## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

less than 100% vested.

## Short Form Annual Return/Report of Small Employee **Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection** 

Annual Report Identification Information For calendar plan year 2014 or fiscal plan year beginning and ending 07/31/2014 X a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list A This return/report is for: of participating employer information in accordance with the form instructions) a one-participant plan a foreign plan the final return/report **B** This return/report is the first return/report an amended return/report a short plan year return/report (less than 12 months) Form 5558 DFVC program automatic extension C Check box if filing under: special extension (enter description) Basic Plan Information—enter all requested information Part II 1a Name of plan **1b** Three-digit NORTHWEST CARDIOTHORACIC & TRANSPLANT SURGEONS, P.S., 401K PROFIT SHARING PLAN plan number (PN) ▶ 001 Effective date of plan 01/01/1992 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) 2b Employer Identification Number NORTHWEST CARDIOTHORACIC & TRANSPLANT SURGEONS, P.S. (EIN) 91-1577893 Sponsor's telephone number 509-462-6504 122 W 7TH AVE SUITE 110 Business code (see instructions) SPOKANE, WA 99204 621111 **3a** Plan administrator's name and address XSame as Plan Sponsor. Administrator's EIN **3c** Administrator's telephone number 4b EIN If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. 4c PN a Sponsor's name Total number of participants at the beginning of the plan year ...... 5a 10 Total number of participants at the end of the plan year..... 5b 0 Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c 0 complete this item) d(1) Total number of active participants at the beginning of the plan year..... 5d(1) 8

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

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

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

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

belief, it is t	true, correct, and complete.						
SIGN	Filed with authorized/valid electronic signature.						
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator				
SIGN							
HERE	Signature of employer/plan sponsor	ual signing as employer or plan sponsor					
Preparer's	name (including firm name, if applicable) and address (include r	oom or suite number	r ) (optional)	Preparer's telephone number (optional)			
DALE STEV	/ENS			500 755 0707			
BREAK-THE	RU BENEFITS, LLC			509-755-3767			
200 NORTH	I MULLAN ROAD, SUITE 216						
SPOKANE \	VALLEY WA 99206						

5d(2)

5e

0

0

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b	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of a under 29 CFR 2520.104-46? (See instructions on waiver eligibility a lf you answered "No" to either line 6a or line 6b, the plan cannot be a continuous continuous answered to the plan cannot be a continuous continuous assets.	an indeper and condit ot use Fo	ndent qualified public accounta ions.)rm 5500-SF and must instead	int (IQ d <b>d use</b>	PA) Form	5500.		X Ye	s 🗌 N	10 10
	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 dete	rmined	
Par –										
	Plan Assets and Liabilities		(a) Beginning of Yea		+		(b) End c	of Year	0	_
	Total plan assets	7a	24028	517	+				0	
	Total plan liabilities	7b	24028	217	+				0	
	Net plan assets (subtract line 7b from line 7a)	7c		717	+		(b) T-	4-1		_
	Income, Expenses, and Transfers for this Plan Year  Contributions received or receivable from:		(a) Amount				(b) To	itai		
	(1) Employers	8a(1)	19	941						
	(2) Participants	8a(2)	28	375						
	(3) Others (including rollovers)	8a(3)								
b	Other income (loss)	8b	774	159						
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c						82	275	
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	24850	92						
	Certain deemed and/or corrective distributions (see instructions)	8e								
	Administrative service providers (salaries, fees, commissions)	8f								
	Other expenses	8g								
h	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h						2485	092	
i	Net income (loss) (subtract line 8h from line 8c)	8i						-2402	817	
j	Transfers to (from) the plan (see instructions)	8j								
Par	t IV Plan Characteristics									
b	2E 2F 2G 2J 2K 2A  If the plan provides welfare benefits, enter the applicable welfare fe  V Compliance Questions	eature cod	es from the List of Plan Charac	cterist	ic Cod	les in t	he instruction	ons:		_
10	During the plan year:				Yes	No	,	Amount		_
	Was there a failure to transmit to the plan any participant contribut 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidure)	iciary Cor	rection Program)	10a		X				
	Were there any nonexempt transactions with any party-in-interest on line 10a.)	·····		10b		Χ				
с	Was the plan covered by a fidelity bond?			10c	X				25000	)0
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?	•		10d		X				
e	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.)	of the ben	efits under the plan? (See	10e		X				
f	Has the plan failed to provide any benefit when due under the plan	n?		10f		X				
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of year e	end.)	10g		X				
h	If this is an individual account plan, was there a blackout period? (2520.101-3.)	•		10h		X				
i	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.10			10i						
Part	VI Pension Funding Compliance									
11	Is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)							Ye	s 🔲 N	lо
11a	Enter the unpaid minimum required contribution for current year fr					11a				
12	Is this a defined contribution plan subject to the minimum funding					302 of	ERISA?	Ye	s X N	Ю
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,						<u> </u>			
а	If a waiver of the minimum funding standard for a prior year is beir granting the waiver.	-			, and e	enter tl Day		e letter r Year	uling	_

