Administrator's EIN         3c       Administrator's telephone number       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 name, EIN, and the plan number form the last return/report.       4b       EIN         a       Sponsor's name       4c       PN         5a       14       5a       14         b       Total number of participants at the beginning of the plan year       5a       14         c       Number of participants at the end of the plan year.       5c       9         d(1)       Total number of participants at the end of the plan year.       5d       13         f(2)       Total number of active participants at the end of the plan year.       5d       5d       0         d(2)       Total number of active participants at the end of the plan year.       5e       0       5d       0         d(2)       Total number of active participants at the end of the plan year.       5e       0       5d       0         d(2)       Total number of active participants at the end of the plan year.       5e       0       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>											
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 name, EIN, and the plan number from the last return/report.       4b       EIN         a       Sponsor's name       4c       PN         5a       Total number of participants at the beginning of the plan year       5a       14         b       Total number of participants at the end of the plan year       5b       13         c       Number of participants at the end of the plan year       5c       9         d(1)       Total number of active participants at the edginning of the plan year       5d(1)       5         d(2)       Total number of active participants at the edginning of the plan year       5d(2)       5         e       Number of participants that terminated employment during the plan year with accrued benefits that were       5e       0         d(2)       Total number of participants at the end of the plan year with accrued benefits that were       5e       0         Caution: A ponalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established.       10der penalties of perjuy and other penalties set forth in the instructions, 1 declare that I have examineter of this return/report, including, if applicable, a Schedule belled, it is que, correct, and complete       Sign         Under penalties of perjuy and											
4       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.       4b       EIN         3       Sponsor's name       4c       PN         5a       Total number of participants at the beginning of the plan year       5a       14         b       Total number of participants at the end of the plan year       5b       13         c       Number of participants with account balances as of the end of the plan year.       5c       9         d(1)       Total number of active participants at the end of the plan year.       5d(1)       5c         d(2)       Total number of participants at the end of the plan year.       5d(2)       5c       9         d(2)       Total number of participants at the end of the plan year.       5d(2)       5c       0         d(2)       Total number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.       5e       0         Under penalties of participant of other panalties of tority nambes of the instructions, Ideclare that In thave examined this return/report, including, if applicable, a Schedule SB or Schedule MB complete 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       Enter name of individual signing as plan administrator       <	3a Plan administrator's name and address XSame as Plan Sponsor.					<b>3b</b> Administrator's EIN					
a Sponsor's name       4c PN         5a Total number of participants at the beginning of the plan year       5a       14         b Total number of participants at the end of the plan year       5b       13         c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)       5c       9         d(1) Total number of active participants at the beginning of the plan year       5d(1)       5         d(2) Total number of active participants at the end of the plan year       5d(2)       5         e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.       5e       0         Cluder penalties of periury and other panellies est for in the instructions, I declare that I have examined this return/report, and to the best of my knowledge and belef. It is true, correct, and complete.       0       0         Signature or plan administrator       Date       Enter name of individual signing as plan administrator       0         HERE       Signature of employ pripian sponsor       Date       Enter name of individual signing as employer or plan sponsor         Preparer's name (including firming	4 If the r	name and/or EIN of the	plan sponsor has changed since t	he last return/report filed	for this plan, enter the						
5a       Total number of participants at the beginning of the plan year       5a       14         b       Total number of participants at the end of the plan year       5b       13         c       Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)       5c       9         d(1)       Total number of active participants at the beginning of the plan year       5d(1)       5         d(2)       Total number of active participants at the end of the plan year       5d(2)       5         e       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/report will be assessed unless reasonable cause is established.       0       0         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.       10			ber from the last return/report.				· · · · · · · · · · · · · · · · · · ·				
