For	m 5500-SF	Short Form Annu	t of Small Emplo	oyee	OMB Nos. 1210-0110 1210-0089						
	rtment of the Treasury nal Revenue Service	This form is required to be file	Benefit Plan d under sections 104 and	4065 of the Employee Re	etirement	rement 2015					
Employee B	epartment of Labor enefits Security Administration enefit Guaranty Corporation	Income Security Act of 1974	(ERISA), and sections 60 Revenue Code (the Cod	957(b) and 6058(a) of the l le).	Internal	This Form is Open to Public Inspection					
Part I		Complete all entries in a dentification Information	accordance with the ins	tructions to the Form 55	00-SF.		-				
	ar plan year 2015 or fisc		015	and ending 12	/31/2015						
A This ret	urn/report is for:	plan (not multiemployer) mployer information in acc									
B This retu	ırn/report is	the first return/report an amended return/report									
C Check	box if filing under:	Form 5558	automatic extension			DFVC prog	ram				
special extension (enter description)											
Part II	Basic Plan Infor	mation—enter all requested inf	ormation		-						
1a Name THE CENTE	•	OGY, LLP PROFIT SHARING PL/	AN		1b Thre plar (PN	number	001				
					1c Effe	ctive date of 01/0	f plan 1/1987				
Mailing	address (include room,	er, if for a single-employer plan) , apt., suite no. and street, or P.O			2b Emp (EIN	-	ication Number 647576				
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) THE CENTER FOR RHEUMATOLOGY, LLP					2c Sponsor's telephone number 518-489-4471						
	105				2d Business code (see instructions)						
4 TOWER PLACE 8TH FLOOR ALBANY, NY 12203						621111					
3a Plan a	dministrator's name and	address XSame as Plan Spons	sor.		3b Administrator's EIN						
			ah a la at ant un (an ant file d	for the plan, or too the		inistrator's t	elephone number				
name		blan sponsor has changed since to ber from the last return/report.	the last return/report liled	for this plan, enter the	4b EIN 4c PN						
		t the beginning of the plan year			5a		70				
		t the end of the plan year		ł	5b		73				
		ccount balances as of the end of t			5c		66				
d(1) Tota	al number of active parti	cipants at the beginning of the pla	an year		5d(1)		54				
d(2) Tot	al number of active parti	cipants at the end of the plan yea	ar		5d(2)		52				
than	100% vested	erminated employment during the			5e		0				
Under pena SB or Sche	alties of perjury and othe	 incomplete filing of this return er penalties set forth in the instruct l signed by an enrolled actuary, a ete. 	tions, I declare that I hav	e examined this return/rep	ort, includ	ing, if applic					
SIGN		alid electronic signature.	07/15/2016	NEAL GREENSTEIN,	MD						
HERE	Signature of plan ad	ministrator	Date	Enter name of individu	al signing	as plan adn	ninistrator				
SIGN HERE											
Preparer's	Signature of employed and a construct of a construc	er/plan sponsor me, if applicable) and address (in	Date clude room or suite numb	Enter name of individu		as employe s telephone					
For Paperwe	ork Reduction Act Notice	and OMB Control Numbers, see the	e instructions for Form 550	0-SF.			Form 5500-SF (2015)				

Form 5500-SF 2015		Page 2									
 6a Were all of the plan's assets during the plan year invested in elig b Are you claiming a waiver of the annual examination and report of under 29 CFR 2520.104-46? (See instructions on waiver eligibilit If you answered "No" to either line 6a or line 6b, the plan car 	of an independ ty and condition	dent qualified public a	iccounta	ant (IQ	PA)			X Yes X Yes			
C If the plan is a defined benefit plan, is it covered under the PBGC	insurance pr	ogram (see ERISA se	ection 4	021)?		Yes	No	Not determined			
Part III Financial Information											
7 Plan Assets and Liabilities		(a) Beginning	g of Yea	ar			(b) End	d of Year			
a Total plan assets	7a		7158	976				7412773			
b Total plan liabilities	7b			0				0			
C Net plan assets (subtract line 7b from line 7a)	7c		7158	976				7412773			
8 Income, Expenses, and Transfers for this Plan Year		(a) Amoເ	unt				(b)	Total			
a Contributions received or receivable from: (1) Employers	8a(1)		124	718							
(2) Participants	8a(2)		255	034	_						
(3) Others (including rollovers)	(3) Others (including rollovers)										
b Other income (loss)	8b		-115	509	_						
C Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)					_			266923			
d Benefits paid (including direct rollovers and insurance premiums to provide benefits)			12	546							
e Certain deemed and/or corrective distributions (see instructions).	8e			0							
f Administrative service providers (salaries, fees, commissions)	8f			580							
g Other expenses	8g		0								
h Total expenses (add lines 8d, 8e, 8f, and 8g)	8h					13126					
i Net income (loss) (subtract line 8h from line 8c)	8i				25379						
j Transfers to (from) the plan (see instructions)	···· 8j			0	D						
Part IV Plan Characteristics											
