Form 5500-SF	Short Form Annu	t of Small Employe	e	MB Nos. 1210-0110 1210-0089			
Department of the Treasury Internal Revenue Service	This form is required to be file	Benefit Plan d under sections 104 and	4065 of the Employee Retire	ment	2015		
Department of Labor Employee Benefits Security Administration	Income Security Act of 1974	(ERISA), and sections 60 Revenue Code (the Cod	057(b) and 6058(a) of the Inter de).	rnal		rm is Open to c Inspection	
Pension Benefit Guaranty Corporation		accordance with the ins	tructions to the Form 5500-9	SF.		•	
Part I Annual Report I For calendar plan year 2015 or fis	dentification Information	015	and ending 12/31/	2015			
Tor balendar plan year 2010 of his	x a single-employer plan		plan (not multiemployer) (File		king this boy	must attach a	
A This return/report is for:	a one-participant plan		mployer information in accord		-		
B This return/report is	the first return/report	the final return/report					
	an amended return/report	a short plan year retu	urn/report (less than 12 month	s)			
C Check box if filing under:	Form 5558	automatic extension		D	FVC progra	m	
	special extension (enter descr	iption)					
Part II Basic Plan Info	rmation—enter all requested inf	ormation					
1a Name of plan PEDIATRIC NEUROLOGY OF HU	DSON VALLEY P.L.L.C. PROFIT	SHARING PLAN	1b	Three plan r (PN)	number	002	
			10	Effect	ive date of p		
2a Plan sponsor's name (employ Mailing address (include room	ver, if for a single-employer plan) n, apt., suite no. and street, or P.O	. Box)	2b	Emplo (EIN)		ation Number	
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) PEDIATRIC NEUROLOGY OF HUDSON VALLEY, P.L.L.C.					onsor's telephone number 845-627-1806		
			20	Busine		ee instructions)	
P.O. BOX 1195 NEW CITY, NY 10956-8195					62111	1	
3a Plan administrator's name and	d address XSame as Plan Spons	sor.	3b	Admir	nistrator's El	N	
			30	Admir	nistrator's te	lephone number	
	plan sponsor has changed since the plan sponsor has changed since the last return/report.	the last return/report filed	for this plan, enter the 4b	D EIN			
a Sponsor's name				; PN			
5a Total number of participants a	at the beginning of the plan year			5a		6	
	at the end of the plan year			5b		2	
• •	account balances as of the end of t			5c		2	
d(1) Total number of active part	ticipants at the beginning of the pla	an year		d(1)		4	
d(2) Total number of active par	ticipants at the end of the plan yea	ar		d(2)		2	
e Number of participants that t	erminated employment during the	plan year with accrued b	enefits that were less	5e		0	
Caution: A penalty for the late o	or incomplete filing of this return	/report will be assesse	d unless reasonable cause i				
Under penalties of perjury and oth SB or Schedule MB completed an belief, it is true, correct, and comp	d signed by an enrolled actuary, a						
SIGN Filed with authorized/v	valid electronic signature.	03/25/2016	ARIEL SHERBANY, M.D.				
HERE Signature of plan ac	dministrator	Date	Enter name of individual s	igning a	s plan admi	nistrator	
SIGN HERE Signature of employ	ver/nlan snopsor	Date	Enter name of individual s	ianina a	s employer	or plan sponsor	
Preparer's name (including firm na					telephone n		
For Panorwork Poduction Act Notice	e and OMB Control Numbers, see the	instructions for Form F50	0.55		E	orm 5500-SF (2015)	