b       Total number of participants at the end of the plan year       5b       13         c       Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)       5c       9         d(1)       Total number of active participants at the beginning of the plan year.       5d(1)       5         d(2)       Total number of active participants at the end of the plan year.       5d(2)       5         e       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 filling of this return/report will be assessed unless reasonable cause is established.       0         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.         SIGN       Im/In/I/K       CRAIG R. JONOV, MD         HERE       Signature of plan administrator       Date       Enter name of individual signing as employer or plan sponsor         Preparer's name (including firmitame, if applicable) and address (include room or suite number ) (optional)       Preparer's telephone number (optional)			t the beginning of the plan year			1	1 /				
c       Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)       5c       9         d(1) Total number of active participants at the beginning of the plan year							······································				
d(1) Total number of active participants at the beginning of the plan year	c Numb	er of participants with ac	count balances as of the end of th	he plan year (defined ber	nefit plans do not						
d(2) Total number of active participants at the end of the plan year	comple d(1) Tota	al number of active parti	cipants at the beginning of the pla	an year							
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested											
Tess than 100 % vested	e Number of participants that terminated employment during the plan year with accrued benefits that were			nefits 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 true, correct, and complete.         SIGN       Ib/IH/IS       CRAIG R. JONOV, MD         HERE       Signature or plan administrator       Date       Enter name of individual signing as plan administrator         SIGN       Ib/IH/IS       CRAIG R. JONOV, MD         HERE       Signature or employer/plan sponsor       Date       Enter name of individual signing as employer or plan sponsor         Preparer's name (including firm the index (include room or suite number) (optional)       Preparer's telephone number (optional)											
Sign HERE       Ip / 14/15       CRAIG R. JONOV, MD         Signature of plan administrator       Date       Enter name of individual signing as plan administrator         Sign HERE       Signature of employer/plan sponsor       Date       Enter name of individual signing as employer or plan sponsor         Preparer's name (including firm of modeme, if applicable) and address (include room or suite number ) (optional)       Preparer's telephone number (optional)	Under pena SB or Sche	alties of perjury and othe dule MB completed and	r penalties set forth in the instruct signed by an enrolled actuary, as	tions. I declare that I have	e examined this return/ren	port, includin	g, if applicable, a Schedule				
Signature of plan administrator       Date       Enter name of individual signing as plan administrator         SIGN HERE       Signature of employer/plan sponsor       Date       CRAIG R. JONOV, MD         Preparer's name (including firm of amplicable) and address (include room or suite number ) (optional)       Preparer's telephone number (optional)	SIGN	CA	/	10/14/15	CRAIG R. JONO	V, MD	·····				
SIGN HERE       IO/IG/IS       CRAIG R. JONOV, MD         Signature of employer/plan sponsor       Date       Enter name of individual signing as employer or plan sponsor         Preparer's name (including firm of modeme, if applicable) and address (include room or suite number ) (optional)       Preparer's telephone number (optional)	HERE	Signature of plan ag	ministrator	Date	Enter name of individu	ual signing a	s plan administrator				
Signature of employer/plan sponsor       Date       Enter name of individual signing as employer or plan sponsor         Preparer's name (including firm or me, if applicable) and address (include room or suite number ) (optional)       Preparer's telephone number (optional)	SIGN	$\int \Delta d$		iotud 15							
Preparer's name (including firm loame, if applicable) and address (include room or suite number ) (optional) Preparer's telephone number (optional)		Signature of employ	er/plan sponsor		Enter name of individu	ual signing a	s employer or plan sponsor				
	Preparer's	name (including firm <b>ina</b> i	ne, if applicable) and address (inc	clude room or suite numb	ver ) (optional)						

Form 5500-SF 2014

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c If the plans is a defined benefit plan, is If covered under the PBGC insurance program (see ERISA section 4021)?		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 conditi	ndent qualified public accountai ions.)	nt (IQ	PA)		
7       Plan Assets and Liabilities       (a) Beginning of Year       (b) End of Year         a       Total plan inside       7a       266177       279122         b       Total plan inside       7b       279122         c       Net plan assets (subtract line 7b from ine 7a)       7c       266177       279122         8       income, Expenses, and Trainfest for this Plan Year       (a) Amount       (b) Total       a         3       Contributions resched or receivable from:       9a(1)       0	С	If the plan is a defined benefit plan, is it covered under the PBGC in	surance p	rogram (see ERISA section 40	21)? .		Yes [	No Not determined
a       Total plan issets       7a       266177       279122         b       Total plan isbilities       7b       7b       7c       266177       279122         8       Income. Expenses. and Transfers for this Plan Year       (a) Amount       (b) Total       (b) Total         a       Contributions received or receivable from:       5a(1)       0       (b) Total       (c) Total         a       Contributions (noduling reflexers)       5a(2)       0       (c) Other (norme (loss)       5a(3)       0       (c) Other (norme (loss)       5a(3)       0       (c) Other (norme (loss)       5a(3)       0       (c) Other (norme (loss)       6a(3)       14553       0       14553         C       Total income (loss) (lockiding reflexers)       6a(1)       1608       6       14553         G       Other income (loss) (lockiding reflexers)       8d       1608       6       6         G       Other expenses (lockiding reflexers)       8d       1608       6       12945         G       Other expenses (lockiding reflexers)       8d       12945       12945       12945         J       Transfer to (room) the plan (see instructions)       8d       12945       12945       12945       12945       12945       12945 </td <td>Pa</td> <td>rt III   Financial Information</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Pa	rt III   Financial Information						
