

<div>Form 5500-SF</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Short Form Annual Return/Report of Small Employee Benefit Plan</div> <div>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).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500-SF.</div>	<div>OMB Nos. 1210-0110 1210-0089</div> <div>2015</div> <div>This Form is Open to Public Inspection</div>														
<div>Part I Annual Report Identification Information</div> <div>For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015</div> <div><div>A This return/report is for:</div><div><div><input checked="" type="checkbox"/> a single-employer plan</div><div><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)</div><div><input type="checkbox"/> a one-participant plan</div><div><input type="checkbox"/> a foreign plan</div></div><div><div>B This return/report is</div><div><div><input type="checkbox"/> the first return/report</div><div><input type="checkbox"/> the final return/report</div><div><input type="checkbox"/> an amended return/report</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months)</div></div><div><div>C Check box if filing under:</div><div><div><input type="checkbox"/> Form 5558</div><div><input type="checkbox"/> automatic extension</div><div><input type="checkbox"/> DFVC program</div><div><input type="checkbox"/> special extension (enter description)</div></div></div></div></div>																
<div>Part II Basic Plan Information—enter all requested information</div> <div><div><div>1a Name of plan NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC CASH BALANCE PLAN</div><div>1b Three-digit plan number (PN) ▶ 002</div><div>1c Effective date of plan 01/01/2011</div></div><div><div>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC P.O. BOX 98 HAWTHORNE, NY 10532</div><div>2b Employer Identification Number (EIN) 13-3940961</div><div>2c Sponsor's telephone number 914-493-7195</div><div>2d Business code (see instructions) 621111</div></div><div><div>3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC P.O. BOX 98 HAWTHORNE, NY 10532</div><div>3b Administrator's EIN 13-3940961</div><div>3c Administrator's telephone number 914-493-7195</div></div><div><div>4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. a Sponsor's name</div><div>4b EIN</div><div>4c PN</div></div><div><div>5a Total number of participants at the beginning of the plan year</div><div>5b Total number of participants at the end of the plan year</div><div>5c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)</div><div>5d(1) Total number of active participants at the beginning of the plan year</div><div>5d(2) Total number of active participants at the end of the plan year</div><div>5e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested</div><div><div>20</div><div>21</div><div></div><div>15</div><div>0</div><div>0</div></div></div><div><div>Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.</div><div>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.</div><table><tr><td rowspan="2">SIGN HERE</td><td>Filed with authorized/valid electronic signature.</td><td>07/15/2016</td><td>RAJ MURALI</td></tr><tr><td>Signature of plan administrator</td><td>Date</td><td>Enter name of individual signing as plan administrator</td></tr><tr><td rowspan="2">SIGN HERE</td><td></td><td></td><td></td></tr><tr><td>Signature of employer/plan sponsor</td><td>Date</td><td>Enter name of individual signing as employer or plan sponsor</td></tr></table><div><div>Preparer's name (including firm name, if applicable) and address (include room or suite number)</div><div>Preparer's telephone number</div></div></div></div>			SIGN HERE	Filed with authorized/valid electronic signature.	07/15/2016	RAJ MURALI	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
SIGN HERE	Filed with authorized/valid electronic signature.	07/15/2016		RAJ MURALI												
	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													
<div>For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500-SF.</div> <div>Form 5500-SF (2015) v. 150123</div>																

- 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
a Total plan assets.....	7a	694476	889241
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	694476	889241
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	232974	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	-38209	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		194765
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	0	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions).....	8f	0	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g).....	8h		0
i Net income (loss) (subtract line 8h from line 8c)	8i		194765
j 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	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a		X		
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b		X		
c Was the plan covered by a fidelity bond?	10c	X			50000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d		X		
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e		X		
f Has the plan failed to provide any benefit when due under the plan?	10f		X		
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				
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				

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 all years from Schedule SB (Form 5500) line 40..... **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 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	12c	
d 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)	12d	
e 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	

Part VII Plan Terminations and Transfers of Assets

13a Has a resolution to terminate the plan been adopted in any plan year? ☐ Yes ☒ No

If "Yes," enter the amount of any plan assets that reverted to the employer this year **13a**

b Were all the plan assets distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? ☐ 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) to which assets or liabilities were transferred. (See instructions.)

