

<b>Form 5500-SF</b> Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	<b>Short Form Annual Return/Report of Small Employee Benefit Plan</b> 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). <b>▶ Complete all entries in accordance with the instructions to the Form 5500-SF.</b>	OMB Nos. 1210-0110 1210-0089  <b>2014</b>  <b>This Form is Open to Public Inspection</b>
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<b>Part I Annual Report Identification Information</b>		
For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014		
<b>A</b> This return/report is for:	<input checked="" type="checkbox"/> a single-employer plan	<input type="checkbox"/> a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list of participating employer information in accordance with the form instructions)
	<input type="checkbox"/> a one-participant plan	<input type="checkbox"/> a foreign plan
<b>B</b> This return/report is	<input type="checkbox"/> the first return/report	<input type="checkbox"/> the final return/report
	<input type="checkbox"/> an amended return/report	<input type="checkbox"/> a short plan year return/report (less than 12 months)
<b>C</b> Check box if filing under:	<input checked="" type="checkbox"/> Form 5558	<input type="checkbox"/> automatic extension
	<input type="checkbox"/> special extension (enter description)	<input type="checkbox"/> DFVC program

<b>Part II Basic Plan Information</b> —enter all requested information		
<b>1a</b> Name of plan DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN	<b>1b</b> Three-digit plan number (PN) ▶	002
	<b>1c</b> Effective date of plan 01/01/2010	
<b>2a</b> Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) DIGESTIVE HEALTH SPECIALISTS, INC., P.S.  3209 S. 23RD ST., SUITE 340 TACOMA, WA 98405-1602	<b>2b</b> Employer Identification Number (EIN) 91-0880426	
	<b>2c</b> Sponsor's telephone number 253-272-5127	
	<b>2d</b> Business code (see instructions) 621111	
	<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.	
	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> 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. <b>a</b> Sponsor's name	<b>4b</b> EIN	
	<b>4c</b> PN	
<b>5a</b> Total number of participants at the beginning of the plan year .....	<b>5a</b>	96
<b>b</b> Total number of participants at the end of the plan year.....	<b>5b</b>	102
<b>c</b> Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) .....	<b>5c</b>	
<b>d(1)</b> Total number of active participants at the beginning of the plan year.....	<b>5d(1)</b>	81
<b>d(2)</b> Total number of active participants at the end of the plan year.....	<b>5d(2)</b>	72
<b>e</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>5e</b>	2

<b>Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.</b>			
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.			
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	10/14/2015	CINDY FRUGE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Preparer's name (including firm name, if applicable) and address (include room or suite number ) (optional)			Preparer's telephone number (optional)

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ..... ☒ Yes ☐ No
- 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.) ..... ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.**
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ..... ☒ Yes ☐ No ☐ Not determined

**Part III Financial Information**

<b>7 Plan Assets and Liabilities</b>		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total plan assets .....	<b>7a</b>	4717657	6298347
<b>b</b> Total plan liabilities .....	<b>7b</b>		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	<b>7c</b>	4717657	6298347
<b>8 Income, Expenses, and Transfers for this Plan Year</b>		<b>(a) Amount</b>	<b>(b) Total</b>
<b>a</b> Contributions received or receivable from:			
<b>(1)</b> Employers .....	<b>8a(1)</b>	1486938	
<b>(2)</b> Participants .....	<b>8a(2)</b>		
<b>(3)</b> Others (including rollovers) .....	<b>8a(3)</b>		
<b>b</b> Other income (loss) .....	<b>8b</b>	113689	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	<b>8c</b>		1600627
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	<b>8d</b>		
<b>e</b> Certain deemed and/or corrective distributions (see instructions) ....	<b>8e</b>		
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	<b>8f</b>		
<b>g</b> Other expenses .....	<b>8g</b>	19937	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	<b>8h</b>		19937
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	<b>8i</b>		1580690
<b>j</b> Transfers to (from) the plan (see instructions) .....	<b>8j</b>		