9a If the plan provides pension benefits, enter the applicable pension 2E 2G 2J 2K 3D 2A 2T 2F 3B B If the plan provides welfare benefits, enter the applicable welfare 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 contribution described in 29 CFR 2510.3-102? (See instructions and DOL's Program) b Were there any nonexempt transactions with any party-in-interest of the plan any party-in-interest of the	s Voluntary Fi	duciary Correction	10a		X						
reported on line 10a.)	`		10b		Х						
C Was the plan covered by a fidelity bond?			10c	Х				5000			
d Did the plan have a loss, whether or not reimbursed by the plan by fraud or dishonesty?			10d		X						
e Were any fees or commissions paid to any brokers, agents, or of carrier, insurance service, or other organization that provides so the plan? (See instructions.)	ome or all of th	he benefits under	10e	х				384			
f Has the plan failed to provide any benefit when due under the p	olan?		10f		Х						

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	Х					16397
h If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				х				
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 X								
11a Enter the unpaid minimum required contribution for all years from Schedule SB (Form 5500) line 40								
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

-										
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)									
a	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									
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	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?		Υe	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								
D		e PBGC?				Yes 🗙	No			
С		ring this plan year, any assets or liabilities were transferred from this plan to another plan(s), identi th 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 Trust's EIN						
14c Name 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?		Y	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	No			
		k the box to indicate the method used by the plan to satisfy the coverage requirements under sect	.,	Цр	atio ercentage est		erage nefit test			
16b		the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by con plan with any other plans under the permissive aggregation rules?	0	Y	es	No				
17a	Has	the plan been timely amended for all required tax law changes?		Y	es	No	N/A			
	for ta	the last plan amendment/restatement for the required tax law changes was adopted//////	•				tructions			
17c		plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter placer sory 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		Υe	S	No				
19	Were	in-service distributions made during the plan year?		Y	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 whether or not retired), as required under section 401(a)(9)?						No	N/A			

Benefit Pian Benefit Pian Benefit Pian This transites Quantity Benefit Pian This transites Quantity Benefit Pian This transites Quantity This tra	Form 5500-	SF Short Form Annu	al Return/Repor	t of Small Employee	OMB Nos. 1210-0110 1210-0089					
Dependent of Labor Dependent of Labor The Point is Open to Point Provide instantial county Creation 1 Complete all sortifies in accordance with the Instructions to the Point Solo SF. The Point is Open to Point Is Annual Report Learning Creations Part I J Annual Report Learning Transmitting Labor set to the point of field part of field part year and the engineering of COLOCIS and ending 1/23/12/015 and ending 1/23/12/015 A This return/eport is If the first return/report is a one-participant plan a number-engineering engineering of COLOCIS and ending 1/23/12/015 B This return/report is If the first return/report a an annoted return/report is of participating endiport form instructions) of Concerce to an annoted return/report C Oreck to xit filling under: Point SS8 _automatic extension DFVC program Part II Constition Information 1 a thore of an instructions) fill Three-digit plan fill a thore of an instructions) I A Name of plan Information (cutor decorption) DFVC program genetic Advantation (cutor decorption) I A Name of plan Information - enter all requested information 1 a thore of an instructions) fill a thore of an instructions) I A Name of plan Inform states return return return returet all requested										
Percent beneficial conserve (support laborities) Complete all entries in accordance with the instructions to the Form S300-SF. Public trapportion Perc1 Annual Report Idon'tification Information and andmg. 12(3) (2015) and andmg. 12(3) (2015) Perc2 and/out Public trapport idon'tification Information and andmg. 12(3) (2015) and andmg. 12(3) (2015) A Thile return/report is or the form public trapport plan in the dispetitivity plan is a single-employer plan in the instruction in accordance with the form instructions) a to expect plan information B This return/report is in the first return/report is an amound in iterur/report is an amound in iteru	Department of Labor	Income Security Act of 1974	(ERISA), and sections 60	57(b) and 6058(a) of the Internal						