13c(1) Name of plan(s):	13c(2) EIN(s)	13c(3) PN(s)

Part VIII Trust Information

14a Name of trust	14b Trust's EIN
14c Name of trustee or custodian	14d Trustee's or custodian's telephone number

Part IX IRS Compliance Questions

15a Is the plan a 401(k) plan? ☐ Yes ☐ No

15b If "Yes," how does the 401(k) plan satisfy the nondiscrimination requirements for employee deferrals and employer matching contributions (as applicable) under sections 401(k)(3) and 401(m)(2)? ☐ Design-based safe harbor method ☐ ADP/ACP test

15c If the ADP/ACP test is used, 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 sections 1.401(k)-2(a)(2)(ii) and 1.401(m)-2(a)(2)(ii))? ☐ Yes ☐ No

16a Check the box to indicate the method used by the plan to satisfy the coverage requirements under section 410(b): ☐ Ratio percentage test ☐ Average benefit test

16b Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by combining this plan with any other plans under the permissive aggregation rules? ☐ Yes ☐ No

17a Has the plan been timely amended for all required tax law changes? ☐ Yes ☐ No ☐ N/A

17b Date the last plan amendment/restatement for the required tax law changes was adopted ____/____/____. Enter the applicable code ____ (See instructions for tax law changes and codes).

17c If the plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter plan that is subject to a favorable IRS opinion or advisory letter, enter the date of that favorable letter ____/____/____ and the letter's serial number _____.

17d If the plan is an individually-designed plan and received a favorable determination letter from the IRS, enter the date of the plan's last favorable determination letter ____/____/____.

18 Is the Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2) has been made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin Islands)? ☐ Yes ☐ No

19 Were in-service distributions made during the plan year? ☐ Yes ☐ No

If "Yes," enter amount

20 Were required minimum distributions made to 5% owners who have attained age 70 ½ (regardless of whether or not retired), as required under section 401(a)(9)? ☐ Yes ☐ No ☐ N/A

<div>SCHEDULE SB (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</div>	<div>Single-Employer Defined Benefit Plan Actuarial Information</div> <div>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).</div> <div>File as an attachment to Form 5500 or 5500-SF.</div>	<div>OMB No. 1210-0110</div> <div>2015</div> <div>This Form is Open to Public Inspection</div>
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015	
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.	
A Name of plan NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC CASH BALANCE PLAN	B Three-digit plan number (PN) 002
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC	D Employer Identification Number (EIN) 13-3940961
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500

Part I	Basic Information
1	Enter the valuation date: Month 12 Day 31 Year 2015
2	Assets:
a	Market value 2a 656267
b	Actuarial value 2b 656267
3	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 21 649449 649449
c	For active participants 0 0 0
d	Total 21 649449 649449
4	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 4a
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 4b
5	Effective interest rate 5 6.24%
6	Target normal cost 6 188928

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.

SIGN HERE		07/11/2016
THOMAS H. COLE	Signature of actuary	Date
A.C.G. ASSOCIATES, INC.	Type or print name of actuary	14-04455
234 MAIN STREET NEW HARTFORD, CT 06057	Firm name	Most recent enrollment number
	Address of the firm	860-379-2566
		Telephone number (including area code)