**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:  
1C
- 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**

<b>10</b> During the plan year:	Yes	No	Amount
<b>a</b> 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	<input checked="" type="checkbox"/>	
<b>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	10b	<input checked="" type="checkbox"/>	
<b>c</b> Was the plan covered by a fidelity bond? .....	10c	<input checked="" type="checkbox"/>	500000
<b>d</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	10d	<input checked="" type="checkbox"/>	
<b>e</b> 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	<input checked="" type="checkbox"/>	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	10f	<input checked="" type="checkbox"/>	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year end.) .....	10g	<input checked="" type="checkbox"/>	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	10h		
<b>i</b> 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**

- 11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below) ..... ☒ Yes ☐ No
- 11a** Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 ..... **11a** 0
- 12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of 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 granting the waiver. .... Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

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.....	<b>12b</b>	
<b>c</b> Enter the amount contributed by the employer to the plan for this plan year .....	<b>12c</b>	
<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 of a negative amount).....	<b>12d</b>	
<b>e</b> Will the minimum funding amount reported on line 12d be met by the funding deadline?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A	

**Part VII Plan Terminations and Transfers of Assets**

<b>13a</b> Has a resolution to terminate the plan been adopted in any plan year? .....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If "Yes," enter the amount of any plan assets that reverted to the employer this year .....	<b>13a</b>	
<b>b</b> Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>c</b> If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)		
<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)

**Part VIII Trust Information (optional)**

<b>14a</b> Name of trust	<b>14b</b> Trust's EIN

<b>SCHEDULE SB</b> <b>(Form 5500)</b>  Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  ▶ <b>File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2014</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

▶ **Round off amounts to nearest dollar.**

▶ **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan <u>DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶ <u>002</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF <u>DIGESTIVE HEALTH SPECIALISTS, INC., P.S.</u>	<b>D</b> Employer Identification Number (EIN) <u>91-0880426</u>
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

<b>Part I</b>	<b>Basic Information</b>
<b>1</b> Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2014</u>	
<b>2</b> Assets:	
<b>a</b> Market value .....	<b>2a</b> <u>4678793</u>
<b>b</b> Actuarial value .....	<b>2b</b> <u>4678793</u>
<b>3</b> Funding target/participant count breakdown	
	(1) Number of participants (2) Vested Funding Target (3) Total Funding Target
<b>a</b> For retired participants and beneficiaries receiving payment.....	<u>0</u> <u>0</u> <u>0</u>
<b>b</b> For terminated vested participants.....	<u>16</u> <u>16502</u> <u>16502</u>
<b>c</b> For active participants.....	<u>81</u> <u>3869115</u> <u>3871440</u>
<b>d</b> Total.....	<u>97</u> <u>3885617</u> <u>3887942</u>
<b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b)..... <input type="checkbox"/>	
<b>a</b> Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>
<b>b</b> Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor.....	<b>4b</b>
<b>5</b> Effective interest rate .....	<b>5</b> <u>6.44%</u>
<b>6</b> Target normal cost .....	<b>6</b> <u>1172923</u>

**Statement by Enrolled Actuary**

To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>		<u>09/29/2015</u>
	Signature of actuary	Date
<u>SARA ARK, FSA, EA, MAAA</u>	Type or print name of actuary	<u>14-06142</u>
		Most recent enrollment number
<u>INDEPENDENT ACTUARIES, INC.</u>	Firm name	<u>503-520-0848</u>
		Telephone number (including area code)
<u>4500 KRUSE WAY</u> <u>SUITE 200</u> <u>LAKE OSWEGO, OR 97035</u>	Address of the firm	