Part II Annual Report Identification Information and endugi 12/31/2015 A "the return/report is for: Is and/e-employer plan a numble-employer plan (and multiple-monopy plan (and			···· •)-						
True including plan year 2016 or ficat plan year experiment 0101/2015 and ending 1202/2015 A This return/eport is 0: a single-employer plan a multiple-employer plan B This return/eport is 0: a one-participant plan a foreign plan B This return/eport is 0: in the first return/report a short plan year return/report in the first return/report C Check box if fing under: Form 558 automatic extension DFVC program Part 11 Basic Plan Information-enter uit requested information 10 The return/report 001 14 Numer of the main structure information-enter uit requested information 10 The return/report 001 12 A Plan sponsor's name (employer, if for a angle-employer plan, uit the complay plan information in accordance size information 10 The employer plan 14 Of The name of RDM PLAN 10 The employer plan 001 12 A Plan sponsor's name (employer, if for a angle-employer plan) 001 12 The employer plan 14 Of The name of RDM PLAN 10 The employer plan information in the employer plan information inform	Part I Annual F			ructions to the Form 5500-51.						
A This return/report is				and ending 12/31/2015						
a one-participant plan a foreign plan B This return/eport is in the fast treturn/eport is short plan year return/eport (loss than 12 months) C Check box if filing under: From 5558 automatic extension DEVC program A Nume of plan apocial extension (arter description) DEVC program 003 Part II Easic Plan Informationenter all requested information 1 1 Three-digit plan number A Nume of plan THE CENTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 10 Three-digit plan number 003 C Endess date of plan Other Three-digit plan number 003 02 (PA) 02 C A Num of plan THE CENTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 20 Employer identification Number C Hield Statistics Rum ageneor's name (employer, if for a single-employer plan) 21 22 Employer identification Number THE CENTER FOR RHEUMATOLOGY, LLP C Foreign postal code (if foreign, see instructions) 21 Employer identification Number 22 Sponsor: A number for the last return/report. 35 Administrator's telephone number 23 Plan administrator's name and address Same as Plan Sponsor. 36 Administrator's telephon	<u>.</u>									
A name of plan A name, plan A name and address A solution A name, plan A name, plan A name and address A solution A name, plan A name and address A name and address A name A name, plan A name and name rom name A name, plan A name of plan A name of plan A name, plan A name A name, plan A name of plan A name A name, plan A name of plan A name A name, plan A name of plan A name A name, plan A name of plan A name A name, plan A name of plan A name A name, plan A name of plan A name A name, plan A name A n	A This return/report is for			mployer information in accordance	e with the form instructions)					
C Check box if #ling under:	R This solum/report is	the first return/report	the final return/report							
Part II Basic Plan Information—enter all requested information A Name of plan THE CENTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 10 Three-tight Plan number (PN) 10 Three-tight Plan sponsor's name (mployer, If or a single-employer plan) Mailing address (Include room of state) CP O. Boxy CPUTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 1 C Enters explore include room of the plan sponsor is name on address (Include room of state) CPUTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 1 C Enters explore include room of the plan sponsor is name and address (Include room of state) CPUTER FOR RHEUMATOLOGY, LLP CONTER FOR RHEUMATOLOGY, LLP CONTENT FOR RHEUMATOLOGY, LP CONTENT FOR RHEUMATOLOGY, LP										
Part II Basic Plan Information—enter all requested information 1a Name of plan 1b Twee-digit 1a Name of plan 1b Twee-digit 1b The CENTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 1c Effective date of plan outber of plan further of plan number (PN). 2a Plan sponsor's name (omployer, LLP PROFIT SHARING PLAN 1c Effective date of plan outber of plan outber of plan outber of plan further outber of plan outber of participants at the end of the plan year. 3b Administrator's telephone number 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 of participants at the end of the plan year. 5a 70 5a Total number of participants at the end of the plan year. 5b 73 6a (1) Total number of participants at the end of the plan year. 5b 73 6a (2) Total number of acticipants at the end of the plan year. 5c 6c 6b 6a (2) Total number of acticipants at the end of the plan year. 5c 6c	C Check box if filing un	der: 🛛 Form 5558	Form 5558 automatic extension DFVC program							
