## Form 5500-SF

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

**HERE** 

SIGN **HERE** 

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

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

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

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to **Public Inspection** 

**Annual Report Identification Information** For calendar plan year 2014 or fiscal plan year beginning and ending 12/31/2014 X a single-employer plan a multiple-employer plan (not multiemployer) (Filers checking this box must attach a list A This return/report is for: of participating employer information in accordance with the form instructions) a one-participant plan a foreign plan the first return/report the final return/report **B** This return/report is an amended return/report a short plan year return/report (less than 12 months) Form 5558 DFVC program automatic extension C Check box if filing under: special extension (enter description) Basic Plan Information—enter all requested information Part II 1a Name of plan **1b** Three-digit LCL PHYSICAL THERAPY 401(K) PLAN plan number (PN) ▶ 001 1c Effective date of plan 04/17/2007 2a Plan sponsor's name and address; include room or suite number (employer, if for a single-employer plan) **2b** Employer Identification Number LCL PHYSICAL THERAPY 14-1854074 (EIN) Sponsor's telephone number 845-342-5170 495 SCHUTT RD EXTENSION SUITE 9 Business code (see instructions) MIDDLETOWN, NY 10940 621340 **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. a Sponsor's name 4c PN Total number of participants at the beginning of the plan year ..... 5a **b** Total number of participants at the end of the plan year..... 5b Number of participants with account balances as of the end of the plan year (defined benefit plans do not 5c complete this item) d(1) Total number of active participants at the beginning of the plan year..... 5d(1) 2 d(2) Total number of active participants at the end of the plan year..... 5d(2) 2 e Number of participants that terminated employment during the plan year with accrued benefits that were 0 5e less than 100% vested. Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including, if applicable, a Schedule SB or Schedule MB completed and signed by an enrolled actuary, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete Filed with authorized/valid electronic signature 10/01/2015 AARON LOEFFLER **SIGN** 

Date

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

Preparer's name (including firm name, if applicable) and address (include room or suite number ) (optional)

Signature of plan administrator

Signature of employer/plan sponsor

Enter name of individual signing as plan administrator

Enter name of individual signing as employer or plan sponsor

Preparer's telephone number (optional)

	Form 5500-SF 2014		Page <b>2</b>								
b	Were all of the plan's assets during the plan year invested in eligib 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 cann	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.		×	Ye:		No No
	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	rogram (see ERISA section 40	)21)?		Yes	No	No	t dete	rmine	∍d
Par	t III   Financial Information		Г								
	Plan Assets and Liabilities		(a) Beginning of Yea		-		(b) End	of Y		044	
	Total plan assets	7a	301	1/5					29	944	
	Total plan liabilities	7b	301	175	-				29	944	
	Net plan assets (subtract line 7b from line 7a)	7c		170	+		(b) T	r <sub>e</sub> tel		011	
	Income, Expenses, and Transfers for this Plan Year  Contributions received or receivable from:		(a) Amount				(b) <sup>-</sup>	otai			
	(1) Employers	8a(1)									
	(2) Participants	8a(2)									
	(3) Others (including rollovers)	8a(3)									
	Other income (loss)	8b	-2	231							
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							-	231	
	Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d									
е	Certain deemed and/or corrective distributions (see instructions)	8e									
f	Administrative service providers (salaries, fees, commissions)	8f									
g	Other expenses	8g									
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	8h								0	
	Net income (loss) (subtract line 8h from line 8c)	8i							-	231	
J	Transfers to (from) the plan (see instructions)	8j									
Par 9a	t IV Plan Characteristics  If the plan provides pension benefits, enter the applicable pension	_									
b		eature cod	es from the List of Plan Charac	cterist			he instruct				
10	During the plan year:  Was there a failure to transmit to the plan any participant contribu	tiono withi	n the time period described in		Yes	No	<u> </u>	Am	ount		
	29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fidu Were there any nonexempt transactions with any party-in-interest	iciary Cor	rection Program)	10a		X					
	on line 10a.)	·····		10b		X					
C	Was the plan covered by a fidelity bond?			10c	X					10	0000
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						91
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 a	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)								Yes	s	No
11a	Enter the unpaid minimum required contribution for current year fr	om Sched	lule SB (Form 5500) line 39			11a					
12	Is this a defined contribution plan subject to the minimum funding	requireme	ents of section 412 of the Code	or se	ection :	302 of	ERISA?		Yes	s X	No
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below,		·								
а	If a waiver of the minimum funding standard for a prior year is beir granting the waiver.	-			, and e	enter th Day		the le Yea		uling	_