Part II Beginning of Year Carryover and Prefunding Balances		
	(a) Carryover balance	(b) Prefunding balance
7 Balance at beginning of prior year after applicable adjustments (line 13 from prior year)	0	0
8 Portion elected for use to offset prior year's funding requirement (line 35 from prior year)	0	0
9 Amount remaining (line 7 minus line 8)	0	0
10 Interest on line 9 using prior year's actual return of <u>0.00</u> %	0	0
11 Prior year's excess contributions to be added to prefunding balance:		
a Present value of excess contributions (line 38a from prior year)		92286
b(1) 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>6.65</u> %		0
b(2) Interest on line 38b from prior year Schedule SB, using prior year's actual return		
c Total available at beginning of current plan year to add to prefunding balance		92286
d Portion of (c) to be added to prefunding balance		0
12 Other reductions in balances due to elections or deemed elections	0	0
13 Balance at beginning of current year (line 9 + line 10 + line 11d – line 12)	0	0

Part III Funding Percentages		
14 Funding target attainment percentage	14	101.04 %
15 Adjusted funding target attainment percentage	15	101.04 %
16 Prior year's funding percentage for purposes of determining whether carryover/prefunding balances may be used to reduce current year's funding requirement	16	119.01 %
17 If the current value of the assets of the plan is less than 70 percent of the funding target, enter such percentage	17	%

Part IV Contributions and Liquidity Shortfalls					
18 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
12/01/2015	192947	0			
06/22/2016	40028	0			
			Totals ▶	18(b)	232975
				18(c)	0

19 Discounted employer contributions – see instructions for small plan with a valuation date after the beginning of the year:		
a Contributions allocated toward unpaid minimum required contributions from prior years.	19a	0
b Contributions made to avoid restrictions adjusted to valuation date	19b	0
c Contributions allocated toward minimum required contribution for current year adjusted to valuation date	19c	232583
20 Quarterly contributions and liquidity shortfalls:		
a Did the plan have a "funding shortfall" for the prior year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
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		
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

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

21 Discount rate:				
a Segment rates:	1st segment: 4.72 %	2nd segment: 6.11 %	3rd segment: 6.81 %	<input type="checkbox"/> N/A, full yield curve used
b Applicable month (enter code)				21b 0
22 Weighted average retirement age				22 65
23 Mortality table(s) (see instructions) <input checked="" type="checkbox"/> Prescribed - combined <input type="checkbox"/> Prescribed - separate <input type="checkbox"/> Substitute				

Part VI Miscellaneous Items

24 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
25 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
26 Is the plan required to provide a Schedule of Active Participants? If "Yes," see instructions regarding required attachment.....	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27 If the plan is subject to alternative funding rules, enter applicable code and see instructions regarding attachment.....	27

Part VII Reconciliation of Unpaid Minimum Required Contributions For Prior Years

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

Part VIII Minimum Required Contribution For Current Year

31 Target normal cost and excess assets (see instructions):			
a Target normal cost (line 6)	31a	188928	
b Excess assets, if applicable, but not greater than line 31a	31b	6818	
32 Amortization installments:	Outstanding Balance	Installment	
a Net shortfall amortization installment	0	0	
b Waiver amortization installment	0	0	
33 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	33		
34 Total funding requirement before reflecting carryover/prefunding balances (lines 31a - 31b + 32a + 32b - 33)	34	182110	
	Carryover balance	Prefunding balance	Total balance
35 Balances elected for use to offset funding requirement.....			0
36 Additional cash requirement (line 34 minus line 35)	36	182110	
37 Contributions allocated toward minimum required contribution for current year adjusted to valuation date (line 19c)	37	232583	
38 Present value of excess contributions for current year (see instructions)			
a Total (excess, if any, of line 37 over line 36)	38a	50473	
b Portion included in line 38a attributable to use of prefunding and funding standard carryover balances	38b	0	
39 Unpaid minimum required contribution for current year (excess, if any, of line 36 over line 37)	39	0	
40 Unpaid minimum required contributions for all years.....	40	0	

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

41 If an election was made to use PRA 2010 funding relief for this plan:			
a Schedule elected	<input type="checkbox"/> 2 plus 7 years <input type="checkbox"/> 15 years		
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		
42 Amount of acceleration adjustment	42		
43 Excess installment acceleration amount to be carried over to future plan years	43		