1a Name of plan 1b Trace-digit (PN) 01 1HE CENTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN 1b Trace-digit (PN) 01 2a Plan spontor's name (simplayer, if for a single-semplayer plan) 1c Effective date of plan 0/07/1897 01 2a Plan spontor's name (simplayer, if for a single-semplayer plan) 000/07/1897 2b Employer identification Number (Si19/480-4471 2c Sponsor's telephone number (Si19/480-4471 2d A TOWER PLACE 2f Dianase and address Same as Plan Sponsor. 3b Administrator's EIN 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's name and address is of the plan sponsor has changed since the last return/report filed for this plan, enter the asponsor in a since out the last roturn/report. 4b EIN 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the asponsor in a me 5b 73 3a Ordan umber of participants at the beginning of the plan year 5b 73 73 5 Number of participants at the edd of the plan year 5c 60 66 d(1) Total number of participants at the edd of the plan year 5c 10 73 c Number of participants at the edd of the plan year 5c 10 73 c Number of participants at the edd of the plan year 5c 10 <t< td=""><td></td><td></td><td>-</td></t<>			-							
THE CENTER FOR RHEUMATOLOGY, LLP PROFIT SHARING PLAN plan number 001 22 Plan sponsof's name (amployer, if for a single-employer plan) 1c Effective date of plan 23 Plan sponsof's name (amployer, if for a single-employer plan) 2b Employer forming and using name and subtrat, or P.O. Box) 2b Employer forming and using name and address (Fields room, add or provides, add or postal code (if foreign, see instructions) 2c Sponsof's telephone number Sponsof's telephone number <td>Part II Basic Pla</td> <td>an Information—enter all requested in</td> <td>formation</td> <td></td> <td></td>	Part II Basic Pla	an Information—enter all requested in	formation							
22 Plan sponsor's name (amployer, If for a single-employer plan) Mailing address (include nom, apt, sulle no. and street, or P.O. Box) City or fown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 2b Employer future (EIN) 14-1647576 7HE CENTER FOR RHEUMATOLOGY, LLP 2c Sponsor's telephone number (S18) 489-4471 2c 4 TOWER PLACE STHELOOR ALBANY, NY 12203 3a Plan administrator's name and address Seme as Plan Sponsor. 3b Administrator's telephone number (S18) 489-4471 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. 3b Administrator's telephone number 5a Total number of participants at the beginning of the plan year. 5a 70 5a Total number of participants at the beginning of the plan year. 5b 73 c Number of participants at the beginning of the plan year. 5c 6c 6c d(1) Total number of articipants at the beginning of the plan year. 5c 5d 5d <td>•</td> <td>JMATOLOGY, LLP PROFIT SHARING PL</td> <td>AN</td> <td>pl</td> <td>an number 001</td>	•	JMATOLOGY, LLP PROFIT SHARING PL	AN	pl	an number 001					
Mailing address (include room, spt., suite no. and street, or P.O. Rox) Image: City or flow, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) THE CENTER FOR RHEUMATOLOGY, LLP Image: City of the postal code (if foreign, see instructions) 4 TOWER PLACE TOWER PLACE TH FLOOR State and the postal code (if foreign, see instructions) 3 a Plan administrator's name and address (Same as Plan Sponsor. 3b Administrator's EIN 3 c Administrator's name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the asme, EIN, and the plan number from the last roturn/report. 3b Administrator's telephone number 5 a Total number of participants in the end of the plan year 5a 70 5b 77 C Number of participants at the end of the plan year 5c 66 66 d(1) Total number of participants at the end of the plan year 5d(1) 54 C Number of participants at the end of the plan year 5c 0 66 d(2) Total number of active participants at the end of the plan year 5c 0 66 d(2) Total number of active participants at the end of the plan year 5c 0 6 d(2) Total number of active participants that the indigner plan year with accrued baenetic participants with accrue talances as of the end of the plan year 5c 0 6 d(1) Tot										
City or lown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Image: City or lown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) THE CENTER FOR RHEUMATOLOGY, LLP Image: City of lown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 4 TOWER PLACE City of lown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 3 Total RELEWARTOLOGY, LLP City of lown, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) 4 Totker PLACE Total Auron PLACE Total number of participants at the edginning of the plan year Sa 5a Total number of participants at the edging of the plan year 5a Total number of participants at the edging of the plan year Sd(1) 5a Total number of participants at the edging of the plan year 5a Sd(1) 64(1) Total number of participants at the edging of the plan year Sd(1) 64(2) Total number of participants at the end of the plan year Sd(2) 65(2) Se 0 64(1) Total number of participants at the end of the plan year Sd(2) 65(2) Se 0 64(1) Total number of active participants at the end of the plan year Sd(2)	Mailing address (incl	ude room, apt., suite no. and street, or P.C		(E						