Total pain labelities         Total pain labelitis         Total pain labelitis         <	7	Plan Assets and Liabilities		(a) Beginning of Yea	r			(b) End of Year
C       Net plan assels (subtract line 7b from line 7a)	a	Total plan assets	7a	26	617	7		279122
6       Income, Expenses, and Transfers for the Plan Year       (a) Amount       (b) Total         a       Contributions received or receivable from:       6a(1)       0         (1)       Engloyers       6a(2)       0         (2)       Participents       6a(3)       0         (3)       Others (including rolovers)       6a(3)       0         (4)       Other income (loss)       6a(3)       0       14:553         (5)       Other income (loss)       6a(3)       14:553       14:553         (6)       Other income (loss)       14:553       14:553       14:553         (7)       Caralin deemed andor corrective distributions (see instructions)       8e       16:08       14:553         (7)       Caralin deemed andor corrective distributions (see instructions)       8e       16:08       12:345         (7)       Caralin deemed andor corrective distributions (see instructions)       8e       16:08       12:345         (7)       Transfers to (from) the plan (see instructions)       8e       12:345       12:345         (8)       If the plan provides pension benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:       12:345         (9)       Duruing the plan year:       Yea	b	Total plan liabilities	7b					
a       Contributions received or receivable from:       Ba(1)       0         (1)       Employees       Ba(2)       0         (2)       Participants       Ba(3)       0         (3)       Others (including relovers)       Ba(3)       0         (4)       Other (income (add lines 8a(1), 8a(2), 8a(3), and 8b)       8e       14553         (5)       Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)       8e       14553         (5)       Cratal income (add lines 8a(1), 8a(2), 8a(3), and 8b)       8e       14553         (6)       Cartain deemed and/or corrective distributions (see instructions)       8e       14553         (7)       Administrative service providers (safaries, (esc. cormitisolnes)       8f       1608         (7)       Corrective distributions (see instructions)       8f       12945         (7)       Transfers to (from) the Bin (see instructions)       8g       12945         (7)       Transfers to (from) the Bin (see instructions)	С	Net plan assets (subtract line 7b from line 7a)	7c	26	617	7		279122
(1)         Employers         Be(1)         0           (2)         Participants         Be(2)         0           (3)         Others (including relovers)         Be(2)         0           (3)         Others (including relovers)         Be(3)	8	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) Total
(1) Employers       94(1)       0         (2) Part(parts)       84(2)       0         (3) Others (including rollovers)       84(3)       14553         (4) Other income (loss)       84(3)       14553         (5) Others (including direct rollovers and insurance premiums to provide benefits)       86       14553         (6) Other expenses       84       1608         (7) Other expenses       84       1608         (8) Other expenses (add lines 84, 66, and 89)       86       14553         (7) Transfers to (from) the 80,	а					0		
(1)       Cherse (including rollowers)       Be(2)	<u></u>			· · · · · · · · · · · · · · · · · · ·				
b       Other income (loss)       8b       14553         c       Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)       8c       14553         d       Benefits paid (including direct rollovers and insurance premiums to provide benefits)       1608         e       Certain deemed and/or corrective distributions (see instructions)       8d       1608         e       Certain deemed and/or corrective distributions (see instructions)       8d       1608         g       Other expenses       8g       1608         g       Other expenses (add lines 8d, 8e, 8f, and 8g)       8h       1608         h       Total expenses (add lines 8d, 8e, 8f, and 8g)       8h       12945         j       Transfers to (from) the plan (see instructions)       8g       12945         g       If the plan provides persion benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:       2A 2E 2F 2G 2J 3D         f       If the plan provides velfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:         2A 2E 2F 2G 2J 3D       During the plan year:       Yes       No         d       Was there a failure to transmit to the plan any participant contributions within the time period described in 28 CFR 2510.3 102? (See instructions and DOL's Voluniary Fiduclary Correction Program)						0		
C Total income (add lines Ba(1), 8a(2), 8a(3), and 8b)								······································
a Benefits paid (including dir)t statute of premiums to provide benefits)       Benefits paid (including dir)t statutes and insurance premiums and insurance premiums be provide benefits)       Benefits paid (including dir)t statutes and insurance premiums and insurance premiums be provide benefits)       Benefits paid (including dir)t statutes and insurance premiums be provides benefits)       Benefits paid (including dir)t statutes and insurance premiums be provides benefits (including dir)t statutes are vice providers (salaries, fees, commissions)       Benefits         g Other expenses       Bit       1608         h Total expenses (add lines 8d, 6e, 8f, and 8g)       Bh       1608         in term (coss) (suburat line 8h from line 8c)       Bit       12945         j Transfers to (from) the plan (see instructions)       Bit       12945         g If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:       2A 2E 2F 2G 2J 3D         g If the plan provides weifare benefits, enter the applicable weifare feature codes from the List of Plan Characteristic Codes in the instructions:       2A 2F 2F 2G 2J 3D         g Ouring the plan year:       Yes       No       Amount         a Was there a fallure to transmit to the plan any participant contributions within the time period described in 129 CFR 2510.3.102? (See instructions and DOL's Voluntary Flotuciary Correction Program)       10e       X         g Under the plan never alsos, whether or not reimbursed by the plan's fidelity bond, that was					455	.3		14550