6a Were all of the plan's assets during the plan year invest	ted in eligible ass	sets? (Se	e instructions.)					X Yes No
b Are you claiming a waiver of the annual examination an								
under 29 CFR 2520.104-46? (See instructions on waive If you answered "No" to either line 6a or line 6b, the								X Yes No
C If the plan is a defined benefit plan, is it covered under the	•						_	No Not determined
Part III Financial Information								
7 Plan Assets and Liabilities			(a) Beginning	g of Yea	ar			(b) End of Year
a Total plan assets		а		1323	705			1275623
b Total plan liabilities	7	b						
C Net plan assets (subtract line 7b from line 7a)		c		1323	705			1275623
8 Income, Expenses, and Transfers for this Plan Year			(a) Amou	unt				(b) Total
a Contributions received or receivable from:					000			
(1) Employers		. /		23	903	_		
(2) Participants					0	_		
(3) Others (including rollovers)	8a	(3)						
b Other income (loss)		-		-29	031	_		
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)		c				_		-5128
d Benefits paid (including direct rollovers and insurance provide benefits)		d		40	592			
e Certain deemed and/or corrective distributions (see inst	ructions) 8	е						
f Administrative service providers (salaries, fees, commis	sions) 8	f			0			
g Other expenses		g		2	362			
h Total expenses (add lines 8d, 8e, 8f, and 8g)		h						42954
i Net income (loss) (subtract line 8h from line 8c)		Bi						-48082
j Transfers to (from) the plan (see instructions)		8j						
Part IV Plan Characteristics								
9a If the plan provides pension benefits, enter the applicat	ole pension featu	re codes	from the List of PI	an Cha	racteris	stic Co	des in t	the instructions:
B If the plan provides welfare benefits, enter the applicab	le welfare feature	e codes fi	om the List of Pla	n Chara	acterist	ic Coo	les in th	ne instructions:
Part V Compliance Questions								
10 During the plan year:					Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participa	ant contributions	within the	e time period					
described in 29 CFR 2510.3-102? (See instructions a Program)				10a		Х		
b Were there any nonexempt transactions with any party reported on line 10a.)				10b		x		
C Was the plan covered by a fidelity bond?				10c		Х		
d Did the plan have a loss, whether or not reimbursed by by fraud or dishonesty?				10d		х		
e Were any fees or commissions paid to any brokers, ag carrier, insurance service, or other organization that pr the plan? (See instructions.)	ovides some or a	all of the l	penefits under	10e		x		
f Has the plan failed to provide any benefit when due un	der the plan?			10f		Х		
g Did the plan have any participant loans? (If "Yes," enter	er amount as of v	ear end.)		10g		Х		
h If this is an individual account plan, was there a blacko	out period? (See	instructio	ns and 29 CFR			X		
2520.101-3.) i If 10h was answered "Yes," check the box if you either	provided the rec	quired not	tice or one of the	10h				
exceptions to providing the notice applied under 29 CF j Did the plan trust incur unrelated business taxable inco				10i 10j				
Part VI Pension Funding Compliance				iuj				1

-	
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)
11a	a Enter the unpaid minimum required contribution for all years from Schedule SB (Form 5500) line 40 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?

Form 5500-SF 2015

Page **3 -** 1

					1				
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)								
a		waiver of the minimum funding standard for a prior year is being amortized in this plan year, see in: ting the waiver.		enter th Day	e date of	the letter ru Year	ling		
lf	you c	ompleted 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					
-		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 (enter a minus sign to the ative amount)		12d					
е	e Will the minimum funding amount reported on line 12d be met by the funding deadline?								
Part	VII	Plan Terminations and Transfers of Assets							
13a	Has	a resolution to terminate the plan been adopted in any plan year?			Ye	es X No			
		es," enter the amount of any plan assets that reverted to the employer this year		13a					
h		e all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brou							
	of th	e PBGC?	-			Yes X	No		
С		ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identi h assets or liabilities were transferred. (See instructions.)	fy the plan(s) to						
1	13c(1)	Name of plan(s):	13c(2)	EIN(s)		13c(3)	PN(s)		
Part	VIII	Trust Information	-						
14a	Name	of trust		14b	Trusťs E	IN			
14c	Nam	e of trustee or custodian		14d Trustee's or custodian's telephone number					
Par	t IX	IRS Compliance Questions							
15a	Is th	e plan a 401(k) plan?		Ye	es	No			
15b		es," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals an hing contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?		b h	esign- ased safe arbor nethod		ADP/ACP test		
15c	testir	ADP/ACP test is used, did the 401(k) plan perform ADP/ACP testing for the plan year using the "c ng method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.4 2)(ii))?		Y	es	No			
16a	Chec	k the box to indicate the method used by the plan to satisfy the coverage requirements under sect	ion 410(b):	Цр	atio ercentag est		erage nefit test		
16b		the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by con lan with any other plans under the permissive aggregation rules?	0	Ye	es	No			
17a	Has	he plan been timely amended for all required tax law changes?		Ye	es	No	N/A		
	for ta	the last plan amendment/restatement for the required tax law changes was adopted///x law changes and codes).	•				tructions		
17c		plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter placer letter, enter the date of that favorable letter/ and the letter's serial r		t to a f	avorable 	IRS opinion	or		
17d		plan is an individually-designed plan and received a favorable determination letter from the IRS, e mination letter/	nter the date of	the pla	in's last fa	avorable			
18		e Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2 e), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgir		Ye	S	No			
19	Were	in-service distributions made during the plan year?		Ye	es	No			
	lf "Y€	es," enter amount		19					
20	Were	required minimum distributions made to 5% owners who have attained age 70 ½ (regardless of w d), as required under section 401(a)(9)?		Y	es	No	N/A		