4 TOWER PLACE 2d Business code (see instructions) 5 TH FLOOR ALBANY, NY 12203 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 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. 4b EIN 5a Total number of participants at the beginning of the plan year. 5a 5a 70 5a Total number of participants at the end of the plan year. 5b 73 70 b Total number of participants at the end of the plan year. 5d 6d 66 d(1) Total number of active participants at the end of the plan year. 5d(1) 54 52 c Number of active participants at the end of the plan year. 5d(1) 54 52 52 6 0 d(1) Total number of active participants at the end of the plan year. 5d(2) 52 6 0 0 52 52 6 0 0 5d(1) 54 52			al code (if foreign, see ins	tructions)	consor's telephone number					
4 TOWER PLACE 621111 3a Plan administrator's name and address (Same as Plan Sponsor. 3b Administrator's EIN 3a Plan administrator's name and address (Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's telephone number 3c Administrator's telephone number 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. 4c PN 5a Total number of participants at the beginning of the plan year 5b 73 5b Total number of participants at the edio file plan year 5b 73 c Number of participants at the beginning of the plan year 5c 66 d(1) Total number of participants at the edio file plan year 5d(1) 54 d(2) Total number of participants at the beginning of the plan year with accrued benefits that were less the file of wested 5e 0 Caution: A penalty for the late or incomplete filing of the return/report will be assessed unless reasonable cause is stablished. Under penalticipants that terminated employment during the plan year will accrued benefits that were less to a complete file on other participants at the ediotarity as well as the electronic version of this return/report, and to the best of my knowledge and belief. It is titre, and other participants at the electronic version of this return/report, and to the best of my knowledge and belief. It is titre, and ther plan individual signing as plan administrator Sion <				2d BL						
3a Plan administrator's name and address Same as Plan Sponsor. 3b Administrator's EIN 3c Administrator's Name 3c Administrator's EIN 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. 4b EIN 3c Administrator's telephone number 4c PN 5a Total number of participants at the beginning of the plan year. 5a 5 Total number of participants at the end of the plan year. 5b 5 Total number of participants at the end of the plan year. 5c 6 Number of participants at the end of the plan year. 5c 6 Number of participants at the end of the plan year. 5d(1) 54 d(2) Total number of active participants at the end of the plan year. 5d(1) 6 Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vesied. 5e 0 Caution: A panalty for the late or incomplete filling of this roturn/report will be assessed unless reasonable cause is established. 0 Under penalities of participants at the east of this roturn/report will be assessed unless reasonable cause is established. 0 Under penalities of participants at the east of this interum/report, including, if applicable, a Schedule SB or Schedule MB complete and signed by an enroled actura, as well as the electrolic version of	8TH FLOOR									
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. 4b EIN a Sponsor's name 4c PN 5a Total number of participants at the beginning of the plan year	3a Plan administrator's	name and address XSame as Plan Spon	sor.	3b Ad	3b Administrator's EIN					
name, EIN, and the plan number from the last return/report. 4c PN a Sponsor's name 4c PN 5a Total number of participants at the beginning of the plan year 5a 70 b Total number of participants at the beginning of the plan year 5b 73 c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) 5c 66 d(1) Total number of active participants at the beginning of the plan year 5d(1) 54 d(2) Total number of active participants at the ed of the plan year 5d(2) 52 e Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested 5e 0 cauton: A penalty for the late or incomplete filling 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 complete and signed by an enrolled actury, as well as the electronic version of this return/report, mol to the best of my knowledge and bellef. It is true. Correct, and complete the signant with account and signed by an enrolled actury, as well as the electronic version of this return/report, including, if applicable, a Schedule Signature of plan administrator slGN 115/16 NEAL GREENSTEIN, MD HERE Signature of employer/plan sponsor Date Enter name of individual signing as				3c Ad	Iministrator's telephone number					