to provide benefits,			8c			_		14553
e       Certain deemed and/or corrective distributions (see instructions)	a		8d		160	8		
f       Administrative service providers (selaries, fees, commissions)	e							
g       Other expenses       8g       1608         h       Total expenses (add lines 8d, 8e, 8f, and 8g)       8h       1608         i       Net income (loss) (subtract line 8h from line 8c)       8t       12945         j       Transfers to (from) the plan (see instructions)       g       12945         j       Transfers to (from) the plan (see instructions)       g       1         g       If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:       2A       2E       2F       2G       2J       3D         b       If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:       2A       2E       2F       2G       2J       3D         b       If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:       2A       2E       2F       2G       2J       3D         0       During the plan year:       Ves       No       Amount       4       Was there a failure to transmit to the plan any participant contributions within the time period described in 129 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)       10a       X       2       50 000       10b       X       <								
h       Total expenses (add lines 8d, 8e, 8f, and 8g)       1608         i       Net income (loss) (subtract line 8h from line 8c)       8i       12945         j       Transfers to (from) the plan (see instructions)       8j       12945         g       If the plan provides pecifies, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:       2A       2E       2F       2G       2J       3D         b       If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:         Part V       Compliance Questions         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)       10a       X         b       Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a)       10b       X         c       Was the plan covered by a fidelity bond?       10c       X       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?       X       50000         d       Did the plan have a nose oreal near other organizati								
I       Net income (toss) (subtract line 8h from line 8c)				· · · · · · · · · · · · · · · · · · ·				1608
j       Transfers to (from) the plan (see instructions)	i							12945
Part IV       Plan Characteristics         9a       If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:         2A       2E       2F       2G       2J       3D         b       If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:         Part V       Compliance Questions         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)	<u> </u>							
9a       If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:         2A       2E       2F       2G       3D         b       If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:         Part V       Compliance Questions         10       During the plan year:       Yes       No         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)       10a       X         b       Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)       10b       X         c       Was the plan covered by a fidelity bond?       10c       X       500000         d       Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonestly?       10d       X         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.)       10d       X         g       Did the plan have any participant loans? (If "Yes," enter amount as of year end.)       10g       X       17818 <td></td> <td></td> <td><u></u></td> <td></td> <td></td> <td></td> <td></td> <td></td>			<u></u>					
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)       10a       X         b       Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a).       10b       X       X         c       Was the plan covered by a fidelity bond?       10c       X       500000         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       X       500000         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       X       17818         f       Has the plan failed to provide any benefit when due under the plan?       10g       X       17818         h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.       10h       X       17818         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       X       17818         h<	r	If the plan provides welfare benefits, enter the applicable welfare fe	eature cod	es from the List of Plan Charac	terist	ic Cod	es in th	ne instructions:
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)       10a       X         b       Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)       10b       X         c       Was the plan covered by a fidelity bond?       10c       X       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       X         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 10e       X         f       Has the plan failed to provide any benefit when due under the plan?       10g       X       17818         h       If this is an Individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3).       10h       X       17818         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       X         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       X       17818						Van	No	A