	F	Form 5500-SF 2014	Page <b>3</b> - 1					
lf y	ou c	ompleted line 12a, complete lines 3, 9, and 10 of Schedule MB (Forr	n 5500), and skip to line 13.					
b	Ente	r the minimum required contribution for this plan year			12b			
С	Ente	r the amount contributed by the employer to the plan for this plan year			12c			
d		ract the amount in line 12c from the amount in line 12b. Enter the result ative amount)	`		12d			
е	Will t	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?			. X	Yes N	lo	
	If "Ye	es," enter the amount of any plan assets that reverted to the employer th	is year		. 13a			
b		e all the plan assets distributed to participants or beneficiaries, transferre e PBGC?		under the o	control		X Yes	No
С	If du	ring this plan year, any assets or liabilities were transferred from this planth assets or liabilities were transferred. (See instructions.)		ne plan(s)	to			
1	3c(1)	Name of plan(s):		1:	3c(2) E	IN(s)	13c(3	<b>)</b> PN(s)

14b Trust's EIN

Part VIII Trust Information (optional)

14a Name of trust

# Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## Short Form Annual Return/Report of Small Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

OM8 Nos. 1210-0110 1210-0089

2014

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation	Complete all entries in	accordance with the Instructions to the Form	5500-SF.	Public Inspection			
Part   Annual Report	Identification Information						
For calendar plan year 2014 or fig		01/01/2014 and ending	07,	/31/2014			
A This return/report is for:	X a single-employer plan	a multiple-employer plan (not multiemployer of participating employer information in acco					
	a one-participant plan	a foreign plan					
B This return/report is	the first return/report an amended return/report	In the final return/report  In a short plan year return/report (less than 12 return/report)	months)				
			_				
C Check box if filling under:	Form 5558	automatic extension	∐ p	FVC program			
	special extension (enter desc						
· · · · · · · · · · · · · · · · · · ·	rmation—enter all requested in	formation	146 =	W. 12			
1a Name of plan NORTHWEST CARDIOTHOR SHARING PLAN	ACIC & TRANSPLANT SU	JRGEONS, P.S., 401K PROFIT	1b Thre plan (PN)	number 001			
			1c Effective date of plan 01/01/1992				
		er (employer, if for a single-employer plan)		loyer Identification Number			
Northwest Cardiothor 122 W 7th Ave	acie & Transpiant Si	irgeons, P.S.		91-1546063			
122 W /CH AVE				nsor's telephone number -462-6504			
Suite 110				ness code (see instructions)			
Spokane	WA 99204		621				
3a Plan administrator's name an	d address XSame as Plan Spons	sor,	3b Admi	inistrator's EIN			
			3c Admi	nistrator's telephone number			
			1	monator o totophone named			
4 If the name and/or EIN of the	plan energy has changed sings	the last return/report filed for this plan, enter the	4b EIN	,			
name, EIN, and the plan num	nber from the last return/report.	the last retorivieport need for this plant, enter the		/****			
a Sponsor's hame	at the beginning of the plan war		4c PN				
				10			
		the plan year (defined benefit plans do not	. 5b	0			
complete this item)		an year		0			
			5d(1)	8			
•		arlan year with accrued benefits that were	5d(2)	C			
less than 100% vested		,	5e	0			
		/report will be assessed unless reasonable ca					
	d signed by an enrolled actuary, a	tions, I declare that I have examined this return/re s well as the electronic version of this return/repor					
SIGN	the b Cont	1/8//5 Timothy Ideno	gle, MD				
HERE Signature of plan ac	Iministrator,	. Date / Enter name of individ	ual signing a	s plan administrator			
SIGN JAMES	ly 15 trepul	Timothy Iceno	gle, MD				
HERE Signature of employ		Date Enter name of individ		s employer or plan sponsor			
	ime, if applicable) and address (in	clude room or suite number) (optional)	Preparer's	telephone number (optional)			
Dale Stevens	LLC		5	09-755-3767			
Break-Thru Benefits, 200 North Mullan Roa							
AVV NOTCH PRITAIL ROA	W, Burre 210						
Spokane Valley	WA 99206						