a Sponsor's name 4c PN 5a Total number of participants at the beginning of the plan year 5a 70 b Total number of participants at the end of the plan year 5b 73 c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) 5c 66 d(1) Total number of active participants at the beginning of the plan year 5d(1) 54 d(2) Total number of active participants at the beginning of the plan year 5d(2) 52 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, and to the best of my knowledge and benefit its true. cored, and complete 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. cored, and completer signature of plan administrator Date Enter name of individual signing as plan administrator signature of plan administrator Date Enter name of individual signing as employer or plan sponsor Preparer's name (including firm name, if applicable) and address (include room			the last return/report filed	for this plan, enter the 4b El	N					
b Total number of participants at the end of the plan year 5b 73 c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) 5c 66 d(1) Total number of active participants at the beginning of the plan year 5d(1) 54 d(2) Total number of active participants at the end of the plan year 5d(2) 52 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 BS 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 115/16 NEAL GREENSTEIN, MD HERE Signature of plan administrator Date Enter name of individual signing as plan administrator Sign Image: 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		plan number from the last return/report.		4c Pr	۷					
b Total number of participants at the end of the plan year 5b 73 c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) 5c 66 d(1) Total number of active participants at the beginning of the plan year 5d(1) 54 d(2) Total number of active participants at the end of the plan year 5d(2) 52 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 BS or Schedule MS 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 115/16 NEAL GREENSTEIN, MD HERE Signature of plan administrator Date Enter name of individual signing as plan administrator Sign 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 t	5a Total number of part	icipants at the beginning of the plan year.		5a	70					
c Number of participants with account balances as of the end of the plan year (defined benefit plans do not complete this item) 5c 66 d(1) Total number of active participants at the beginning of the plan year 5d(1) 54 d(2) Total number of active participants at the end of the plan year 5d(2) 52 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 filling 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 BS or Schedule MS 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 115/16 NEAL GREENSTEIN, MD HERE Signature of plan administrator Date Enter name of individual signing as plan administrator Sign Image: 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	b Total number of part	icipants at the end of the plan year		5b	73					
d(1) Total number of active participants at the beginning of the plan year 5d(1) 54 d(2) Total number of active participants at the end of the plan year 5d(2) 52 e Number of participants that terminated employment during the plan year with accrued benefits that were less 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 BS 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 11/5/16 NEAL GREENSTEIN, MD HERE Signature of plan administrator Date Enter name of individual signing as plan administrator Preparer's name (including firm name, if applicable) and address (include room or suite number) Preparer's telephone number	C Number of participar	nts with account balances as of the end of	the plan year (defined bei	efit plans do not 5c	66					
d(2) Total number of active participants at the end of the plan year. 5d(2) 52 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. 5e 0 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 MS 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 115/16 NEAL GREENSTEIN, MD HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SiGN Interv 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					54					
e Number of participants that terminated employment during the plan year with accrued benefits that were 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 SIGN Image: Correct, and complete filing of this return/report. NERRE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN Image: 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	e Number of participa	nts that terminated employment during the	plan year with accrued b	enefits that were less						
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 Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor Preparer's name (including firm name, if applicable) and address (include room or suite number) Preparer's telephone number	Caution: A penalty for t	he late or incomplete filing of this return	n/report will be assessed	unless reasonable cause is es	Ltablished.					