Neurological & Spine Surgery, P.C. Cash Balance Plan
EIN: 13-3940961
PN: 002

SCHEDULE SB, PART V - STATEMENT OF ACTUARIAL ASSUMPTIONS/METHODS

VALUATION DATE: December 31, 2015

ACTUARIAL COST METHOD: Unit Credit

SEGMENT RATES: 1st Segment - 4.72%
2nd Segment - 6.11%
3rd Segment - 6.81%

EFFECTIVE INTEREST RATE: 6.24%

MORTALITY ASSUMPTION: A) Preretirement: None
B) Postretirement: 2014 Mortality tables prescribed by the IRS
under Section 430(h)(3)

TURNOVER ASSUMPTION: None

SALARY SCALE ASSUMPTION: 0.00%

MODE OF ANNUITY: Life Annuity

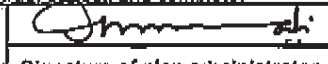

Form 5500-SF Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Short Form Annual Return/Report of Small Employee Benefit Plan This form is required to be filed under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA), and sections 8057(b) and 6058(a) of the Internal Revenue Code (the Code). Complete all entries in accordance with the instructions to the Form 5500-SF.	OMB Nos. 1210-0110 1210-0089 2015 This Form Is Open to Public Inspection
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Part I Annual Report Identification Information		
For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>		
A 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 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)	
C Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> DFVC program <input type="checkbox"/> special extension (enter description)	

Part II Basic Plan Information—enter all requested information		
1a Name of plan NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC CASH BALANCE PLAN	1b Three-digit plan number (PN) ▶	002
	1c Effective date of plan	01/01/2011
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC P.O. BOX 98 HAWTHORNE NY 10532	2b Employer Identification Number (EIN)	13-3940961
	2c Sponsor's telephone number	914-493-7195
	2d Business code (see instructions)	621111
3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor. NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC P.O. BOX 98 HAWTHORNE NY 10532	3b Administrator's EIN	13-3940961
	3c Administrator's telephone number	914-493-7195
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN, and the plan number from the last return/report. a Sponsor's name	4b EIN	
	4c PN	
5a Total number of participants at the beginning of the plan year	5a	20
b Total number of participants at the end of the plan year	5b	21
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item)	5c	
d(1) Total number of active participants at the beginning of the plan year	5d(1)	15
d(2) Total number of active participants at the end of the plan year	5d(2)	0
e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	5e	0

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

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		7-15-16	Raj Murali
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		7-15-16	Raj Murali
	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)			Preparer's telephone number

Form 5500-SF 2015

Page 2

- 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 2520.104-467? (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
a Total plan assets	7a	694,476	889,241
b Total plan liabilities	7b	0	0
c Net plan assets (subtract line 7b from line 7a)	7c	694,476	889,241
8 Income, Expenses, and Transfers for this Plan Year		(a) Amount	(b) Total
a Contributions received or receivable from:			
(1) Employers	8a(1)	232,974	
(2) Participants	8a(2)	0	
(3) Others (including rollovers)	8a(3)	0	
b Other income (loss)	8b	-38,209	
c Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c		194,765
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)	8d	0	
e Certain deemed and/or corrective distributions (see instructions)	8e	0	
f Administrative service providers (salaries, fees, commissions)	8f	0	
g Other expenses	8g	0	
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h		0
i Net income (loss) (subtract line 8h from line 8c)	8i		194,765
j Transfers to (from) the plan (see instructions)	8j		

Part IV Plan Characteristics

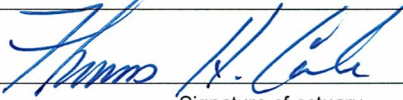
- 9a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:
1C
- B If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

Part V Compliance Questions

10 During the plan year:	Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	10a	X		
b Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 10a.)	10b	X		
c Was the plan covered by a fidelity bond?	10c	X		50,000
d Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	10d	X		
e Were any fees or commissions paid to any brokers, agents, or other persons by an insurance carrier, insurance service, or other organization that provides some or all of the benefits under the plan? (See instructions.)	10e	X		
f Has the plan failed to provide any benefit when due under the plan?	10f	X		
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			
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			