and the second second		
_		_

Form 5500-SF	Short Form Annua	l Return/Report o Benefit Plan	f Small Employee	*	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service	This form is required to be	e filed under sections 104 a	nd 4065 of the Employee	the second second second second second	2015
Department of Labor mployee Benefits Security Administration	Retirement Income Security / the Ir	Act of 1974 (ERISA), and senternal Revenue Code (the	ection 6057(b) and 6058(a) of Code).		is Open to Public nspection
Pension Benefit Guaranty Corporation	Complete all entries in ac		ctions to the Form 5500-SF.		
	dentification Information	01/01/2015	and ending 1	2/31/2015	
r calendar plan year 2015 or fisc			lan (not multiemployer) (Filers		ox must attach
This return/report is for: This return/report is:	x a single-employer plan a one-participant plan the first return/report	a list of participating e a foreign plan the final return/report	mployer information in accord	lance with the fo	orm instructions)
	an amended return/report	a snort plan year retu	rn/report (less than 12 months	>)	
Check box if filing under:	Form 5558	automatic extension		DFVC prog	ram
	special extension (enter desc	cription)		11	
Part II Basic Plan Info	rmation enter all requested	information	·		
a Name of plan				Three-digit plan number	
PEDIATRIC NEUROLOGY	OF HUDSON VALLEY P.L.	.L.C. PROFIT SHARIN	NG PLAN	(PN) ►	002
			10	Effective date 01/01/199	
Mailing Address (include roo	yer, if for a single-employer plan) m, apt., suite no. and street or P. e, country, and ZIP or foreign pos	.O. Box)	-	Employer Ider (EIN) 13-3	ntification Number 949843
	OF HUDSON VALLEY, P.1		20	Sponsor's tele (845) 627	
			20	Business cod	e (see instructions)
P.O. BOX 1195				621111	,
US NEW CITY NY 10956-819	5 nd address 🗴 Same as Plan S	ponsor Name			
US NEW CITY NY 10956-819		ponsor Name	3t 3c	621111 D Administrator	's EIN
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th			3t 3c	621111 O Administrator	's EIN
US NEW CITY NY 10956-819 Plan administrator's name a lf the name and/or EIN of th name, EIN, and the plan num	nd address 🗵 Same as Plan S e plan sponsor has changed sinc		for this plan, enter the 4	621111 C Administrator C Administrator D EIN C PN	's EIN 's telephone number
US NEW CITY NY 10956-819 Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num Sponsor's name Total number of participants	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report.	e the last return/report filed	3t 3c for this plan, enter the 4t 4c	621111 D Administrator C Administrator D EIN C PN 5a	's EIN 's telephone number
US NEW CITY NY 10956-819 Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num Sponsor's name Total number of participants D Total number of participants	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year at the end of the plan year	e the last return/report filed	3t 3c for this plan, enter the 4t 4c 4c 4c 4c	621111 C Administrator C Administrator D EIN C PN	's EIN 's telephone number
US NEW CITY NY 10956-819 Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num Sponsor's name Total number of participants Total number of participants Number of participants with	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year at the end of the plan year account balances as of the end of	the last return/report filed	for this plan, enter the 41	621111 D Administrator C Administrator D EIN C PN 5a	's EIN 's telephone number
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants c Number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year at the end of the plan year	e the last return/report filed r of the plan year (defined ber	for this plan, enter the 41	621111 D Administrator C Administrator D EIN C PN 5a 5b	's EIN 's telephone number 6 2
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end of rticipants at the beginning of the	te the last return/report filed r of the plan year (defined ber plan year	for this plan, enter the 41	621111 O Administrator C Administrator D EIN C PN 5a 5b 5c	's EIN 's telephone number 6 2 2
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants with complete this item)	nd address 🗵 Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end of rticipants at the beginning of the p rticipants at the end of the plan year terminated employment during the	the last return/report filed r of the plan year (defined be plan year ear ear he plan year with accrued be	for this plan, enter the 41	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1)	's EIN 's telephone number 6 2 2 4
US NEW CITY NY 10956-819 Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num Sponsor's name Total number of participants Total number of participants Number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end of rticipants at the beginning of the plan ye terminated employment during th	the last return/report filed r of the plan year (defined being plan year ear ne plan year with accrued being	for this plan, enter the 40 40 40 40 40 40 40 40 40 40	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1) d(2) 5e	's EIN 's telephone number 6 2 2 4 2 4 2 0