SIGN HERE Actual Descention 1/15/16 NEAL GREENSTEIN, MD Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE Image: 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	Under penalties of perjury SB or Schedule MB comp	y and other penalties set forth in the instru- pleted and signed by an enrolled actuary, a	ctions, I declare that I have	e examined this return/report, inclu	iding, if applicable, a Schedule					
HERE Signature of plan administrator Date Enter name of individual signing as plan administrator SIGN HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor Preparer's name (including firm name, if applicable) and address (include room or suite number) Preparer's telephone number	SIGN Au		0 7/15/16	NEAL GREENSTEIN, MD						
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor Preparer's name (including firm name, if applicable) and address (include room or suite number) Preparer's telephone number	HERE Signature o	f plan administrator		Enter name of individual signin	g as plan administrator					
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	HERE									
For Paperwork Reduction Act Notice and OMB Control Numbers see the instructions for Form 5500-SF										
	For Paperwork Reduction A	Act Notice and OMB Control Numbers. see th	e instructions for Form 550)-SF.	Form 5500-SF (2015)					

Form 5500-SF 2015

Page **2**

	Were all of the plan's assets during the plan year invested in eligib						••••••		X Yes	s 🛛 No		
	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) ander 29 CFR 2520.104-46? (See instructions on waiver eligibility and conditions.)								5 🗌 No			
	If you answered "No" to either line 6a or line 6b, the plan cann									, []e		
	If the plan is a defined benefit plan, is it covered under the PBGC in]No []	Not deter	mined		
	t III Financial Information	· · · ·				ت						
	Plan Assets and Liabilities	1	(a) Beginning					(b) End	of Voar			
	Total plan assets			715897		-	(b) End of Year 7412773					
	Total plan liabilities	7a 7b		0				0				
	Net plan assets (subtract line 7b from line 7a)	7c	7158976				7412773					
-	· · · · · · · · · · · · · · · · · · ·				-							
	Income, Expenses, and Transfers for this Plan Year Contributions received or receivable from:		(a) Amount			_	(b) Total					
	(1) Employers	8a(1)		12471	8							
	(2) Participants	8a(2)	255034									
	(3) Others (including rollovers)	8a(3)		268	80							
b	Other income (loss)	8b		-11550	19		÷ .					
С	Total income (add lines 8a(1), 8a(2), 8a(3), and 8b)	8c							266923	3		
	Benefits paid (including direct rollovers and insurance premiums	_		1254	6							
	to provide benefits)	8d		12546								
	Certain deemed and/or corrective distributions (see instructions)	8e		0 580					· · · · ·			
f	Administrative service providers (salaries, fees, commissions)	8f				_						
	Other expenses	8g			0	. ·	the second s					
<u>h</u>	Total expenses (add lines 8d, 8e, 8f, and 8g)	<u>8h</u>							1312			
	come (loss) (subtract line 8h from line 8c)				··· ·	-			25379	7		
j	Transfers to (from) the plan (see instructions)											
	t IV Plan Characteristics											
9a												
В	2E 2G 2J 2K 3D 2A 2T 2F 3B If the plan provides welfare benefits, enter the applicable welfare for	esture cod	es from the List of Pla	n Char	octoriet	lic Cod	les in th	e instructi	ione:			