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 all years from Schedule SB (Form 5500) line 40. 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

SCHEDULE SB (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	Single-Employer Defined Benefit Plan Actuarial Information <small>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).</small> ► File as an attachment to Form 5500 or 5500-SF.	<small>OMB No. 1210-0110</small> 2015 This Form is Open to Public Inspection	
<small>For calendar plan year 2015 or fiscal plan year beginning</small> 01/01/2015 <small>and ending</small> 12/31/2015			
► 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.			
A Name of plan NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC CASH BALANCE PLAN	B Three-digit plan number (PN) ► 002		
C Plan sponsor's name as shown on line 2a of Form 5500 or 5500-SF NEUROLOGICAL & SPINE SURGERY ASSOCIATES, PC	D Employer Identification Number (EIN) 13-3940961		
E Type of plan: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Multiple-A <input type="checkbox"/> Multiple-B	F Prior year plan size: <input checked="" type="checkbox"/> 100 or fewer <input type="checkbox"/> 101-500 <input type="checkbox"/> More than 500		
Part I Basic Information			
1 Enter the valuation date: Month <u>12</u> Day <u>31</u> Year <u>2015</u>			
2 Assets:			
a Market value.....	2a	656,267	
b Actuarial value.....	2b	656,267	
3 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.....	21	649,449	649,449
c For active participants.....	0	0	0
d Total.....	21	649,449	649,449
4 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	4a		
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	4b		
5 Effective interest rate.....	5	6.24%	
6 Target normal cost.....	6	188,928	
Statement by Enrolled Actuary <small>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.</small>			
SIGN HERE			
	Signature of actuary		
Thomas H. Cole			
Type or print name of actuary			
A.C.G. Associates, Inc.			
Firm name			
234 Main Street			
New Hartford CT 06057			
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 <input type="checkbox"/>			
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-SF.			
Schedule SB (Form 5500) 2015 v. 150123			

Neurological & Spine Surgery, P.C. Cash Balance Plan

EIN: 13-3940961

PN: 002

SCHEDULE SB, LINE 19 - DISCOUNTED EMPLOYER CONTRIBUTIONS

Deposit Date	Quarterly Due Date	Contribution	Interest Rate	Discounted Contribution	Valuation Date	Interest Rate	Discounted Contribution
	4/15/2015	0	11.65%	0	12/31/2015	6.65%	0
	7/15/2015	0	11.65%	0	12/31/2015	6.65%	0
	10/15/2015	0	11.65%	0	12/31/2015	6.65%	0
	1/15/2016	0	11.65%	0	12/31/2015	6.65%	0
12/7/2015	N/A	192,947	0.00%	192,947	12/31/2015	6.65%	193,765
6/22/2016	N/A	40,028	0.00%	40,028	12/31/2015	6.65%	38,818
		232,974		232,974			232,583

Neurological & Spine Surgery, P.C. Cash Balance Plan
EIN: 13-3940961
PN: 002

SCHEDULE SB, LINE 22 - DESCRIPTION OF WEIGHTED AVERAGE RETIREMENT AGE

Each participant is assumed to retire at his or her normal retirement age.

The age specified in the plan as normal retirement age is 65
or the fifth anniversary of participation, if later.

Neurological & Spine Surgery, P.C. Cash Balance Plan
EIN: 13-3940961
PN: 002

SCHEDULE SB, PART V - SUMMARY OF PLAN PROVISIONS

ELIGIBILITY: A) Minimum Age: 21
B) Minimum Service: 1 Year

BENEFIT FORMULA: Group One Participants: 63.00% of Compensation, Group Two Participants: 5.00%,
Group Three Participants: 0.00% of Compensation, and Group Four Participants: 5.00%.

NORMAL RETIREMENT DATE: Later of age 65 and 5th anniversary of employment.

OTHER ASSETS IN TRUST: None