If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

**For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.**

**Schedule SB (Form 5500) 2014**  
**v. 140124**

<b>Part II Beginning of Year Carryover and Prefunding Balances</b>		
	(a) Carryover balance	(b) Prefunding balance
<b>7</b> Balance at beginning of prior year after applicable adjustments (line 13 from prior year) .....	0	0
<b>8</b> Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....		
<b>9</b> Amount remaining (line 7 minus line 8) .....	0	0
<b>10</b> Interest on line 9 using prior year's actual return of <u>4.27</u> % .....	0	0
<b>11</b> Prior year's excess contributions to be added to prefunding balance:		
<b>a</b> Present value of excess contributions (line 38a from prior year) .....		364584
<b>b(1)</b> Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.24</u> % .....		22750
<b>b(2)</b> Interest on line 38b from prior year Schedule SB, using prior year's actual return .....		0
<b>c</b> Total available at beginning of current plan year to add to prefunding balance .....		387334
<b>d</b> Portion of (c) to be added to prefunding balance .....		0
<b>12</b> Other reductions in balances due to elections or deemed elections .....	0	0
<b>13</b> Balance at beginning of current year (line 9 + line 10 + line 11d – line 12) .....	0	0

<b>Part III Funding Percentages</b>		
<b>14</b> Funding target attainment percentage .....	<b>14</b>	120.34 %
<b>15</b> Adjusted funding target attainment percentage .....	<b>15</b>	120.34 %
<b>16</b> Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement .....	<b>16</b>	109.52 %
<b>17</b> If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage .....	<b>17</b>	%

<b>Part IV Contributions and Liquidity Shortfalls</b>					
<b>18</b> Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
02/02/2015	166667	0	07/28/2015	166667	0
03/05/2015	166667	0	08/28/2015	166667	0
03/26/2015	166667	0	09/14/2015	153602	0
05/05/2015	166667	0			
06/22/2015	166667	0			
06/30/2015	166667	0			
<b>Totals ▶</b>			<b>18(b)</b>	1486938	<b>18(c)</b> 0

<b>19</b> Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
<b>a</b> Contributions allocated toward unpaid minimum required contributions from prior years .....	<b>19a</b>	0
<b>b</b> Contributions made to avoid restrictions adjusted to valuation date .....	<b>19b</b>	0
<b>c</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date .....	<b>19c</b>	1361717
<b>20</b> Quarterly contributions and liquidity shortfalls:		
<b>a</b> Did the plan have a "funding shortfall" for the prior year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>b</b> If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>c</b> If line 20a is "Yes," see instructions and complete the following table as applicable:		
Liquidity shortfall as of end of quarter of this plan year		
(1) 1st	(2) 2nd	(3) 3rd

**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 4.99 %	2nd segment: 6.32 %	3rd segment: 6.99 %	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code).....				<b>21b</b> 4
<b>22</b> Weighted average retirement age .....				<b>22</b> 62
<b>23</b> Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

**Part VI Miscellaneous Items**

<b>24</b> Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>25</b> Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>26</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	<b>27</b>

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

<b>28</b> Unpaid minimum required contributions for all prior years .....	<b>28</b>	0
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a).....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29) .....	<b>30</b>	0

**Part VIII Minimum Required Contribution For Current Year**

<b>31</b> Target normal cost and excess assets (see instructions):			
<b>a</b> Target normal cost (line 6).....	<b>31a</b>	1172923	
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	790851	
<b>32</b> Amortization installments:			
<b>a</b> Net shortfall amortization installment.....	Outstanding Balance	Installment	
<b>b</b> Waiver amortization installment .....	0	0	
<b>33</b> If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>		
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) ..	<b>34</b>	382072	
	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement.....			0
<b>36</b> Additional cash requirement (line 34 minus line 35).....	<b>36</b>	382072	
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c).....	<b>37</b>	1361717	
<b>38</b> Present value of excess contributions for current year (see instructions)			
<b>a</b> Total (excess, if any, of line 37 over line 36) .....	<b>38a</b>	979645	
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	<b>38b</b>	0	
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....	<b>39</b>	0	
<b>40</b> Unpaid minimum required contributions for all years .....	<b>40</b>	0	

**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)**

<b>41</b> If an election was made to use PRA 2010 funding relief for this plan:			
<b>a</b> Schedule elected .....	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
<b>b</b> Eligible plan year(s) for which the election in line 41a was made .....	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
<b>42</b> Amount of acceleration adjustment .....	<b>42</b>		
<b>43</b> Excess installment acceleration amount to be carried over to future plan years .....	<b>43</b>		

**EIN: 91-0880426    PN: 002**

### Distribution of Active Participants

[illegible]

**DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN****EIN: 91-0880426 PN: 002**

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**2014 Form 5500 Schedule SB, Part V – Statement of Actuarial Assumptions/Methods****Actuarial Method for Minimum Required Contribution**

Asset Valuation Method	Fair market value.
Valuation Date	First day of plan year.
Yield Curve Selected	24-month average Segmented Yield Curve, subject to corridor provided by MAP-21 and HATFA.
Lookback Month for Determining Segment Interest Rates	4 <sup>th</sup> month prior to valuation date.