0	In the plan provides wenter benefits, enter the applicable wenter in	eature cou			LUCH S		ca ni ui		iuna.			
Parl	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 contribu											
	described in 29 CFR 2510.3-102? (See instructions and DOL's V	-	-	4.5		X						
h	Program)			10a								
u	Were there any nonexempt transactions with any party-in-interest reported on line 10a.)			10b		х						
c	Was the plan covered by a fidelity bond?			40-	x					500000		
	Did the plan have a loss, whether or not reimbursed by the plan's			10c								
u	by fraud or dishonesty?	•	•	10d		х						
е	Were any fees or commissions paid to any brokers, agents, or oth											
	carrier, insurance service, or other organization that provides som			100	X					38444		
f	the plan? (See instructions.) Has the plan failed to provide any benefit when due under the pla			10e 10f		x						
 g	Has the plan failed to provide any benefit when due under the plan? Did the plan have any participant loans? (If "Yes," enter amount as of year end.)			10g	x					16397		
9 h				109	<u> </u>				•	10001		
	2520.101-3.)			10h		Х						
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 requirem 5500) and line 11a below)								Yes	s 🛛 No		
11a	Enter the unpaid minimum required contribution for all years from											

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 - 1							
	(If "Yes," complete line 12a or lines 12b, 12c, 12d, and 12e below, as applicable.)							
	If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see ins granting the waiver.	/lonth	enter the Day		e letter ruli Year	ng		
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					
с	Enter the amount contributed by the employer to the plan for this plan year		12c					
	Subtract the amount in line 12c from the amount in line 12b. Enter the result (enter a minus sign to the negative amount)	eft of a	12d					
е	Will the minimum funding amount reported on line 12d be met by the funding deadline?	Π	Yes	No 🗌	N/A			
Part	VII Plan Terminations and Transfers of Assets							
	Has a resolution to terminate the plan been adopted in any plan year?		Yes	X 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 broug	ght under the co		Π	Yes X 1	No		
С	of the PBGC? If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identi which assets or liabilities were transferred. (See instructions.)				<u> </u>			
	13c(1) Name of plan(s):	13c(2)	EIN(s)	1	13c(3) P	N(s)		
Part	VIII Trust Information							
14a	Name of trust		14b ⁻	frust's EIN				
14c Name of trustee or custodian					14d Trustee's or custodian's telephone number			
Par	t 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 an 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 "c testing method" for nonhighly compensated employees (Treas. Reg sections 1.401(k)-2(a)(2)(ii) and 1.4 2(a)(2)(ii))?	101(m)-	Yes		No			
16a	Check the box to indicate the method used by the plan to satisfy the coverage requirements under section	on 410(b):	Ll pe	atio ercentage st		rage efit test		
16b	Does the plan satisfy the coverage and nondiscrimination tests of sections 410(b) and 401(a)(4) by con this plan with any other plans under the permissive aggregation rules?		□ Ye	s	No			
	Has the plan been timely amended for all required tax law changes?		Ye		No	N/A		
17b	Date the last plan amendment/restatement for the required tax law changes was adopted		pplicab	le code	(See ins	structions		
	If the plan sponsor is an adopter of a pre-approved master and prototype (M&P) or volume submitter plance advisory letter, enter the date of that favorable letter and the letter's serial	number				or		
	If the plan is an individually-designed plan and received a favorable determination letter from the IRS, e determination letter		the pla	n's last fav	orable			
18	Is the Plan maintained in a U.S. territory (i.e., Puerto Rico (if no election under ERISA section 1022(i)(2 made), American Samoa, Guam, the Commonwealth of the Northern Mariana Islands or the U.S. Virgin		Ye	S	No			
19	Were in-service distributions made during the plan year?		Ye	s	No			
	If "Yes," enter amount		19	T				
20	Were required minimum distributions made to 5% owners who have attained age 70 ½ (regardless of w retired) as required under section 401(a)(9)?	hether or not		l IS	No	N/A		