	Form 5500-SF 2014	Page <b>3</b> - 1					
lf :	you completed line 12a, complete lines 3, 9, and 10 of Schedule MB (For	m 5500), and skip to lin	e 13.				
b	Enter the minimum required contribution for this plan year			12b			
С	Enter the amount contributed by the employer to the plan for this plan year			12c			
d	Subtract the amount in line 12c from the amount in line 12b. Enter the result negative amount)			12d			
е	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?			Y	es X No		
	If "Yes," enter the amount of any plan assets that reverted to the employer the	nis year		13a			
b	Were all the plan assets distributed to participants or beneficiaries, transferred the PBGC?		•	ontrol		Yes	( No
С	If during this plan year, any assets or liabilities were transferred from this pla which assets or liabilities were transferred. (See instructions.)	in to another plan(s), ide	ntify the plan(s) to	)			
1	3c(1) Name of plan(s):		130	c(2) EI	N(s)	<b>13c(3)</b> P	N(s)
			1			l	

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 Pension Benefit Guaranty Corporation

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

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). Complete all entries in accordance with the instructions to the Form 5500-SF.

2014

OMB Nos. 1210-0110

1210-0089

This Form is Open to Public Inspection

Part   Annual Repo	ort Identification information	01/01/2014	and ending	12/31/201	.4
For calendar plan year 2014 o		a multiple-amployer plan			
B. 100 1 1 1 1 1	x a single-employer plan	of participating employer	r (not multiamployer) (r	ance with the form ins	structions)
A This return/report is for:	a one-participant plan	a foreign plan			
E Miles - A	the first return/report	the final return/report			
B This return/report is	an amended return/report	a short plan year return/s	eport (less than 12 mo	nths)	
				DFVC progr	rom.
C Check box if filling under:	Form 5568	automatic extension		☐ DEVC brogi	dili
<del>-</del>	special extension (enter des	cription)			
	nformation—enter all requested i	nformation		• • • • • • • • • • • • • • • • • • • •	
	mormation—enter all requested i	nomado.	· · · · · · · · · · · · · · · · · · ·	1b Three-digit	
1a Name of plan LCL PHYSICAL THERM	APY 401(K) PLAN		ļ	plan number	001
Bon Illionom man	(			(PN) •	of plan
				04/17/200	
<b>A</b>	d address; include room or suite num	her (employer if for a single-e	mpiover plan)	2b Employer Iden	tification Number
LCL PHYSICAL THER	address; include room of some name APY	Del (employer, il 10: 4 aliigio a		(EIN) 14-18	
DOM TITTETOWN				2c Sponsor's tele	phone number
495 SCHUTT RD EXT	ENSION			845-3 <u>42-</u> 5	<u> </u>
SUITE 9				2d Business code	(see instructions)
MIDDLETOWN	NY 1.0940		- H-H-17	621340  3b Administrator	- CIN
3a Plan administrator's nam	ne and address XSame as Plan Spo	nsor.		Administrator	\$ □114
				3c Administrator's	s telephone number
				!	
	•	•			
	and the same of th			dh cu	,
4 If the name and/or EIN o	of the plan sponsor has changed since	e the last return/report filed to	this plan, enter the	4b EIN	
name, EIN, and the plat <b>a</b> Sponsor's name	n number from the last return/report.			4c PN	
	ants at the beginning of the plan yea	[ ,,,-,-,-		5a	
	ants at the end of the plan year				
	with account balances as of the end			5c	
complete this Item)	**************************************				
d(1) Total number of activ	e participants at the beginning of the	plan year		5d(1)	
d(2) Total number of activ	e participants at the end of the plan	vear	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5d(2)	
	hat terminated employment during th			5e	
	nat terminated employment during to			9e	
Caution: A penalty for the	late or incomplete filing of this ret	um/report will be assessed (	miess reasonable car	use is established.	
- A - A	nd other penalties set forth in the instead and signed by an enrolled actuary	ructione I decista 1091 i DSVP (	examined this reductivite	SOURL INCIDENTIAL IF ORR	nicable, a Schedule nv knowledge and
SB or Schedule MB complet belief, it is true, correct, and	ed and signed by an enrolled actuary complete.	, as well as the electronic ver	son or this retain repor	t, dire to the best of	.,,
2704.080.070.043	10.	"""	AARON LOEFFLE	R	
SIGN (_/) (		Date 9/30/15	Enter name of Individ	tual signing as plan a	administrator
Signature of p	lan administrator	Date 7/30//2	Litter Harris of trial lie		
SIGN HERE			postantia de la constantia della constantia della constantia della constantia della constantia della constan	hual aignine se emple	wer or plan cooper
1 Signature of e	mployer/plan sponsor firm name, if applicable) and address	Date	Enter name of individ	Preparer's telepho	ne number (optional)
Preparer's name (including t	rimi name, ii appiicable) and address	fillower toom at sake usuale	· / (opnoron)		,,
					**************************************