**Actuarial Assumptions for Minimum Required Contribution**

Segment Interest Rates	First Segment: 4.99%
	Second Segment: 6.32%
	Third Segment: 6.99%
Assumed Form of Payment	Lump sum.
Lump Sum Payment Assumptions	Projected Hypothetical Account Balance discounted by applying the appropriate yield curve segment to deferral period.
Interest Rate to Project Hypothetical Account Balances	4.58% per annum.
Assumed Commencement Date	Normal retirement date.
Weighted Retirement Age	Age 62. Age is weighted on funding target.
Mortality	
Pre-Retirement	None.
Post-Retirement	See lump sum payment assumptions (above).



**DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN**

**EIN: 91-0880426 PN: 002**

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**2014 Form 5500 Schedule SB, Part V – Statement of Actuarial Assumptions/Methods  
(Concluded)**

Salary Scale	No explicit assumption.
Turnover Rate	No explicit assumption.
Expenses	None.
Future Annual Hours Worked	1,000 or more in each future year.
Changes Since Prior Valuation	None, other than changes in mandated interest and mortality as required under the Pension Protection Act of 2006 (PPA) and HATFA.

**Form 5500-SF**Department of the Treasury  
Internal Revenue ServiceDepartment 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  
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	<input type="checkbox"/> special extension (enter description)			

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN		<b>1b</b> Three-digit plan number (PN) ▶	002
		<b>1c</b> Effective date of plan	01/01/2010
<b>2a</b> Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) DIGESTIVE HEALTH SPECIALISTS, INC., P.S.  3209 S. 23RD ST., SUITE 340  TACOMA WA 98405-1602		<b>2b</b> Employer Identification Number (EIN)	91-0880426
		<b>2c</b> Sponsor's telephone number	253-272-5127
		<b>2d</b> Business code (see instructions)	621111
<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor.		<b>3b</b> Administrator's EIN	
		<b>3c</b> Administrator's telephone number	
<b>4</b> 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.		<b>4b</b> EIN	
<b>a</b> Sponsor's name		<b>4c</b> PN	
<b>5a</b> Total number of participants at the beginning of the plan year .....		<b>5a</b>	96
<b>b</b> Total number of participants at the end of the plan year .....		<b>5b</b>	102
<b>c</b> Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) .....		<b>5c</b>	
<b>d(1)</b> Total number of active participants at the beginning of the plan year .....		<b>5d(1)</b>	81
<b>d(2)</b> Total number of active participants at the end of the plan year .....		<b>5d(2)</b>	72
<b>e</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....		<b>5e</b>	2

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

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	<i>Cindy Fruge</i>	10/14/15	Cindy Fruge
	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 name, if applicable) and address (include room or suite number) (optional)			Preparer's telephone number (optional)

- 6a** Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.) ..... ☒ Yes ☐ No
- 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.) ..... ☒ Yes ☐ No
- If you answered "No" to either line 6a or line 6b, the plan cannot use Form 5500-SF and must instead use Form 5500.
- c** If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? ..... ☒ Yes ☐ No ☐ Not determined