US NEW CITY NY 10956-819 Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num Sponsor's name Total number of participants Total number of participants Number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end o rticipants at the beginning of the plan year terminated employment during the cor incomplete filing of this ret other penalties set forth in the inst and signed by an enrolled actuar	te the last return/report filed r of the plan year (defined being plan year ear the plan year with accrued be turn/report will be assessed tructions. I declare that I ha	for this plan, enter the 40 for this plan, enter the 40 mefit plans do not 50 enefits that were 50 enefits that be 50 enefits that 50 enefits that 50 enefits that 50 enefits th	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1) d(2) 5e is established t, including, if ap	's EIN 's telephone number 6 2 2 4 2 4 2 0
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end o rticipants at the beginning of the plan year terminated employment during the cor incomplete filing of this ret other penalties set forth in the inst and signed by an enrolled actuar	te the last return/report filed r of the plan year (defined being plan year ear the plan year with accrued be turn/report will be assessed tructions. I declare that I ha	for this plan, enter the 40 for this plan, enter the 40 mefit plans do not 50 enefits that were 50 enefits that be 50 enefits that 50 enefits that 50 enefits that 50 enefits th	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1) d(2) 5e is established t, including, if ap nd to the best o	's EIN 's telephone number 6 2 2 4 2 4 2 0
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants c Number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end of rticipants at the beginning of the plan year terminated employment during the other penalties set forth in the inst and signed by an enrolled actuar mplete.	te the last return/report filed r of the plan year (defined be plan year ear he plan year with accrued be turn/report will be assessed tructions, I declare that I ha y, as well as the electronic	for this plan, enter the 40 for this plan, enter the 40 for this plan, enter the 40 for this plans do not 50 enefit plans do not 50 enefits that were 50 enefits that were 50 enefits that were 50 for this return/report, and 50 for this return/report, and 50 for this plan, enter the 50 for the 50 for this plan, enter the 50 for the 50 for this plan, enter the 50 for	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1) d(2) 5e is established t, including, if ag nd to the best o D.	's EIN 's telephone number 6 2 2 4 2 4 2 0 0 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants c Number of participants with complete this item)	nd address X Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end of rticipants at the beginning of the plan year terminated employment during the other penalties set forth in the inst and signed by an enrolled actuar mplete.	the last return/report filed tr of the plan year (defined being plan year ear the plan year with accrued being turn/report will be assessed tructions, I declare that I have y, as well as the electronic of 1/25/1/6	3t 3c for this plan, enter the 4t 4c 5c	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1) d(2) 5e is established t, including, if ap nd to the best o D. gning as plan ac	's EIN 's telephone number 6 2 2 4 2 4 2 0 0 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
US NEW CITY NY 10956-819 a Plan administrator's name a If the name and/or EIN of th name, EIN, and the plan num a Sponsor's name a Total number of participants b Total number of participants c Number of participants with complete this item)	nd address 🗵 Same as Plan S e plan sponsor has changed sinc mber from the last return/report. at the beginning of the plan year account balances as of the end o rticipants at the beginning of the plan year rticipants at the beginning of the plan year e or incomplete filing of this ret other penalties set forth in the inst and signed by an enrolled actuar mplete.	the last return/report filed tr of the plan year (defined being plan year ear the plan year with accrued being turn/report will be assessed tructions, I declare that I have y, as well as the electronic of 1/25/1/6	for this plan, enter the 40 for this plan, enter the 40 mefit plans do not 50 enefits that were 50 enefits that were 50 enefits that were 50 ARIEL SHERBANY, M.	621111 D Administrator C Administrator D EIN C PN 5a 5b 5c d(1) d(2) 5e is established t, including, if ap nd to the best o .D. gning as plan ad .D.	's EIN 's telephone number 6 2 2 4 2 0 0 policable, a Schedule f my knowledge and dministrator