	Form 5500-SF 2014		Page 2		_				
1.	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 2520.104-467 (See Instructions on waiver eligibility a	in indepen	ident difamied books accomitem	. (INCEL	ny .			X Yes	No No
	s you are worsed "No" to olther line 6a or line 6b, the plan canno	ot use Fol	m 6500-SF and must instead	NOA L	Orm v	1000.		_	
c i	f the plan is a defined benefit plan, is it covered under the PBGC in	surance p	rogram (see ERISA section 402	1)?	🗌 .	Yes [	]No [	Not deter	mined
	III Financial Information								
	Plan Assets and Liabilities	Karata.	(a) Beginning of Year		Γ	,,	(b) End o	of Year	
	Total plan assets	7a		0175	>				29944
	Total plan liabilities	7b							
	Net plan assets (subtract line 7b from line 7a)	7c	3	03.75	S .				29944
	Income, Expenses, and Transfers for this Plan Year		(a) Amount				(b) T	otal	
	Contributions received or receivable from:								
	(1) Employers	8a(1)				<u> </u>		1954, A.S.	
	(2) Participants	8a(2)			1000	4-0.00			
	(3) Others (including rollovers)	8a(3)		~23:	1	1	4,5 7 - 5		2
	Other income (loss)	8b			+-	- <u>(1</u> -3-47)			-231
	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c	The Control of the Co		1.50	T	1.3.4.3.5	e y Gyara	
d	Benefits pald (including direct rollovers and insurance premiums to provide benefits)	. 8d			<u> </u>		<u>, 1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (</u>	er Heliotik	<u>Tarifación</u>
	Certain deemed and/or corrective distributions (see instructions)				15. 7				
	Administrative service providers (salaries, fees, commissions)					Mari		<u> </u>	
9	Other expenses	i .			(All S			<u> </u>	
	Total expenses (add lines 8d, 8e, 8f, and 8g)								0
<del>-</del>	Net income (loss) (subtract line 8h from line 8c)			1.4					-231
<u> </u>	Transfers to (from) the plan (see instructions)	8]			<u> </u>			<u> </u>	
Pa	t IV Plan Characteristics								
9a	If the plan provides pension benefits, enter the applicable pension	feature c	odes from the List of Plan Chara	icteris	tic Co	des in	the instruc	tions:	
	1 OF OF OC OT OK 3D				•				
b	If the plan provides welfare benefits, enter the applicable welfare	teature co	des from the List of Flan Charac	rei ibir	Ç COG	Co III U	14 11 130 000		
N 22 12	t V Compliance Questions	***							
Par 10					Yes	No		Amount	
10	During the plan year.  Was there a failure to transmit to the plan any participant contrib	utions with	in the time period described in			x	Ţ.		
	29 CFR 2510.3-102? (See Instructions and DOL's Voluntary Fig.	luctary Co	rrection Program)	10a					
	Were there any nonexempt transactions with any party-in-interest on line 10a.)	st? (Do no	t include transactions reported	10b		X			4.000
0	Was the plan covered by a fidelity bond?			10c	X				10000
	Did the plan have a loss, whether or not reimbursed by the plan' or dishonesty?			10d		Х			
•	<ul> <li>Were any fees or commissions paid to any brokers, agents, or of insurance service, or other organization that provides some or a instructions.)</li> </ul>	ii of the be	nefits under the plan? (See	10e	х				91
	Has the plan failed to provide any benefit when due under the pl			10f		х	<u> </u>		
	Did the plan have any participant loans? (If "Yes," enter amount			10g		х			
	If this is an individual account plan, was there a blackout period				一		1. 25	nazja ya.	NOW HE
'	2520.101-3.)			101	<u> </u>	X	100 (Factor)		
	If 10h was answered "Yes," check the box if you either provided exceptions to providing the notice applied under 29 CFR 2520.1	the requir	ed notice or one of the	101	<u></u>				
Pa	t VI Pension Funding Compliance								
11	ls this a defined benefit plan subject to minimum funding require 5500) and line 11a below)				*******	dule SI	B (Form	. П ү	es No
11	a Enter the unpaid minimum required contribution for current year	from Sch	edule SB (Form 5500) line 39	,,,,		11a		T	
12	Is this a defined contribution plan subject to the minimum funding	ng require	ments of section 412 of the Cod	e or se	ection	302 of	ERISA?.	. Ц У	es IX No
	(IF "Vec " complete line 12a or lines 12b, 12c, 12d, and 12e beig	w. as app	icable.)						ndina
	a If a waiver of the minimum funding standard for a prior year is b granting the waiver.	eing amon	tized in this plan year, see instru Moi	ictions nth	s, and	entert _ Day	ne date 01 /	Year _	·unity
	granding the waiver.								