**Part III Financial Information**

7 Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
<b>a</b> Total plan assets .....	7a	4717657	6298347
<b>b</b> Total plan liabilities .....	7b		
<b>c</b> Net plan assets (subtract line 7b from line 7a) .....	7c	4717657	6298347
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
<b>a</b> Contributions received or receivable from:			
(1) Employers .....	8a(1)	1486938	
(2) Participants .....	8a(2)		
(3) Others (including rollovers) .....	8a(3)		
<b>b</b> Other income (loss) .....	8b	113689	
<b>c</b> Total income (add lines 8a(1), 8a(2), 8a(3), and 8b) .....	8c		1600627
<b>d</b> Benefits paid (including direct rollovers and insurance premiums to provide benefits) .....	8d		
<b>e</b> Certain deemed and/or corrective distributions (see instructions) ....	8e		
<b>f</b> Administrative service providers (salaries, fees, commissions) .....	8f		
<b>g</b> Other expenses .....	8g	19937	
<b>h</b> Total expenses (add lines 8d, 8e, 8f, and 8g) .....	8h		19937
<b>i</b> Net income (loss) (subtract line 8h from line 8c) .....	8i		1580690
<b>j</b> Transfers to (from) the plan (see instructions) .....	8j		

**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:  
1C
- 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
<b>a</b> 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>b</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.) .....	10b		X	
<b>c</b> Was the plan covered by a fidelity bond? .....	10c	X		500000
<b>d</b> 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	
<b>e</b> 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	
<b>f</b> Has the plan failed to provide any benefit when due under the plan? .....	10f		X	
<b>g</b> Did the plan have any participant loans? (If "Yes," enter amount as of year end.) .....	10g		X	
<b>h</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	10h			
<b>i</b> 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**

- 11** Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions and complete Schedule SB (Form 5500) and line 11a below) ..... ☒ Yes ☐ No
- 11a** Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line 39 ..... **11a** 0
- 12** Is this a defined contribution plan subject to the minimum funding requirements of section 412 of the Code or section 302 of 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 granting the waiver. .... Month Day Year

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.....	<b>12b</b>	
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<b>c</b> Enter the amount contributed by the employer to the plan for this plan year.....	<b>12c</b>	
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<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 of a negative amount).....	<b>12d</b>	
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<b>e</b> Will the minimum funding amount reported on line 12d be met by the funding deadline? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
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**Part VII Plan Terminations and Transfers of Assets**

<b>13a</b> Has a resolution to terminate the plan been adopted in any plan year? .....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
--	------------------------------	--

If "Yes," enter the amount of any plan assets that reverted to the employer this year .....	<b>13a</b>	
---	------------	--

<b>b</b> Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
--	------------------------------	--

<b>c</b> If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)		
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<b>13c(1)</b> Name of plan(s):	<b>13c(2)</b> EIN(s)	<b>13c(3)</b> PN(s)
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**Part VIII Trust Information (optional)**

<b>14a</b> Name of trust	<b>14b</b> Trust's EIN
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<b>SCHEDULE SB</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	<b>Single-Employer Defined Benefit Plan</b> <b>Actuarial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6059 of the Internal Revenue Code (the Code).  <b>► File as an attachment to Form 5500 or 5500-SF.</b>	OMB No. 1210-0110  <b>2014</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014

► **Round off amounts to nearest dollar.**

► **Caution:** A penalty of \$1,000 will be assessed for late filing of this report unless reasonable cause is established.

<b>A</b> Name of plan DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN	<b>B</b> Three-digit plan number (PN) ►	002
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF DIGESTIVE HEALTH SPECIALISTS, INC., P.S.	<b>D</b> Employer Identification Number (EIN) 91-0880426	
<b>E</b> Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B <input type="checkbox"/> Other		
<b>F</b> Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500		

<b>Part I Basic Information</b>			
<b>1</b> Enter the valuation date: Month <u>01</u> Day <u>01</u> Year <u>2014</u>			
<b>2</b> Assets:			
a Market value .....	<b>2a</b>	4678793	
b Actuarial value .....	<b>2b</b>	4678793	
<b>3</b> Funding target/participant count breakdown	(1) Number of participants	(2) Vested Funding Target	(3) Total Funding Target
a For retired participants and beneficiaries receiving payment .....	0	0	0
b For terminated vested participants .....	16	16502	16502
c For active participants .....	81	3869115	3871440
d Total .....	97	3885617	3887942
<b>4</b> If the plan is in at-risk status, check the box and complete lines (a) and (b) <input type="checkbox"/>			
a Funding target disregarding prescribed at-risk assumptions .....	<b>4a</b>		
b Funding target reflecting at-risk assumptions, but disregarding transition rule for plans that have been in at-risk status for fewer than five consecutive years and disregarding loading factor .....	<b>4b</b>		
<b>5</b> Effective interest rate .....	6.44%		
<b>6</b> Target normal cost .....	1172923		