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b	Were all of the plan's assets during the plan year invested in eligible. Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-467 (See instructions on waiver eligibility if you answered "No" to either line 6a or line 6b, the plan cannot be plan is a defined benefit plan, is it covered under the PBGC in	an Indepe and condit not use Fo	ndent qualified public accounts tions.) orm 5500-SF and must instea	ant (IC	PA) Forn	ı 5500		s No
	rt III   Financial Information		and and the same of the same of			]	Дж Цтига	
7	Plan Assets and Liabilities	T :	(a) Beginning of Ye	7.5	Т	_	(b) End of Year	
a	Total plan assets	. 7a		028:	17		(b) cha or real	
	Total plan liabilities	·			_			
	Net plan assets (subtract line 7b from line 7a)		24	028	17			,
8	Income, Expenses, and Transfers for this Plan Year		(a) Amount	•	T		(b) Total	
а	Contributions received or receivable from: (1) Employers	_8a(1)	W/	194	11			
	(2) Participants	. 8a(2)		28	75			,
	(3) Others (including rollovers)	8a(3)						
	Other income (loss)	8b		7749	59			
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c 8d	24	8509	92		* 5 E	82275
e	Certain deemed and/or corrective distributions (see instructions)	80			+			
	Administrative service providers (salaries, fees, commissions)	Bf			1			
g	Other expenses	8g				:		
	Total expenses (add lines 8d, 8e, 8f, and 8g)						2	485092
i	Net Income (loss) (subtract line 8h from line 8c)					· · · · · · · · · · · · · · · · · · ·		402817
j	Transfers to (from) the plan (see instructions)	81				٠.		
Par	t IV Plan Characteristics							
b	If the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits, enter the applicable welfare for the plan provides welfare benefits.	sature cod	es from the List of Plan Chera	cterist	ic Cod	les in i	he instructions:	
10	During the plan year:		<del></del>		Yes	No	Amount	
	Was there a failure to transmit to the plan any participant contribu 29 CFR 2510.3-1027 (See instructions and DOL's Voluntary Fidu	ciary Corr	rection Program)	10a		Х		
b	Were there any nonexempt transactions with any party-in-interest on line 10a.)			10b		х		
C	Was the plan covered by a fidelity bond?			10c	Х			250000
d	Did the plan have a loss, whether or not reimbursed by the plan's or dishonesty?			10d		х		
. 6	Were any fees or commissions paid to any brokers, agents, or oth insurance service, or other organization that provides some or all instructions.)	of the ben	efits under the plan? (See	10 <del>0</del>		x		
f	Has the plan failed to provide any benefit when due under the plan	n? ,		10f		х		
g	Did the plan have any participant loans? (If "Yes," enter amount as	s of year e	nd.)	10g		Х		
h	If this is an individual account plan, was there a blackout period? (2520.101-3.)	· · · · · · · · · · · · · · · · · · ·	CHRONICAL DE CENTRALINE AND POST PORTE	10h		х		
	If 10h was answered "Yes," check the box if you either provided the exceptions to providing the notice applied under 29 CFR 2520.101			10i				
Part			•				· · · · · · · · · · · · · · · · · · ·	
11	is this a defined benefit plan subject to minimum funding requirem 5500) and line 11a below)							No No
_11a	Enter the unpaid minimum required contribution for current year for					11a	<u> </u>	<u></u>
12	Is this a defined contribution plan subject to the minimum funding			or se	ction 3	302 of	ERISA? Yes	X No
a	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, If a waiver of the minimum funding standard for a prior year is being	ig amortize	ed in this plan year, see Instruc		and e	nter th		iling
	granting the waiver					Day	Year	

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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 Enter the minimum required contribution for this plan year	12b			
C Enter the amount contributed by the employer to the plan for this plan year	120			
d Subtract the emount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the left of a negative amount)	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	_	3 BOST 6		18 18
13a Has a resolution to terminate the plan been adopted in any plan year?	X	Yes N	0	
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?	e control		X Yes	No
C If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) which assets or liabilities were transferred. (See instructions.)	) to			
13c(1) Name of plan(s):	13c(2) E	EIN(5)	13c(3	) PN(s)
Part VIII Trust Information (optional)		PROGRAMMA AND AND AND AND AND AND AND AND AND AN		
14a Name of trust	14b 1	Trust's EIN		