	Form 5500-SF 2014	Page 3 -			
If y	ou completed line 12a, complete lines 3, 9, and 10 of Sch	hedule MB (Form 5500), and skip to line 13.			
b	Enter the minimum required contribution for this plan year		126		2 2009 1440
	Enter the amount contributed by the employer to the plan for	r this plan year	12c	1	
d	Subtract the amount in line 12c from the amount in line 12b. negative amount)	. Enter the result (enter a minus sign to the left	ofa 12d		1111
0	Will the minimum funding amount reported on line 12d be m			Yes	No N/A
Part					
13a	Has a resolution to terminate the plan been adopted in any plan	year?		Yes X No	A
	If "Yes," enter the amount of any plan assets that reverted to	o the employer this year	13a	İ	
b	Were all the plan assets distributed to participants or benefit of the PBGC?	claries, transferred to enother plan, or brought	under the control		Yes X No
C	If during this plan year, any assets or liabilities were transfer which assets or liabilities were transferred. (See instructions	rred from this plan to another plan(s), identify t s.)	the plan(s) to		
	3c(1) Name of plan(s):	9 1445 AUG	13c(2)	EIN(s)	13c(3) PN(s)
Tax one				**************************************	4. (8.88)
100 100	VIII Trust Information (optional)		145	Trust's EIN	****
14a	Name of trust		140	iiusts ⊏iiv	

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