**Statement by Enrolled Actuary**  
 To the best of my knowledge, the information supplied in this schedule and accompanying schedules, statements and attachments, if any, is complete and accurate. Each prescribed assumption was applied in accordance with applicable law and regulations. In my opinion, each other assumption is reasonable (taking into account the experience of the plan and reasonable expectations) and such other assumptions, in combination, offer my best estimate of anticipated experience under the plan.

<b>SIGN HERE</b>	Sara Ark Signature of actuary Sara Ark, FSA, EA, MAAA Type or print name of actuary Independent Actuaries, Inc. Firm name 4500 Kruse Way Suite 200 Lake Oswego, OR 97035 Address of the firm	09/29/2015 Date 1406142 Most recent enrollment number 503-520-0848 Telephone number (including area code)
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If the actuary has not fully reflected any regulation or ruling promulgated under the statute in completing this schedule, check the box and see instructions ☐

**Part II Beginning of Year Carryover and Prefunding Balances**

	(a) Carryover balance	(b) Prefunding balance
<b>7</b> Balance at beginning of prior year after applicable adjustments (line 13 from prior year).....	0	0
<b>8</b> Portion elected for use to offset prior year's funding requirement (line 35 from prior year) .....		
<b>9</b> Amount remaining (line 7 minus line 8) .....	0	0
<b>10</b> Interest on line 9 using prior year's actual return of <u>4.27%</u> .....	0	0
<b>11</b> Prior year's excess contributions to be added to prefunding balance:		
<b>a</b> Present value of excess contributions (line 38a from prior year).....		364584
<b>b(1)</b> Interest on the excess, if any, of line 38a over line 38b from prior year Schedule SB, using prior year's effective interest rate of <u>6.24%</u> .....		22750
<b>b(2)</b> Interest on line 38b from prior year Schedule SB, using prior year's actual return .....		0
<b>c</b> Total available at beginning of current plan year to add to prefunding balance.....		387334
<b>d</b> Portion of (c) to be added to prefunding balance.....		0
<b>12</b> Other reductions in balances due to elections or deemed elections.....	0	0
<b>13</b> Balance at beginning of current year (line 9 + line 10 + line 11d – line 12) .....	0	0

**Part III Funding Percentages**

<b>14</b> Funding target attainment percentage .....	<b>14</b>	120.34%
<b>15</b> Adjusted funding target attainment percentage .....	<b>15</b>	120.34%
<b>16</b> Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement.....	<b>16</b>	109.52%
<b>17</b> If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage. ....	<b>17</b>	%

**Part IV Contributions and Liquidity Shortfalls**

<b>18</b> Contributions made to the plan for the plan year by employer(s) and employees:					
(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees	(a) Date (MM-DD-YYYY)	(b) Amount paid by employer(s)	(c) Amount paid by employees
02/02/2015	166667	0			
03/05/2015	166667	0			
03/26/2015	166667	0			
05/05/2015	166667	0			
06/22/2015	166667	0			
06/30/2015	166667	0			
07/28/2015	166667	0			
08/28/2015	166667	0			
09/14/2015	153602	0			
<b>Totals ▶</b>			<b>18(b)</b>	1486938	<b>18(c)</b> 0

**19** Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:

<b>a</b> Contributions allocated toward unpaid minimum required contributions from prior years.....	<b>19a</b>	0
<b>b</b> Contributions made to avoid restrictions adjusted to valuation date .....	<b>19b</b>	0
<b>c</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date .....	<b>19c</b>	1361717