29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)       10a       A         b       Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a)       10b       X         c       Was the plan covered by a fidelity bond?       10c       X       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       X       50000         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       X         f       Has the plan failed to provide any benefit when due under the plan?       10g       X       17818         h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)       10h       X       17818         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.       10i       V         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.       10i       V         i       If 10h was answered "Yes," check the box if you eithe			tione withi	n the time period described in		Tes	NO	Amount
on line 10a.)       10b       A         c       Was the plan covered by a fidelity bond?       10c       X       50000         d       Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonestly?       10d       X       X         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       X         f       Has the plan failed to provide any benefit when due under the plan?       10f       X       17818         h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)       10h       X         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.       10i       Image: Compliance         11       Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form       Image: Compliance		29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu	uclary Cori	rection Program)	10a		Х	
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       X         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       X         f       Has the plan failed to provide any benefit when due under the plan?       10f       X       17818         h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)       10h       X       17818         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.       10i       X         Part VI       Pension Funding Compliance       10i       10i       10i       10i		on line 10a.)			10b		Х	
or dishonesty?       10d       A         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       X         f       Has the plan failed to provide any benefit when due under the plan?       10f       X       17818         g       Did the plan have any participant loans? (If "Yes," enter amount as of year end.)       10g       X       17818         h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)       10h       X       17818         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       10i       X         Part VI       Pension Funding Compliance       10i       I       I         11       Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form       I       I	C		0102022		10c	X		50000
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?       10f       X         g       Did the plan have any participant loans? (If "Yes," enter amount as of year end.)       10g       X       17818         h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)       10h       X       17818         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.       10i       X         Part VI       Pension Funding Compliance       10i       10i       10i       10i	d	or dishonesty?			10d		х	
g       Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	e	insurance service, or other organization that provides some or all	of the ben	efits under the plan? (See	10e		x	
h       If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR       10h       X         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       X         Part VI       Pension Funding Compliance       10i       10i         11       Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form       D	f	Has the plan failed to provide any benefit when due under the pla	n?		10f		Х	
2520.101-3.)       10h       A         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       10i       10i         Part VI       Pension Funding Compliance       10i       10i       10i         11       Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form       Data Data Data Data Data Data Data Data	g	Did the plan have any participant loans? (If "Yes," enter amount a	s of year e	end.)	10g	Х		17818
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       10i         Part VI       Pension Funding Compliance       10i         11       Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form       Description	h						x	
11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form	i	If 10h was answered "Yes," check the box if you either provided the	he require	d notice or one of the	10i			
11 Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form	Par	VI Pension Funding Compliance		<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>				9 <u>999999999999999999999999999999999999</u>
5500) and line 11a below)		Is this a defined benefit plan subject to minimum funding requirem						
11a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 11a	11a							
12 Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of ERISA?		Is this a defined contribution plan subject to the minimum funding	requirem	ents of section 412 of the Code				ERISA? Yes 🛛 No
(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)  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					ctions	and	enter th	e date of the letter ruling

Year

	Form 5500-SF 2014	Page 3 -	]						
lf	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Forr	n 5500), and ski	p to line 13.						
b	Enter the minimum required contribution for this plan year				12b	1			
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 negative amount)	(enter a minus si	gn to the left	ofa	12d				
e	Will the minimum funding amount reported on line 12d be met by the funding					Ye:	sП	No	N/A
Part	VII Plan Terminations and Transfers of Assets							<u></u>	
_13a	Has a resolution to terminate the plan been adopted in any plan year?					Yes 🛛	No		
	If "Yes," enter the amount of any plan assets that reverted to the employer this	is year			13a				<del></del>
d	Were all the plan assets distributed to participants or beneficiaries, transferre of the PBGC?	d to another plar	, or brought	under the c	ontrol		0000-X	Yes	X No
с	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 th	ne plan(s) t	0				
1	3c(1) Name of plan(s):			13	3c(2) E	IN(s)		13c(3	) PN(s)
				<b>.</b>					

## Part VIII Trust Information (optional)

14a Name of trust	14b Trust's EIN	