Form 5500-SF 2015

Page 2

	Were all of the plan's assets during the plan year invested in eligible assets? (See instructions.)	X Yes No
b	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA)	X Yes No
	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 cannot use Form 5500-SF and must instead use Form 5500.	
с	If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)?	Not determined

Part III Financial Information			
Plan Assets and Liabilities		(a) Beginning of Year	(b) End of Year
a Total plan assets	7a	1,323,705	1,275,623
b Total plan liabilities	7b		
C Net plan assets (subtract line 7b from line 7a)	7c	1,323,705	1,275,623
Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from: (1) Employers	8a(1)	23,903	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)		
b Other income (loss)	8b	(29,031)	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		(5,128)
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	40,592	
e Certain deemed and/or corrective distributions (see instructions)	8e		
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	2,362	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		42,954
Net income (loss) (subtract line 8h from line 8c)			(48,082)
i Transfers to (from) the plan (see instructions)			

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: 2E

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Pai	t V Compliance Questions			1	Core State			
0	During the plan year:		Yes	No	N/A	A	mount	
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	jā.	x				
С	Was the plan covered by a fidelity bond?	10c		x		-		
d	Did the plan have a loss, whether or not reimbursed by the plan's 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		х			-	
g	Did the plan have any participant loans? (If "Yes," enter amount as of year end.)	10g		x				
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						
j	Did the plan trust incur unrelated business taxable income?	10j					2 - 1 - 1 - 1 2	9
Pa	rt VI Pension Funding Compliance							- 21 M
11	Is this a defined benefit plan subject to minimum funding requirements? (If "Yes," see instructions ar 5500) and line 11a below)	nd cor	nplete	e Sche	edule S	B (Form	Yes [X
11	a Enter the unpaid minimum required contribution for current year from Schedule SB (Form 5500) line	40 .			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?...

Yes X No



	Form 5500-SF 2015 Page 3-					
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)					
ç	I fa waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instr granting the waiver. Month	uctions, and Da	enter th ay	ne date of t Yea	he letter ru r	lling
lfy	ou completed line 12a, complete lines 3, 9, and 10 of Schedule MB (Form 5500), and skip to line 13.				5 n	<u> </u>
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 (enter a minus sign to the lef negative amount)	t of a	12d			
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?			Yes 🗌] No 🗌	N/A
Part						
13a				es X No)	
154	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 brough	under the c			Yes 🗴	
С	of the PBGC? If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify which assets or liabilities were transferred. (See instructions.))			
	13c(1) Name of plan(s):	13c	(2) EIN	(s)	13c(3) F	N(s)
		×.				
Par	t VIII Trust Information					2
14a	Name of trust		14b ⊺	rust's EIN		
140	Name of trustee or custodian			Frustee or opponent		;
Pa	rt IX IRS Compliance Questions	9	I			
15	I is the plan a 401(k) plan:		Ye	es	No No	
15	If "Yes," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals and matching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)?	employer	ba ha	esign- ased safe arbor ethod	ADP// test	ACP
15	If ADP/ACP test, did the 401(k) plan perform ADP/ACP testing for the plan year using the "current year testing method" for nonhighly compensated employees (Treas. Reg. section 1.401(k)-2(a)(2)(ii) and 1.401 (2(a)(2)(ii))?	(m)-	T Ye	es .	🗌 No	
	a Check the box to indicate the method used by the plan to satisfy the coverage requirements under section			atio ercentage est	Avera Benef	ge fit Test
16	Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by comb this plan with any other plans under the permissive aggregation rules?	ining	D Y	es	No No	
	a Has the Plan been timely amended for all required law changes?			es	No (N/A
17	b Date of the last plan amendment/restatement for the required tax law changes was adopted/_//	Enter th	ne appli	cable code	(Se	e
	 C If the plan sponsor is an adopter of a pre-approved master, prototype (M&P), or volume submitter plan th advisory letter, enter the date of that favorable letter / / and the letter's serial numl d If the plan is an individually-designed plan and recieved a favorable determination letter from IRS, please 	ber.				
	determination letter / / /	as been				
	made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin I	siands)?		es es		
19	Were in-service distributions made during the plan year?					
-	If Yes, enter amount		19		<u> </u>	
20	Were minimum required distributions made to 5% owners who have attained age 70 ½ (regardless of who not retired) as required under section 401(a)(9)?			'es	No No	N/A



5500-SF Electronic Filing Authorization

PEDIATRIC NEUROLOGY OF HUDSON VALLEY P.L.L.C. PROFIT SHARING PLAN Plan Name: 13-3949843/002 EIN/PN: 01/01/2015 - 12/31/2015 Plan Year:

I hereby authorize Everett Berger to electronically file the above return with the US Department of Labor's Electronic Filing Acceptance System (EFAST).

I have signed Form 5500-SF for this return and understand a scanned copy of this return bearing my manual signature will be included in the electronic filing and posted on the US Department of Labor's internet site for public disclosure.

Plan Administrator 3/25/16 (sign)

Plan Sponsor M (sign)

16 3/25 (date