**20** Quarterly contributions and liquidity shortfalls:

- a** Did the plan have a "funding shortfall" for the prior year? ☐ Yes ☒ No
- b** If line 20a is "Yes," were required quarterly installments for the current year made in a timely manner? ☐ Yes ☐ No
- c** If line 20a is "Yes," see instructions and complete the following table as applicable:

Liquidity shortfall as of end of quarter of this plan year

(1) 1st	(2) 2nd	(3) 3rd	(4) 4th

**Part V Assumptions Used to Determine Funding Target and Target Normal Cost**

<b>21</b> Discount rate:				
<b>a</b> Segment rates:	1st segment: 4.99%	2nd segment: 6.32%	3rd segment: 6.99%	<input type="checkbox"/> N/A, full yield curve used
<b>b</b> Applicable month (enter code) .....				<b>21b</b> 4
<b>22</b> Weighted average retirement age .....				<b>22</b> 62
<b>23</b> Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

**Part VI Miscellaneous Items**

<b>24</b> Has a change been made in the non-prescribed actuarial assumptions for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>25</b> Has a method change been made for the current plan year? If "Yes," see instructions regarding required attachment. ....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>26</b> Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment. ....	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>27</b> If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment .....	<b>27</b>

**Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years**

<b>28</b> Unpaid minimum required contributions for all prior years .....	<b>28</b>	0
<b>29</b> Discounted employer contributions allocated toward unpaid minimum required contributions from prior years (line 19a) .....	<b>29</b>	0
<b>30</b> Remaining amount of unpaid minimum required contributions (line 28 minus line 29) .....	<b>30</b>	0

**Part VIII Minimum Required Contribution For Current Year**

<b>31</b> Target normal cost and excess assets (see instructions):			
<b>a</b> Target normal cost (line 6) .....	<b>31a</b>	1172923	
<b>b</b> Excess assets, if applicable, but not greater than line 31a .....	<b>31b</b>	790851	
<b>32</b> Amortization installments:	Outstanding Balance	Installment	
<b>a</b> Net shortfall amortization installment .....	0	0	
<b>b</b> Waiver amortization installment .....	0	0	
<b>33</b> If a waiver has been approved for this plan year, enter the date of the ruling letter granting the approval (Month _____ Day _____ Year _____) and the waived amount .....	<b>33</b>		
<b>34</b> Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33) .....	<b>34</b>	382072	
	Carryover balance	Prefunding balance	Total balance
<b>35</b> Balances elected for use to offset funding requirement .....			0
<b>36</b> Additional cash requirement (line 34 minus line 35) .....	<b>36</b>	382072	
<b>37</b> Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c) .....	<b>37</b>	1361717	
<b>38</b> Present value of excess contributions for current year (see instructions)			
<b>a</b> Total (excess, if any, of line 37 over line 36) .....	<b>38a</b>	979645	
<b>b</b> Portion included in line 38a attributable to use of prefunding and funding standard carryover balances .....	<b>38b</b>	0	
<b>39</b> Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37) .....	<b>39</b>	0	
<b>40</b> Unpaid minimum required contributions for all years .....	<b>40</b>	0	

**Part IX Pension Funding Relief Under Pension Relief Act of 2010 (See Instructions)**

<b>41</b> If an election was made to use PRA 2010 funding relief for this plan:			
<b>a</b> Schedule elected .....	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
<b>b</b> Eligible plan year(s) for which the election in line 41a was made .....	<input type="checkbox"/> 2008 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011		
<b>42</b> Amount of acceleration adjustment .....	<b>42</b>		
<b>43</b> Excess installment acceleration amount to be carried over to future plan years .....	<b>43</b>		

# DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN

EIN: 91-0880426 PN: 002

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## 2014 Form 5500 Schedule SB, Part V – Summary of Plan Provisions

1. Effective Date January 1, 2010. Last amendment effective January 1, 2012.
2. Plan Year January 1 to December 31.
3. Plan Eligibility
  - Eligible Employees All employees except those whose retirement benefits are subject to collective bargaining, certain non-resident aliens with no US income, leased employees, and anyone who is not employed as a doctor or receptionist.
  - Requirements Later of attainment of age 19 and completion of 1 year of service.
  - Entry date January 1 or July 1 coinciding with or next following completion of eligibility requirements.
4. Years of Service
  - Eligibility 12-Month period commencing on employee's date of hire during which the employee is credited with at least 1,000 hours; switches to plan year on anniversary of employee's date of hire if employee fails to complete 1,000 hours in first 12-month period.
  - Vesting Plan year during which employee is credited with at least 1,000 hours of service.
  - Benefit Plan year during which the participant is credited with at least 1,000 hours of service.
5. Normal Retirement
  - Eligibility The first day of the month coincident with or following the later of the participant's 62<sup>nd</sup> birthday or 5 years of plan participation.
  - Benefit Hypothetical Account Balance resulting from annual pay credits and interest credits.
6. Pay Credits As specified in plan document for select doctors.  
2% of compensation for receptionists.  
0% of compensation for all other participants.



**DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN****EIN: 91-0880426 PN: 002**

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**2014 Form 5500 Schedule SB, Part V – Summary of Plan Provisions****(Continued)**

7. Interest Credits	Lesser of 5.5% or third segment rate applicable to 417(e).						
8. Early Retirement	Not provided.						
9. Late Retirement							
Eligibility	Defer commencement of benefit beyond normal retirement date.						
Benefit	Hypothetical Account Balance.						
10. Disability Benefit	Not provided.						
11. Death Benefit							
Eligibility	Death of participant prior to commencement of benefits.						
Benefit	Hypothetical Account Balance.						
12. Termination Benefit							
Eligibility	Termination of employment for reasons other than retirement or death.						
Benefit	A percentage of a participant's accrued benefit based on the following schedule:						
	<table><tr><td><u>Years of Vesting Service</u></td><td><u>Vested Percent</u></td></tr><tr><td>Less than 3</td><td>0%</td></tr><tr><td>3 or more</td><td>100%</td></tr></table>	<u>Years of Vesting Service</u>	<u>Vested Percent</u>	Less than 3	0%	3 or more	100%
<u>Years of Vesting Service</u>	<u>Vested Percent</u>						
Less than 3	0%						
3 or more	100%						
13. Compensation							
Limits	\$200,000 as indexed; \$260,000 for plan years beginning in or after 2014.						
Plan	W-2 compensation. Compensation includes regular pay and excludes leave cashouts paid within 2½ months of the participant's severance from employment. All other types of post-severance compensation are excluded from compensation.						
14. Accrued Benefit	Life annuity which is the Actuarial Equivalent of the Hypothetical Account Balance.						

# DIGESTIVE HEALTH SPECIALISTS, INC., P.S. CASH BALANCE PLAN

EIN: 91-0880426 PN: 002

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## 2014 Form 5500 Schedule SB, Part V – Summary of Plan Provisions

(Concluded)

- |                               |   |
|-------------------------------|---|
| 15. Normal Form of Benefit    | Life annuity which is the Actuarial Equivalent of the Hypothetical Account Balance.   |
| 16. Optional Forms of Benefit | Lump sum, joint & survivor annuity (50%, 75%, 100%).  |
| 17. Actuarial Equivalent      |   |
| Interest                      | 5.5% pre- and post-retirement.  |
| Mortality                     | Pre-retirement: None.<br>Post-retirement: Applicable mortality table.   |
| §417(e)                       | Stability Period is plan year; lookback month is third month preceding plan year.   |
| 18. Top-Heavy Provisions      | In the event the plan becomes top-heavy, certain provisions will apply. Generally, a plan is top-heavy if more than 60% of the total present value of accrued benefit and account balances are held for key employees, as defined in the Internal Revenue Code. |
| Minimum Accrual               | Top-heavy minimums are provided by contributions to a companion profit sharing plan.  |
| Vesting                       | The regular vesting schedule meets the minimum requirements.  |
| Status                        | Plan is top-heavy.  |
| 19. Changes Since Last Report | None.   |